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Patterns of interaction and psychotherapeutic change

Eva Bänninger-Huber & Christine Widmer

Today most psychotherapists and researchers agree that a "good" relationship between client and therapist contributes essentially to therapeutic change. But what are the distinctive characteristics of a good therapeutic relationship? What interactive behavior can enhance therapeutic change? This paper investigates the significance of psychotherapeutic interaction for psychotherapeutic work and change (1)

In former studies we have described interactive patterns that the client enacts with the therapist when talking about guilt feelings. We call these patterns *traps*. This name is meant to reflect the seductive power of these interactive patterns. The enactment of a trap is perceived by the therapist as a strong appeal to react in a specific way (the therapist thus "being trapped"). We were particularly interested in the functions of these traps for the client's affective regulation and for the therapeutic relationship (Bänninger-Huber, 1996; Bänninger-Huber & Widmer, 1995). Our actual research concentrates on the therapist's participation in these traps, and on psychotherapeutic change (Bänninger-Huber & Widmer, 1996b).

Our research approach integrates concepts, methods and knowledge from emotion psychology, psychoanalysis, interaction research, and cognitive science. While invaluable procedures for the systematic observation of interactive behavior have been developed in the fields of interaction and emotion research, psychoanalysis provides sophisticated models of intrapsychic processes and pertinent concepts of the therapeutic relationship.

Data and methods

Five successive sessions of a psychoanalytic psychotherapy with a young woman, Mrs. D., have been investigated, using a single case design. The client had sought therapeutic help because of depressive symptoms. Therapy sessions took place twice a week and the therapy lasted about one year and a half. The main topic of the therapy were the client's relationship problems, especially conflicts with her husband. During the sessions under scrutiny she repeatedly talked about her guilt feelings.

The videotapes of the therapy sessions were analyzed on different conceptual levels using different methods, focusing on verbal as well as nonverbal aspects of the material. The occurring narrative episodes, in which the client mentions experienced guilt feelings and reports the situations of her everyday life that led to this emotion, are extracted. They are analyzed by a so-called frame (2) (Lüthy & Widmer, 1992; Widmer, 1997). For the description of nonverbal aspects, especially the facial behavior of client and therapist, we developed a method for the microanalytic description of cognitive-affective processes in dyadic face-to-face interactions (Bänninger-Huber, Moser & Steiner, 1990; Bänninger-Huber, 1992; Bänninger-Huber & v. Salisch, 1994). This method is based on the Facial Action Coding System (FACS) by Ekman & Friesen (1978).

We understand interaction as a dyadic process, which is induced and influenced by both interactive partners. Therefore, the goal of the methods applied is to capture the behavior of both, client and therapist, and their interdependence. Whereas the investigated narrative episodes last up to several minutes, the nonverbal processes under scrutiny take only few seconds.

What are traps?

During the sessions examined, specific patterns of interaction could be observed, which repeatedly occur in the context of reported guilt feelings. As mentioned above, we call these patterns "traps" (e.g., Bänninger-Huber & Widmer, 1995; Widmer & Bänninger-Huber, 1996). Traps may be understood as follows (Bänninger-Huber & Widmer, 1996a):

The remembering and reporting of an episode which elicited guilt feelings reactivates this emotion in the client in the hic et nunc of the psychotherapeutic session. The feelings of guilt occur in the present situation either as an experienced or as an unconscious affect. In order to cope with his or her disturbance of affective regulation indicated by guilt feelings, the client shows specific interactive behavior that is likely to induce specific reactions in the therapist.

In the context of guilt feelings the client's offer of specific roles to the therapist is mostly the role of an authority figure that is asked to comment on the conflict presented by the client. The therapist may accept this role and react accordingly or not. (The interactive behavior shown by a client is characterized by specific patterns of verbal and nonverbal, especially facial behavior. As these processes take place very rapidly we assume that they mostly occur unconsciously. Such interactive patterns are perceived by the therapist, however, as an appeal to show a particular reaction.)

In different therapies investigated by us, several types of traps with distinctive structures could be distinguished. One example of such an interactive pattern is the legitimation trap (3) In legitimation traps the therapist as an authority figure is encouraged to legitimize the client's reported behavior and reactions, that cause him or her guilt feelings. Mrs. D. mainly describes situations, in which she acted out her aggressive impulses such as provocative behavior or nasty remarks in connection with her attempts to undertake autonomous endeavors. Thus, legitimation traps basically serve the function to reduce a client's guilt feelings (at least for a short period of time). By that, a client may avoid to deal with his or her intrapsychic conflicts. From a psychoanalytical perspective traps may therefore be understood as a form of resistance acted out interactively.

According to their interactive course, i.e., the reaction of the therapist, *successful* and *unsuccessful traps* can be distinguished (4) In successful traps the therapist takes on the role of the authority figure and reacts verbally with a comment as wished by the client. In unsuccessful traps, however, she or he omits such a verbal reaction.

Prototypical Affective Microsequences (PAMs)

Traps usually last between 15 seconds and one or two minutes. So-called *prototypical affective microsequences* (= PAMs) are important elements of these traps; they last some seconds. PAMs are mainly expressed nonverbally and are characterized by frequent smiling and laughing of both, client and therapist (Bänninger-Huber, 1992, 1996; Bänninger-Huber, Moser & Steiner, 1990). They serve as a mean of relationship regulation and are a product of the regulatory activity of both persons involved in the interaction. PAMs are not specific for guilt feelings, but can be observed in the context of several negative emotions.

We differentiate between successful and unsuccessful PAMs. *Successful PAMs* are characterized by the fact that the client succeeds, by smiling or laughing, in establishing a resonant affective state with the therapist: He or she reciprocates the client's smile or laughter. This gives the client a sense of security that is a precondition for him or her to go on working on conflictive topics. In *unsuccessful PAMs*, however, the client does not succeed in establishing a resonant state with the therapist. Instead, the therapist may (for example) respond with a verbal intervention, in which he or she refers to the negative emotions mentioned previously by the client.

Presentation of a legitimation trap: "it's not as bad as that"

In the following, an example of a legitimation trap will be presented. In order to picture the phenomena investigated we restrict our description to the core elements of this sequence and try to describe the process in everyday language. This legitimation trap ("it's not as bad as that") takes place about 16 minutes after the beginning of the 38th therapy session and lasts approximately 7 seconds.

We start about one minute before the onset of the trap. After a narration, in which Mrs. D. explicitly talks about guilt feelings, the following narrative episode comes to her mind:

The client tells the therapist that she once more had a quarrel with her husband because she planned to miss one of two drawing lessons she regularly attended. These lessons were paid by her husband. Instead of attending the second lesson she was going to leave after the break and to go to a rock concert with a woman friend. She stresses that she regarded this as a good compromise - to visit at least one lesson before she was going to have fun. Her husband, however, had got mad at her when she had let him know her plans. Shortly after completing this story the client turns her head away and shrugs. Then, she turns towards the therapist again, commenting "but I don't think that's so bad, it's not as bad as that." This kind of appraising comment can be observed frequently in the context of the narrative episodes in which guilt feelings occur.

During this comment the client shows a particular facial expression: While smiling, she raises her eye-brows and simultaneously contracts them (AUs: 1+2+4+12y+25). With her tone of voice and her facial movements the client can be perceived as a person who seeks sympathy and support. At the same time, her performance leaves a slightly ironical impression. It is not clear whether the client's utterances are meant to be taken seriously or if she is just joking. It is up to the therapist to choose which meaning seems appropriate to her. Here, the client's expressive behavior provokes the therapist's laughter and the client joins in.

Additionally, the nonverbal behavior of the client is a request to the therapist to respond verbally to the client's comment. We suppose that the client would like the therapist to confirm the legitimacy of her action (the missing of the drawing lesson), saying something like "of course as a grown up woman it is up to you to decide whether you prefer to go drawing or to the concert." Here, the therapist merely laughs spontaneously and says "no", thus confirming the clients comment.

How can we understand productive therapeutic work in terms of traps and PAMs? With regard to the effectiveness of psychotherapeutic performance we now have to focus on the question, which reactions of a therapist to such traps can enhance therapeutic change.

The "balance hypothesis"

In recent years psychoanalysts emphasize the importance of interactive processes for psychotherapeutic change (e.g., Sandler, 1976; Klüwer, 1983; Roughton, 1993; for an overview see *Psychoanalytic Inquiry*, 1996, Vol. 16). Interactive role offers by which the client unconsciously invites the therapist to show specific reactions are described. In the therapist's countertransference, these enactments are experienced as emotions, fantasies or action tendencies. Several authors stress the significance of the therapist's involvement in enactments for the understanding of a client's neurotic relationship patterns (e.g., Krause, 1997). Therefore, it is the therapist's task to recognize these role offers rather than to participate in their repetition or to omit them by a strict realization of abstinence. The interpretation of these neurotic patterns, however, requires a solid working alliance.

Basically, the therapist has to fulfill a double function: On the one side, he or she has to provide a reliable working alliance to give the client a basic sense of security. This enables the client to explore his or her experiences and behaviors and to accept and understand the therapist's interventions. On the other side, the therapist has to maintain a certain level of conflictive tension by not taking over the client's role offers repeatedly. The maintenance of the tension is a prerequisite for recognizing and working on the client's problems. Sullivan, for example, advises the therapist to keep up the level of tension which a client just can bear and which does not evoke destructive manifestations of resistance (Sullivan, 1954; Moser, 1964).

The therapist's observable reactions to traps: Theoretical considerations

Traps and PAMs can be described from a phenomenological and from a functional perspective. From a phenomenological point of view, different combinations of successful or unsuccessful traps with successful or unsuccessful PAMs may occur (see Table 1).

A successful PAM, for example, may be integrated in an unsuccessful trap: The therapist may show

no verbal reaction but specific nonverbal behavior as wished by the client (e.g., smiling, laughing). In another case (unsuccessful PAM, unsuccessful trap), the therapist may neither react with a smile or laughter nor give the desired verbal confirmation.

		TRAP	
		unsuccessful	successful
PAM	unsuccessful	no smiling/laughing no verbalization	no smiling/laughing verbal confirmation
	successful	smiling/laughing no verbalization	smiling/laughing verbal confirmation

Table 1. Prototypical combinations of the therapist's reactions in successful and unsuccessful traps and PAMs

According to their function, the following types of interaction may be distinguished (see Table 2). The combination of an unsuccessful trap with an unsuccessful PAM increases the conflictive tension and thus allows therapeutic work on the conflict and the related affects. At the same time, a temporary destabilization of the working alliance has to be accepted. This strategy follows the rules of *classical psychoanalytical abstinence*.

A successful trap combined with a successful PAM stabilizes the working alliance and a reduces the conflictive tension. Such an interactive pattern are characteristic for *interactions in everyday life*: The therapist reacts as wished by the client and tends to take over the roles offered by the client.

An unsuccessful trap in combination with a successful PAM results in an enhancement of the working alliance while the conflict remains activated. This attitude could be designated *friendly refusal*.

		TRAP			
		unsuccessful		successful	
		classical abstinence		**reserved confirmation**	
	unsuccessful	conflict	activated	conflict	deactivated
		affect (guilt feelings)	occurrent	affect (guilt feelings)	absent
		working alliance	insecure	working alliance	insecure
PAM		**friendly refusal**		**every day interaction**	
	successful	conflict	activated	conflict	deactivated
		affect (guilt feelings)	occurrent (experienced)	affect (guilt feelings)	absent
		working alliance	secure	working alliance	secure

Table 2. Functions of successful and unsuccessful trap/PAM combinations

Theoretically, a fourth combination, i.e., an unsuccessful PAM integrated in a successful trap, may occur. The current conflict is deactivated while the working alliance is experienced as insecure. We

have not found this combination, which we call *reserved confirmation,* in our data yet.

Starting out from our clinical considerations on the balance between conflictive tension and working alliance we formulate the following hypotheses:

Comparing the functions of the four different trap/PAM combinations we can assume that "the friendly refusal" is optimal for maintaining the balance proposed. By this reaction the therapist keeps up a reliable working alliance and at the same time maintains the necessary conflictive tension. This is true if we try to evaluate just the effect of a single event. No analyst, however, will always react to traps in the same way. Therefore, the productivity of a therapist's interventions have to be assessed with regard to the process of the therapy. From this perspective we make the following assumption: The balance between conflictive tension and a secure working alliance can not only be maintained by one optimal type of reaction but rather by the variability of the therapist's reactions over time.

The significance of traps for psychotherapeutic change: Empirical data

In order to study a therapist's reactions to traps and their effect on the psychotherapeutic process, we now are investigating a productive sequence of the same 38th therapy session. During this sequence, relevant change took place according to a defined criterion. The criterion is the observable increase of self-reflection on the side of the client (see Thomä & Kächele, 1989). This increase is operationalized by the structure of the narrative episodes occurring in this session. These episodes are systematically represented by means of the frame method: While in the beginning of the session the client concentrates on external events ("my husband came and made reproaches to me") she begins to focus more and more on intrapsychic processes ("I made him jealous on purpose, because my husband neglected me") in the last third of the session. For the first step of our current research we selected the 15 minutes of psychotherapeutic interaction that precede the observable increase in self-reflection. The analysis of a non-productive segment will be tackled in the near future.

In the following, we will concentrate on five minutes of the material investigated up to now. This sequence lasts from minute 15 up to minute 20 of the session and includes the legitimation trap presented before ("it's not as bad as that").

Figure 1 gives on overview over the sequence analyzed and has the following features: A temporal scale divided into units of minutes; bars represent the occurrence of the corresponding narrative episodes (38-3 and 38-4), the sequences of verbal interaction, traps, PAMs, and episodes of simultaneous smiles, respectively.

Clinical description

From a clinical perspective, the sequence investigated can be described as follows: The sequence begins with a comment Mrs. D. makes about her husband. According to her, he was afraid to loose control over her now that she had become more autonomous. Next, she reports that she had had another argument with her husband because she planned to go to a rock concert with a woman friend. Doing this she would miss a drawing lesson paid by her husband. This narrative episode is repeatedly interrupted by short comments in which Mrs. D. either presents her husband as intolerant and impulsive or judges her own behavior as "not as bad as that" (cf. the legitimation trap "it's not as bad as that" presented above). The therapist refrains from taking a position. The client finishes her story by telling that she had proposed to her angry husband to pick her up after the concert if he wanted to be sure that she would be home in time. Here, the therapist asks her how she had said that. The client changes the topic and explains that, according to her, the lack of own money was the reason of all these problems. We suppose that this change of topic is related to an increase of resistance. The therapist challenges the client's interpretation and asks: "but is it really always because of the money? If you go out for a drink, for example, ..." With this intervention the therapist insists on the conflictive theme. The client interrupts her: "that's legitimate, isn't it?!" The therapist continues her intervention and asks if it was not something else that annoyed her husband. "Oh I see", the client replies with surprise and turns her head away.

Finally, client and therapist agree that having fun with friends and spending her own money could also be positive for the client. Both are smiling and laughing. Suddenly, Mrs. D. says seriously "I

think I know quite well what annoys my husband." In the following narrative episode she confesses that she had provoked her husband's jealousy by telling him about her flirts with other (often older) men.

Description in terms of traps and PAMs

As shown in Figure 1, in this sequence we could identify eight traps, namely four legitimation traps and four chicken traps. We categorize seven of these eight traps as unsuccessful: According to our balance hypothesis the conflict as well as the corresponding affect - guilt feelings - remain activated during the entire sequence.

The only successful trap ("it's not as bad as that"; 16.53-17.00) is a special case. By saying "no" the therapist indeed gives the desired confirmation. The meaning of this verbal reaction, however, is qualified by her simultaneous laughter giving it the sense of "no, of course it's not as bad as that. But that's not the point. Why are you telling me this?" By that, in this sequence also, the intrapsychic conflict remains activated.

In the sequence investigated the following trap/PAM combinations can be observed: Five out of the eight occurring PAMs are integrated in a trap. One of them is successful and two are unsuccessful PAMs. Two further PAMs belong to a third category, the so-called participation smile. This category has been developed during our data analysis. In such PAMs the therapist only weakly reciprocates the client's smile. The establishment of the affective resonance as wished by the client though does not succeed. The client's disturbance in his or her self-regulation remains activated and is not overcome with the help of the therapist. The smile, however, serves the function to show the therapist's participation. Thus, the occurring trap/PAM combinations can be classified mainly as "classical psychoanalytical abstinence" or "friendly refusal".

Interestingly enough, all three successful PAMs do not occur simultaneously with traps. This is also true for five of the six sequences of shared smiling of therapist and client which can not be classified as PAMs according to our definition.

These observations may lead to the following interpretations: The therapist reacts especially reserved and abstinent whenever the client seeks her approval, and by this, relief from her guilt feelings. The therapist tends to accept the relationship offers more easily, however, when these offers occur independently from conflictive contents. In these moments the maintenance of the working alliance (and not an interactive establishment of resistance) has priority.

Taking a look at the course of the sequence, we can see that seven out of eight traps occur during the discussion of the conflict which elicits guilt feelings. As the traps remain unsuccessful again and again we suppose that the conflictive tension increases over time. In order to cope with this increase the client takes up another topic (at time marker 18.00). She explains her difficulties by an external reason - the lack of money. This coping strategy seems to be effective as no more traps occur. Only when the therapist insists on the intrapsychic conflict and tries to understand the client's participation Mrs. D. produces one more trap (she interrupts the therapist's intervention at time marker 18.55-19.03).

The two successful PAMs occurring at the end of the sequence (time markers 19.50-19.54 and 20.06-20.11) lead to an increase of the affective relatedness between client and therapist. This gives the client a sense of security, a precondition for her to be able to explore her own part in the confrontations with her husband. This effect can in fact be observed in the progress of the therapy session.

Conclusion

In this productive sequence it seems to be important that the therapist does not "fall into the traps". By her abstinence and by her interventions she does not support the client's resistance interactively. Rather, she continues to explore the client's guilt feelings eliciting conflict. The therapist's nonverbal reactions to PAMs, however, show more variety. We suppose that in this difficult sequence in which the therapist continuously refuses to take over the client's role offers the confirmation of the

working alliance by successful PAMs is crucial.

The sequence we have presented seems to confirm the clinical concept of abstinence as a means of productive psychotherapeutic work. We assume, however, that from a more long-term perspective to be trapped from time to time is important for the psychotherapeutic process. We are convinced that the experience of falling into a client's specific traps is a fundamental source of information for the therapist on which interpretations may be based.

As our investigations point out, the therapeutic relationship differs from everyday interactions by specific professional behavior. In psychoanalytic therapies, this professional behavior is not so much the mastery of an optimized technique (e.g., "never give a verbal confirmation but keep a friendly smile on your face"), but rather an attitude of self-reflection which effects the therapist's interactive involvement with his or her client.

Our work combines two methodological approaches: Firstly, we aim at a systematic and objective description of the observable phenomena. Secondly, models of the function of the observable processes in terms of cognitive affective regulation are developed. These models take into consideration theories and empirical knowledge from psychoanalysis and emotion research. The integration of these two approaches allow a more explicit "translation" between the abstract clinical terms such as working alliance, abstinence or countertransference and the concrete psychotherapeutic material observable in psychotherapeutic interaction. Thus, our approach helps us to examine the question, as to which processes on the level of direct affective interaction facilitate psychotherapeutic change.

Footnotes

(1) This research project is supported by the Swiss National Science Foundation (Project No. 11-43408.95).

(2) The frame concept was originally introduced by Minsky (1975). In psychotherapy research it is mainly known through the work of Dahl and his colleagues (e.g. Dahl, 1988).

(3) Other types of traps are the chicken trap or the self-accusation trap (Bänninger-Huber & Widmer, 1995; Widmer & Bänninger-Huber, 1996).

(4) This categorization is oriented at the client's perspective. Whether a trap is productive from a clinical point of view is another question that will be discussed in the last section of this paper.

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Psychoanalytic Process: the Montréal Transference Countertransference Measure

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Towards a Multidimensional Monitoring of the Psychoanalytic Process:

The MTCM (Montréal Transference Countertransference Measure) represents the efforts of our group to achieve the objective of offering a psychoanalytically grounded multidimensional descriptive and operational measure of the psychotherapeutic process. As it's name suggests, it organized and focused around the crucial and time-honored phenomena of transference and countertransference. Transference is construed within an object-relations framework, to which we add a description of three classically distinguished manifest situations (transferential, extra-transferential and past), an indication of displacements and allusions (Gill), and finally of defensive turning of aggression against the self (Gray). Countertransference includes independent ratings of (a) the therapist's interpretative focus (transferential or not, awareness or resolution, etc.); (b) the degree of inference (clarification, direct opinion, confrontation and interpretation); (c) moving beyond some of our previous work, a differentiation between three in-session mental states: objective-rational, reactive and reflective.

Internalized Object Relations in the Transference

The analysis of the transference is of central concern to the psychotherapeutic/psychoanalytic process. From the present object relations viewpoint, analyzing transference means focusing on the reactivations in the here-and-now of past internalized object relations. The notion of internalized object relations is fundamental to the approach proposed by Jacobson, Mahler and Kernberg, and basic to the present operational effort. An internalized object relation (IOR) consists, in its fundamental core, of a fantasy (unconscious, preconscious or conscious), composed of a self representation, an object representation and of their accompanying affects, wishes and desires (drive derivatives).

The MTCM

There has been persistent efforts to study object relations empirically (Smith, 1993). Projective tests (Blatt, Brenneis, Schimek & Glick, 1976; Westen, Lohr, Silk, Gold & Kerber, 1990), elicited early memories (Fowler, Hilsenroth & Handler, 1995; Ryan & Bell, 1984), dreams (Krohn & Mayman, 1974), descriptions of significant others (Diamond, Kaslow, Coonerty & Blatt, 1990), as well as rating scales of the quality of representations of people and relationships (Westen, 1990; Westen, Ludolph, Block, Wixom and Wiss, 1990) and have all been used as measures of object relations. But as discussed elsewhere (Dymetryszyn, Bouchard, Bienvenu, de Carufel & Gaston, 1997), it has been our belief, shared with others (e.g. Kantrowitz, Katz, Paolitto, Sashin and Solomon, 1987; Kernberg, 1984), that the transference is a unique "in vivo" object relationship available for assessment, in particular when observed in comparatively unstructured situations, such as occurs in a psychodynamically oriented psychotherapy or in psychoanalysis.

On the transference side, four dimensions are examined.

1. **Maturity of object relations**. A continuum of maturity of object relations is described, from the

psychotic (levels ONE and TWO) to the borderline (level THREE) projective identification mode of relating to the familiar neurotic (level FOUR) and integrative (level FIVE) positions. The principal aim is to provide a measure of the patient's contribution to the psychotherapeutic process through a detailed examination of continual shifts in presently actualized object relations within the transference. Each category of the rating Manual contains a definition and illustrative examples are documented.

In what we have called "A" and "B" ratings, the patient's levels of maturity of object relations are thus specified. Presently, eleven (11) categories define level three functioning, for the most part made of projective identifications and primitive idealizations, but also including splitting, enactments and somatizations typical of this level. Level Quasi-four (twelve categories) reflects what has been termed the narcissitic resistances to a level three conflict. It contains such ego states as a defensive maintenance in fantasy of an ideal object-ideal self couple, an identification with a grandiose self, etc. Also included are such phenomena as an idealizing transference, obsessional operations in the service of a quasi-four posture (in contrast to a true level four obsessional functioning), etc. Comprised here are categories reflecting the crucial dividing line of self and object constancy (Mahler). Therapeutic alliance, understood as a collaboration between the patient's observing ego and the therapist's observing functions, is also included, at each level.

Level four covers the neurotic level of maturity of object relations, in two sections. In the first part, thirty (30) categories describe the transference moments as organized by the drives and in a form not typical of an identifiable neurotic character structure. Expressed in more classic freudian terminology, these cover oedipal transferences, those involving the ego-ideal (mature narcissism), as well as the phallic-narcissistic, anal regressive and oral regressive transferences. In the second part the definitions (sixty-one categories), represent typical neurotic forms of transferences, of either the hysterical, obsessional-compulsive or depressive-masochistic type. Under each character configuration, some specific manifestations are included, such as the "hysterical theatrical self", or the obsessional "sadistically overpowering self", or the depressive-masochistic "identification with sadistic superego imago", etc.

Finally, level five is meant to reflect moments when the patient demonstrates an integrative, comparatively more abstract and reflective understanding of any of the previously defined level four or less conflicts.

In addition to the maturity of reactualized internalized object relations (IOR), the MTCM allows for a description of other crucial components of the patient's experience as part of the transference and process: the manifest register of the relationship ("C" rating), allusions and displacements, and defensive turning of aggression against self ("D" ratings).

2. **There manifest relationship situations**. As is well established, examination of the patient's manifest associations may reveal the present intentional focus to be transferential (TR), that is, concerned with the immediate here-and-now situation with the therapist, or extra-transferential either from the present (OEX: "Object is External"), or past-genetic, i.e. extra-transferential from the remote past (OPA: "Object from the past"). These divisions in time reference are both necessary and convenient. But it is also important to underline that in our view, when the patient is manifestly expressing himself as involved with an extra-transferential, past or present object, this always reflects something of the present status of the transference since these associations are made **in the presence of the therapist**. This is following Klein's notion of transference as a total situation.

3. **Allusions and displacements**. Particularly when the patient does not feel secure enough about a given conflict presently being reactivated in the transference, it is hypothesized, following Gill's initial suggestions (see Gill, 1979; 1982; Gill and Hoffman, 1982), that the present conflictual experience within the transference is displaced (rated DIS) and expressed indirectly by means of allusions (rated ALLU) through an extra-transferential register (OEX or OPA), while still being unconsciously meant to refer to the present transaction.

4. **Defensive Turning of Aggression Against Self**. One major additional rating of the transference experience adopts a line of thinking developed by Paul Gray (1992), following Anna Freud, in monitoring the ego's activity motivated by considerations of safety (S. Freud). Following the

expression of some wish or drive-derivative in the presence of the therapist, the patient, presumably encountering some difficulty with a superego function, or perhaps even an internal persecutory object, defensively turns aggression against self (TAS). At a higher, neurotic level of functioning, this may be recognized by explicit self-derogatory statements, especially following expression of some drive-derivative (Gray). It may then imply typical higher-level defenses like repression, undoing, etc. On occasion, superego activity may further become apparent and manifest in the material, and then specified by the following: (S/E).

The Countertransference.

Under the general heading of **countertransference**, the MTCM offers a multidimensional evaluation of the therapist's contribution to the process.

1. **Interpretive Focus**. First, adapted from Gill and Hoffman's (1982) contributions, is the interpretive focus, being either transferential (TR) or non-transferential (NTR; or extra-transferential). Within the transferential field, the therapist may focus on resistances to an awareness of the transference (RAWR), or may be aiming towards resolution (RES: a proposed connection or understanding). Within the resolution mode, the therapist could focus his interpretive work on the here-and-now immediate situation (HNOW), or else relate the immediate transference to some contemporary (CONT) scene, or to an ancient scene by proposing a genetic (GEN) interpretation. Within the non-transferential (NTR) field of activity, the therapist is not addressing the patient's immediate situation, and is either focusing on a contemporary (CONT) or genetic (GEN) extra-transferential register. Finally, the therapist could be concerned with addressing the frame, the contract or the rationale (C/R).

2. **Therapist Level of Inferential Communication**. Second, therapist interpretative activity is situated on a continuum of inferential communications which we have proposed previously (see Bouchard, Lecomte, Charbonneau and Lalonde, 1987; Bouchard, Brueckmann and Lecomte, 1987). This is now integrated with classic distinctions made between kinds of interpretive work. Thus the MTCM proposes, following also work by others (e.g. Koenigsberg, Kernberg, Rockland, Appelbaum, Carr and Kernberg, 1988) to distinguish four levels of inferential communication: clarification (CLA), confrontation (CFR), direct opinion (DOP) and interpretation (INT).

3. **Therapist Mental State**. Also following up on our previous work with the Countertransference Rating System (CRS: Bouchard, Normandin & Séguin, 1995; Lecours, Bouchard & Normandin, 1995; Normandin & Bouchard, 1993; Séguin and Bouchard, 1997), three mental states are differentiated: the objective-rational mode, the reflective (process-oriented mode) and the reactive (classical freudian) mode.

From an objective-rational attitude (OBR), the therapist demonstrates that he adopts a certain distance from the patient, but in an adaptive, non-defensive manner, so as to occupy the position of a non-participating observer. The therapist is in a **I-It mode** (Buber, 1970); (s)he is mentally oriented towards observation **from the outside** rather than participation as subject and observation **from within** the "intersubjective field" (Atwood et al., 1989). This is a process of objectification aimed at a rational understanding of the analysand based on one's **working model** (Greenson, 1960; Peterfreund, 1983).

The **process-oriented mode** (POR), usuallly devolves from a preconscious and conscious **reflective** type of psychical activity. Here the therapist is both subject and object, involved in self-analysis (Reik, 1949). According to Racker (1957, p. 308), such reflective processing rests "on the continuity and depth of one's conscious contact with oneself." This mental state serves as an instrument, the result of a maintaining of an interpretive attitude linked to the process. This implies some recognition and elaboration of one's inner reactions as a participating subject (e.g. Freud's "evenly suspended attention", 1912b, p. 111).

Finally, the **reactive** (REAC) mental state corresponds to the classic freudian view of countertransference as an **obstacle** and a **defense**, the outcome of an unconscious reaction, a "blind spot", a residual neurosis, or projective counter-identification (Freud, 1910, 1912; Reich, 1951; Grinberg, 1962; 1979). The content of the therapist's understanding or technique is accordingly

distorted, and (s)he appears to be more in touch with his/her own desires, conflicts and defenses or else resolutely enmeshed in those of the patient.

4. **Immediate (microscopic) Impact to the Resolution of the Current Transference Conflict**. Finally, the immediate, microscopic impact is assessed through the patient's resolution (as opposed to repetition) of his presently actualized conflict in the transference. Five possibilities are identified: negative (NEG), positive (POS), neutral (NEU), negative therapeutic reaction (NGR), or unspecified (UNS). This approach is in part related to the notion of confirmation of expectancies, but mostly understood psychoanalytically as cycles of projection and reintrojection.

The DMRS (Defense Mechanisms Rating Scales)

The DMRS (Perry, 1990; 1993) defines 28 defense mechanisms distributed along seven hierarchically organized levels of maturity. The mature defenses (level 7) are adaptive coping strategies including affiliation, altruism, anticipation, humor, self-assertion, self-observation, sublimation and suppression. The obsessional defenses (level 6) are isolation, intellectualization and undoing. The other neurotic defenses (level 5) comprise repression, dissociation, reaction formation and displacement. Omnipotence, idealization and devaluation form the minor image-distorting (level 4) or narcissistic defenses. The disavowal mechanisms (level 3) include denial, projection and rationalization; although scored at this level but not a disavowal defense is autistic fantasy. The major image-distorting (level 2) or borderline defenses consist of splitting of other's images, splitting of self-images and projective identification. Finally, the action defenses (level 1) are acting out, hypochondriasis (or "help-rejecting complaining") and passive aggression.

Method

Subject and Material

Mrs. A. is a 44 year-old divorced woman, a mother of three children in their twenties. The youngest is still living with her. Unemployed during the time of her treatment, she had just completed six years as a management secretary. She has a stable but strained and distant relationship with a man twenty years older than her. Mrs. A. suffered from anxious and depressive symptoms following a burn-out episode. She was seen twice a week by an experienced male psychoanalyst. The sessions, conducted face to face, were all audiotaped. Her psychotherapy proper consisted of 14 sessions at the end of which she unilaterally decided to terminate her treatment. The therapist described her as being articulate but defensively "slippery", in reference to the fact that he felt she had been escaping him throughout most of their meetings.

Rating Procedure

The rating procedure involves two separate steps, each performed by a set of at least two independent judges. Following the collecting of the independent ratings, used for assessing interrater agreements (minimum Kappas so far are around .65), consensual agreements are reached, and used for further analyses.

Preliminary Rating. The preliminary rating entails the identification of significant units (SU). This involves a first pair of independent judges reading the transcription and delimiting successive spontaneous figures (**gestalten**) as they form through the flow of the events of the session. There is no priority in the rules. So far however the number of units per 45-50 minute sessions has typically varied from 7-8 to 25-28.

Main Rating. The first task is preparatory and requires that raters read the segmented material (including eventually the listening of audio or videotaped versions), underline key words, perhaps comment in the margins and write a 3-5 sentence summary of the story line of the presently considered unit. The idea is to observe and to document what is manifest, in order to remain as close as possible to the surface material. Summary formulations should be seen as an attempt at reformulating the material with minimal inference. The rating phase proper means to shift to an interpreting of the "observables", when raters then proceed to sense whatever is felt to be actualized by both participants within the given unit. Inferences are permitted but should enlighten and be

articulated with the observable elements identified in the preparatory work. A possible countertransference response of the rater to the therapist is always a possibility to keep in mind...

Judges

Preliminary ratings for the MTCM were performed by one male and one female graduate students in psychology. In addition, two female doctoral level students in clinical psychology separately scored the MTCM. They received approximatively 60 hours of training. Consensual agreements were obtained and used for the analyses.

Two other graduate students in clinical psychology, one female and one male, scored the DMRS. They were supervised by J. C. Perry and received approximatively 35 hours of training.

Results

Reliability Estimates

Reliability estimates for the MTCM were based on the scoring of all 14 of the psychotherapy sessions. Based on a conservative method (see Stinson, Milbrath, Reidbord & Bucci, 1994), the percentage of agreement varied from 67% to 79% (M=74%). The scoring proper of the MTCM categories yielded mean kappas of .72 (range .63 to .87). This indicates good agreement beyond chance (Shrout, Spitzer & Fliess, 1987).

This report will be limited to the first nine sessions of the series of fourteen. This should not however affect the value of the overall description, as by the time the patient got to session 9 she had reached (at least unconsciously) a decision to leave. Further, very little change is observed form then on.

Overall Portrait

To briefly summarize, Mrs. A. spoke mainly during the sessions of her intolerance of dependency, both in herself and others, and of the ways she tried to avoid feelings of pain and frustration related to her denied longings. She also alluded to primitive aspects of her relationship with her mother, which she felt as rejecting and smothering, and to her father's and uncle's inappropriate sexualized attitude towards her precocious developing of large breasts. Through her transference she expressed an intense ambivalence towards the therapy, compounded by her frustrated demands for more direct guidance. The therapist's contribution to the process could be characterized by an insistence in providing correct but premature interpretations. The two participants thus seemed to have been caught up in a complementary transference-countertransference relationship as she protected herself from disappointment and intrusion by closing herself from intimate contact with her therapist, by becoming "slippery" and unavailable, yet demanding and frustrated, which the therapist attempted to interpret but in a way that was perceived as confirming some of her expectations that he was trying to force his way through her distancing manoeuvres. Mrs. A. thus showed signs of ambivalence towards the therapy from the very first session, but her ambivalence became more obvious when, in session 3, she reported fighting a part of her that she knew mobilized her strong avoidance-defensive reactions whenever she was confronted with a potentially painful experience. Her mixed feelings towards the therapy seemed to have peaked during sessions 6, 7 and 8, in which she spoke openly about the frustrations, fears and concerns the treatment aroused in her. She also showed manifest signs of resistance when she brought a friend to sessions 7 and 8, a point to which the therapist reacted and also attempted to interpret as part of her transference. During these two meetings, Mrs. A. mentioned the possibility of leaving the therapy. However, she never was able to directly discuss her anger towards her therapist in spite of recurring interpretations to that effect. Eventually she shared her decision to leave. Several years later she still had not contacted the therapist.

The Course of the Manifest Transference

The patient's manifest, immediate transferential focus follows a quite striking course. Two indices are used to describe this part of the process: the percent number of words in the transferential mode ("C" rating described above), and the ratio of this score over the sum of the two other registers. A

ratio smaller than one would indicate that the transference material is comparatively less abundant, and vice-versa for a ratio higher than one. For the first four sessions, the transference is a comparatively secondary point of concentration (M for sessions 1-4= 15.50% and M ratio= .167). Then during sessions 5 and 6 a clear intensification of the manifest transference is seen (M= 42.96% and M ratio=0.90), a more balanced distribution among the three registers being observed. But then the transference conflict seems to peak during the following two sessions (M= 80.7%, M ratio= 4.61), which gives us an indication of the clinical significance of these two sessions, in light of what will follow from session 9 and on, where the manifest transferential focus recedes (32.92% with a ratio of .49).

Maturity of Object Relations

Mean maturity of object relations scores for all nine sessions reveal a clear dominance of the quasi-four rating (M= 65.24%), some marginal level three (M= 9.08%), to which we will return below, and very little level four (neurotic) functioning (M= 11.48%). More precisely, it appears that substantial level four mental states are observed only for the first two sessions (M= 42.18%), to become marginal (8.23%) or to disappear completely in other sessions as the therapy progresses. The dominant quasi-four ratings is typical of a person functioning at a narcissistic level of false autonomy, illustrating basically a level of narcissistic defense and resistance against level three conflicts over pregenitally, particularly orally invested, dependency needs (Kernberg, 1984).

This level three functioning is indeed seen to appear, but in a clinically significant way only during sessions 4 and 5, at a moment of high vulnerability, in the form of the RTHRAPI score, which indicates an intense projective identification, an identification with the victimized persecuted self, with a simultaneous projection of the dangerous persecutory object representation (therapist). This level three mode of object relating is to reappear briefly during the crucial session 7, one where the transference is at it's height, never to be reactualized again until the end, and, most significant, this time in it's reversed form (THRAPI). This is when the patient is identified with the aggressor, with a simultaneous projection of the victimized self representation onto the therapist, the scenario now being played-out even at a manifest level, in the transference (85.88%). Unfortunately at this point, the therapist is being then at his most reactive (55.43%). Further, examination of the more detailed ratings show that the specific form of quasi-four functioning is frequently obsessional for this patient, which is independently confirmed through the DMRS ratings, showing that the neurotic, particularly obsessional defenses, are the most frequent (M=16.91%).

The Story Line We wish now to examine the process, proceeding from the session 1 to 9. As the story unfolds, we will point to specific quantified observations.

Sessions 1 and 2. The series starts with sessions 1 and 2, characterized by the fact that they are the only ones where any significant neurotic functioning is observed (level four: 35.31% and 49.06% respectively). Even then, specific ratings show that this functioning is, for the most part, in the form of FOALL, the alliance rating, which raters probably could not differentiate from a quasi-four alliance, at the time. No level three nor somatic-anxious preoccupation is observed. The manifest register of the relationship is for the most part external or focused on the past, with very little room for the immediate relationship with the therapist. For his part the attitude is mostly process-oriented or objective-rational, with minimal reactive moments.

Session 3. Session 3 shows the appearance of the anxious-somatic preoccupations (15.92% FOSOME rating), in the form of the return of some nightmares and a long-disappeared rash. This is immediately fought by the patient's ego, as shown by a sharp increase in the level of quasi-four functioning (81.69%, in contrast to the mean of 57.14% for sessions 1 and 2). For the patient, this experience however is for the most part, due to external circumstances (OEX= 61.88%) and she cannot at this point accept to relate it to her therapy (TR=23.80%), which however the therapist insists in interpreting to her as indeed being transferential. His attitude is strikingly reactive here, given we are at such an early phase. This session indeed gets the second highest rating for this mental state (REAC=50.8%).

Sessions 4 and 5. These sessions are unique in their showing the appearance of a significant portion of level three functioning, which is then at it's highest (M= 36.23%). Ninety-five percent of this is

aggressively determined, either in the form of a menacing persecutory experience (RTHRAPI) or a splitting towards an aggressively invested object relations (THRASP). The anxiety seems to have led to this increased regressive defensive posture. The neurotic and obsessional defenses as rated by the DMRS are at their highest during these two sessions (25.95% of all words). The therapist's global response is to be either silent or process-oriented (session 4) or process-oriented (73.30%, session 5). His silence during session 4 could be interpreted as a further maintenance of his reactive contribution in session 3, or as an appropriate withdrawal to feel through and understand the patient's transference as well as his own countertransference. Examination of immediate post-session written free associations confirms that this time his withdrawal was in the service of an appropriate reflective work, an understanding of a complementary attitude to her transference.

Sessions 6, 7 and 8. These three sessions seem to contain the intensification and culmination of this complex transference-countertransference encounter and impasse, which will be resolved by the patient's decision to end the therapy, first an unconscious decision which we can observe indirectly in session 9, but only later to be fully acknowledged, during session 14. As stated previously, these three sessions are characterized by a very clear intensification of the manifest transference.

Session 6 reveals a complex state of affairs. It indicates the disappearance of the level three persecutory experience or defensive splitting (RTHRAPI or THRASP), replaced first by a subtle form of quasi-four resistance, disguised as an alliance (QF-FOALL=30.13% an alliance felt ultimately to be part of the quasi-four resistance), and by other forms of obsessional and narcissistic quasi-four resistances (62.56%). If included under the overall quasi-four ratings, such "false alliance" moments observed in other sessions as well (i.e. 3,4,5,7,8 and 9), would increase the global quasi-four score to 75.37%. These observations make use once more of the time-honored distinction introduced by Freud between the manifest and latent contents of the material: manifestly, there is an on-going, one could even say at first view, a robust alliance between the patient's observing functions and the therapist's interpretive function. But beneath this surface, it can be seen that the overall context of some of these sessions, particularly perhaps sessions 3, 7, 8 and 9, has a definite quasi-four resistance mark. The therapist during session 6 is most withdrawn (silence= 52.42%) and process-oriented, an attitude similar to the one observed during session 4. It was at first difficult to ascertain whether this silence had a reactive-defensive function or not. You may note that the session ends with a reactive moment. After the patient left the reactive mental state is still apparent through the post-session response: he is angry. And this is carried on through the next session.

Session 7 is indeed striking on several accounts. First the manifest transference is at it's most intense, but precisely at a moment when the therapist's in-session mental state is the most reactive (55.43%). Not surprisingly perhaps, the patient's quasi-four activity is very high (72.79%). Further, the DMRS reveals for this session and next one a very high percentage of action defenses (36.20% and 36.56%), combining hypochondria (defined as a "help-rejecting-complaining" attitude) and passive-aggressive manifestations. It is also one of the three sessions (with 5 and 6) where no displacement (QFADIS category) is observed. Reading the session material, one can easily indeed observe a combination of a clear sense of drama, risk and misunderstanding. Even after the session the therapist can still be seen to be reactive, but in a more defensive way.

Session 8 demonstrates a further increase in the patient's defensive-narcissistic attitude (89.63%), which is then at it's strongest, and no doubt in part in response to her conflict which was just reenacted and thus consciously and unconsciously reconfirmed during the preceding session. The attitude is still manifestly in the transference, again in the form of the action defenses described above, but there is a return to some displacement (QFADIS). This time also, the therapist's mental state during the session would seem "cooler" as he has shifted to an objective-rational mode (OBR=54.05%), with nevertheless still some reactive moments (REAC=23.47%). This is reflected after the session in his interesting reflective involvement with his own experience in the transference.

Session 9. Session 9 could be described as a "closing-in and return to status quo". First this session still in part occurs within a transferential focus, it also initiates a clear reduction in the intensity of the immediate transference, which will never return to the level observed in the previous three sessions (TR= 32.92%). The overall quasi-four mental state is down from 89.63% to 58.27%, which is still a sizable portion, replaced in part by an important alliance activity (FOALL= 41.65%). This we interpret as discussed above, as a manifest collaborative attitude, but clearly embedded in the

underlying narcissistic resistance. Everything discussed now feels "safe", out of reach of the dangers represented by the therapy (and therapist). This view is supported by the return on the "front of defenses", to a situation which prevailed before sessions 7 and 8, of a dominance of the obsessional defenses (19.41%) and a simultaneous significant reduction in the action defenses (8.59%), as measured by the independent DMRS ratings. Paradoxically, but systematically in line with these important changes within the patient, the therapist here shows his most process-oriented session (88.81%) and absolutely no reactive moments.

Discussion

One main objective of this study was to test out the possibility of using the transference manifestations as an indication of the maturity of object relations as measured by the MTCM. Overall ratings of the clinical sessions here discussed indicate a clear predominance of a specific form of object relations, the quasi-four level of maturity, which would situate Mrs. A. in the range of the narcissistic character structures, reflecting her life-long struggle over her dependency needs. However, the MTCM ratings proved sensitive to the momentary shifts within the transference, as when some level three projective identification appeared, where particularly during sessions 4 and 5, she would project her harsh, malevolent object onto the therapist, while being in touch with her vulnerable self representation; as well her somatic-anxious preoccupations could be reflected in the ratings. Moments of therapeutic alliance were also at times predominant (see Table 4, sessions 1, 6 and 9), but the status of these alliance ratings (FOALL) was found to vary in more complex ways than was expected.

Interestingly, ratings for defenses were complementary to those provided for the affect-laden and defensively actualized object relations in the MTCM. Further, some complex combinations would also seem to occur. Certainly the most striking contribution of the DMRS came with the observation of the sharp increase of the "action defenses" during sessions 7 and 8, which, when combined with the MTCM "C" rating of the manifest register, gave a very useful portrait of the conflict being played out within the transference. This converged with other observations of the therapist's intensely reactive mental state.

A second major objective of this study was to investigate the use of the MTCM as an index of the contribution of the therapist to the process. In particular, the careful examination of three mental states were hypothesized as reflecting the countertransference. In our opinion this trial is satisfactory and very encouraging. Raters can differentiate between basically the same three mental states which we had previously defined. This then moves beyond the work we have reported elsewhere (Normandin & Bouchard, 1993; Lecours et. al**.**, 1995; Séguin & Bouchard, 1997), which was limited to reactions to vignettes presented to the therapist, in contrast to the present observation of in-session attitudes and activity. The MTCM therapist ratings seem to allow for finely tuned monitoring of the shifts in the therapists' attitude, as required by a process measure. Obviously further work is in order to validate this measure of therapist mental state, which will also benefit from a close examination of the therapist transferential focus and degree of inference.

It is clear already though, that the phenomenon of therapist mental state corresponds to just that: a mental state which varies considerably, and that it should not be considered a trait. Thus we do not think it would be pertinent to develop a typology of therapists based on the three categories used here. On the contrary, it still needs to be shown whether or not a given therapist systematically demonstrates, in recurring fashion, some stable, characterologically determined, mental state, across patients. More typical is our observation of important variations from session to session, and, in one limited observation (one therapist), from one patient to another.

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

Wilma Bucci

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.

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Psychotherapeutic Processes in a psychotic patient: A pilot study

Sylvia Gril & Andres Roussos

General Objective

Adaptation of the Therapeutic Cycle Model to Spanish language
Specific Objective

To determine the clinical usefulness of the Therapeutic Cycle Model as a guide for the study of psychotherapeutic processes in psychotic patients.

Method

Emotion-Abstraction Patterns EAP (Mergenthaler 1996): The EAP is a computer assisted approach to identify key moments in verbatim transcripts of psychotherapy sessions. The Therapeutic Cycle provides an adequate theory of change.

Key moments are defined as one or more sessions of a treatment or segments within a session that are seen as clinically important.
Emotion-Abstraction Patterns identify cognitive states and are based on the combination of two independent language measures: 1) Emotion Tone measures the density of emotionally tinged words within a text and thus serves as a marker for the activation of emotion schemata. 2) Abstraction measures the density of abstract nouns and serves as a marker for reflective processes, based on linguistic phenomena that allow for the possibility of building abstract terms out of concrete concepts. The pattern CONNECTING indicates Key Moments.

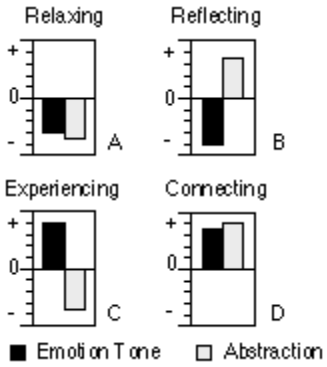

Figure 1: Emotion-Abstraction Patterns

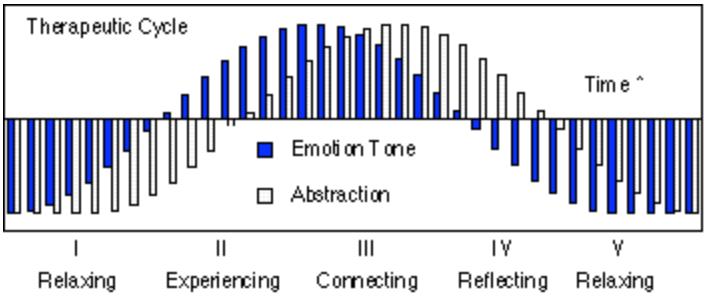

Figure 2: Therapeutic Cycle

Requirements

Transcripts of psychotherapy sessions; a segmentation into word blocks of 150 words each will be done automatically.
Dictionaries for Emotion Tone and Abstraction need to be updated for new texts.
Software Realization: Text Analysis System TAS/C (Mergenthaler 1993); needs an UNIX environment.

Material

Session #78 from a psychoanalytic treatment with a psychotic patient; this hour was considered by the analyst to be a key session and also bearing a key moment.
Results

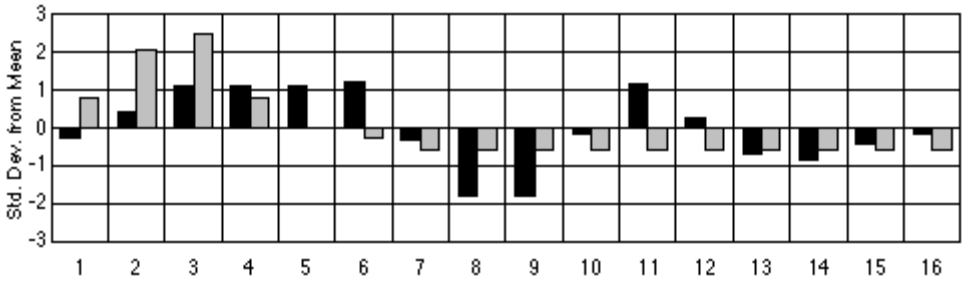

Figure 3: Flow of the EA-Patterns across the session for patient speech only
A Therapeutic Cycle can be observed in word blocks 2 through 4 and the pattern Connecting, indicating a key moment, was due to the fact that the patient ironically repeated the analyst's interpretation on the patient's self destructive tendencies. The irony was revealed through her tone of voice rather than through the words the patient used.

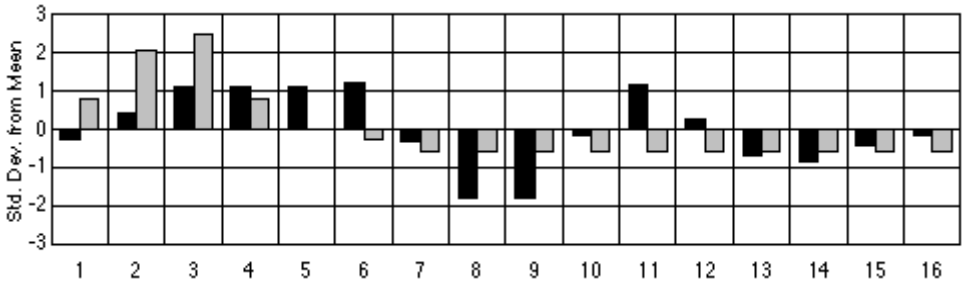

Figure 4: Proportion of speech (patient gray, therapist black)
The therapist was very active and shows many interventions.

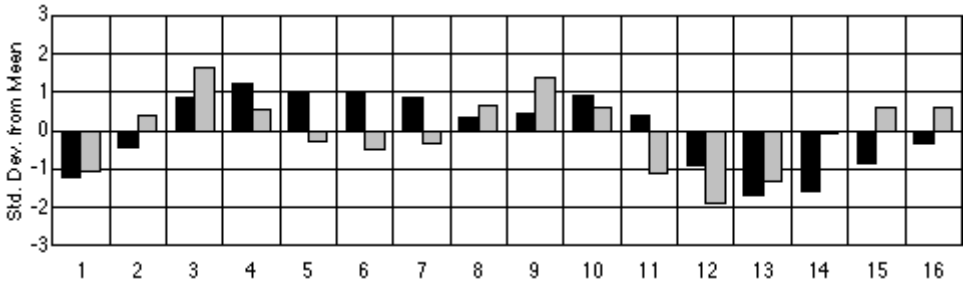

Figure 5: Flow of the EA-Patterns across the session for patient and therapist speech together
The pattern Connecting can be observed in word blocks 3 through 5, and also in word blocks 8 through 10, where the analyst is interpreting the patient's self destructive tendencies.

Comparing this graph to the patients speech in figure 3 clearly shows the analyst's dominating verbal behavior in this patient-therapist dyad: the analyst contribution is determinant.

Discussion

From a clinical viewpoint this session is a key session. This could however not be verified with a macro-analysis for the EA-Patterns as the surrounding or preceding sessions at least were not available as transcripts. The key moment clinically is located close to word block 13: the analyst was paralyzed in his function by the projection of primitive aspects from the patient. But he managed to recover his function by no longer using interpretations, but rather to use a more concrete language style. Thus he became interested in the patient's projection, showing a clinically supportive function as container and promoting some organization within the patient.
Near word block 13 the Connecting pattern, as we would expect for a key moment, does not predominate, rather does the relaxing pattern. The data analysis and the clinical view do not correspond.

Conclusions

1. The method presented here originally was conceived for the analysis of treatments with patients best being described with psychoneurotic or psychosomatic diagnoses. For psychotic patients due to their peculiar use of language "false" Connecting patterns like "irony" may be obtained. This highlights about the need of going back from the graphs to the clinical material, but also supports the discriminative power of the EA-Patterns.

2. Taking into account that the analyst's contribution is determinant here, we suggest to also study the analyst's speech in the light of the Therapeutic Cycle as a means of studying psychotherapeutic processes with psychotic patients: If a therapeutic cycle completely can be found in the therapist's speech he or she is about to trigger the therapeutic process.

3. Another issue that follows from this pilot study is the role of the Relaxing pattern for psychotic patients and its relations to key moments.
Future Work

1. Incorporation of Referential Activity for use with the Cycles Model (Bucci and Mergenthaler). Referential Activity RA is defined as the activity of the system of referential links between verbal and nonverbal representations and thus as the narrative quality of language style (Bucci, 1993). High RA is seen as an important step toward the activation of emotion schematas.

2. Further Development (selection criteria, validity and reliability) of the Spanish Dictionaries for Emotion Tone, Abstraction, and Referential Activity.

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Empirical study of a six year successful psychoanalytic therapy of a patient with anorexia nervosa

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1.0 Introduction

The reasons to report this case are many: **First**, the patient G, a fifteen year old girl was referred by her Nutritionist to Dra. S.A.G. A Psychiatrist and advanced Candidate of our Psychoanalytic Institute for consultation her about her severe eating disorder syndrome. According to her clinician and Nutritionist, G was diagnosed with Bulimia Nervosa with associated Anorexia Nervosa (DSM-III-R) and a long amenorrhoea. Dra. S.A.G. checked and agreed with the diagnosis and accepted G to a long and high frequency analytic therapy which lasted from 1990 to 1997 (just finished). **Second,** the case, anorexia and bulimia is described as a complex syndrome with chronic course and with severe psychic, social, and physical impairments (Kächele, 1993); , which made the G case interesting to study. **Thirds,** in our Research groups it was considered most important to study the abundant full-tape-recorded sessions including thousands of inferred negative and/or positive interpersonal interactions useful to investigating object relations in this Category of patients who presumably, are unsuitable for Psychoanalytic therapy. **Fourth,** to systematically study the transcriptions according too pre determined fixed variables, to investigate this special therapeutic process without interfering the inter subjective interactive patient-analyst relationship. There are few other existing reasons to study the case that will be explained in future communications.

The psychoanalytic therapy outcome, after almost six years duration, was positive in the three specific domains (Kordy & Send, 1985): symptomatic, personality, family and social context (optional: biological and endocrinology parameters).

1.1 THE DESIGN OF THIS STUDY

For this Research the tape recorded sessions have been studied according to three basic variables (originally five): object relations, anxieties and defenses (remaining other two variables: structures and psycho sexual development, were omitted not forgotten). One of our most important concerns was to choose proper tools for our purposes. We finally came to a decision and started using the Luborsky's CCRT Method (Luborsky, 1990) for "Understanding Transference," that is to say object relations. To study anxieties, we applied a special tool, combining Freud's theories on anxieties with the ULM and our own studies. Finally to systematically study the problem of defenses, Freud's conceptions on defenses plus Perry's (Perry,) systematic investigations and recent not yet published papers have been used. A report on the correlation of the implementation of those three tools is at stack.

Luborsky's method has been useful in this study in several ways. It has not only been crucial to obtain the CCRT but also, using located Relationship Episodes as special units to identify different categories and sub-categories of anxieties and consequently to evaluate the different categories of defenses used to modulate the assessed anxieties Whether Prof. Luborsky would agree to our postulation that the CCRT not only contains patterns that occur in object relations established by any object but also appear with specific anxieties and defenses for the present CCRTs. An other advantage obtained from located RE is being able to use them to compare RE in the session itself (synchrony of the therapeutic process) and to compare RE belonging to different periodic sessions (diachronic of the process), thus being useful to establish efficiency and efficacy of therapies.

1.2 Ms. G. CASE

The three **s**essions used to study the case have been a randomly chosen to represent therapy over a four years period:

S-1) Feb./7/1990 (fifteen years old)
S-2) July/11/1992 (seventeen years old)
S-4) October/10/1994 (nineteen years old)

1.3 SESSION 16 (S-1)

Our Referees located six REs in this session:
Table 1

Abbreviated six Relationship Episodes (Ms. Gilda, Session 16 or S-1)

RE 1 **Mother**
To mother : look how my hair falls out(1) because a lot of hair had fallen out and I am very worried//and she told me: "don't worry, soon everything will be over" //...the thing is you have grown weak for not eating and your hair has also grown weak", that's why it falls out//Perhaps she saw me unwell and she wanted...sort of.... to comfort me (2)//..she held me tight//she didn't let go off me//I told her: "let go of me//don't be such a nuisance"//and she didn't do anything...she didn't let go of me (3)//she says that I am as cold as my father//that I don't show my feelings perhaps that's why she tries to hold me//she is absolutely tiresome that way.// She is always complaining that I don't show her any love//.....//this is me.....she's also very inquisitive,//she is always asking, where are you going? who are you going with? all like that, she wants to know everything, control everything//she is bossy//and this triggers off an unpleasant atmosphere//.....// And...I don't know...//I feel bad// I feel like getting rid of her (4)// but...I don't do anything special I'm afraid she'll take offense if I reject her//today I told her: "don't be such a drag....//but it is unusual, generally I put up with it//I don't do anything but I feel resentment//

RE 2 **Self**
//I'm always stiff...//I'm not natural//It seems as if I always have to be pretending or planning everything//that I am afraid of doing whatever I want.// I have never had the freedom of yelling if somebody does something I don't like//...I swallow everything (1)//I am always paying attention to other peoples reactions//

RE 3 **Mother**
I like freedom, to feel free//but I can't with my mother//with the food issue she is hellish//she is paying attention whether I put oil or butter into the mashed potatoes s///or whether I use sugar or saccharin.//..when she serves me potatoes, she leaves the oil on the table//and she watches if I put some or not....(she thinks I don't realize, that I am a fool//she doesn't understand that I want to eat, but healthily (1).....With my mother it's impossible//On Monday it was my sister's birthday and I didn't know whether to eat or not//and my mother said: eat! //and I felt pressed and very sad (2)// I thought "you only care if I eat//you don't care if I have a friend or not"//I tried to eat because I wanted my mother to see me eating//but it is worse if they are keeping an eye on me//besides it wasn't a proper dinner, it was a snack and that gets me disorganized//I feel bad when something is disorganized (3).

RE 4 **Grandma.**
//Its different with my grandmother//she is not always on my back(1)//The other day we went to eat out to a refilling vegetarian restaurant//and I ate well because it was healthy food (2)//My grandmother didn't care if I ate or not//we talked about anything and she wasn't concerned about what I ate//

RE 5 **Mother**
//My mother feels that the family is splitting apart (1),(2)//Once I told her that when I start University I would like to have an apartment, like the one the dentist has to live with my sister//and she tells me How would you be able to live alone?" //She wants to have me under her control//She doesn't want

us to leave her//I feel that she wants to hold me back//

RE 6 **Classmates** Imagine from USA to Pergamino and to a religious single-sex school, there were many changes//I felt lonely and bored//besides without being able to speak, as if I had my lips sealed//without being able to speak because I don't know why but// I didn't say what was happening to me//The girls didn't accept me they rejected me //and they made me feel rejection, they left me alone(1)//....//and...nobody got near me//I noticed that the girls talked among themselves in the breaks// but they didn't get near me//of course!...as I am so studious (2) they knew I was going to work hard and they took advantage of that....I knew that the girls spoke badly behind my back (3)//they made fun of me(4)//of my way of being because I didn't say swear words and I said: "please"(5)//...I started almost without realizing//I remember that I wanted to go on a diet to lose some weight//and then I wanted to keep slimming and slimming//I started with this feeding disorder...I ate only vegetables, fruit and water//cracks started appearing in my legs because she saw me very thin//andbesides because I was not having my period (6)

1.4 Relation Episodes CCRTs and Session CCRT

RE 1 (Mother)	RE 2 (SELF)	RE (Mother)
W SC	W SC	W SC
13 to be helped	16 to hurt others	29 to not be responsible or obligated
10 to be distant from others	to express anger to others	20 to be submissive, to be assive

CCRT of the Session

In spite of belonging to different categories, there would be a prevailing wish that could be expressed as an independence wish in the sense of not being controlled. I wish to be independent, not to be controlled (Fr. 1, SC 10; FR. 1, SC 29; Fr. 1, SC 21; Fr. 1, SC 23), I feel inhibited (Fr. 7) and then somatize. (Fr. 6). When they are going to help me I feel myself being controlled (Fr. 10). Few times I feel at ease with others (grandmother) (Fr. 3) or I meet people that make me feel at ease.

RE 4 (Grandma)	RE 5 (Mother)	RE 6 (Classmates)
W SC	W SC	W SC
21 to have self control feel free	23 to be independent	11 to be closed to others
	27 to be like other	

Note: It is important to point out that in this session REs have blurred limits especially as usual the end points (Luborsky, 1990). We can see that in all RE the Responses of Self are plagued with feelings about others with whom she interacts, interpreting others with whom she interacts in a very indiscriminate way, interpreting other people's attitude in relation to her feelings. This can be corroborated since there are hardly any dialogue included in her REs. The REs structure is therefore reduced to descriptions of other people's attitudes, feelings and somatizations such as responses of the Self. I think that the wishes have no heterosexual content and they are frequently pathological (to lose weight to a ridiculous extent).

1.5 ON THE ANXIETY LEVEL IN RE

Thomä and Kächele (Kächele, Schaumburg & Thomä, 1973) started studying the proper methodology to create tools to determine the possibilities to measure, validate and to operationalize psychoanalytical clinical observations on anxiety. Thus questions like: how reliable and valid are clinical observations?..they cropped up many papers stressing the necessity to deal with basic concepts about anxiety, to properly define theoretical constructs allowing them to capture observations very close to the operational level. Taking advantage of their teachings we have tried to create a manual on anxiety that we are here applying for the first time in this kind of context.

For anxiety's assessment we applied thirteen categories related to anxiety and a variable number of

sub categories for each category designed with Baires/Ulm studies. Every assessed form of anxiety receives a number indicating its category and Roman Number indicating its sub category of anxiety. In our G. Case Anxieties corresponding to each of the six REs reproduced above have been included.

1.) RE # 1 (Keeping chronological order of appearance in session)
11-VI (Somatic Anxiety)
4-IV (Adolescent Anxiety)
3-IV (Neurotic Anxiety)
2.) RE # 2
11-VI (Somatic anxiety)
2-III (Inconnscient feeling of Guilt)
3-IV (Self Deception Feeling in front of her Ideal Ego)
3.) RE # 3
3-IV (Neurotic Anxiety)
4.) RE # 4

5.) RE # 5
4-IV (Adolescent Anxiety)
6.) RE # 6
4-IV (Adolescent Anxiety)

Almost all categories of anxiety (including sub-categories of anxiety) have anatomic, physiological and psychological components. They have conscient and inconscient qualities. They may be reduced to internal expressions or compromise external single or group objects and/or natural things. We have a phylogenetic prenatal disposition to feel, to modulate and to discharge anxieties. Being very reliable it was originally a response stemming from protoplasm's irritability and later on transformed into Conservation instinct. This original situation meant that the object received diversity of stimuli that produced states of irritation that had to be discharged through escape or endogenous-structural modifications (PROTODEFENSES) that remained imprinted in a hypothetical organisms memory in a sort of inherited facilities (Mnemonic phylogenetic traces.) Thus the primitive creature learnt how to filtrate, select and adequate external stimuli in quality and quantity starting to develop our actual complex defensive system.

After birth and under the influence of a Historic factor, anxieties interweave with sensations but remain unchanged like their primitive identity being a typical subject's reaction against any kind of danger eventually useful to prevent and to signal it.

In session 16 (Gilda's case) we may analyze her present anxieties in the six REs and observe that all anxieties are very primitive and coherent with different CCRTs found in the same session. Wishes are naïve and Infantile. They are unsuitable for her situation. Very seldom may we track heterosexual genital Contents. Object (real) anxiety is almost absent, explaining weakness of her sexual strivings. Before leaving the fascinating campus of anxieties a small and necessary space should be allotted to the complementary problem of defenses as understood according to Freudian basic ideas, to Vaillant Vaillant, 1971 and to Perry (1991) and later Perry's reprints. It is true that the original Perry's scales were designed for use in making reliable judgments of defenses in psycho dynamically-oriented clinical interviews but it is also true that in more recent papers (1993) he reviews issues pertinent to studying defenses in psychotherapy sessions

1.6 Defenses in session # 16

In RE # 1 is possible to identify (1) **somatizations (L-1),** (2) **hypocondriasis (L-1),** (3) **dissociation (L-5),** and (4) **hypocondriasis (L-1)** again as defenses. It is remarkable the prevalence of hypocondriasis (help -- rejecting) defense. There is a perfect correlation between CCRT, anxieties and defenses, specially because of the regressive nature of the wish of being looked after by her mother. It is also relevant to point out the poor Self-other discrimination that is shown by the somatic manifestations and symptoms.

In RE # 2 and in connections with G's impossibility to express aggression to others in this RE with

the Self, it is most important to observe the accurate description of the **turn against the self** defense.

In RE # 3 there is a predominance of inferences and interpretations that G. makes of her mother's behavior out of her pathological desires and feelings. The level of anxieties and defenses fully agree with the regressive characteristics of CCRT, **Denial (L-3) and dissociation (L-5).**

In RE # 4 It is observable that her relationship with her Grandmother is very positive due to a firm **dissociation (L-5):** grandmother = ideal object and mother persecutory object; her **rationalization (L-3) is clear** (I ate well because it was healthy food...). The CCRT is based on G's attitudes and interpretations of behaviors and feelings more than on a dialogue. The R. Self is positive modification of her eating disorder.

In RE # 5 Gilda uses **idealization defense (L-4)** of the personal and family situation in USA. She also uses **Self and Others devaluation defense (L-4)** right now. **Projection (L-3) and rationalizations (L-3) are also present.** Nevertheless this RE is more in agreement with her age; with her tendency to exogamy, in other words farther from body responses. And finally in RE # 6 we observe that it is a rich episode with her classmates; we can assess (1) **Self and other's devaluation (L-4),** (2) **Self idealization (L-4)** (better at school, with a higher level), (3) **projection (L-3) (**the girls spoke badly behind my back, (4) **devaluation (L-4) (**they made fun of me), (5) **Self idealization (L-4) (**I had a special education) and (6) **aggression (L-1)**(turning against the Self. Acting out: I wanted to loose weight (Anorexia, somatizations). It is remarkable in this CCRT the pathological answers of the Self expressed by feelings and severe somatizations at the failure of her wish to mix with her classmates. The narcissistic idealization and Self-other devaluation defenses alternately agree with her poorly discriminated way of reacting physically before others through sensations.

Table 1

CORRELATION OF ANXIETIES AND DEFENSES IN S-16

ANXIETIES	DEFENSES
	RE # 01
A1) ***11-IV PRESENT*** **(x of origin)**	**D1)** ***HYPOCONDRIA*** **(L-1)**
A2) ***4-IV ADOLESCENT*** **(L. cycle)**	**D2)** ***SOMATIC*** **(L-1)**
A3) ***3-IV NEUROTIC*** **(Psychopath)**	**D2)** ***SELF REJECTING*** **(L-2)**
	RE # 02
A1) ***11-IV PRESENT*** **(x of origin)**	**D1)** ***PASSIVE AGRESSION*** **(L-1)**
A2) ***2-III INC. FEEL. GUILT*** **(STRUCT.)**	**D2)** ***PASSIVE AGRESSION*** **(L-1)**
A3) ***3-IV NEUROTIC*** **(Psychopath)**	***.....***
	RE # 03
A1) ***3-IV NEUROTIC*** **(Psychopath.)**	**D1)** ***PASSIVE AGRESSION + ACT.OUT*** **(L-1)** **D2)** ***DENIAL*** **(L-3)** **D3)** ***PROJECTIVE IDENT.*** **(L-2)**
	RE # 04
NO ANXIETIES	**D1)** ***SPLITTING*** **(L-2)**

RE # 05

A1) ***4-IV ADOLESCENT*** **(L. Cycle)**

D1) ***DENIAL-PROJECTION*** **(L-3)**
D2) ***RATIONALIZATION (L-3)***
PROJECTION **(L-3)**
D3) ***IDEALIZATION (L-3)***
D4) DEVALUATION (L-4)

RE # 06

A1) ***ADOLESCENT (L.*** **Cycle)**

D1) ***SELF AGRESSION*** **(L-1)**
D2) ***PROJECT. IDENT. (L-3)***
PROJECTION **(L-3)**

As we shall observe in following figure in session # 16 we can hardly find a higher degree of defenses beyond level four. Nevertheless we can observe that within the session there is an improvement of defense's quality used by the patient between minute 35' and 45' to decline again at the end of the session. In later sessions we shall assess much better levels of defenses.

Graphic 1

1.7 SESSION # 197 (JULY/11/1992) . FIRST COMPARATIVE SESSION
I shall include only one ER corresponding to S-197 (First comparative session) which is a key one since it is a turning point in the therapy. It describes a Synchronous point in which we can observe the end of a long symptomatic period of the patient.

RE # 01

of course it was//terrific, the day that my menstruation came-back. I couldn't believe,//you see?. Because...of course...after two and a half almost three years it didn't come to me// I was afraid, How should I communicate it?// well...the fact is that.../ I realized that it had come back to me just before lunch//I thought...shall I tell them now ?..// I hesitated...shall I tell them now or after lunch ?// because...// I didn't want to communicate "the news".// My father and sister were at home and I know them// they become so bothering! You know?// My mother could start making difficult questions, you know ?too feminine in front of my father//....I will not tell her now because I know her well, // she will ask for a toast, and she will say, How lucky the girl is !.// she might start crying// I say...shall I be able to wait until lunch is finished ?// for in that moment each one shall disperse towards their own business//"the news" it is not just a toast altogether...I didn't want that// I wanted my father watching TV or going to his bed for sleeping a nap//....// I had lunch very nervously//...I realized...I must let her know !//I am sure she wants to know whether I am menstruating,.// Then, Mo....., I called her// She became very moved,//.....//she looked at me and could not believe it,//She calmed down and told me: "now you need a little towel"// Of course I Knew that..!//You must call the Doctor"//..Oas not the first time.!//I knew she would be coming with all those ideas//Should I have said that at lunch she would have said : "Lets toast for G..."and I didn't want that// nevertheless, to tell the truth// I wanted them to be informed// what a pleasure!// however I wanted to avoid their adhering to me// I touched my belly, and I asked my self Does it hurt ?//....//I didn't want them to making a party//Everybody like do give good news.// I know my mother, she is very bothersome//I think that she expected this fact more that I did// I was very ashamed to my father// It is a subject I don't want to talk to my father about//....//My sister M. came afterwards, she came to greet me, Everybody came to say hello//...//that night and in front of my father my mother asked me (about her menstruation)//...I knew I was going to have troubles with.....since I had given no information (to father)// I didn't go to my father and tell him: "Daddy, menstruation is back with me",// //When we came back home from somewhere, she asked me: "and G., are you in pain?..../I answered: "No, No, No"..../I was embarrassed because Daddy was there...//...//Then my mother asked me: Did you call E. ? //"Yes, I did !// Did you inform your father that you are menstruating is back to you? // Enough, I said! // I confirmed very silently that I had //I hate my mother when she behaves in such an old fashioned way..//

CCRT RE # 01:

I want to communicate (Fr. 5; SC 9) but I don't want to show happiness (Fr. 3; SC10), and I don't want my father be present.
My mother is interested in me (Fr. 3; SC 9); she helps me (Fr. 1; SC 13) and she is happy and proud of me (Fr. 1; SC 29).
My mother is not empathic (Fr. 4; SC 2), she will cry (Fr. 1; SC 28).
I am happy; my period is back (Fr. 1 SC 19)
I am ashamed (Fr. 8; SC 26); I don't like mother telling me what to do (Fr. 6 SC 21). I feel
inhibited with my father (Fr. 3; SC 8)

COMMENTS: In this CCRT we observe more positive wishes and Object and Self reactions. We are describing the exact moment of psychotherapy in which hypocondriasis starts disappearing and G. starts menstruating again. Sexual components are present again. Emotions are in the manifest content of the RE though she is not ready to display and communicate them to her father because she feels ashamed to do so. A mayor change has taken place in responses from the other and also in her Self responses.

1.7 ON THE ANXIETY LEVEL IN RE 1
(Keeping chronological order of appearance in session)
The two more assessed anxieties by our Referees in this RE were **EXPECTANT (8-III)** and **ADOLESCENT (4-IV).** Expectant means course and duration. Adolescent anxiety is a type of anxiety equivalent to **Virginal anxiety.** This means that G.'s Anxieties are rather adequate now to her adolescent conditions.

1.8 DEFENSES IN RE 1 SESSION 176
In chronological order our referees assessed seven different defenses: (1) **Affiliation (L-7),** (2) **Hypocondriasis (L-1),** (3) **Projection (L-3),** (4) **Denial (L-3),** (5) **Repression (L-5),** (6) **Acting out (1) and** (7) **Devaluation (4).**
It is most important to point out that there is no quantitative correlation between anxieties and defenses. For instance in RE1 there are only two main anxieties assessed whereas seven different defenses were tracked. What are correlated however are the qualities of anxieties and defenses.
An improvement to display anxiety is always followed by higher levels of defenses.
Following figure illustrates changes of defenses and levels of them in RE 1 that is in 15'

Graphic 2

1.9 SESSION # 382 (OCT/15/1994). SECOND COMPARATIVE SESSION
For this session and for obvious reasons I will transcribe only three REs that I consider enough to make evident the therapeutic analytic process evolution.

2.0 RE # 1 (CLASSMATES)
//Everybody was very on edge because T. had made a phone call//I started to cry//nobody understood anything at all(1)//what happened they asked me?//I explained to them that strange things were happening to me//since a week ago, I was telling some girls (D. and P.)//that I was feeling terrible//that I feel very oppressed(2)//and with that I finished to tell them about what happened to me//that's it//...I was altered//very nervous//very worried about many things// and I almost explained things to them because nobody was understanding clearly what was happening to me//finally I realized that they wanted to help me//They came to me and asked me and told me and they looked at me//the four boys looked at me as a strange being(3)//"What's the matter with this girl?"//she is always so witty and in peace with everybody//because and for your information I am the most stable character of all my class mates//...I never have sudden outbursts// I am that kind of person that gets along fine with everybody//I never make up stories//that's me!//That's why they didn't understand anything at the very beginning//

2.1 CCRT RE # 1
3 SC I WISH TO BE VALUED; TO BE IMPORTANT TO my class mates; I was anxious, tense and I cried [11 RS (-)]; they did not understand why I was crying. They are accepting (3 SC); They

are helpful (13 SC); Usually I feel happy (SC 29) and I like Others (SC 5)

2.2 ANXIETIES RE # 1
Our Referees considered G's anxieties "Difficult to assess **(CC-13)**" and essentially **Pathological,** that is **Hysterical (3-III) one.**

2.3 DEFENSES RE # 1
Our referees integrated to assess defenses in this RE using Perry's system to do so and considered that **Acting-out, Dissociation,** accompanied by **Hysterical Convertion and Somatic Convertion with permanent Self-observation were most important defenses used in the first part of this RE.**
It is very important to underline that in the second part of RE # 1 besides **Rationalization, Anticipation and Affiliation, it was easy to assess SEXUAL REPRESSION and soft Acting-out**

2.4 RE # 2 (GIRL CLASSMATES)
//It's as they are proving OK to me that they are worried about me//some one came and told me:" ..Well, G. Are you any better? Are you all right? How are you?//some other classmates paid no attention to me and asked me nothing at all// M. and I. even they were at home and they heard about everything, they asked nothing//I was in the bathroom with my mother and I cried (Soft acting-out)// and I am sure they hear me crying//that time they came home but.....//

2.5 CCRT RE # 2
I Wish that M. and I. (Friends) were concerned about Me. They were very unconsidered with me. They did not care about Me when I felt bad, when I cried and I was very anxious.

2.6 The most assessed Anxiety in ER # 2 was C-3-I (**Phobic anxiety**)

2.7 Most assessed fluctuating defenses were:
Hysterical Acting-out, SEXUAL REPRESSION, Dissociation: Very secondarily, **Anticipation, Rationalization and Anticipation.** The real issue in this RE is the clear use of Sexual Repression Mechanism (more neurotic Mechanisms).

2.8 RE # 3 (Girl Classmates)
//but I felt suffocated(1)//because M. and I. came home that day//and mother who did not pay attention to me//did not talk to the girls//and my sister telling me every two minutes//how can you invite M. and I.?//You were supposed not to talk to them any more?////my father had a long face//I felt horrible//nobody understood me//I felt engulfed among them and my parents(2)//and I was hungry//and I felt very sick(3)//you know//and I don't know, I think that to be hungry and to have a low glucemia//I had the sensation of being nervous//not to be able to breathe//more over I could not breathe(4)//I couldn't swallow//imagine it was hard for me to try to swallow and to breathe (5) at the same time//or to do both things//I had to make an effort to concentrate//I had to discriminate and say: I swallow now, I breath now//when you are in these conditions your larynx gets closed//you can't breathe not even for swallowing your own saliva//it was even hard to swallow my own saliva//I was nervous(6)//I had a balloon in my stomach//no, no, no, I couldn't explain it//furthermore I was nervous because I had decided not to eat for a longtime//suddenly to have food and to have decided not everything(symptoms)//everything is weak//nevertheless I could have suffered it but I was nervous and tense//may be I could have devoured like an animal//because I was hungry.....too nervous//

2.9 CCRT RE # 3 (PARENTS AND SISTER)
I WISH TO BE UNDERSTOOD (SC 1), **TO BE EMOTIONALLY STABLE** (SC 30); **MY MOTHER OPPOSED ME. MY SISTER AND MY FATHER TOO. I FELT ENGULFED AMONG MY CLASSMATES AND MY PARENTS. I REACTED VERY ANXIOUS, WITH ANXIETY AND CONVERSE SYMPTOMS, SOMATIC** (I couldn't breathe, I couldn't swallow, I felt sick)

In this CCRT we observe a predominant negative Self tendency, with somatizations (conversions) sickness, difficulties to breathe, a balloon at the stomach. Etc., and high intensity of anxieties. You

can also observe R.O. (-): my parents and sister do not understand me.

3.0 The most assessed anxieties in this RE # 3 are:

3-IV (Adolescent anxiety) and secondarily **11-VI (Somatic Anxiety).** This RE is a real turning point in Gilda's therapy because Adolescent Anxiety, from a clinic point of view is properly an Adolescence Anxiety equivalent to **Virginal Anxiety.** This last Anxiety was used by Freud in his early Papers to describe anxieties that young or virginal people display when facing sexuality. Concerning the Somatic Anxiety, Freud considered it as a Convertion of the an xiety neurosis into somatic sensations (fainting, diarrhea, rheumatic problems, cardio-vascular functional diseases, respiratory dysfunctions, etc.), All of which share one important common trait: the ideational content has been suppressed. Something is undoubted: they are essential mature anxieties and are based on (but not entirely) sexual conflicts..

3.1 Defenses used by Gilda to modulate above mentioned anxieties in this RE are seven: (1)**Dissociation (L-5) with** (2) **light Hysterical convertion; some** (3) **Anticipation (L-7);** (4) **dissociation (L-5) with** (5) **converse symptoms (L-1),** (6) **Self observation (L-7) and again** (7) **SEXUAL REPRESSION (L-5) are present in this RE.**

Table 2

CORRELATION OF ANXIETIES AND DEFENSES S-382

ANXIETIES	**DEFENSES**
	RE # 01
A1) 11-IV *PRESENT* (x of origin)	**D1) *HYPOCONDRIA* (L-1)**
A2) 4-IV *ADOLESCENT* (L. cycle)	**D2) *SOMATIC* (L-1)**
A3) 3-IV *NEUROTIC* (Psychopath)	**D2) *SELF REJECTING* (L-2)**
	RE # 02
A1) 3-1 *PHOBIC ANX*. (Psychopath)	**D1) DISSOCIATION (L-5) ACTING-PUT (L-1)**
A2) 3-1I *HYSTERIC ANX*. (Psychopath)	**D2) HYSTERIC ACTING OUT (L-7)**
A3) 3-I *PHOBIC ANX.* (Psychopath)	
	RE # 03
A1) 3-IV *NEUROTIC ANX.* (Psychopath)	**D1) *DISSOCIATION* (L-5)**
A2) 3-IV *NEUROTIC ANX.* (Psychopath)	**D2) *RATIONALIZATION* (L-3)**
A3) 11-VI *SOMATIC ANX.* (X of origin)	**D3) *DISSOCIATION* (L-5) and *HYSTERIC CONV.* (L-5)**

If we compare these described defenses with defenses modulated in previous sessions by the patient there are no doubts that an important evolution has taken place towards much more mature levels. **F**ollowing is a synthetic illustration Defenses session # 382

Graphic 3

Now, if you compare the three sessions illustrations you will have a clear picture about how defenses have evolutioned from session # 16 to session # 382

3.2 A great effort has been made to obtain this extended but yet compact phenomenological descriptive abstract of a long Psychotherapy of more that six hundred sessions. It was a necessary way to give an approximate idea of the evolution of the case concerning CCRT, Anxieties and also defenses

3.3 CCRT EVOLUTION

From the very beginning the method followed for extracting the CCRT was a two-phase guided system called A and B. During phase A we located and identified the Narratives (REs) in tape recorded sessions. During phase B. REs were reviewed and CCRTs were extracted from REs.

The sessions were chosen according to a randomized system but leaving a sufficiently long period between the studied sessions to facilitate diachronic comparisons. In to avoid interference with the intersubjective therapeutic field of analyst-patient, we did a clear "off-line" study. According to the Referees information, (we received sessions with REs identified), they had used first **Tailor made Categories** that they translated into **Standard Categories** afterwards. We considered the agreement between pairs of Judges was reliable so we started working upon their already scored work.

If we consider the **prevailing wish** in session # 16 **"to be independent, not to be controlled"** is very inadequate for a girl of her age, for instance that she is very sick, that she lost much weight, and that she has no material possibilities to leave towards exogamy. She has no symbolic dimensions in her thinking or she is unable to relate her wishes according to future times. If we analyze the six REs of Session # 16 we come to the conclusion that she feels negative and regressive: **to be helped, to be distant, to not be responsible or obligated, to be submissive or to be passive (mother);** very secondarily, we find positive wishes like: **to have self control, (grandmother); to be independent (mother) or to be close to others (classmates).** With an acceptable level of inference clear heterosexual wishes are not obvious or apparent.

As we stated before, if we consider Responses of her Self , they are poorly differentiated and she frequently interprets peoples' attitudes with relation to her feelings.

Now, if we come to session # 382 more than four years later, we shall observe interesting changes in her CCRT: We even find predominant negative Self tendencies, with somatizations (conversions) like sickness, difficulties to breathe, a balloon at the stomach, etc., she is able to formulate few positive and more mature wishes of a feasible nature: **to be understood (SC 1)** and to be **emotionally stable (SC 3).** Using a small degree of inference, sexual desire (she is hungry again) is now present.

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An empirical basis for case assignment

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All psychotherapy begins with some form of referral. Usually, a prospective patient contacts a health professional and that professional suggests a suitable therapist. This judgment of suitability, however, is seldom based on any evidence that the particular therapist is or would be more effective (i e., information about the treatment course or outcome of previous patients). Instead, referrals tend to be made on the basis of intuition and some informal appraisal of the therapist's professional competence (standing). Since psychotherapy entails a substantial commitment of time and energy, it would seem important that we develop some way of providing evidence that might help the referring professional in determining the best therapist for the particular patient - that is, the therapist who is likely to provide the most efficient and effective treatment. It also would be important to provide therapists with this evidence to enable them to compare this information with their own experience in order to decide whether or not they will be able to provide the most efficient and effective treatment for any given patient.

But how could we develop such evidence? The first problem would be in agreeing on some criteria for successful treatment outcome. Next, we would have to develop some method for assessing the effectiveness and efficiency of treatments. Finally, we would have to develop a system for evaluating a therapist's past performance, particularly with specific kinds of patients.

Successful Treatment Outcome

Lambert and his colleagues found that over a ten-year period more than 1400 different outcome measures had been used in psychotherapy research; only a few had been used in more than 10 studies (e.g. Lambert & Hill, 1994). In 1995 the American Psychological Association and the U.S. National Institute of Mental Health sponsored a conference of psychotherapy researchers to attempt to reach some consensus on the evaluative criteria for psychotherapy (and to suggest a core battery of measures). Although this conference did not result in a consensus regarding measures, there was some general consensus that what should be appraised in the determination of treatment outcome were: (a) wellbeing; (b) psychiatric symptoms; and, (c) role functioning (Strupp, Horowitz, & Lambert, 1997).

Over the past several years, we have developed conceptions and measures of these constructs - subjective well-being, symptoms, life functioning - and have been gathering data on the response of these criteria to treatment. We have also developed a Mental Health Index which is based on the combination of these assessments. Moreover, we have proposed a "phase-theory" of psychotherapeutic outcome and have empirically tested that theory (Howard, Lueger, Maling, & Martinovich, 1993).

Based on this work, we propose that treatment outcome can be assessed through the comparison of a patient's scores on these criteria at different times in therapy in relation to the patient's initial scores.

Assessing Effectiveness and Efficiency

Another consideration in the assessment of outcome is the patient's potential responsiveness to treatment, independent of the particular therapist. Some patients require more intensive and extended treatment than do others, some patients may've problems that respond quite quickly, and some

patients may be unsuitable fo rpsychotherapy, altogether, etc. This (case-mix) must be taken into account before therapists can be fairly compared.

- In our previous work we have demonstrated a lawful dose-response relationship for psychotherapy (Howard, Kopta, Krause, & Orlinsky, 1986). The "dosage model" posits that a patient's response to therapy will be a function of the log of the number of treatment sessions. Using this model, we were able to model the responses of a panel of about 1000 patients, and to determine a slope (course of recovery) for each case. We next used Hierarchical Linear Modeling to relate the patients' initial characteristics (independent variables - demographic and clinical) to these slopes dependent variables) (Lutz, Martinovich, & Howard, in press). In this way we are able to "profile" each patient (see, for examples, Howard, Moras, Brill, Martinovich, & Lutz, 1996). Next, on the basis of each patient's initial characteristics, we calculated an expected course of response to treatment for that patient. Using a much larger sample, we then compared the actual course of treatment to this expected course, and for each case, we calculated the algebraic average deviation from expected course. (A positive average means that the treatment went better than expected; a negative average means that the treatment went worse than expected.)

Evaluating Therapist Performance

Using these average deviations for each completed case, we are able to average across the patients in a therapist's case load to obtain a summary appraisal (single score) of the effectiveness and efficiency of that therapist.

One approach to constructing "An Empirical Basis for Case Assignment" would be to simply refer patients to the best therapist, overall. The question is, "Are some therapists just better than others, regardless of case-mix?" The research evidence that we have suggests that the answer is "No." We find little difference among the efficiency and effectiveness of various therapists. It seems that professional training and experience lead to the development of therapists who are more or less equally competent across their diverse case loads -- indeed, there is tremendous variation in outcomes within a therapist's case load.

Does this mean that we are unable to construct "An Empirical Basis for Case Assignment?" Again, the answer is, "No." We can provide such an empirical basis, but it has to be based on matching specific therapists to specific patients. For example, we have found that some therapists are much better than others with severe cases, while others are better (more effective) with less severe cases.

Some Case Examples

We desegregated the level of data analyses further and looked into the caseload of different therapists in the set. The goal was to explore their performance as well as to provide additional information for supervision and training. Therefore we analyzed each therapist's case-load and explored every therapists' performances in relation to specific patient problem areas.

The following case examples of different therapists demonstrate the usefulness of this potential feedback method for training and supervision purposes:

Therapist A had 40 cases. Half did better than expected, half did worse than expected.

1. All six patients who had very low initial concerns with "Intimate Relationships" did better.

2. Of the 34 patients who were concerned with Intimacy, the five that had very high concerns in this area all did less well than expected.

3. Of the 29 patients who were moderately concerned with Intimacy, but did not have very high concerns in this area, eleven of the fifteen who were functioning well in this area did better than expected.

4. Of the 14 patients who were moderately concerned with Intimacy, but did not have very high

concerns in this area, and were functioning poorly in this area, the nine that had a GAS above 42 did better than expected. So, Therapist A should be assigned patients with very low concern with problems of intimacy, and should not be assigned cases with very high concern in this area. If a patient with moderate intimacy concerns has to be assigned to this therapist, it should be a patient who is functioning well in this area or one with a GAS above 42.

Therapist B had 53 cases. 28 did better than expected, 25 did worse than expected.

1. Of the 21 patients who rated being in therapy of very high importance 17 did better than expected.

2. Of the 32 patients who did not rate being in therapy of very high importance, all of the 16 patients who were functioning poorly (self-report) did less well than expected.

3. Of the 32 patients who did not rate being in therapy of very high importance, of the 16 patients who were not functioning poorly (self-report), all 8 of the married or single patients did better than expected.
So, Therapist B should be assigned patients who feel that therapy is essential to them (81% will do better than expected) or patients with less involvement who are functioning well and not divorced, widowed, or separated (100% will do better than expected) and should not be assigned cases with less involvement in therapy and poor life functioning (100% will do less well than expected).

Therapist C had 43 cases. 24 did better than expected, 19 did worse than expected.

1. Of the 7 patients with low scores on the Bipolar symptom subscale, all did less well than expected.

2. Of the 36 patients who had some bipolar symptoms, the 6 that were rated by the therapist as high on self-management (functioning) all did better than expected.

3. Of the 30 patients who had some bipolar symptoms and were rated by the therapist as not high on self-management (functioning), 10 of the 12 patients with low concerns with intimate relationships did better than expected.

4. Of the 18 patients who had some bipolar symptoms and were rated by the therapist as not high on self-management (functioning) who had high concerns with intimate relationships, all 5 of the patients with low family functioning did less well than expected.

So, Therapist C should be assigned patients who have some bipolar symptoms, and are functioning well with regard to self-management (100% will do better than expected) or who are not functioning high in this area, but are not concerned with intimate relationships (83% will do better than expected). This therapist should not be assigned cases with some bipolar symptoms who are not functioning well in the family area (100% will do less well than expected).

Therapist D had 49 cases. 30 did better than expected, 19 did worse than expected.

1. Of the 10 with obsessive-compulsive symptoms, all did better than expected.

2. Of the 39 patients who had low obsessive-compulsive symptoms, the 6 that were rated by the therapist as low in social functioning all did better than expected.

3. Of the 33 patients who had low obsessive-compulsive symptoms and were not functioning poorly socially, those that presented with low concern with self-management all did less well than expected.

4. Of the 25 patients who had low obsessive-compulsive symptoms and were not functioning poorly socially and presented with self-management concerns, those who were functioning well with regard to health and grooming did less better than
expected.

So, Therapist D should be assigned patients who have some obsessive-compulsive symptoms (100% will do better than expected), and are functioning well with regard to self-management (100% will do better than expected) or who have few obsessive-compulsive symptoms and are not functioning well socially (100% will do better than expected), This therapist should not be assigned cases with low obsessive-compulsive symptoms who are functioning well in the social area and are not concerned with self-management (100% will do less well than expected).

Conclusion

In addition to guiding case assignment, this kind of information regarding therapist performance can be used in supervision to guide the further development of the therapist. With relevant feedback, therapists can pursue experiences that will make them more effective with a wider variety of patients.

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Expressed relationships, dream atmosphere and problem solving in Amalie´s dreams - Dream series as process tool - A single case study

Horst Kächele, Marianne Eberhardt & Marianne Leuzinger-Bohleber

1 Introduction: 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 analyst differ to the extent they use the dreams offered by the patient. As a compromise formation a non-conscious, non-intential agreement on the relevance od 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 has 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; Saul and Sheppard 1954; Saul and Sheppard 1956)) ; he discussed the "utilization of early current dreams in formulating psychoanalytic cases". Saul L Later he and his collegue Sheppard E (1954, 1956) attempted to quantify emotional forces using manifest dreams. This track was also taken up by Tim Beck & his collegues ((Beck and Hurvich 1959; Beck and Ward 1961))

The true pioneering work on dream series had come from Thomas French who from 1952 onward published his five volumes on "The Integration of Behavior". In the second volume 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 1952; 1954; 1958)). In the third volume he applied this understanding for a thorough description of the re-integrative process within one psychoanalytic treatment (French 1958).

The method of process studies using dreams series in the German psychoanalytic world was first elaborated by Enke et al. (Enke et al. 1968); they were able to demonstrate that certain syndromes of affective developments in the dream series of psychosomatic patients, like increase of active-positive affective qualities with relative decrease of passive -negative were correlated to favorable outcome in inpatient psychoanalytic therapy (p. 32).

Our own experience with dream series analysis began with demonstrating the usefulness of Hall & van de Castle spotlight analysis (Hall and van de Castle 1966) studying two levels of transference constellations in a single case dream series (Geist and Kächele 1979). Later the study group by Leuzinger-Bohleber & Kächele (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 session before the end) comparing the cognitive functioning by a content-analytic tool that was based on the theory of Clippinger´s (Clippinger 1977). and Pauker´s et al. (Pauker et al. 1976) computer simulation models. We did not evaluate the development over the whole of the treatments - as task we have taken up in this study. We shall use the total dream material of one patient - the patient Amalia X that has been clinically described in Thomä & Kächele (1988, engl. 1992) and in Leuzinger-Bohleber write-up of the whole project in her second volume (Leuzinger-Bohleber 1989).

2. Theoretical model

This study continues the use a theory of cognitive processes based on computer simulation models that has been fashionable more than ten year ago 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 1996), we have found it useful for our descriptve purpose to remain with the old model (see also Pfeifer and Leuzinger-Bohleber 1986).

> "Clippinger's theory of cognitive processes was convincing to us because it embodies the conception of conflicting processes taking place inside a black box, just as the structural theory in psychoanalysis does. That is, it conceptualizes cognitive processes as being 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 & Kächele 1988).

In this study as background theory we use a modified version of Clippinger's model that has been developed by Leuzinger ((Leuzinger 1984) defining the six modules shown in Figure 1. 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 models assumes reciprocal pathways of communication among the cognitive modules.

For a detailed understanding of the operation of the model see Clippinger (1977). Nonetheless it is obvious that unconscious motivations ultimately reveal themselves 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 imput comes from Moser´s and his collegues (Moser et al. 1980) work on sleep-dream simulation; there they have developed 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 the afore mentioned project. It is the declared intention of this study to again use the same instrument applying it to a more complete data base of the patient of this study, called Amalia X.

3. Method: Theory-Guided Complex Ratings & hypothesis:

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, undecisive, trial with support, trial with hindrance, problem solved, passive solution)

C.3 which kinds of problem-solving strategies do you find the in manfest 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)

The basic question of this study explores to the issue whether the aforementioned pre-post design - 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 on 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 variablels (Kächele & 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 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 our which of the descriptors are most likely to follow the linear trend model.

4. Description of the Material

As the case of Amalia´s has been one of our research cases we already have a large number of transcribed sessions out of 517 recorded sessions 218 have been transcribed for various studies

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

Part 2: sessions
100-105,109-116,126-130,150-157,172-179,181,202-209,213,221-225,

236-237,241-243,246-256,276-280,286-287,297-299:
a total of 76 sessions

Part 3: sessions 300-304,326-330, 335, 339,343-346,348-357,376-383;
a total of 34 sessions

Pat 4: 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 one of us (ME) identified all dreams; the dreams in part 1 and part IV 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 rated was 111.

Part 1: 63 sessions:

dreams No 1-18

Part 2: 76 sessions

dreams No 19-54

Part 3: 34 sessions

dreams No 55-70

Part 4: 45 sessions

dreams No 71-93

The Reliability Study

Three judges - two of them medical students (M.E. & M. B.) and one of them a psychoanalytic oriented experienced clinical psychologists with more than ten years of clincial experience (L. T) - were intensively trained to understand Clippinger´s and Moser´s models of cognitive processes. In several pretests they were acquainted with the kind of material to be rated. The training was very time-consuming; the interrater reliability achieved were quite impressive:

Results of interrater-reliability:

The three raters judged 1/3 of all identified dream reports (N = 38 out if 111 in 93 sessions):

Item B2.1, B2.2, C4: Pearson 0.82-0.89
Item A1, A2, C1, C3: Kappa 0.9 - 1.0
Item A3.1, A3.2, B1, C2: Kappa 0.47 - 1.0; 84% of all values are beyond 0.7

Interrater Reliabilities:

Overall results: 0.80 across all ratings !

5 Merkle´s study

From the summary of the results on Amalia X as established in the earlier study (Leuzinger-Bohleber 1989) we quote the main features:

I. 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 "gestaltlike" 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: (1) increased cognitive and affective knowledge used in a functional way in different modules, (2) interrupt programs that functioned well and corresponded better to reality, and (3) an uninhibited interaction of cognitive processes in the different modules.

Changes Within the Cognitive Module *MOZART*:
Changes in What was Attended To

The later the sessions in the 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 their 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 his objects and himself.
-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 conflictual 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 we found less concern with the major psychopathological symptoms in the patient. 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 of the successful patients was enlarged.

6 Replication study

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

4.4.6.1 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 the more surprising as the patient come with a mild depressive basic mood to analysis. In contrast to Beck & Ward (1961) finding this patient never gave up the pace making function at least in her dreams.

A2. Do dream partner 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 the relationship the analyst is one.

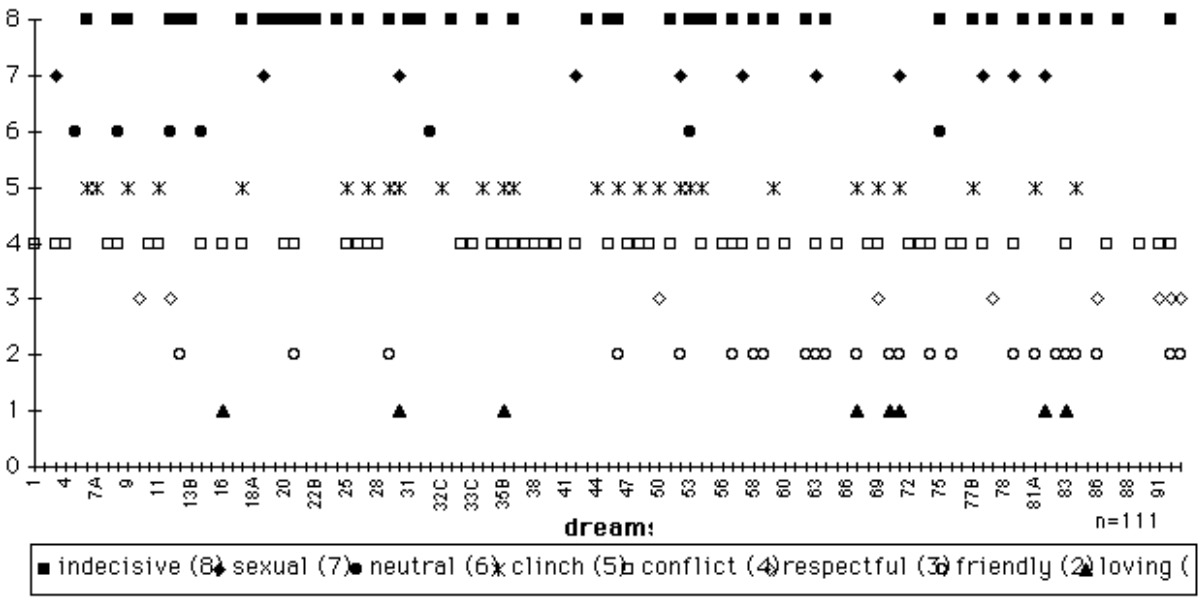
A3.1. What kind of relationship do occur between dreamer and dream partner ?

> Statistically there are more loving, friendly, respectful relationship and less neutral relationships (significant Cureton-Coefficients). We see this as a shift to the development of more pronounced qualities in relationships.

A3.2 What are the relationships among the dreampartners?

> The findings point to the same development as in A3.1
> To summarize the findings we use the graphical illustration to make our point that the overall impression of these items along the course of the analysis remains open for quite straight forward conclusions. There is less dramatic change and more stability as the findings from the Merkle-study had suggested:

picture1
Witch kind of relations do you find between the dreamer and the dream partner in the manufest dream content ?



Which 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-positiv in relation to the total amount of sentences where she comments about the atmosphere:

phase sessions	dreams	sentences with neutral-positive to total	percentage
I 1-99	1-18	1/11	9%
II 100-299	19-54	5/24	21%
III 300-399	55-70	6/8	75%
IV 400-517	71-93	6/10	60%

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

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

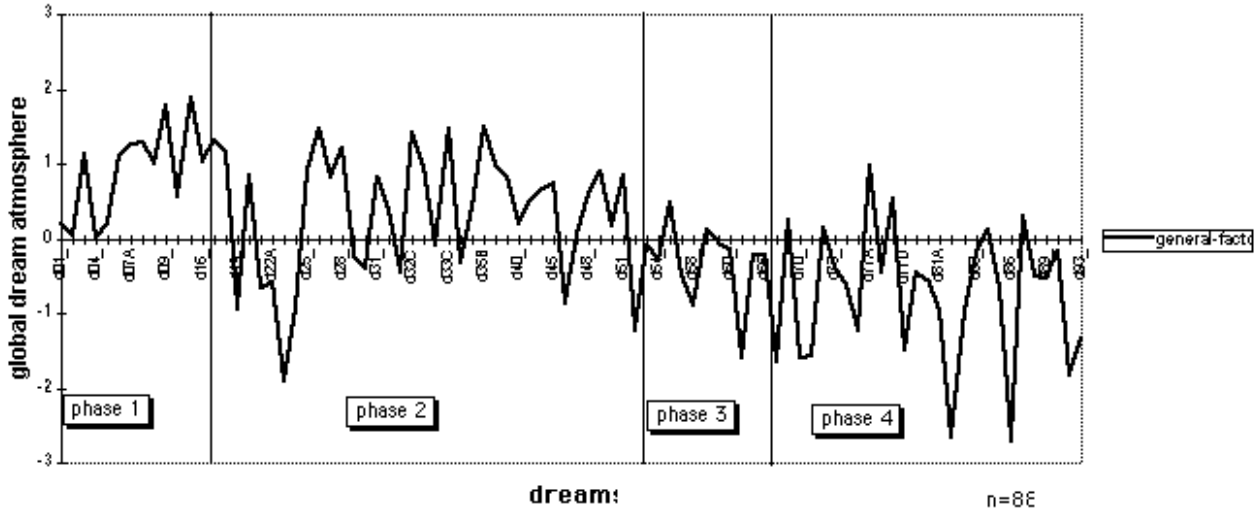
By Spearman rank correlations we find rather impressive systematic changes with time in some of the bipolar adjectives like pleasurable/unpleasure (-0.56), euphoric/depressive (-0.64), harmonic/disharmonic (-0.42), hopeful/resigned (-0.70), happy /sad (-0.58), easygoing/ painful (-0.61), peaceful/ dangerous (-0,52), happy/desparate (-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 like 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: a the beginning there was very little, than it peaked

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

picture 2
Global dream atmosphere.
General factor: negative (high) versus positive (low) emotions.

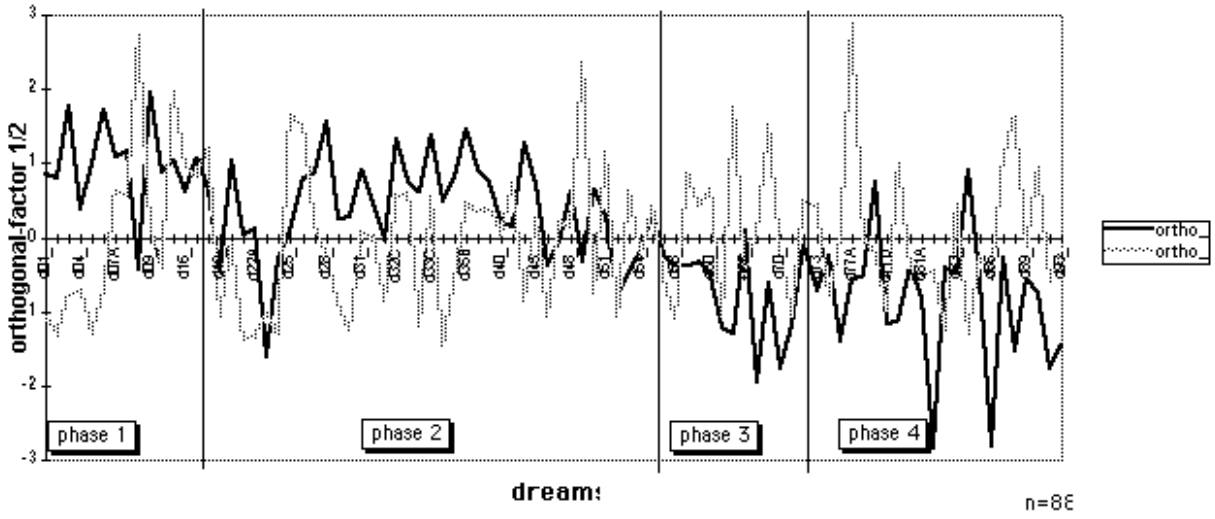


Global dream atmosphere.
General factor: negative (high) versus positive (low) emotions.
Keeping in mind the diverse findings on the level of single items we then performed an orthogonal

varimax rotation. 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) incorporate the self emotion states whereas the factor "negative it" assembles the aggressive and anxious states that are object-oriented.

picture 3
Factor analysis.
Orthogonal factor 1 = negative me
Orthogonal factor 2 = negative it



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 ?

> The percentage of successful problem solving strategies is increasing and the unsuccessful strategies are decreasing; furthermore partially successful solutions tendentially are increasing.

C3. Which problem solving strategies do you find ?

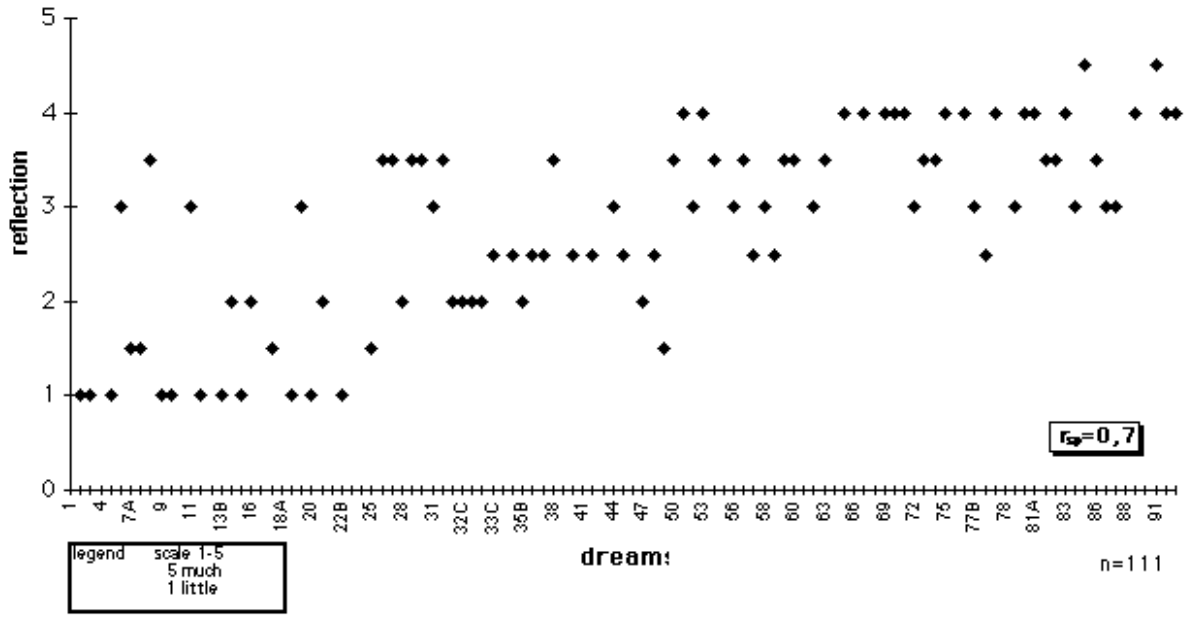
> The patient throughout the analysis is actively seeking solutions of problems; there is a slight increase in deferred (storniert) actions. A clinician might surprised by this result.

C4. Are the problem solving strategies reflected upon ?

> There is a powerful increase of the reflection upon these strategies continously taking place over the course of the analysis.

This finding is well represented in a graphical representations. The changes occur in a continous non-dramatic fashion along the continuuum of treatment.

picture 4
Is there a reflection of the problem solving strategies?



7. Discussion & Summary

The hypothesis focused on the issue whether the changes can be modeled as linear trends or whether other, nonlinear models are necessary. Here the findings are very univocal: either we find stationary processes with variations in intensity (like in aggressive or anxious feelings) or the changes are either increases of decreases that are patterned along the time axis in a linear fashion.

Some surprises in the findings have to do with that patient particular properties 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 concerns the systematic change in dream atmosphere along the time axis: negative me emotions decreased, but negative it emotions remain at a stable variability.

Another impressive finding is the systematic shift of the capacity to shift from unsuccessfull 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 they way. If the materials dreams are made of is considered a valid extract from the patient psychic life, than this study has demonstrated

a) change does occur

b) change mainly takes place in linear trend

c) relationship, atmosphere and problem solving are valuable dimensions of caturing a patient´s change process.

Summary

We have presented the results of a replication study designed to extend a former investigation about changes in problem-solving cognitive processes of a patient during her psychoanalytic treatment. The findings demonstrate that if change in dream relationships, dream atmosphere and dream problem solving strategies occurs, increases or decreases tamely follow a linear trend over the course of the psychoanalytic treatment.

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9 Appendix: additional results

We provide some additional results from the Amalia Study by Leuztinger-Bohleber (1989)

2. CALVIN: Changes in the Superego and Internal Values

The raters observed significant changes in the internal values of the patient. Their criticisms and judgments grew more mature, milder, more flexible, more adequate, and more encouraging, but remained consistent with inner ethical values already present at the beginning of her treatment. This included how the patient judged herself as well as how other relevant other persons judged her.

3. MACHIAVELLI: Changes in Problem-Solving Strategies for Dreams

The raters judged that the patient increased her ability to interpret her dreams. In later sessions she displayed more strategies for interpreting her dreams, such as working with dream symbols, integrating different themes in the dream and associations, and dealing with contradictory information.

4. CICERO: Changes in Language Expression

We found a variety of changes in the ratings of the patient´s language. Two of these changes were: (1) the language became more socially communicative rather than egocentric and (2) affects were more integrated into expressions rather than remaining isolated.

5. MARX: Changes in Reality Perception and Reality Testing

We observed fewer changes in these functions than we had expected. We had significant results only in changes in the patient's self-descriptions. The patient described herself more realistically and less conflictually in the later sessions. And by the end the patient became more "empathic" in her self-descriptions.

6. FREUD: Changes in the Capacity for Introspection

The raters found that the patient showed the most increase from the beginning to the end in her ability to introspect. Moreover, her introspections were "productive" (complex, profound, more intensely experienced) rather than "intellectualized" or "rationalized," and led to new insights and thorough working-through of conflicts. The raters also found more "good" late analytic sessions in the patient. There were also some instances in which the patient reflected on her own dream interpretation strategies. Finally, although raters could not find support for our hypothesis that these capacities would be based on demonstrable identifications with the analyst, the analyst and the patient were emotionally "closer" to each other at the end. Thus we concluded that the introspective capacities of the patient were less inhibited and analytically more fruitful.

7. Changes in Patients' Motivation to Understand Dreams

The raters found an increase in the motivation to understand dreams in patients

On the effectiveness and efficacy of outpatient (Jungian) psychoanalysis and psychotherapy - a catamnestic study

W. Keller, G. Westhoff, R. Dilg, R. Rohner, H.H. Studt and the study group on empirical psychotherapy research in analytical psychology

Despite a great number of studies on the effectiveness of psychodynamic psychotherapy, there are so far no studies on the efficacy and effectiveness of long-term psychoanalysis performed in a naturalistic design that include psychoanalysts and psychotherapists in private practice. Background of this are the long duration of prospective case studies and the high costs involved as well as methodological difficulties in the field of private treatment practice.

Psychoanalysis and psychoanalytic psychotherapy increasingly come under pressure to offer convincing evidence of its effectiveness. The presented study is an effort to close this gap.

This study was financed by independent funding.

Objectives

1. Proving the effectivity of long-term analyses > 100 sessions in the treatment practice and examining the stability of treatment results by a follow-up study 6 years after the end of therapy.

2. Evaluating aspects of cost-effectiveness.

3. Implementing research strategies in the area of outpatient psychotherapy care as a measure for quality assurance.

Methods and design

All members of the German Society for Analytical Psychology, the umbrella organization of Jungian psychoanalysts (DGAP) were asked to participate in this retrospective study. 78% answered our request, 24.6% participated (Tab. 1, 2).

Tab. 1 Therapists reasons to decline

Total number of the members DGAP	N (%)
(adult psychoanalysts) invited to take part in the study	223 (100)
No reaction	49 (22.0)
Participation refused	48 (21.5)
Therapists consenting participation for the first, later refused or they did not contact their finished patients	32 (14.4)

Therapists with documented agreement of the patients to participate and complete follow-up assessment of this patients	35 (15.7)
no finished cases in 1987/88	59 (26.4)

Tab. 2 Selection of included therapists and patients

	Therapists n (%)	Patients n (%)
Total number of contacted therapists	223 (100)	
Therapists sending back the invitation questionnaire	174 (78)	
Therapists assessing the pre-treatment status of their finished cases in 1987/1988 (drop-outs included)	55 (24.6)	353 (100)
Therapists contacting their finished patients in 1987/1988	42 (18.8)	259 (73.4)
Therapists we got the documented agreement of participation from their finished patients in 1987/1988	35 (15.7)	152 (43.1)
Therapists we got the complete follow-up assessment from their finished patients in 1987/1988	35 (15.7)	111 (31.4)

On the basis of their notes, the participating therapists in private practice documented all their cases (including dropouts) finished in 1987 and 1988 with a basic questionnaire regarding clinical and sociodemographic data and setting characteristics at the onset of therapy and gave a retrospective global assessment of their patients' state at the end of therapy.

Based on the applications for payment of the former therapists, in a consens rating a retrospective ICD-10 classification was carried out by two independent raters and additionally the severity of disease before treatment was assessed using the Schepank method of impairment severity index (BSS, 1987, 1994).

In 1994 111 former patients, who finished either psychoanalysis or long-term-psychotherapy in 1987 or 1988 and who agreed to take part could be included in the study sending back a complete follow-up questionnaire consisting different self-assessments of life satisfaction, well-being, social functioning, personality traits, interpersonal problems, self rated health care utilization and some psychometric tests (SCL-90R, VEV, Gießen-Test). In 33 cases (regional sample of Berlin) a follow-up interview was carried out and an actual health status was rated by two independent psychologists trained in psychoanalysis.

Additionally objective data on utilization of health care services were recorded from health insurance companies (number of work disability days and inpatient hospital days) 5 years before and after therapy. In this comparison only those cases were included with complete prae and post data. Thus, for this calculation the sample was reduced to 47 (work disability) respective 58 (hospital days). Both subgroups did not differ from the entire sample in sociodemocraphic data, prae treatment characteristics or criteria of treatment success.

The selection of the follow-up sample was controlled by comparing the included patients with the

total of 358 therapist documented therapies finished in 1987 and 1988 with respect to central sociodemographic and clinical characteristics. The selection of therapists participating in the study was controlled by an independend survey of all DGAP members with respect to central therapist's and setting characteristics. There was no difference in both comparisons.

Results

1. patients

The mean age at follow-up was 44.5 yrs. (range 27-69), more than 2/3 (69.1%) were women. Compared to the reference sample in the follow-up sample was found a greater rate of unmarried (26% vs. 8%) or separated patients, a higher education level, in the professional status less workers (4% vs 15%) and a higher level of employees (62% vs 13%).

2. Treatment characteristics (Tab. 3)

The mean catamnestic follow-up time was nearly 6 years. Together with an average treatment length only less than 3 years the patients were at follow-up about 10 years older since the beginning of therapy. 76% had psychoanalysis with an average of 193 sessions and a mean duration of 3 years; 63% of the psychoanalytic patients had more than 100 sessions. 17.5% of the included patients were drop-outs finishing treatment at different moments of therapy. We assess this as a "variable of confidence" indicating that the treating therapists sent us not only their successful patients.

Tab. 3 Treatment characteristics

Follow-up sample n=111	mean	SD
Age at follow-up 1994	44.5	(4.8)
Age at begin of treatment (yrs.)	35.0	(8.8)
Age at the end of treatment	37.0	(8.0)
Time of follow-up (yrs.)	5.8	(0.79)
Treatment length (0.3-8.3 yrs.)	2.9	(1.7)
Number of therapy sessions (range 15-399)	161.9	(94.9)
Type of therapy		
Psychoanalysis (76%)		
Treatment length (0.3-8 yrs.)	3.0	(1.6)
Number of therapy sessions (range 17-399)	192.9	(88.9)
Psychotherapy (16%)		
Treatment length (0.8-8.3 yrs.)	2.4	(1.9)
Number of therapy sessions (range 30-200)	78.3	(40.5)
Drop-outs (%)	17.5	

3. Status before treatment 34% of the patients have had symptoms for more than 10 years. In 17% was found a personality disorder and 46% were classified as affective disorders according to ICD-10. (Tab. 4)

Tab. 4 ICD-10 Classification prior to treatment

retrospective expertrating n=100

main groups only

		n	%
F3 Affective disorders	F31 bipolar. affect. disease	1	1.0
	F32 depressive episode	13	13.0
	F33 recurrent depress. episode	13	13.0
	F34 cyclothymia	19	19.0
F4 Neurotic and somatoforme disorders	F40 phobic disorder	4	4.0
	F41 anxiety disorder	10	10.0
	F42 compulsion disorder	3	3.0
	F43 stress reaction	3	3.0
	F45 somatoforme disorder	8	8.0
F5 Behavioral disturbance with physical symptoms	F50 eating disorder	3	3.0
	F52 sexual dysfunction	3	3.0
F6 Personality disorders	F60 specific personality disorder	17	17.0
	F61 complex or other personality disorder	1	1.0
	F63 abnormal habits	2	2.0

In 96% of the patients psychotherapy was necessary because of disturbance of emotional, psychosocial and physical functioning (Total impairment severity score BSS 6.8- the cut-off point for clinical relevance of BSS is determined at 5.0- ; Schepank 1987, 1994). Fig.1 show the distribution of BSS.

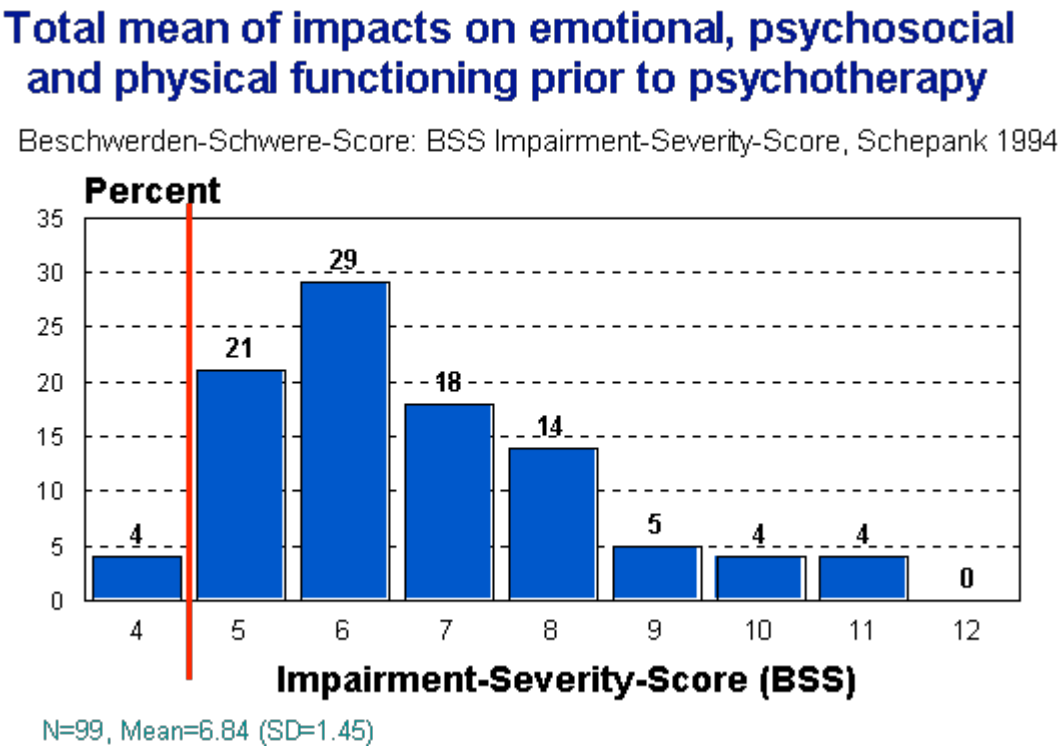


Fig. 1

4. Self-assessment of the patients at follow-up

Compared with the state before therapy 70-94% of the former patients reported 6 years after the termination of treatment good to very good improvements with respect to physical or psychological distress, general well-being, life satisfaction, job performance and partner and family relations as well as social functioning. Some results are presented in Tab. 5

Tab. 5 Global self reports of the patients at follow-up

compared prior to therapy

	n	better %	unchanged %	detoriated %
How developed problems indicating treatment ?	111	93	6	1
How do you see your emotional condition today ?	111	94	5	1
How do you compare your physical health status to that before treatment ?	111	66	24	10
How developed the physical problems indicating psychotherapy ?	63	83	10	7
Compared: how satisfied are you with your partnership today ?	80	74	19	7
Compared: how satisfied are you with your job conditions ?	111	75	17	8
		good to excellent	moderate	poor
How about your actual health state ?	111	51	37	12

- **Global health-state**

Comparing the self reported global health state of the patients at follow-up with a representative randomly assigned calibration sample of a "normal population" (Gerdes and Jäckel 1992) adapted to our study with regard to sex and age, 88% of the follow-up sample range within the 75th percentile

of the reference sample indicating that 88% of our sample reported their global health state as 75% of the calibration sample as "normal health".

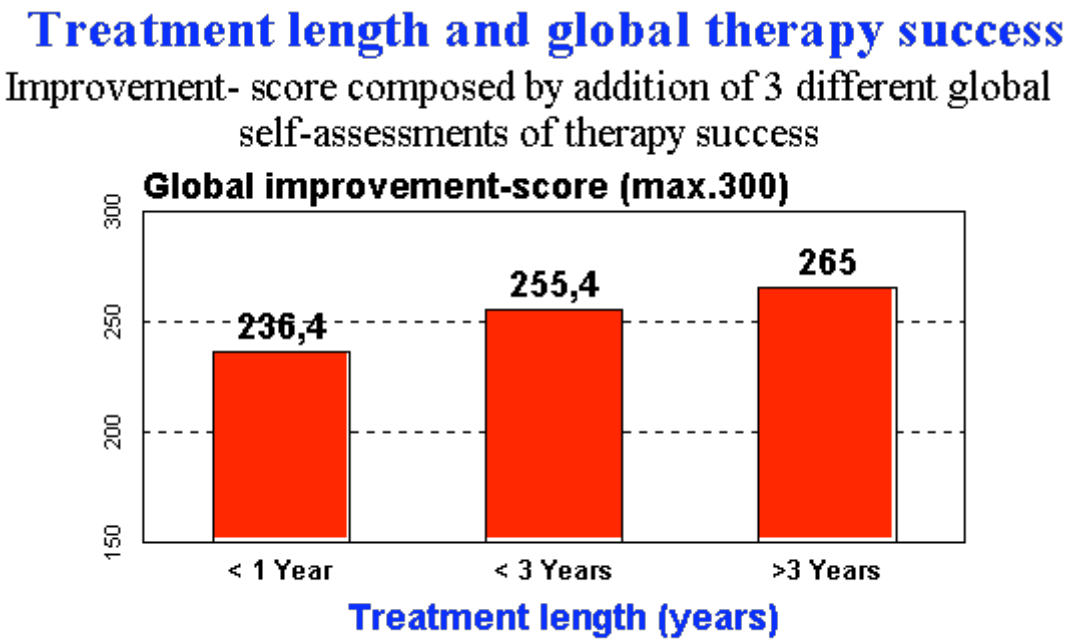
- **Clinical significance of global well-being**

The global well-being was assessed by a 6 point Lickert-scale (from very poor to very good). Out of 60.4% (n=67) of patients reporting their well-being as very poor prior to therapy, later 86.6% (n=56) rated 6 years after termination of psychotherapy at follow-up their global well-being as very good, good or moderate. This indicate improvement in global-well-being long after the termination of treatment. These results have been confirmed by the "Consumer's Report-Study" from Seligman (1995).

- **Relation between global success and treatment length**

The addition of 3 total mean scores (ranging from 0 to 100) of different self reported global ratings (degree of improvement of the complaints indicating psychotherapy, how much psychotherapy helped the patient, satisfaction with the actual psychological and emotional state) created a global variable of therapy success. Fig. 2 shows a relation of therapy success with the treatment length ($p<0.05$) indicating the longer the treatment the better the treatment success 6 years after termination of psychotherapy.

With regard to this criteria long-term psychotherapy was more successful than short-time psychotherapy. Similar results were found by Seligman (1995) and Sandell (1996).



p<0.05

Fig. 2

5. The global assessment by former therapists of the patients' state at the end of therapy shows a comparatively good agreement with the patients' own assessment at the time of follow-up 6 years after the end of therapy (*therapist*: 64.9% good, 29.7% moderate, 5.4% unchanged or deteriorated overall state, *patients*: 70.3% good, 22.5% moderate, 7.2% unchanged or deteriorated).

6. Results of psychometric test examinations at follow-up

- **SCL-90R:** In the standardized **psychometric test examinations** of the actual state of health at follow-up, the sample tested lies within the range of healthy standard random samples and compared to other clinical groups with respect to the relevant alteration qualities of symptoms Fig. 3 shows the total means of the 9 subscales of SCL-90R.

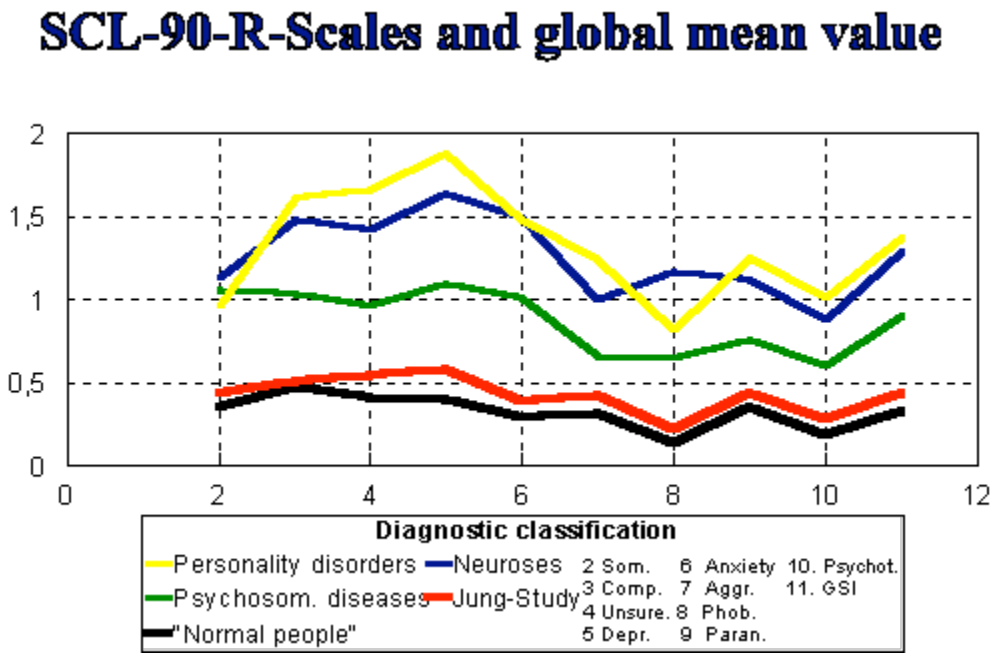


Fig.3

- **Gießen-test (personality)**: The standardized (sex, age) total means of the Gießen test scales (T-values) range within the calibration values (two SD's from 50) indicating absence of clinical relevant disturbance. (Tab. 6)

Tab. 6 Gießen-Test (T-values)

	Mean	Std Dev
Dominance	44,23	9,68
Social resonance	46,83	9,81
Control	51,05	9,14
"Permeability"	51,27	11,40
Social potency	51,84	8,70
Basic mood	58,51	10,18

- **VEV :**

Regarding the "Change in Experience and Behavior" (VEV), the test subjects showed significant improvements in various areas of life ($p < 0.01$) compared to the calibrated random sample. Compared to an other clinical sample treated with an inpatient cognitive behavior therapy after a one year follow-up there are no marked differences (Tab. 7).

Tab. 7 VEV-questionnaire of Change in Experience and Behavior:

comparison of the follow-up sample (N=111) with a 1- year follow-up-sample of an inpatient cognitive behavioral treatment (N=142, Zielke 1993)

follow-up n=111 comparison-group n=142

	N	%	N	%

positive change (>187) (value>187)	78	70.3	105	73.9	
Indifferent or moderate change (>150	31	27.9	34	24.0	
(((value between >150 and <187					
negative change (< 150) (value<150)	2	1.8	3	2.1	
	M	SD p	M	SD	p
Total mean	**200.4**	24.3 p<0.01	**210.7**	32.1	p<0.01

7. Change of the Impairment severity score (BSS):

In the comparative pre- and post-expert rating of the actual state of the disease by clinical interviews during the follow-up, a partial sample of n=33 patients (regional sample of Berlin) by independent raters showed a significant (p<0.01) decrease of the severity of the disease (Impairment Severity Index according to Schepank). The effect size was 2.1 (Fig.4)

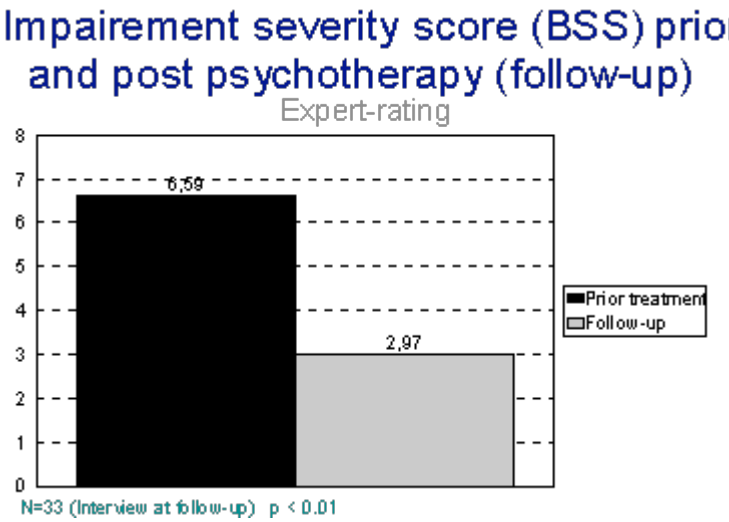


Fig.4

8. Health care utilization:

- **Drug-intake (Fig. 5):**

A high percentage of the patients indicate a remarkable reduction in drug-intake compared to the

status before psychotherapy.

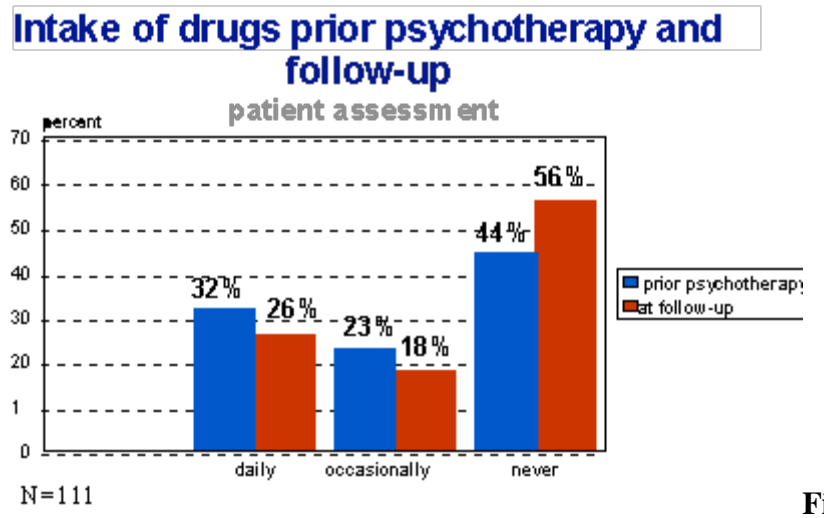


Fig. 5

- **Frequency of doctor visits (Fig. 6):**

More than half of the patients reported a substantial reduction in the frequency of doctor visits compared prior to psychotherapy. 8.1% had a higher frequency and nearly 40% reported an unchanged frequency to the year before follow-up.

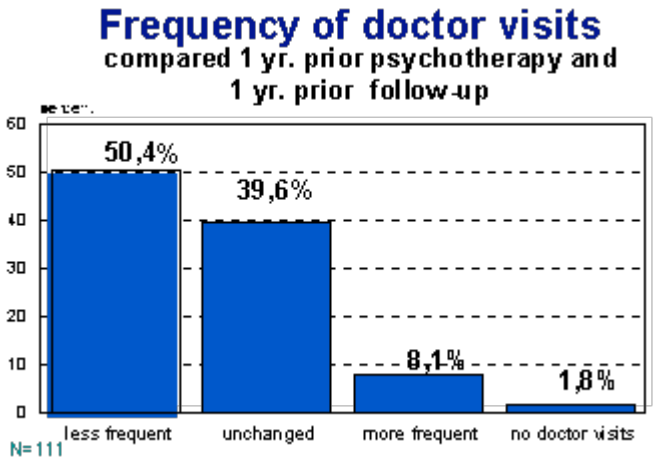


Fig. 6

The mean frequency of doctor-visits in the year before follow-up range within the mean frequencies of two representative studies from private praxis (Hoffmeister 1988, Schacht 1989) (Fig. 7).

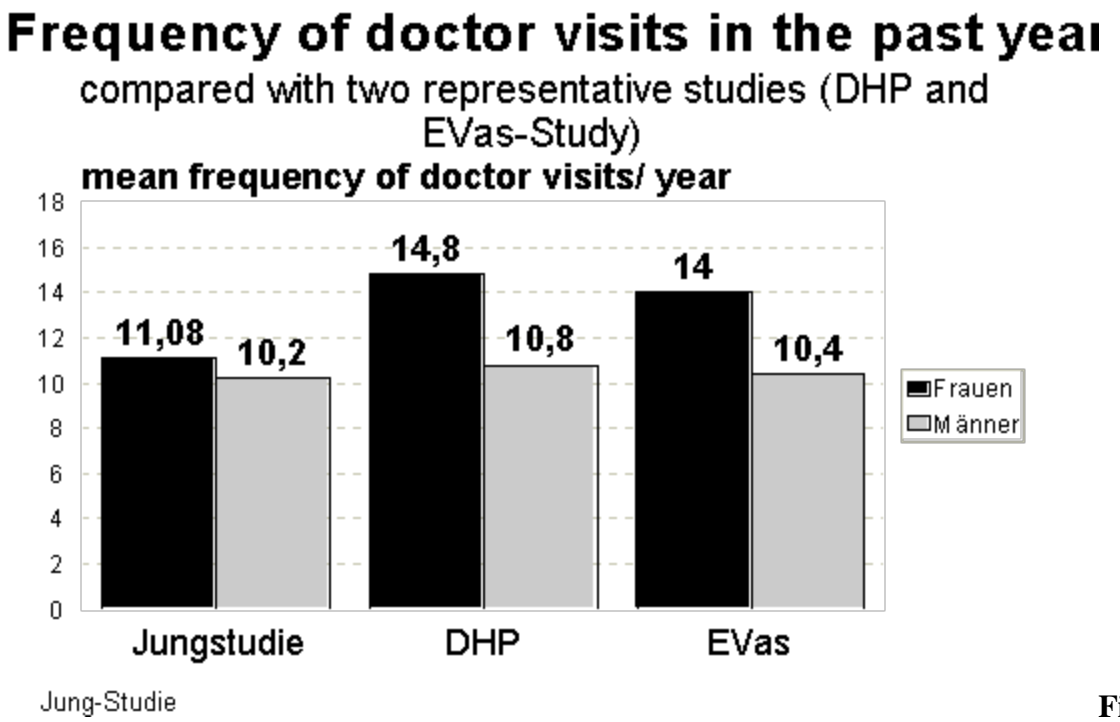
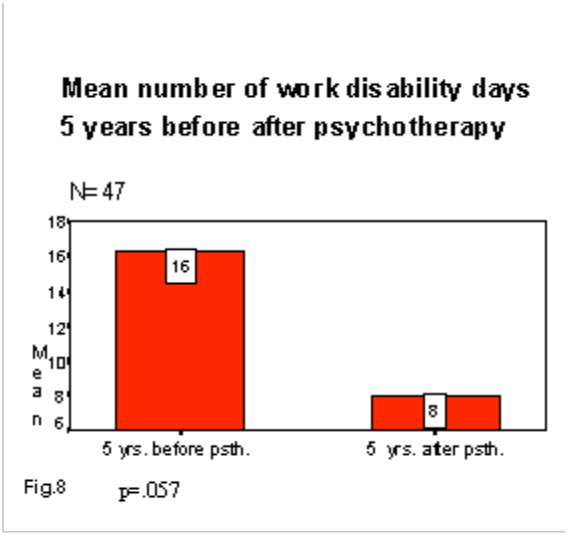


Fig. 7

- **Work disability and hospitalization days (Fig. 8, 9):**

A comparison of the data recorded by cost carriers 5 years and 1 year before and after treatment showed a reduction of objective work disability of 50% from 16 to 8 days and a reduction in hospitalization days of 87.5%from 8 to 1 day in the year before and after therapy (Fig. 8 and 9).

Generally, a reduction of work disability and hospitalization days after treatment can be regarded as an indirect measure of therapy success. In order to assess the number of work disability days, the study participants had to be continuously employed. A part of the sample is therefore not applicable. Thus the sample was reduced from 111 to 47 patients for work disability days and to 58 patients for hospitalization days.



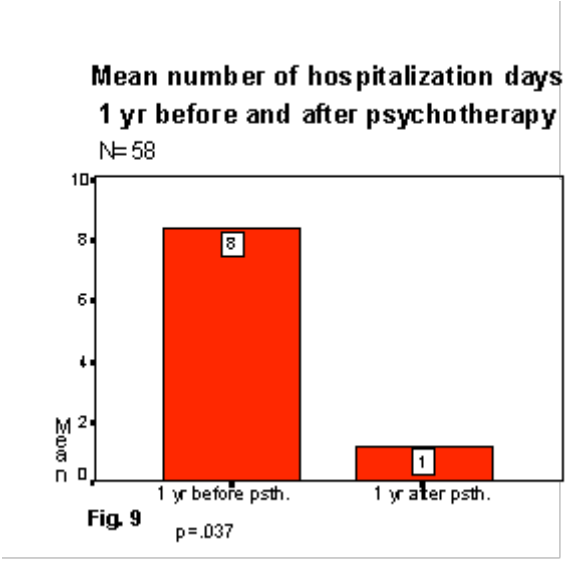


Fig. 9

Conclusion

The effectiveness of Jungian psychoanalysis and psychotherapy was determined on the basis of 5 different perspectives and different success criteria. 76% of the patients examined had had psychoanalysis so that empirical proof of the effectiveness of long-term analyses could be demonstrated after an average of 6 years. Even after 5 years, the improvement in the patients' state of health and attitude toward the disease still resulted in a markedly constant reduction of health insurance claims (work disability days, hospitalization days, doctor's visits and drug intake) in a large number of the patients treated and thus in a reduction of costs. Cost effectiveness aspects increasingly play an important role as success criteria especially for health administrations. As we have demonstrated in this retrospective study, psychotherapy apparently also has a long-lasting effect on the patients' health care utilization. The complete recording of these data (in Germany) requires great care and a methodologically confirmed approach toward the interpretation of these data (Richter et al. 1994). However, when these prerequisites are provided, convincing arguments for the effectiveness of psychotherapy or psychoanalysis together with the clinical results can be found even for a retrospective design.

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Analytic Intervention Rating System (AIRS): a rating system for psychoanalytic interventions

Guenther Klug & Dorothea Huber

Since Strachey published his seminal paper in 1934 on the central role of transference interpretation as the mutative interpretation, a great deal of work has been done to empirically verify his hypothesis, for example by Malan (1976), Marziali (198o, 1984), Luborsky et al. (1979), Silberschatz et al. (1986), Piper et al. (1986, 1991), Mc Cullough et al. (1991) and Crits-Christoph (1993) to mention only the most important contributions for example. Henry et al. (1994) reviewed the literature and pointed out the need for further research because of the many open questions about such a central issue of psychodynamic psychotherapy. In our Munich Psychotherapy Study (MPS) we are studying the process-outcome-link with the transference interpretation being regarded as the most important intervention of the psychotherapist.

In this connection we developed a system for rating the interventions of the psychoanalyst: The Analytic Intervention Rating System (AIRS). The key features of the AIRS are as follows:

a) it is based on a psychoanalytic theory of technique (and is not pantheoretical, as are all of the systems intended for use in comparing different psychotherapies).

b) it is, in Russell and Stiles´ typology (1979), intersubjective; that is, it is descriptive of syntactically implied and other relationships between the communicator and the recipient.

c) it uses a pragmatic coding strategy, describing the characteristics of the communicator by inferring the communicator´s intent (as opposed to the classical coding strategy, describing the characteristics of the text, with only minimal inference).

d) it has mutually exclusive categories, that is there is only one way to classify a given intervention.

e) The categories within the system are exhaustive, that is, all relevant interventions can be put into one of the categories.

f) it pays special attention to one intervention, the interpretation, differentiating it along a temporal line from the "there and then" to the "here and now".

g) it pays special attention to the context of one type of intervention, the interpretation.

h) it is especially suitable for evaluating long-term treatments.

From this list of key features it is clear that the existing rating systems, e.g. those of Strupp (1957), Stiles (1979), Hill (1978), Piper (1984), Stuhr (1984) and Gaston (1988) to name only the best known, were not appropriate for our purposes.

I will now give a brief overview of the intervention categories. The manual includes a precise definition of each type of intervention and some typical examples.

I. Type of Intervention

A. Silence

> 30 seconds of silence after last utterance by analysand

B. Phonetic Interventions

Sounds indicating affirmation or astonishment

Sounds indicating confrontation, disapproval or negation

C. Explorative Interventions

Unspecific and specific inquiries

Encouragement for self-exploration

D. Clarifying Interventions

Differentiations

Amplifications

Recapitulations

E. Confrontational Interventions

Pointing out omissions

Pointing out contradictions

Direct contradiction

F. Interpretation-like Interventions

Mirroring

Implicit and explicit accentuation

Affective reinforcement

Combining conscious material

Combining conscious material with the analyst

G. Interpretations

Reconstructions

There-and-then interpretations

Current extra-transference interpretations

Not-current transference interpretations

Current transference interpretations

H. Structuring Interventions

Making arrangements and providing information about place, time, setting and theory of treatment

Information concerning the role of analysand

Information concerning the role of analyst

I. Directive Interventions

Requests concerning activity within the session

Requests concerning activity outside the session

Suggestions and advice

J. Formal Interventions

Saying hello and good-bye, using set social phrases

Saying kind words

Saying unkind words

K. Not elsewhere classifiable

In addition, each **interpretation** had to be evaluated on the following dimensions using a 5-point Likert scale:

II. Depth of interpretation (from too trivial to too deep)

III. Style of interpretation (from stereotypic to overadaptive)

IV. Correctness of interpretation (from completely wrong to completely correct)

V. Timing of interpretation (from much too early to much too late)

VI. Enlightening enhancement of interpretation (from too confrontational to too supportive).

We made a first attempt to establish content validity by having the AIRS evaluated by 5 psychoanalysts who had a completed training at an approved psychoanalytic institute and had many years of psychoanalytic experience. Their suggestions led to some improvements in the rating system, above all to clearer definitions.

Interrater reliability was assessed with the aid of three raters (B, W and K), all of whom had completed training at an approved psychoanalytic institute and had many years of psychoanalytic experience.

Rater training consisted of a careful study of the manual before the raters got together and then assessment of three 10-minute segments of an audiotaped session, which had also been transcribed, followed by an extensive discussion of each rating; total training time was between 4 and 5 hours.

Two pairs of sessions of a psychoanalysis that was totally audiotaped (the first author was the therapist) were transcribed according to the rules suggested by Mergenthaler (1986). The whole text spoken by the therapist was segmented by the first author; the units were chosen by following principles of clinical meaningfulness more than of automatic exactness; interrater reliability for segmentation was not assessed because it was done by only one person.

Three raters independently judged a total of 192 interventions by the therapist. Interrater reliability was assessed for the types of intervention (which were scored in a nominal category system) by computing kappa (Cohen 1960) for all three pairs of raters.* Kappa for pair B / W was .45; for pair B / K .50 and for pair W / K .51. Since the total number of interpretations was too small, the level of agreement between the pairs of raters for the dimensions of interpretation (depth, style, etc.) could not be computed.

In a first attempt to establish construct validity, the first author determined two "good hours" and two "bad hours" using a retroreport (Meyer 1981) he had made after each approximately 3 years ago; a "good hour" and a "bad hour" were close together in the course of psychoanalysis but the pairs came from different phases of the psychoanalysis; two of the judges (B and W) were blind to this assessment. The prediction was:

a) in the "good hour" there are more interpretations than in the "bad hour" and b) in the "good hour" the dimensions of the interpretation (depth, style, correctness, timing and enlightening enhancement) are scored better than in the "bad hour".

In order to infer construct validity the measure should operate in the predicted way.

As already stated, a statistical analysis could not be performed because of the limited number of judgements. A merely descriptive statistic showed that there was a clear tendency towards more identical rating of interpretations in the "good hour" and a tendency towards a better score on the dimensions of the interpretation. Moreover, though not predicted and therefore no measure of construct validity but in line with the theory of psychoanalytic technique, in the "good hour" the raters reached a higher level of agreement in scoring an interpretation than in the "bad hour". We also computed a chi-square test for all interventions and found no significant difference between "good hour" and "bad hour" for two judges (B and K) and a significant difference at the 10% level for the third judge (W).

We would like to thank Dr. Dipl. psych. G. Henrich, for his contribution to this paper.

Our first reaction to the unacceptably low interrater reliability (according to Landis and Koch (1977) a kappa of .41 to .60 is only moderate) was to omit some of the subcategories of the AIRS and to combine others under a new heading after a systematic analysis of the divergent scores on the item level. The modifications were:

B. Accompanying Interventions (instead of **Phonetic Interventions)**

Sounds indicating affirmation or astonishment

Paraphrasing

E. Confrontational Interventions

Sounds indicating confrontation, disapproval or negation

Indirect contradiction

Direct contradiction

F. Interpretationlike Interventions

Whole category deleted.

A new reliability and validity study was then conducted with this altered version of AIRS but with the same raters. Meanwhile two years had passed since the first evaluation, and we hoped that they all had forgotten the first round.

The second round with the new version of the AIRS was in May 1997. Kappa for pair B/W was now .66; kappa for pair B/K was .59; and kappa for pair W/ K was .60. Again the level of agreement between the pairs of raters for the dimensions of interpretation (depth, style, etc.) could not be computed because of the small number of interpretations.

Construct validity was again assessed by comparing "good hours" and "bad hours". On a descriptive level - because of the small number of judgements - we again found more ratings of interpretations in the "good hour" and a tendency towards better scores on the dimensions of the

interpretation. In the "bad hour" either no interpretation was scored (hour 3) or there was a low level of agreement between the judges (hour 1), with one judge scoring interpretations frequently and the others scoring none. The chi-square test for all interventions showed significant differences between the "good hour" and the "bad hour" for all judges: for judge B at the 5% level, for judge K at the 10% level and for judge W at the 10% level; on the subcategory level C.0 (= unspecific and specific inquiries) and E.1 (= indirect contradiction) differed significantly at the 10% level between "good hours" and "bad hours".

We will try to refrain from anticipating what we hope will be a lively discussion but simply have to give some interpretations of the results - in a presentation dealing with interpretations we simply have to.

Clearly better interrater reliability was achieved with the new version of the AIRS. This was the result of deleting the category Interpretationlike interventions and replacing it with the subcategory paraphrasing, as a comparison between the distributions of frequency of interventions in the first and second investigations suggests. Five subcategories (mirroring, implicit and explicit accentuation, affective reinforcement, combining conscious material and combining conscious material with the analyst) were reduced to one subcategory (paraphrasing); it is obvious that this operation reduces the possibilities for disagreement between the judges, and it yielded a better inter-rater reliability, but what got lost are the interventions aiming at the preconscious of the analysand or, in other words, the different interventions that make the preconscious conscious are lost and in this regard clinical validity is reduced.

Now some comments on the validity study. For sure we would not claim that our instrument can distinguish between a "good hour" and a "bad hour" since the sessions were evaluated by simple clinical impression by one analyst, who moreover was one of the raters and therefore not blind before the rating procedure. But there must be a difference between the different pairs of sessions anyway and the AIRS is evidently able to reproduce it. Looking at the differences at the category level, it makes sense clinically that in the "bad hour" the analyst asks more and interprets less than in the "good hour".

I will stop now in order to have a "good half an hour" of discussion. Thank you for your patience and for your attention.

The intersubjective field: Behavioral basis of therapeutic relationships and their mental representation

Rainer Krause, Cord Benecke & Jörg Merten

Abstract: The social emotional side of the therapeutic bond in the first therapy session is analyzed and related to the therapeutic outcome after the fifteenth therapy session. Facial affective behavior of 11 experienced therapists of different theoretical orientation (psychodynamic, cognitive behavioral, client-centered) and that of their patients is used as an indicator of different forms of affective relationship regulation (compensatory vs. reciproque). The following results were found: successful therapists showed a lot of negative distance regulating affects like anger, contempt and disgust while mutual smiling was related to poor outcome. To enhance comprehension of these results and to scrutinize therapeutic process the relation of facial behavior, verbal contents and emotional experience were investigated in a successful psychoanalytic brief therapy. EMFACS (Emotional Facial Action Coding System) was used to code facial affective behavior. Verbal content was analyzed using SASB (Structural Analysis of Social Behavior). Patients' and therapists' emotional experience were measured with the Differentielle Affekt-Skala (DAS).

Part I: Facial-affective behavior and therapeutic outcome (J. Merten)

The studies we present are attempts to analyze emotional processes between patient and therapist by means of an analysis of facial behavior, other nonverbal behavior as well as verbal behavior. The theoretical rationale of these studies is based on one of the authors work (Krause, 1981) and has been investigated in several studies (Steimer-Krause et al, 1989; Schwab & Krause, 1994; Krause et al, 1996; Merten, 1996; Steimer-Krause, 1996).

So for example studying the interactive behavior of subjects suffering from different disorders it could be shown that different groups of mentally ill persons are characterized by their tendency to induce reactions, emotions, and fantasies in their social partners by using specific interactive strategies, which are neither deliberate nor self-reflective.

An important result of this research was that schizophrenic subjects showed above all contempt as most frequent facial-affective behavior, while healthy subjects showed Duchenne Smiles most frequently. A Duchenne Smile is defined as the combined contraction of zygomaticus major and orbicularis oculi and is hypothesized to occur with spontaneously occurring enjoyment (Ekman, 1989).

Further major findings of three DFG projects on interactive behavior of patients suffering from mental disorders can be summarized as follows:

- Healthy subjects *adapt* their facial behavior to that of their interaction partners suffering from a mental disorder (Steimer-Krause et al, 1989; Schwab & Krause, 1994).
- *Negative facial-affective behavior* of schizophrenic as well as of psychosomatic patients more often refers to the interaction partner than in interactions between two healthy subjects. As a consequence it is negatively correlated with the experience of joy (Merten, 1997). The healthy subjects negative affects more often refer to objects talked about and are positively related to the experience of joy.
- To distinguish these different references the nonverbal context of facial behavior gives important hints. The negative affects referred to objects talked about are found in different kinds of gazing-contexts in comparison to those elicited by the interaction partner and related to him or the emotional quality of the relationship (Merten, 1996a; Merten, 1996 b).
- Dyadic phenomena are of major importance for the understanding of relationship-regulation.

So for example high interactional involvement of interaction partners operationalized as synchronous smiling while gazing at each other is a crucial issue in relationship regulation with ill subjects (Merten, 1996a; Steimer-Krause, 1996).

Method and hypotheses

The analysis of relationship regulation of ill subjects and laymen represents the preparatory background for the study of relationship regulation in psychotherapies. The psychotherapy process study presented is part of a research project, funded by Deutsche Forschungsgemeinschaft DFG.

11 experienced therapists of cognitive-behavioral, psychoanalytic and client-centered theoretical orientation treated severely-disturbed patients in a brief psychotherapy setting of 15 hours during which they were videotaped by 2 cameras. The patients were selected by the therapists as being very severely disturbed, 9 of them had been treated before without success.

The following data sets have been analyzed Facial behavior of both protagonists was measured using EMFACS, a technique developed by Friesen & Ekman (1984) based on the Facial Action Coding System (FACS; Ekman & Friesen, 1978). While FACS comprehensively measures all movements in the face, EMFACS measures only movements which are potentially relevant to affect. Using a dictionary (Friesen, 1988; Wagner, 1986) the measured facial events are interpreted as expressions of the primary emotions of happiness, anger, contempt, disgust, fear, sadness, and surprise or as social smiles.

After each session, patient and therapist completed the "Differentielle Affektskala" (DAS, Merten & Krause, 1993), a questionnaire asking the subject to rate his or her own feelings during the session as well as the perceived feelings of the interaction partner. The DAS consists of 30 items that are rated to provide scaler data for interest, joy, surprise, sadness, anger, disgust, contempt, fear, shame and guilt. In addition therapists gave semi-structured reports of the session which also were videotaped.

All therapy session were transcribed and analyzed with CCRT (Luborsky, 1977) and SASB (Benjamin, 1974)

During the course of treatment, each patient completed a diary which included a standardized affect-rating, a symptom checklist and optional, free reports of important events of the day.

Outcome was measured using ratings of success, goal attainment, helpfulness, and contentment with the treatment from both patient and therapist following the 15th session. The 11 therapies were ranked according to these outcome measures. The resulting ranks were consistent with changes in the scores of the Freiburger Beschwerdenliste (FBL; Fahrenberg, 1975), a list of complaints completed by the patient at the start and the end of treatment.

Hypotheses

The following hypothesis depict the relation between facial affective behavior and therapeutic bond in the first session to therapeutic outcome after 15th session.

a) Frequency and valence of patients' "Leitaffekt" and the frequency of their facial illustrators as constituting parts of their affective expressivity and their interactional involvement are related to therapeutic outcome.

b) Frequency and valence of therapists' "Leitaffekt" are related to therapeutic outcome. In most studies dealing with patient's and therapist's expressivity a positive relation to therapeutic outcome is found.

c) The dyadic combination of patient's and therapist's "Leitaffekt" is related to therapeutic outcome. To do that the patient's "Leitaffekt" is combined with that of the therapist forming the "Dyadic Leitaffekt". Based on the theoretical assumption of reciproque and compensatory forms of

relationship regulation, *positive facial reciprocity* is operationalized as both's "Leitaffekt" being felt happiness, *negative facial reciprocity* as both negative and *facial affective compensation* as one being positive the other negative letting unconsidered if therapist shows positive "Leitaffekt" or patient.

This dyadic "Leitaffekt" describes the extend of both forms of relationship regulation reciprocity and compensation.

Based on observations in a single case analysis of two therapies one with bad outcome, the other with good outcome (Merten et al., 1996) the categories of the dyadic "Leitaffekt" are hypothesized to relate to therapeutic outcome in the following manner. The best prognosis is given when the form of affective regulation in the first session is compensation and the worst when we find positive affective reciprocity. Negative affective reciprocity lies in between.

d) Although the dyadic and temporal organization of facial affective behavior like mutual smiling determines the affective quality of a relationship its relation to therapeutic outcome has not yet been analyzed. One can hypothesize that an accurate positive bond makes it possible to let negative affects inherent to the problems of the patient become part of the interaction between patient and therapist without the risk of abandoncy. Which amount of a positive affective bond is necessary for the therapeutic process to develop successfully and if there can be too much of positive affection is still unknown. The preliminary results given in Merten et al. (1996) suggest that an overflow of positive reciprocity hampers interpersonal conflicts to be dealt with. So it is hypothesized that high amounts of positive reciproque facial affective behavior in the first session indicate worse therapeutic outcome. Whereas compensatory forms of facial affective relationship regulation are related to better outcome.

Results

Patients' and Therapists' facial behavior

The facial activity in the first session is highly variable across patients and therapists. Patients display facial events in a range from 145 to 641 events per session, therapists from 48 to 226. In 10 of the eleven therapies the patients facial activity in the first session is higher than that of their therapists. Taking into account only primary affects only 8 patients are more expressive than their therapists. In general the therapists show less idiosyncratic facial behavior, less affective blends and more "pure" primary affects than the patients.

Therapists' theoretical orientation and facial behavior

Therapists' facial behavior shows no relation to their theoretical orientation. The variance between therapists of the same theoretical orientation is higher than that between the groups of different theoretical orientation. The facial behavior depends more on individual characteristics and/or dyadic adaptation processes than on theoretical orientation.

Facial-affective behavior in first session and therapeutic outcome

Now the relation of facial behavior to therapeutic outcome are presented. The following aspects of facial behavior in the first therapy session show significant relations to the outcome perspective of patient and/or therapist.

Fig. 1: Correlations between facial affective behavior and therapeutic outcome

	$Outcome_T$	$Outcome_P$	Combination
$Illustrators_P$		.75	
%"$Leitaffekt_T$"	-.63		
Negative $Affects_T$	+.81		

Dyadic "Leitaffekt"			+.70
Happy $felt_{Pa}$ / Neg_{Th}	-.64	-.55	-.76
S_P felt happiness	-.63		
S_T felt happiness, b2	-.64		

S_P: Synchronous Duchenne Smiles initiated by the patient

S_T: Synchronous Duchenne Smiles initiated by the therapist

Happy $felt_{Pa}$ / Neg_{Th}: Ratio of happy felt patient to negative affects therapist

$Outcome_T$: Therapist's outcome rating

$Outcome_P$: Patient's outcome rating

Combination: A combination of both

Illustrators

Illustrators are speech accompanying facial actions interpreted as indicating involvement in dyadic interactions (like brow raising or lowering). The amount of illustrators in the first session correlates positive with the outcome perspective of the patient after 15th session (ILLU_R2 mit ERF_P: r= .75; P= ,01, N = 10).

"Leitaffekt" of patient and therapist

In dyadic interactions between two healthy subjects the most frequent facial affective event is the Duchenne Smile. But only 6 therapists and 5 patients out of eleven follow this rule. The others show mainly contempt or disgust and in one dyad anger is the most frequent facial affective event.

One could consider this affects as indicators of interactive and self-regulatory processes like transference for example that could be related to therapeutic outcome. But neither the affective valence of the "Leitaffekt" of the patient nor its absolute frequency correlates significantly with one of the outcome measures (Perspective of therapist: r=.23, p=.49; patient: r = .22, p=.54; FBL: r = .08, p=.83, all 2-tailed).

Since healthy people adapt their facial behavior when interacting with mentally ill people of different diagnoses one could expect that the facial behavior of the therapist influenced by their patients is related to therapeutic outcome. The affective valence did (but not significantly) correlate negatively with the therapists' outcome perspective, in a sense that the therapies with therapists showing felt happiness as "Leitaffekt" were worse (r=-.41, p=.21, N=11) than those with negative "Leitaffekt" like anger, contempt or disgust.

Relative frequency of "Leitaffekt"

The "Leitaffekt" is shown with different pithiness. One patient f.ex. displays 187 facial events interpreted as disgust during the 50 minutes of the first session but only one Duchenne Smile. An essential finding is that the relative frequency of the "Leitaffekt" of the therapist correlates significantly negative with his outcome rating, in a sense that therapists who displayed high amounts of a specific facial affect in the first session assessed the therapeutic outcome as having been worse after the 15. session.

Negative Affects (anger, contempt, disgust)

To further scrutinize this relation a specific subset of the negative facial affective events, namely those interpreted as anger, contempt and disgust was investigated. All three affects signal a negative relationship between a subject and an object together with the wish that the object should leave. Subject and object need not to be identical with the actual interacting persons as is illustrated in the second part of the presentation.

A somewhat surprising relation of these negative facial events to therapeutic outcome was found. There is a highly significant positive correlation between the amount of negative affects shown by the therapist and his outcome rating (r=.81, p=.003, N=11) and a weaker one exists with the FBL prae-post differences (r=.54, p=.11, N=10).

Dyadic Leitaffekt

Although already the monadic analysis reveals substantial relations to therapeutic outcome we have to analyze facial behavior from a dyadic point of view to understand the interactive processes representing the affective bond. To do that the dyadic "Leitaffekt" is related to therapeutic outcome.

Based on the theoretical assumption of reciproque and compensatory forms of relationship regulation, *positive facial reciprocity* is operationalized as both's "Leitaffekt" being felt happiness, *negative facial reciprocity* as both interacting persons Leitaffekt being negative and *facial affective compensation* as one being positive the other negative letting unconsidered if therapist shows positive "Leitaffekt" or patient.

Fig. 2: "Dyadic Leitaffekt-Scale"

Label	Definition	Value
positive facial reciprocity	"Leitaffekt" of patient and therapist is positive (f.ex. genuine joy expression)	1
negative facial reciprocity	"Leitaffekt" of patient and therapist is negative	2
facial affective compensation	one "Leitaffekt" is positive the other negative letting unconsidered if therapist shows positive "Leitaffekt" or patient	3

The "Leitaffekt" is the most frequent facial affect shown by a person

One yields a correlation of r=.70 (p=.03, 2-tailed) with a combined outcome rating that integrates therapist's and patient's perspective.

Ratio of happy felt patient to negative affects therapist (mediated compensation)

Only *mediated compensation* has established in the dyads. The frequency of the therapist's negative affects correlates negatively with the positive facial affects of the patient (r_{T-P+}=-.61, p=.046, N=11). The ratio of these two frequencies correlates negatively with the therapist's outcome perspective (r=-.67, p=.022, N=11) and in tendency with the patient's outcome perspective (r=-.55, p=.10, N=10). In therapies where the patient's felt happiness expressions are not compensated by therapist's negative, distance regulating facial affects outcome has been worse.

Synchronous Duchenne Smiles (local reciprocity)

Since the dyadic "Leitaffekt" is a measure that is aggregated across time we are not able to clarify if the facial affects of patient and therapist happened at the same time. In respect to the 11 therapies analyzed we found that only the frequency of synchronous events of patient and therapist in the category "felt happiness" are above chance level (p=.05). The frequency of synchronous events in all other categories (patient positive affect, therapist negative affect or vice versa; both negative affect) can be explained using a pure random model. One can conclude that for most of these therapies it is

only meaningful to talk about facial affective reciprocity concerning felt happiness.

Nevertheless correlations between all values depicted in the table and the outcome variables were correlated. But consistent with the conclusion only the frequency of the synchronous expressions of felt happiness correlates significantly with therapeutic outcome, namely the perspective of the therapist.

In addition we find a curvelinear quadratic relation between the frequency of mutual smiling initiated by the therapist (S_T) and therapeutic outcome (P=.038, b2=-.64). Therapies without any positive reciprocity initiated by the therapist are rated on a medium level of outcome. In therapies with deterioration or abundance we find more than 4 events of positive reciprocity initiated by the therapist in the first session. The therapies with best outcome ratings lie in between.

Interpretation

It has been shown that facial behavior and especially facial affective behavior of patient and therapist especially dyadic aspects of it are indicators of the affective bond and power- and meaningful predictors of therapeutic outcome.

Patients with low interactional involvement indicated by low frequency of facial illustrators rated outcome as less successful than those with high interactional involvement. Furthermore the amount of facial illustrators shown by a patient have been proposed to be indicators of the severity of his mental illness by Steimer-Krause (1989). Krause analyzed the facial behavior of schizophrenic patients interacting with healthy ones and found a reduction of the illustrative facial events in the case of the schizophrenics. So one can speculate that the more severe patients did profit less in the short psychotherapeutic settings analyzed here.

It has to be stated that illustrators are the only facial behavior of the patient that has a relation to outcome. Patient's "Leitaffekt" nor any other variable of his facial affective behavior in the first therapy session correlates with any outcome perspective.

In contrast the therapist’s outcome perspective is far more related to facial affective behavior of himself and of the dyad. An important finding has been that especially the therapist’s negative facial affective behavior is very useful in predicting therapeutic outcome.

So therapist’s negative facial expressiveness seems to be a necessary condition for a problem-oriented therapeutic process. The negative affects can be indicators of different psychological contents in respect to the therapist. They can be reactions to the patient’s actual behavior or its narratives, but they can also be tied to the behavior of protagonists talked about in the narratives. In both cases they represent important starting points for the understanding of the patient’s problems which are centered around conflictous affective exchange processes with others, themselves and/or the therapist.

The *more successful therapists* can be characterized by the missing of a specific, highly frequent "Leitaffekt". Furthermore the dyadic combination of the most frequent affects ("Leitaffekt") and it’s correlation with the combined outcome rating was the starting point for a scrutinization of reciproque and compensatory forms of relations between therapist’s and patient’s facial affective behavior.

On the level of *mediated reciprocity and compensation* one finds better outcome when a *compensatory form* of dyadic facial behavior has been shown. Compensatory forms had been operationalized as one category of the variable "Dyadic Leitaffekt" and as the ratio of patient’s happy felt expressions in comparison to therapist’s negative affects (anger, contempt and disgust). The latter ones being the best predictors of outcome.

On the level of *local reciprocity* it has been shown that the frequency of positive facial reciprocity and especially reacting to patient’s offers of felt happiness is a predictor of worse outcome. In the better therapies the therapists initiated positive LR only at a medium level.

Returning to the issue of therapy outcome, we suggest that failures are not related to a false handling of these techniques as the therapists were all experienced. Rather, we suggest that failures are the result of the linkage of the therapist's affective relationship regulation to the unconscious signals of the patient which leads to a stabilization of the patient's conflictive structure. The degree to which unconscious signals are accessed consciously differs by therapist. Therapists might not notice patient signals or they might notice and fight against reciprocating. However, for some patients, the therapist might respond to the patients signals without trying to react against them. Such therapists often develop a model for the patient's personality to justify their strategy. For example, they might call the patient "ego weak", which would dictate the need for a supportive strategy and not allow confrontation. Behavioral indicators of stabilization of a patient's maladaptive system include the absence of clear cut phases in the therapy, e.g., in facial affectivity and its temporal structure. Another indicator of failure seems to be the existence of very extensive relationships between the affective behavior and experience of affect for both interaction partners. Both indicators might reflect dependencies, which hamper the treatment technique in such a way that success is unlikely.

In cases where the therapist cannot resist the patient's unconscious signals, the irresistibility is probably related to the therapist's own biography and countertransference to the affective regulations of the patient. It is worth considering that therapy strategies should include the compatibility of the patient and therapist's affect regulation systems in addition to symptomatology and treatment technique.

Part II: A single case study; context analysis of the facial affects of the therapist (C.Benecke)

These results raise many questions, especially according to the function of the negative affects of the therapists. How can we understand the result of the positive correlation between the frequency of anger, contempt and disgust expressed by the therapist in the first session and successful outcome ratings?

We assume that the same facial expressions might have different functions, depending on their points of reference. A rough distinction of the points of reference could be:

Fig. 3: Possible Points of Reference of Negative Facial Affects of the Therapist:

Self	e.g. in the sense of selfcontempt
Interaction-Partner	e.g. the therapist is angry at the patient, disgusted by the patient, full of contempt for the patient
Mental Object	affect refers to other persons or themes patient and therapist are talking about

Using this idea, we analyzed the context of the affective facial expressions of the therapist of a 55 years old male patient with a hystrionic personality disorder and sexual and alcohol-problems. It was the most successful psychodynamic therapist, who indeed showed a lot of negative affects, mainly disgust and contempt, not only in the first session but during the whole course of the treatment.

We supposed that most of the negative affective expressions of the therapist are not addressed directly towards the patient, but to things or persons patient and therapist are talking about. That is to say the negative affects of the therapist are no direct interaction-regulation-signals, but are assessments of the cognitive contents, of the speech-contents.

We tried to distinguish the different points of reference of the affects by analyzing the context of the affect-expression. The interaction-partner, in this case the patient, needs information about the (intended) point of reference of a facial affect, and this information is supposed to be available by the context of an affect-expression. Our context-analysis included gazing behavior and speech-content.

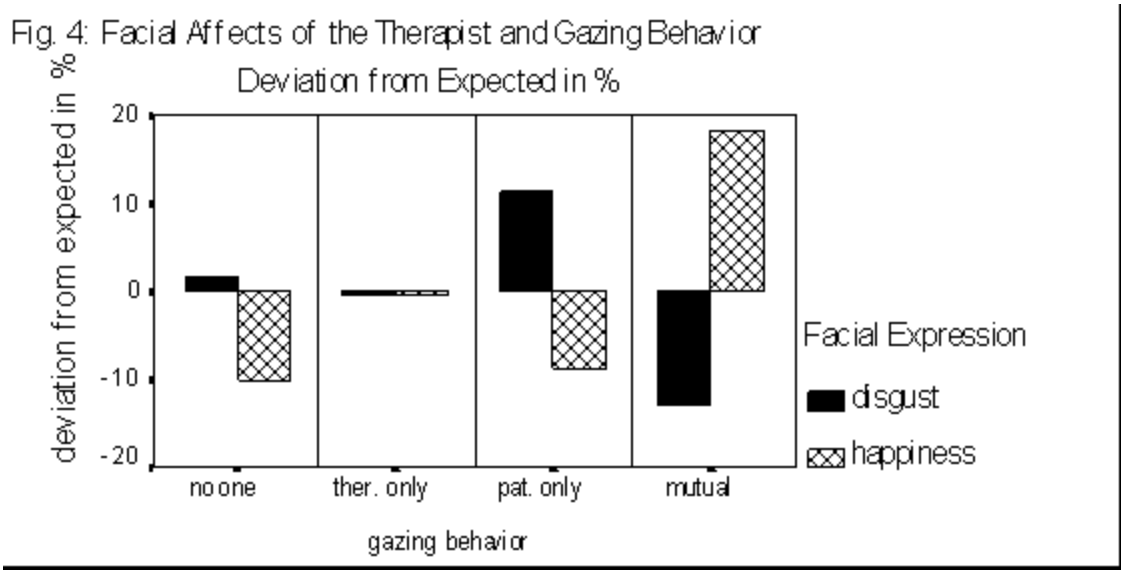
There are 4 possible states of dyadic **gazing behavior** at one specific moment: 1) no one is looking at the other, 2) therapist is looking at the patient while the patient is not looking at the therapist, 3)

patient is looking at the therapist while the therapist is not looking at the patient, 4) both are looking at each other: mutual gazing contact.

The gazing behavior is used as a metasignal for the interpretation of facial affective expressions. In every-day-interactions with healthy people negative affects are increased when only the partner is looking, but are reduced while the expressing person is looking at the partner (Merten 1996). This metasignals indicate that most of the negative affects are not directed towards the partner.

We investigated the **speech-content** by using a modified version of the SASB-content-analysis. SASB (Benjamin 1974) allows to code most utterances during which somebody is talking about interactions with other persons, but it does not include categories where someone is talking about feeling states or emotional experience. For this reason, we added categories which are orientated on the experience of the primary emotions and the CCRT-self-reactions. All utterances were coded during which patient or therapist talked about any kind of interactions or where they talked about emotional states, not only of the patient but of any persons.

The results of the context-analysis refer to 8 sessions of this treatment.



If we contextualize facial affects and gazing behavior (Figure 4), we find that disgust and happiness are combined more often with specific gazing behavior than it would be expected on a chance-level. Disgust is expressed more often than expected in the simultaneous gazing-context where only the patient is looking at the therapist, but is reduced in the context of mutual gazing contact. For the happiness expressions it is the other way round. This suggests that most of the disgust expressions of the therapist are not direct interaction-regulation-signals, but refer to something or someone else. Most of the happiness expression however can be seen as interaction regulating.

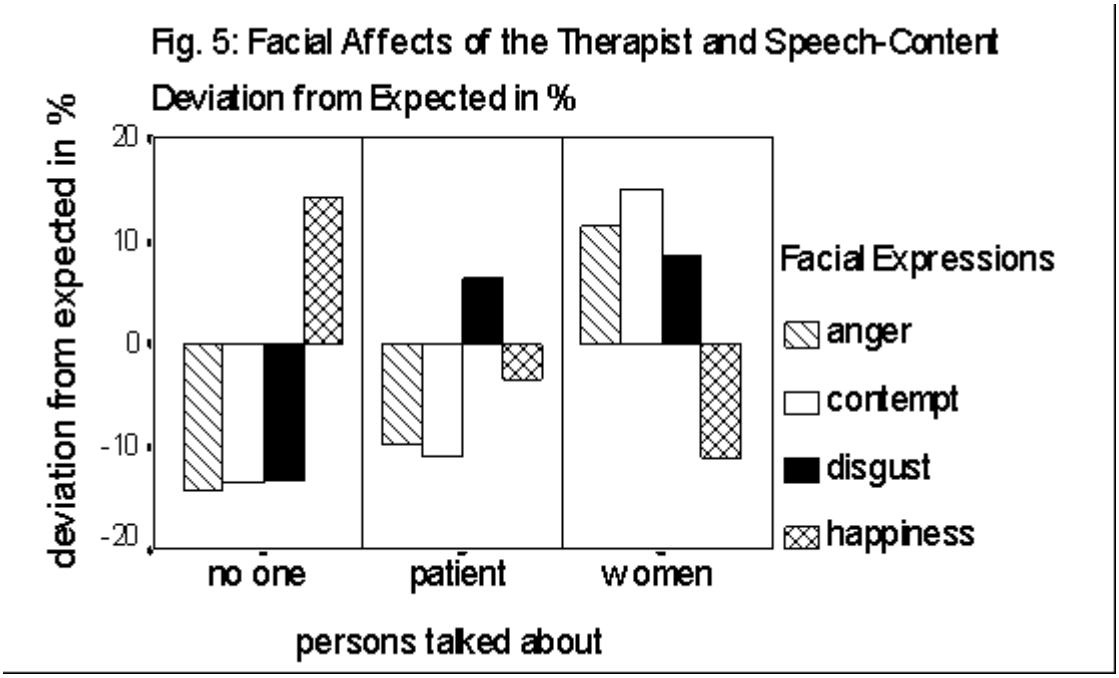


Figure 5 contains deviations from the expected of the therapist's facial expressions in the context of different speech-contents (here: a selection of the persons therapist or patient are talking about at the same moment of the therapist's affective facial expression). The therapist's expressions of anger, contempt and disgust are reduced when there is no SASB-codeable speech-content. But the negative affects are placed more often than expected in a speech-context talking about women (mainly how badly wife and mother of the patient treat the patient).

The happiness-expressions of the therapist are increased when there is no codable speech-content; but are reduced when they talk about women.

When the speech-content is the patient (how he treats himself or how he feels) anger and contempt are reduced, but disgust is increased. We assume that in this cases the disgust is addressed towards the introjects of the patient.

Departing from these results we assume that the facial affects of the therapist, which are placed without talking about any interactions or feeling states, could be seen as direct interaction-regulation-signals towards the patient; and that only these affects can be seen as indicative for the actual relationship. That is to say only these are indicative for the acting-in of the countertransference of the therapist. We call them "interactive affects". Facial affects which are placed in a context where patient or therapist talk about other people, we call "object-related affects", that is to say object-related affects of the therapist are not addressed towards the patient in that actual moment.

Evidence for the usefulness of this distinction can be investigated by correlating the affect-context-combinations with emotional ratings of patient and therapist after the sessions. Both protagonists gave emotion-ratings after each session: about how they felt in that session and how they think the partner felt (DAS, Merten & Krause 1993).

The hypothesis is that the more negative *interactive affects* of the therapist there are in one session, the less joyful the patient feels in that session and the more negative feelings does the patient attribute to the therapist.

There is no correlation of any rating with the total frequency of therapist's facial contempt. But there are high correlations between ratings and the contempt placed in different contexts.

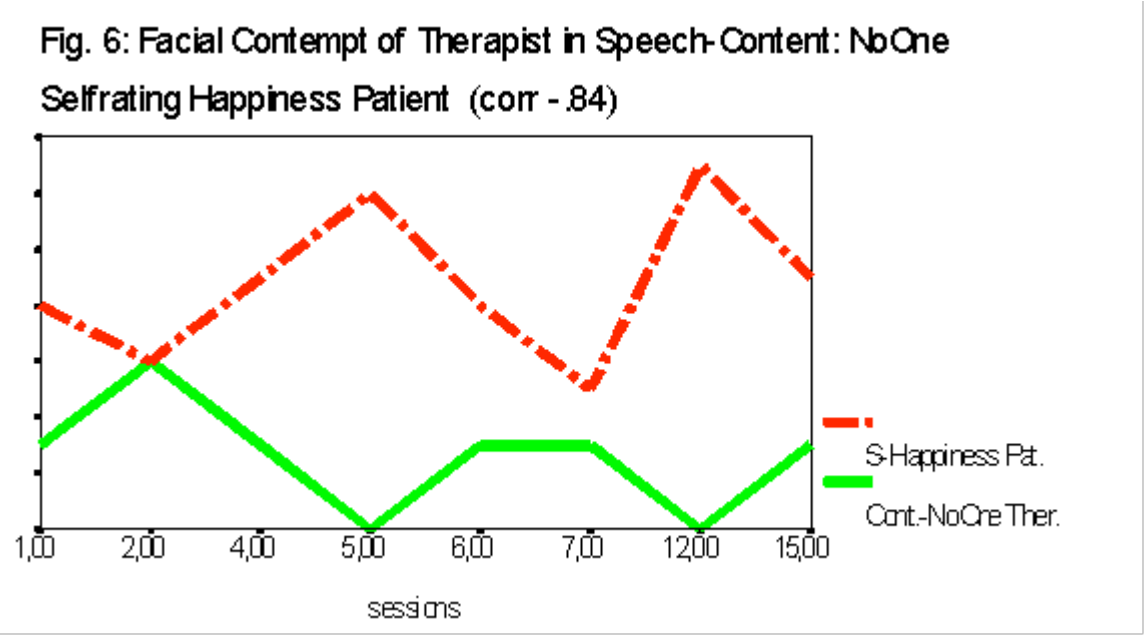
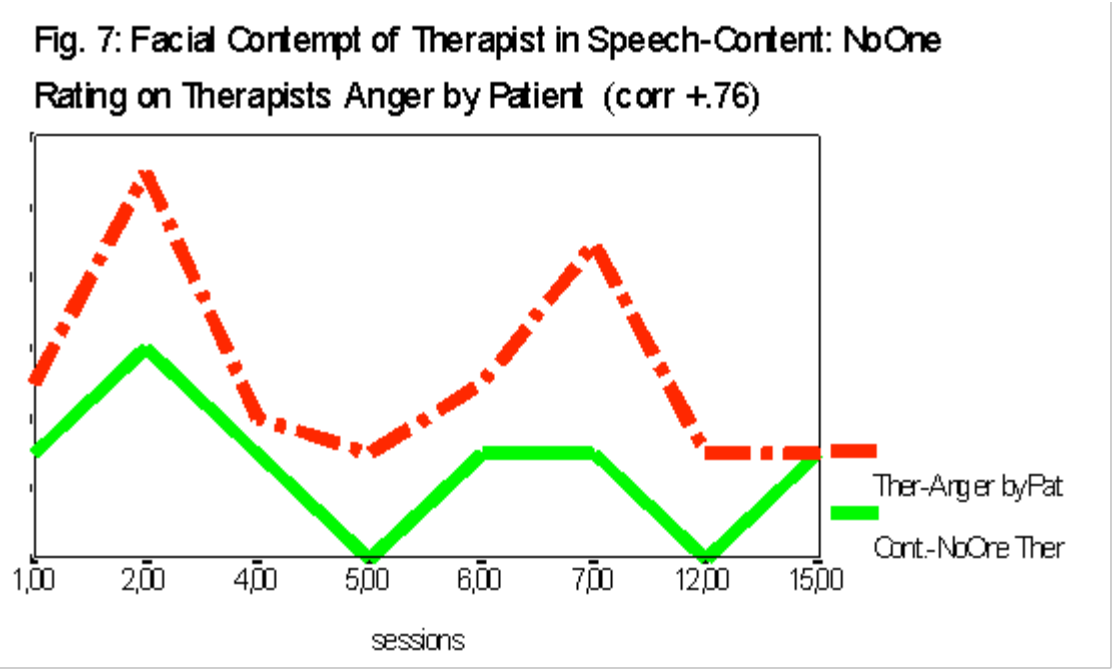
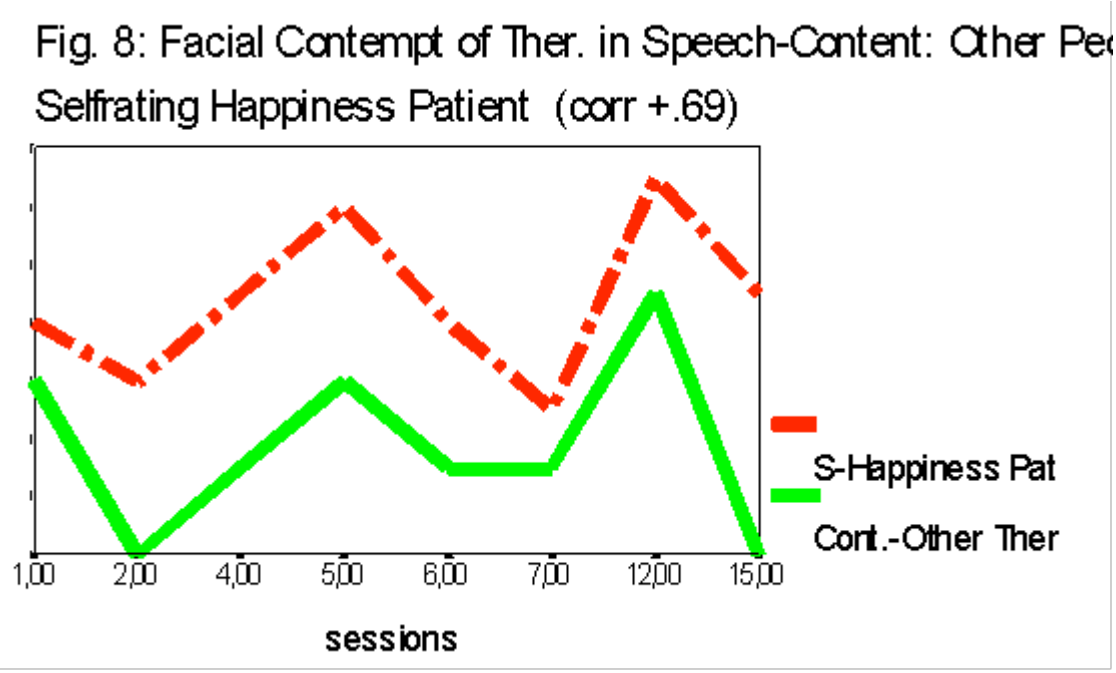


Fig. 6 shows the negative correlation between the frequency of the therapist's contempt-expressions which are not placed in a codable speech-content (Cont.-NoOne Ther.) and the patients selfrating of happiness after the session (S-Happiness Pat.). The more "interactive" contempt the therapist shows in one session, the less happy does the patient feel in that session.



In the sessions where are more of the "interactive" contempt expressions of the therapist, the patient is rating the therapist as being angry (Fig. 7).



The frequency of therapist's contempt placed in a context where they talk about **other persons** (Cont.-Other Ther.) correlates positively with the patients selfrating of happiness (Fig. 8).

These correlations show that it is absolutely essential to contextualize affect-patterns, in order to understand their functions within the interactive process. Is the therapist's contempt placed without a clear point of reference, the patient feels less happy and thinks the therapist is angry; but if the contempt-expressions are placed in a speech-content talking about other people, the patient feels happy. An interpretation of affective facial expression is impossible unless we consider the specific context of these expressions. The results indicate that similar affects have totally different impact to the process of therapy depending on the points of reference.

Part III: the intersubjective field: a clinical interpretation (R.Krause)

Let me first give some overall ratings about the general feelings the patient mentioned after the first session out of which these clips were taken. First of all he had the general impression that the therapeutic alliance was good. That this form of therapy is well suited and that he is in very good hands. The emotional distance between him and myself was rated 4 on a scale from 1 very close to 10 very distant. He would have liked to have a 3 on this scale and he had the feeling that this session was special. "Several times puzzlement, as invasion of astonishment, the real (small?) world beyond the great words, very difficult to formulate that further on now."

The written stile reflects the baroque and oblique oral form of communication which was used during the session.

From the primary affects there is nothing special besides concentration and attentiveness (very strong), joy (middle), awake (middle) funny, bewildered (middle). He thought that I was very attentive, surprised, concentrated, and mildly bewildered, angry, awake, happy and ashamed. Indeed I felt very attentive, very concentrated more enjoyful than he thought but in addition anxious, ashamed, guilty, restricted, inhibited, fearful, surprised, restricted and remorseful. All these ratings were middle in intensity. After the sessions I commented this hour spontaneously into the video camera following 4 questions:

1. Well whether the hour was very good or very bad. It was difficult yes. First of all this noise was very distracting. In addition I was excited, my heartbeat was quite high and for some time I was afraid I would get no connection to this men out of my own fears. Then after I understood that thing with the shining and when I was able to draw a bridge to the difficulty that he works for me and he shines for me and he somehow plays a piece of theater, it was

quite relieving and I could go on. Well I think in fact he has played a theater piece.

2. The most important theme inside this hour. I think the working out of sobriety as contrast to his drunken romanticism. All this has different names but in the essence it`s always the same. The idealization of contempt, the idealization of disapproval and I think there we proceeded a bit further. I also think that our relationship has improved a bit further on in this theme that he has felt something of my sobriety, and may be, he realized that he is not forced to make the "jumping jack". Yes that was important. What else was important? Well important was to get adopted to the setting a bit more. I would have liked to have a different setting. I don`t like it as it is, maybe I can tell that later to the technicians.

3. The most important insight: nothing special new, well may be one or two things. Now I realize how tired and exhausted I am. First of all the idea with the earthshaking insights that it doesn't have to be the case, that was probably an important intervention. The second one was about a remark of his wife, that he only makes music to get women into his bed.

I assume that the mother was very reduced in her capacity to love. I think she misused the common act of creation, not the common, but the act of creation within music or art, or writing or whatever, in the sense of a partialobject to fillup her deficient narcissistic structure. From there I think these feelings of emptiness result. This reminds me of a homosexual patient who had played in a theater and his mother was sitting in the front row and there was great acclamation and, as the piece was coming to an end she went up to the stage with the greatest matter of course, took him at his hand and bowed down together with him and he than described this that somehow the whole narcissistic benefit of the clapping of the audience was sucked out of his arm filling his mother instead of him.

4. He is however very strongly identified with these women. I think we first must repair the father a bit, that will be most of the work.

Well which kind of interactions and changes I realized in the patient today; well he was happy to get this treatment; he has moved very much on his chair. In relation to his symptomatology, well, may be his masochistic attitude is coming a bit more to the surface.

5. His behavior vis a vis myself; well a mixture of submissivness and nevertheless something like a relationship like a dim hunch of an equal relationship. I myself am in many of his fields ignorant for example relating to music, and so I am full of admiration of him. Somehow I experience the discrepancy that this men should not be needy for all this clownesc behavior.

The patient had as his most important central relationship theme the wish to shine and to be admired. He had talked about this theme but it was never clear who was supposed to shine. He himself, his wife, his pupils or his mother or may be even myself. In the same time he had behaved in a very ridiculous nonverbal way making it very difficult not to laugh at him or to feel contemptuous. He had recorded a deeply shame inducing scene during which his wife, after brilliant concert had accused him to make music in order to be able to look in the decolletes of young women. Some of the behavior to be seen within the video clips are in the context of this theme.

The question we are going to discuss which behavior is related to the analyst and the patient`s intersubjective field.

We have a lot of literature on the mind of the analyst and his emotional life during work (Baranger 1993). We have few data how this emotional life comes all about. It is however clear that the invisible, silent intersubjective field is based on visible audible actions. They determine indirectly the content of the interpretation and the conviction that the interpretation must be given now or later. The concious and unconcious work of both participants is performed within an intersubjective relationship which is partly defined by the individual`s and partly the collective fantasies, which are related to the actual behavior. The intersubjective field is not defined through the countertransference alone nor the transference processes but it is a dynamic form of exchange, where the whole is more than the sum of the pieces.

According to Barranger (1993) the field is structured on 3 levels: functional framework of the

therapy, the analytic dialogue and the unconcious dynamic structure implanted within this dialogue.

Insert Picture

Within the picture a flowchart of some possible processes determining the intersubjective field can be found. They depict possible relations between conscious cognitive content and the affective interaction. So we might have a relationship between B's conceptualization of A and A's affective behavior which we can call empathy. We might have a direct induction of affect on the level of facial expression which we can call affect induction. We might have a relationship between B's conceptualization of A's feelings states and B's affective expression which we can call projection. We might have a relationships between A's expressed affect and his feelings experience which we can call congruence. We may have a strong relationship between B`s selfexperience and A`s affect expression which we can called introjection. In addition we have purely mental relationships within this intersubjective field, which means that A`s conceptualization of B is related to the self conceptualization of B. This is called validity. Resemblance means that person A described himself similar to the self description of B. All these are dynamic processes which may be activated simultaneously in a parallel fashion. So we assume all healthy people constantly project, react empathic and congruent and change according to the specificity of the situation the impact of some of these processes. Pathology leeds to an ossification of the interplay of the moduls which constitute the intersubjective field. The patient uses only one or two algorithms of linking the moduls in a very fixed and repetitive way which does not allow his partner to construct a situation specific and plastic adaptive intersubjective field. Most of the work as we have shown to be done within treatment consists of entering mentally into the intersubjective field of the patient without sharing it on the behavioral level. It might well be shared on a cognitive and internal experiential level, leading to a description and some form of sharing of the patient's intersubjective field. The possibility for a remobilization of all possible algorithms in a flexible way is a consequence of successful treatment.

How can these thoughts be related to the first hour which I have commented and were we took the clips of. As I already mentioned I experienced feelings of shame and guilt which were related to the possible misuse of the patient as a guinea pig of this project, which included a misuse of myself as a therapist for research. This feeling however was very helpful in understanding what had happen to the patient, who was constantly misused by "sadistic" women around him to create an artful piece of work which was afterwards put down, because they didn't fulfill the unconcious narcistic sexual desires the women had. The man however was unable to fulfill the sexual desires because he knew that he would create the discontent of his women who had very envirous and contemptuous feelings vis a vis potent men.

So the internal intersubjective field I created was somehow determined through my own problems with the research project which was of course related to my history of being a researcher and therapist, and where probably quite fare away from the thoughts of the patient. Nevertheless I took out of this intersubjective internal field a specific aspect which was emotionally fitting to the patient`s problems, which allowed me to understand him relying on my own history. Part of the work to be done was to overcome my own shameful inhibitions to do "sadistic" research, by sticking to my basic idea that good research is not a misuse but a genuine for the patient. This new internal algorithm the patient could successfully use after the therapy, in creating pieces of musical art without humilisation.

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Freud goes Multimedia: Psychoanalytic Resources in the Internet*

Parfen Laszig

"Autoren werden sich nützlich machen als Lotsen im Ozean der wißbaren und zusammenstellbaren Dinge, als scouts in der informatisierten Welt, als Navigationsberater für Menschen, die Erfahrungen suchen als Infonauten und Dokunauten und als Trainer für Verkehrsfähigkeit in einer Welt, mit deren Größe und Abenteuerlichkeit noch immer kaum jemand ernsthaft rechnet ..."

Peter Sloterdijk, Über die versuchende Klasse

In the age where media are defined by communications, human ratio has experienced "an electronic extension". The "global village", a term introduced in 1964 by Marshall McLuhan as a visionary methapher, has now started to adopt virtual shape. Also, or especially psychoanalysis, as science of the unconscious and its effects on individuals and society, has been affected by this worldwide development.

There is no question that Internet, as a "Zeitgeist" phenomenon, poses for psychoanalysts the question of individual access, be it in form of theoretic analysis or by direct use of this tool.

Undoubtedly, networks, like Internet, provide users with access to a vast collection of historical and topical, written, visual, and spoken information.

The sheer quantity of saved and accessible data produced by way of electronic data processing increases at the same time rapidly, as well as the various methods for accelerated access by application of different technologies. Because human capacity for data reception does not grow in the same way, guidance is increasingly needed into that "symbolic space" into which no physical admittance may yet be obtained.

This means on a functional level, that description is required of computer technology used and its applications, as well as explicit knowledge of the location of specific resources, which will then support the individual user in finding his way through the "oceans of electronic documents".

After achieving this intermediate objective, network supported information and communication systems permit direct access to library- and bibliographical search via personal computer.

Exchange of information between experts of different countries will be facilitated, and results, latest scientific findings, and opinions of discussion groups, online conferences, and experts discussions will be imparted and exchanged immediately. The information, circulating within the networks of computers, is going to support the build up of an intersubjectively shared scientific basis and will thus create new perspectives for psychonanalytic thinking (Laszig 1997).

Brief Introduction into History of Network

Based on the idea of guaranteeing a continuous flow of military communication during war, the research department of the US Department of Defense "**A**dvanced **R**esearch **P**roject **A**gency" (ARPA), in 1968 started to develop the first network, operating out of 4 locations. In order to offer everybody within the scientific community access to such an efficient computer net, the National Science Foundation built up its own net (NSFNet), in 1986. In support of the net five US-american universities installed the required computer sytems. Even today the links to these computers are established by a world wide routing-system, operating through computer networks at the next university in location. Commercial services (*CompuServe, T-Online*, etc) also offer gateways to Internet. So far the number of users is estimated up to 60 millions, worldwide, in early 1997.

Connection and Costs

For actual access to Internet a modem attached to a regular telephone line is needed (a more powerful, but also more cost-intensive alternative is provided by the digital ISDN-Telephone net). For students, academic staff, scientists and other institutions in Germany, the costs are paid by the respective university/institution. For private user, there is the possibility to access Internet through a number of commercial services (such as *CompuServe, AOL, T-Online*, etc.) by paying a basic fee and in addition a user fee by the hour.1

World Wide Web

Very often World Wide Web is identified with "Internet". In reality, however, it is only one detailed application of the latter (however the most widely used version at the moment). World Wide Web, or short WWW, makes it possible, by use of so-called Browser programmes2, to transfer written text, voice and music, as well as pictures and graphics.3 Ultimately it is this "multimedial capability" of Internet that not only fascinates the academic community, but also attracts an increasingly wider usage.

These single "multimedial" documents are linked in WWW by markings, the so-called "HyperLinks". By directly "clicking" onto these markings with a (computer) mouse, the connected background information may be called up. However it is also possible to call up directly each of these documents by use of its "computer-address"4. Frequently used document-addresses may be saved as so-called "bookmarks" and need a direct mouse-click only, if repeated use is required.

Freud in World Wide Web - a search

In the following exemplary search we would like to describe the specific resources systematically and beyond some "guidance for navigation", also offer encouragement for your personal use of this medium.

In accordance with the first part of the title, we start an online search for "Sigmund Freud".

Following Goethe´s dictum, that a thing has to be found first of all, if you would like to know where it is located. We have to navigate first through the search engines in the WWW. In a next step we scoured virtually through libraries and databases, look there for associations, societies and institutes, participate in discussion groups via e-mail and leave through or rather "scroll" in electronic journals. As we did not want to exclude the commercial online market, we log into chargeable services, too, ending with a discussion of the capabilities and limitations of network supported searches.

Searchsystems in WWW

"The curse of the immense quantity" is true for WWW, too. In early 1996 the number of documents available in WWW was estimated at 16 millions, with a total of 8 billion single words. The WWW document by Jacobs (1996) "*Psychologische Beiträge im Internet aufspüren*"5 describes different searchsystems and different approaches through the use of exemplary searches.

In our search for "Sigmund Freud", we use the system "*HotBot*"6, which within 2 seconds has found 7428 entries, of which the first 10 (- 100) are listed.

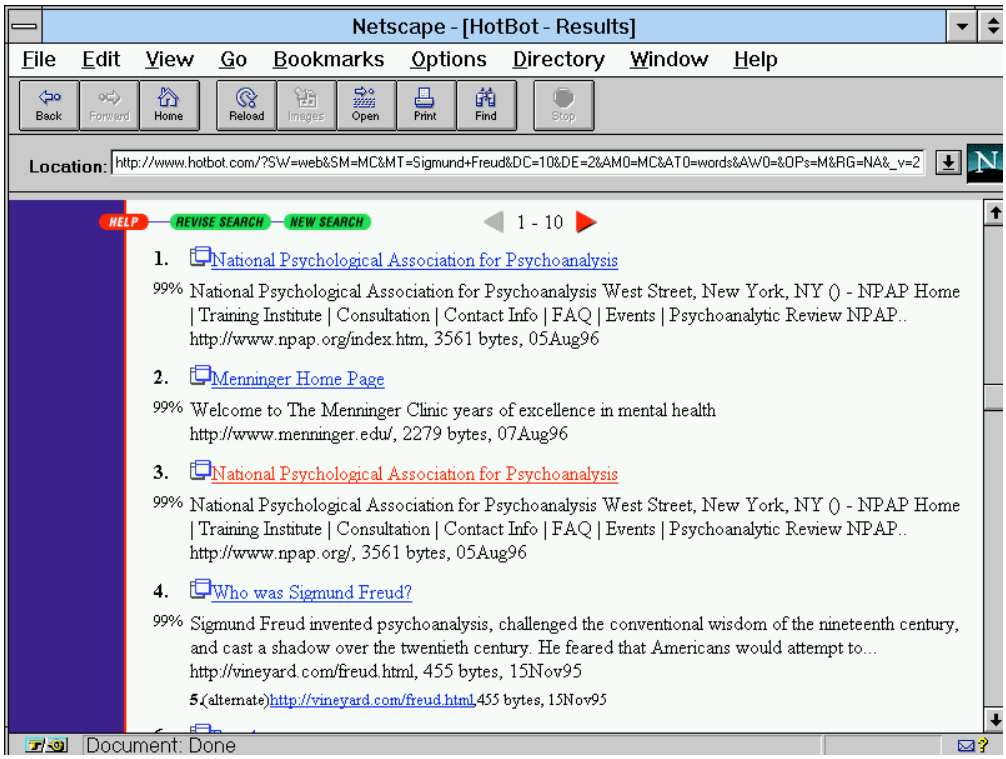

Chart 1: Screenshot: Results of search for Sigmund Freud

For more details the listed resources/addresses in this file, can then be called up by mouse-click, in our example we found at the above screenshot "*the Menniger Klinik*". Even without a detailed analysis, the advantage of these search-engines becomes evident. It is, however, very often not clear, in which way, or based on which criteria the search engine is actually searching the databases and files; therefore we strongly recommend the use of different search engines within the same search.7

Databases, Libraries

In addition to these general search engines, WWW offers access also to specific bibliographical databases, like *PsycLit, Psyndex, Medline*8 as well as search facilities in databases of individual institutes and libraries. Of special importance for psychoanalytically oriented searches are services like Jourlit, *Bookrev, and Duallook*9 of the "*American Psychoanalytic Association*", which at this point comprise 30,000 contributions from journals and books.

Basically, there is a distinction between chargeable and cost-free services. In our search we found the following results:

- A *Medline*-search of all journal articles published in 1996, with the key-word "Freud", showed a total of 68 entries. The individual entries are ready for print out or downloading into a computer or onto a diskette with title, author, summary, references etc.10

1 of 68

TI: Predictors of outcome in child psychoanalysis: a retrospective study of 763 cases at the Anna Freud Center.

AU: Fonagy-P; Target-M

SO: J-Am-Psychoanal-Assoc. 1996; 44(1): 27-77

2 of 68

TI: Anna Freud: her life and her biography.

AU: Solnit-AJ

SO: J-Am-Psychoanal-Assoc. 1996; 44(1): 11-25

3 of 68

TI: Psychic reality: its relationship to defenses involving negative mechanisms.

AU: Yorke-C

SO: Int-J-Psychoanal. 1996 Feb; 77 (Pt 1): 97-102

The same search in the services *Jourlit, Bookrev and Duallook*, looking for "Sigmund Freud", resulted in 259 books & articles. The various entries are ready for print out or copying - with author, title, reference etc.

(See below for a listing of all the contributions of authors with the initial A)

Your Search Found 259 Matches / Showing Matches 1 to 50.

Abraham, H. & Freud, E. (eds.) (1965). A Psychoanalytic Dialogue. The Letters of Sigmund Freud and Karl Abraham., New York: Basic Books.

Acklin, T. (1989). Review of Sigmund Freud's Christian Unconscious., Int. Rev. Psychoanal., 16:510-511.

Adams, L. (1954). Sigmund Freud's correct birthday: misunderstanding and solution, Psychoanal. Rev., 41:359-362.

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Altman, L. (1983). Review of Sigmund Freud's Dreams., J. Amer. Psychoanal. Assn., 31:786-788.

Anon, Z. (1970). Review of On Sigmund Freud's Dreams., Int. J. Psychoanal., 51:562-562.

- Search and ordering of literature through the "*Deutsche Institut für Medizinische Dokumentation*" *(DIMDI)*.11 This page in WWW will inform you on services and charges. Due to the fact that the range of costs is determined by different factors (e.g. connection time, costs for use of database, number of required pages, etc.), the final cost can only be determined individually. Independent from the individual cost, the standard contracts are chargeable with an annual administrative fee of 100,- DM.

- Further search-capacities are offered by libraries, which are now also represented in WWW. Within the Heidelberg area, this applies for the *Library of the University of Heidelberg*12 and the *Badische Landesbibliothek* in Karlsruhe13. Key-word search for "Sigmund Freud" shows 118 entries at the Heidelberg University Library, while the Badische Landesbibliothek lists only 35 books on this same item. A very user-friendly possibility to search is offered by the "*Südwestdeutscher Bibliotheksverbund*" (SWB). Under the keyword "Sigmund Freud" 193 books are listed in total. By mouse click the respective library, classification number, circulating times and lending conditions can be called up.14

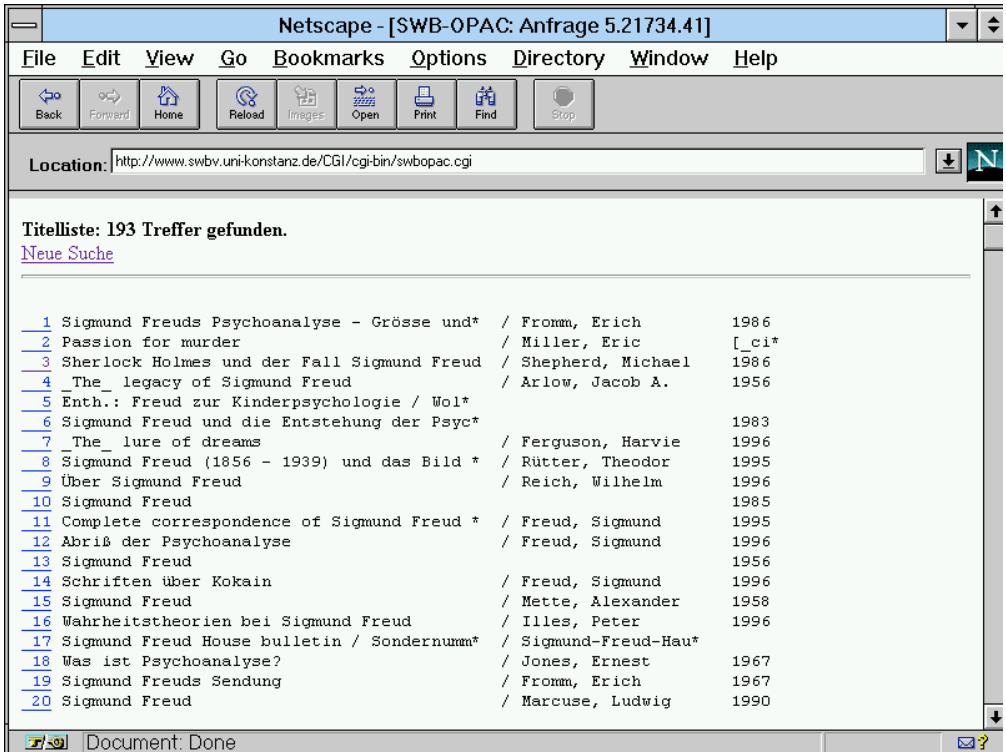

Chart 2: Screenshot SWB ; Results on Search "Sigmund Freud"

Associations and Specific Groups

Specific institutions increasingly offer services in WWW. Within the German speaking area, there are also represented - beside universities and departments - other associations, such as *DGPT, DPV* and individual institutes. An international listing of organizations and addresses of institutions, as well as additional information on research promotion, congresses, etc, is made available by the information service of the "*Deutsche Gesellschaft für Psychologie*" (DGPs Online).15 A listing of all German Medical Servers plus cross references to international data resources is offered by the *University of Frankfurt*.16 Last but not least, it has to be noted, that, almost incidentally, we happened to stumble over Freud¢ s "Traumdeutung" (in a complete english version, translated by A.A. Brill).17

The following three tables list a number of psychoanalytic associations, professional societies, institutes, and some topical compilations of cross-references with corresponding WWW-addresses.

American Psychoanalytic Association (APsaA)	http://www.apsa.org
American Psychoanalytic Foundation	http://www.cyberpsych.org/apf.htm
Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften: Psychoanalyse und Psychotherapie	http://www.uni-duesseldorf.de/ WWW/AWMF/gb/ e_psyana.htm
Asociación Psicoanalítica Argentina	http://www.pccp.com.ar/apa/apa.htm
Canadian Psychoanalytic Society	http://www.io.org/~psy/
Chicago Psychoanalytic Society	http://members.aol.com/leow707093/ChiPsaSoc.html
Deutsche Gesellschaft für Psychoanalyse, Psychotherapie, Psychosomatik und Tiefenpsychologie e.V. (DGPT)	http://ourworld.compuserve.com/homepages/DGPT/
European Federation for Psychoanalytic Psychotherapy in the Public Sector (E.F.P.P.)	http://www.vol.it/IIPG/STORIA/efppital.htm
International Psychoanalytical Association (IPA)	http://web.ukonline.co.uk/Members/ipat/
International Society for the Psychoanalytic Study of Organizations (ISPSO)	http://www.sba.oakland.edu/ispso/
Los Angeles Institute and Society for Psychoanalytic Studies (LAISPS)	http://www.earthlink.net/~laisps/
National Psychological Association for Psychoanalysis	http://www.npap.org/
New York Psychoanalytic Institute & Society	http://plaza.interport.net/nypsan/institute.html
San Francisco Society for Lacanian Studies	http://www.slip.net/~lacan/
Società Psicoanalitica Italiana	http://www.sicap.it/~merciai/spi.htm

Table 1: Associations & and Professional Societies

Alfred Adler Institute of San Francisco	http://ourworld.compuserve.com/homepages/hstein/
Australian Centre for Psychoanalysis	http://www.suburbia.net/~je/acpff.html
Boston Graduate School of Psychoanalysis	http://www.bgsp.edu/

Center for Modern Psychoanalytic Studies	http://www.cmps.edu
Center for Psychotherapeutic Studies; University of Sheffield	http://www.shef.ac.uk/~psysc/
Centre for Research in Psychoanalysis and Psychodynamic Psychology; Universiteit Leuven	http://www.kuleuven.ac.be/facdep/psy/eng/onderz/crppp.htm
Centri Ricerche Psicoanalitiche di Gruppo (C.R.P.G.)	http://www.vol.it/IIPG/CRPG/crpghome.htm
Centro Torinese di Psicoanalisi	http://www.sicap.it/~merciai/ctp.htm
Chicago Institute of Psychoanalysis	http://www.chianalysis.org/
Frankfurter Psychoanalytisches Institut e.V.	http://home.t-online.de/home/Frankfurter_Psa_Institut/
Istituto Italiano di Psicoanalisi di Gruppo (IIPG)	http://www.vol.it/IIPG/
Metropolitan Center for Object Relations Theory and Practice	http://www.object-relations.com/
The Self Psychology Page	http://www.selfpsychology.org/

Table 2: Addresses of Institutes

Burying Freud: The Web site	http://www.shef.ac.uk/uni/projects/gpp/burying_freud.html
Fonda's Freud Materials	http://www.strangelove.com/~marc/frdsrch1.html
Freud Museum of London	http://www.nltl.columbia.edu/students/DBS/freud/index.html
FreudNet: The A.A. Brill Libary	http://plaza.interport.net/nypsan/
JungWeb	http://onlinepsych.com/jungweb/
La Psychanalyse[18]	http://www.odyssee.net/~desgros/index.html
Melanie Klein Homepage	http://www.mysite.com/mklein/index.htm
Mental Health Net:	http://www.cmhcsys.com/guide/pro11.htm
Psychoanalysis & Psychodynamic Topics	
Psychoanalytic Connection	http://www.psychoanalysis.net/
Sigmund Freud and the Freud Archives	http://plaza.interport.net/nypsan/freudarc.html

Table 3: Topical compilation of cross-references

Discussiongroups via e-mail

With all these plentiful offers of information, it sometimes slips the mind that Internet, resp. WWW, is mostly a communication medium. Newsgroups and electronic mailing lists form a virtual core for scientific exchange of ideas and data.

Newsgroups are defined as topical discussiongroups and bulletin boards in the Internet, which are hierarchically structured and cover a variety of subjects.[19] Quite opposite to these newsgroups, the so-called "mailing-lists" include a smaller audience and deal with more detailed questions on specific topics. A list of topical listservers (Bowlby, Jungian Analytic Psychology etc), of required commands, and informations on address, content, and registration, as well as other tips has been collected by Hahn (1996).[20]

For psychoanalysts and candidates, among other things, the following discussion lists are of interest:

BBS	Research Division of the Chicago Institute for Psychoan.	owner-bbs@apsa.org
Child Psychoanalysis	New England Institute for Psychoanalytic Studies	majordomo@gwi.net
Freud-L	Interdisziplinäres Diskussionsforum	freud-l@rz.uni-karlsruhe.de
Group Psychoanalysis	New England Institute for Psychoanalytic Studies	majordomo@gwi.net
IJPA Discussion Group	Institute of Psycho-Analysis, London	100450.1357@compuserve.com
Open Forum on Psychoanalysis	New England Institute for Psychoanalytic Studies	majordomo@gwi.net
Psychoan	St. John´s University	listserv@sjuvm.stjohns.edu
Psychoanalysis and the Public Sphere	Centre for Psychotherapeutic Studies at Sheffield	listserv@netcom.com
Psychoanalytic Studies	Centre for Psychotherapeutic Studies at Sheffield	listserv@netcom.com
Psychoth	Dr.med. C. Anger; Arzt für Psychoth. Med.; Erfurt	psychoth-owner@erfurt.thur.de
SSCPnet	Society for a Science of Clinical Psychology	blanchar@unm.edu

Table 4: eMail-Discussiongroups

After registration in a specific list all discussion contributions of the participants are transmitted automatically to your own e-mail address. Each of these news may be opened for reading by mouse click. The command "reply" allows - if required - the sending of a personal comment on the contribution, which will be sent in due course to all the other participants of this particular list.

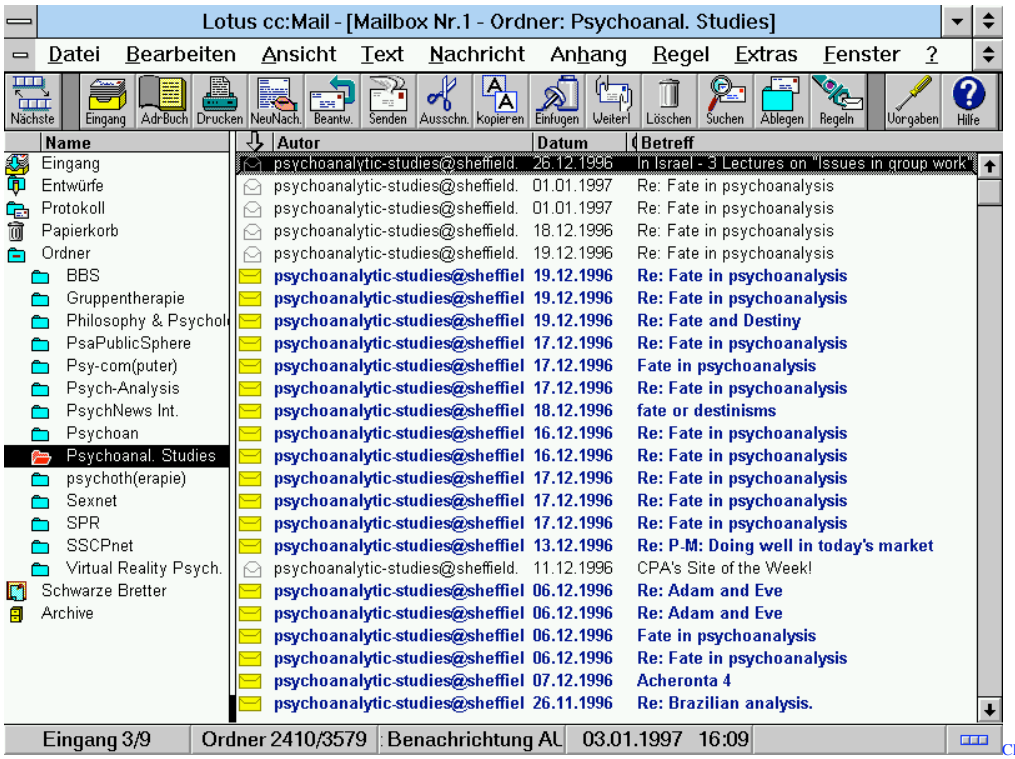

Chart 3: Screenshot e-mail-Program: Messages from the Discussion-Group "Psychoanalytic Studies"

"Electronic" Journals

The journals offered in WWW are on the one hand purely electronic, virtual journals, and on the other hand part of regularly printed journals. The conventional printed journals in WWW represent more an offer for information than regular textual contributions. This means, that for journals like e.g. the "*Journal of the American Psychoanalytic Association*", you call up the indices of the last two years, as well as the summaries of selected articles.

American Imago	http://muse.jhu.edu/journals/american_imago/index.html
American Psychoanalyst	http://www.apsa.org/tap/index.htm
Canadian Journal of Psychoanalysis	http://www.io.org/~psy/cjp.htm
Les Carnets de Psychanalyse	http://www.presscom.com/carnetspsy.shtml
International Journal of Psycho-Analysis	http://www.ijpa.org/
Journal of Clinical Psychoanalysis	http://plaza.interport.net/nypsan/jcp.html
Journal of the American Psychoanalytic Association	http://www.apsa.org/japa/index.htm
Journal of Melanie Klein and Object Relations	http://www.tier.net/esfpub/
Modern Psychoanalysis	http://www.cmps.edu/journal.html
Psychoanalytic Review	http://www.eden.com/fineprint/43064.html
Review Française de Psychanalyse	http://psydoc-fr.broca.inserm.fr/RFP.html
Riss - Zeitschrift für Psychoanalyse	http://kunst.erzwiss.uni-hamburg.de/Pazzini/riss.html
Scandinavian Psychoanalytic Review	http://www.munksgaard.dk/journals/psychoanalytic/index.html
Trans21	http://tornade.ere.umontreal.ca/~scarfond/index.html
Werkblatt	http://hhobel.phl.univie.ac.at/werkblatt/

Table 5: Print-News inWWW

Like regular publications, many of the electronic journals have to pass an experts review, but printing and distribution are more cost-effective, and they are more quickly available. Thus interactive publishing needs less time for publication, and, with respect to feedback, allows a much broader and distinguished forum to be addressed, than it is possible by convential means for printing.

Contrary to the technical capacities of electronic newsletters (such as text, tone, picture, video) are restrictions because of organisational problems (e.g. the problem of permanent digital archivation), or by legal aspects. Electronic publishing is nevertheless increasing in significance in the medical-psychological area.

Some journals are published exclusively in an electronic mode, e.g. "*Psycoloquy*"and "*Psyche*". In the latter one (which is not a virtual edition of the german "Mitscherlich Journal") we are faced with a passionate discussion on topic of virtual networks, such as the question of ownership, copyright, - and more broadly put - the question of personal boundaries. In response to this development, *APA* has submitted specific rules for quotation, in an attempt to uniformly organize copyrights of authors and to limit abuse.22

Acheronta23	http://www.psiconet.com/acheronta/index.html
Psyart24	http://www.clas.ufl.edu/ipsa/journal/
Psyche25	http://psyche.cs.monash.edu.au/
Psycoloquy26	http://www.w3.org/pub/DataSources/bySubject/Psychology/Psycoloquy.html

Table 6: Electronic newspapers in WWW

A list of the publishings of pychological E-Journals and relevant cross-references was edited by Günther (1996), and includes around 600 titles, organized in alphabetical order.27

Commercial Services for Information

In addition to specific WWW offers of universities and specific associations and compilations for references (*PsychWeb, Freud Net, JungWeb*), we find commercial (german speaking) services on the market (*Health Online*28, *Deutsches Medizin Forum*29, *Multimedica*30, *Medicus.de*31.), which offer not only search functions and data bases (like e.g. *Medline* free of charge), references for journals and bibliographies, but also additional information on specific forums, legal

aspects, congress planning.

The majority of these commercial services is still in a process of organization and set up. Their advantage is primarily a clear and well structured compilation of WWW-resources. The suggested and often advertised completeness of information (e.g."*The Whole World of Medicine in Your Hand*") is and will continue to be an illusion, and cannot hide the limitations and problems of commercial online-services.

The Homepage

An interesting aspect of WWW is the possibility to offer and publish your own information yourself.The personal homepage can be understood as a type of a "virtual visiting-card", which not only by quality and type of presentation, but also by its underlying concept defines the profile of the represented institution/user. The homepage represents a forum for the above mentioned contents, as well as a description of the institution, its tasks, objectives, training-principles etc.

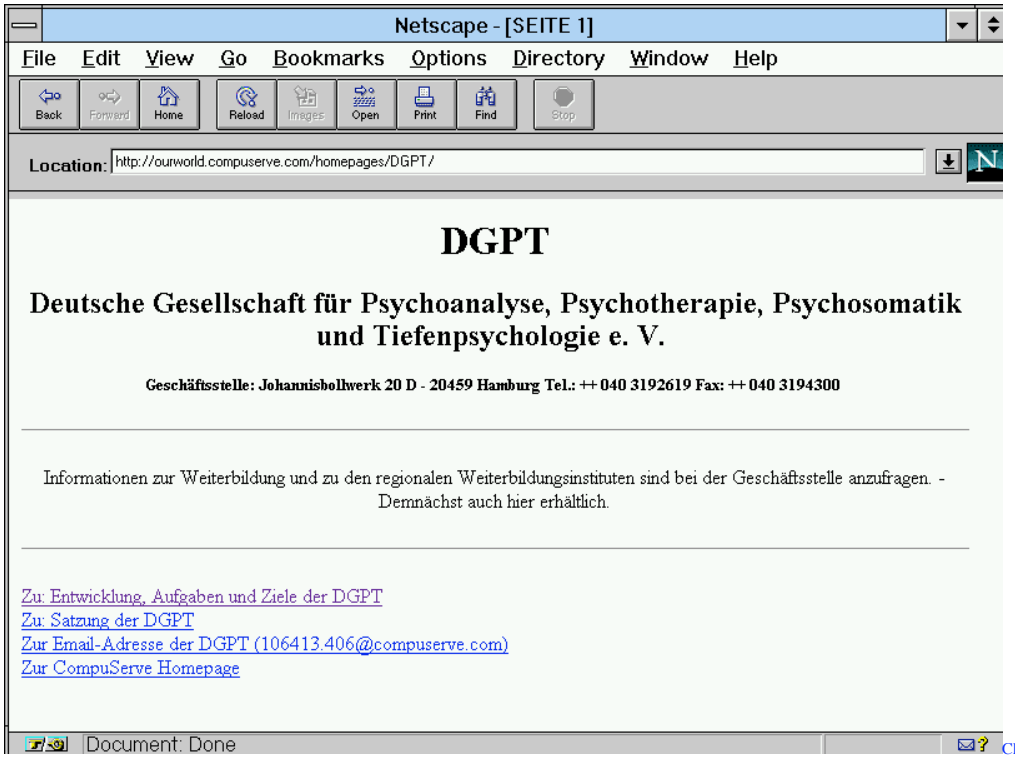

Chart 4: Screenshot Homepage of DGPT

Furthermore, the homepage can create extended or additional possibilities for scientific publications and presentations to the public, which are more cost-effective and easily accessible than all other media at the moment.

Outlook

Although the boundaries in Internet are often not evident, it must be said that on user level, you will find, beside political and economical problems[32] also technical ones, which complicate work in the net. The currently existing connections are often overloaded during "rush-hour" and an efficient use of the system is aggravated by the time-consuming process of loading documents. Continuous changes and the development of network structures, result in frequent changes in address. This is the reason why some search for information will lead to a dead end. At the same time the lack of reliable and transparent criteria for selection and assessment, as well as differing quality of specific resources, restrict the effiency of search and data transfer.

Therefore the results of a search, conducted via Internet, are to be characterized as generating hypothesis and will only add but not substitute individually approved possibilities.

Nevertheless the "digital convergency", the amalgamation of TV, telephone and PC into one single communication medium, leads to the increase of computer supported (scientific) work. Since we are living in an extremely visual epoch, one aspect of accelaration is the speed of looking.

The World Wide Web, offers here a new possibility for the presentation of written and thought language, that is to say the linked up "dimensional text". These novel "webs of meaning" do not any longer recognize the fundamental attributes of linear text: beginning and end (see Glaser 1996).

Regarding these texts a variety of aspects become evident. Certainly electronic media does not compete with "the culture of books", as it has been mentioned very often. On the contrary the written language has been enriched by this new and additional so-called "sculptural space".

But even this "unlimited space", which occasionally offers ecstatic feelings of "Spider(wo)man´s omnipotence" to individuals, remains a narcistic and childlike illusion.

Even the digital urbanization in form of libraries, conference rooms and book-shops, deludes for the briefest of moments from the fact, that the Internet remains inanimate.

Therefore the longed for boundaries should not be looked for within the medium but should be guaranteed by the users themselves.

As a rule new modes of communication do not replace existing ones. The way into the "Information-Society", via Internet and WWW, in comparison to other steps of technological development (such as the introduction of letterpress printing, telephone, and TV) makes no exception. It is characterized by chances and risks. Discussions on commercialisation, abuse, and the necessity for institutionalisation and a regulated control system are urgently required, but should not suppress any ideas on the potential use of the medium.

Without phantasy and creative use the window leading into the electronic world will not be opened, but will remain an empty one. In this sense it is to be hoped that the psychoanalytic community will accept this view and develop its own perspectives regarding this medium.

Footnotes

* The german version of this article was first published in the journal
Psychoanalyse im Wiederspruch, 17, 77-92, 1997

1 The selection for the most appropriate services depends, beside costs, also on service desired, resp. on service needed. Detailed information on respective hard- and software, configuration of computer would extend the frame of this article too far. Therefore information on those details has to be inquired at special PC-shops, resp. from providers like e.g.

Telekom

2 The equivalent program is delivered by the providing company. Current programmes are e.g. Mosaic and Netscape

3 Simultaneously WWW integrates so-called standard-applications, such as the electronic sending of mail, the so-called e-mail.

4 This address (URL: Uniform Resource Locator) marks the location and type of the document.

5 http://www.phil.uni-sb.de/FR/Medienzentrum /verweise/psych/suche.html

6 http://www.hotbot.com

7 Another search engine is "Savysearch", a program to integrate 30 (!) different search engines (http://rampal.cscolostate.edu.2000)

8 Medline can be called up on various addresses. In Germany most Medical Services offer this service (at the moment without any charges), see above, under "Commercial Providers".

9 http://www.apsa.org/jourlit/index.htm

10 Downloading allows further use of text in e.g. a text-program such as *WinWord*.

11 http://www.dimdi.de

12 http:www.ub.uni-heidelberg.de/

13 http:/www.ubka.uni-karlsruhe.de/hylib/blb_suchmaske.html

14 http:www.swbv.uni-konstanz.de/CGI/cgi-bin/opacform.cgi

15 http://www.psychologie.uni-freiburg.de/dgps.html

16 http://www.klinik.uni-frankfurt.de/findex/index.htm

17 http:/www.ul.cs.cmu.edu/books/FreudDream/interpretation.txt.

18 "Ce site web a pour but de proposer une image globale de la situation de la Psychoanalyse contemporaine dite freudienne. Il s¢ inscrit dans la philosophie qui a présidé à l¢ élaboration du réseau internet, soit la mise en commune desconnaissance dans un contexte d¢ ouverture, de respect et de graduité. Aussi, ce site nécessite la collaboration de tous pou s¢ enrichir et se développer".

19 For an overview of psychologically relevant discussion groups see Grohol (1991-96): Psychology & Support Mailing List Pointer, http://www.coil.com/-grohol/mail.htm; Psychology & Support Groups Newsgroup Pointer [Online]. Available HTTP: http://www.coil.com/%7Egrohol/news.htm

20 http:/userpage.fu-berlin.de/-ahahn/listserv.htm

21 "La revue Trans est une publiée deux fois l¢¢ an, en langue francise."Montreal

22 http://www.uvm.edu/ ~ xli/reference/apa.html

23 "Revista de Psicoanálisis y Cultura." "Revue multilingue, produite en Argentine."

24 A Hyperlink Journal for the Psychological Study of Arts. PSYART publishes on the World Wide Web articles using psychology of any kind to study the arts, but PSYART, specializes in the psychoanalytic study of literature.

25 "PSYCHE (ISSN: 1039-723X) is a refered electronic journal decidated to supporting the interdisciplinary exploration of the nature of consciousness and its relation to the brain. PSYCHE publishes material relevant to that exploration from the perspectives afforded by the disciplines of cognitive science, philosophy, psychology,physics, neuroscience, and artificial intelligence. Interdisciplinary discussions are particularly encouraged."

26 PSYCHOLOQUY is a refereed electronic journal (ISSN 1055-0143) sponsored on an experimental basis by the American Psychological Association and currently estimated to reach a readership of 20,000.PSYCHOLOQUY publishes brief reports of new ideas and findings on which the author wishes to solicit rapidly per feedback, international and interdisciplinary ("Scholarly Skywriting"), in all areas of psychology and its related fields (biobehavioral, cognitive, neutral, social, etc.). All contributions are refereed by members of PSYCOLOQUY¢ s Editorial Board".

27 http://www.wiso.uni-augsburg.de/sozio/hartmann/pscho/journals.html

28 http://www.hos.de29 http://io.mto.de/forum/

30 http:/www.multimedica.de/

31 http://www.medicus.de

32 According to a study of the American Marketing Research Institute Simba, Internet is represented almost only in North America (72%) and in Europe (23%). Additionaly, specific countries (e.g. China) have established a strict control policy for access, which makes restrictions not only for user groups but also for applications.

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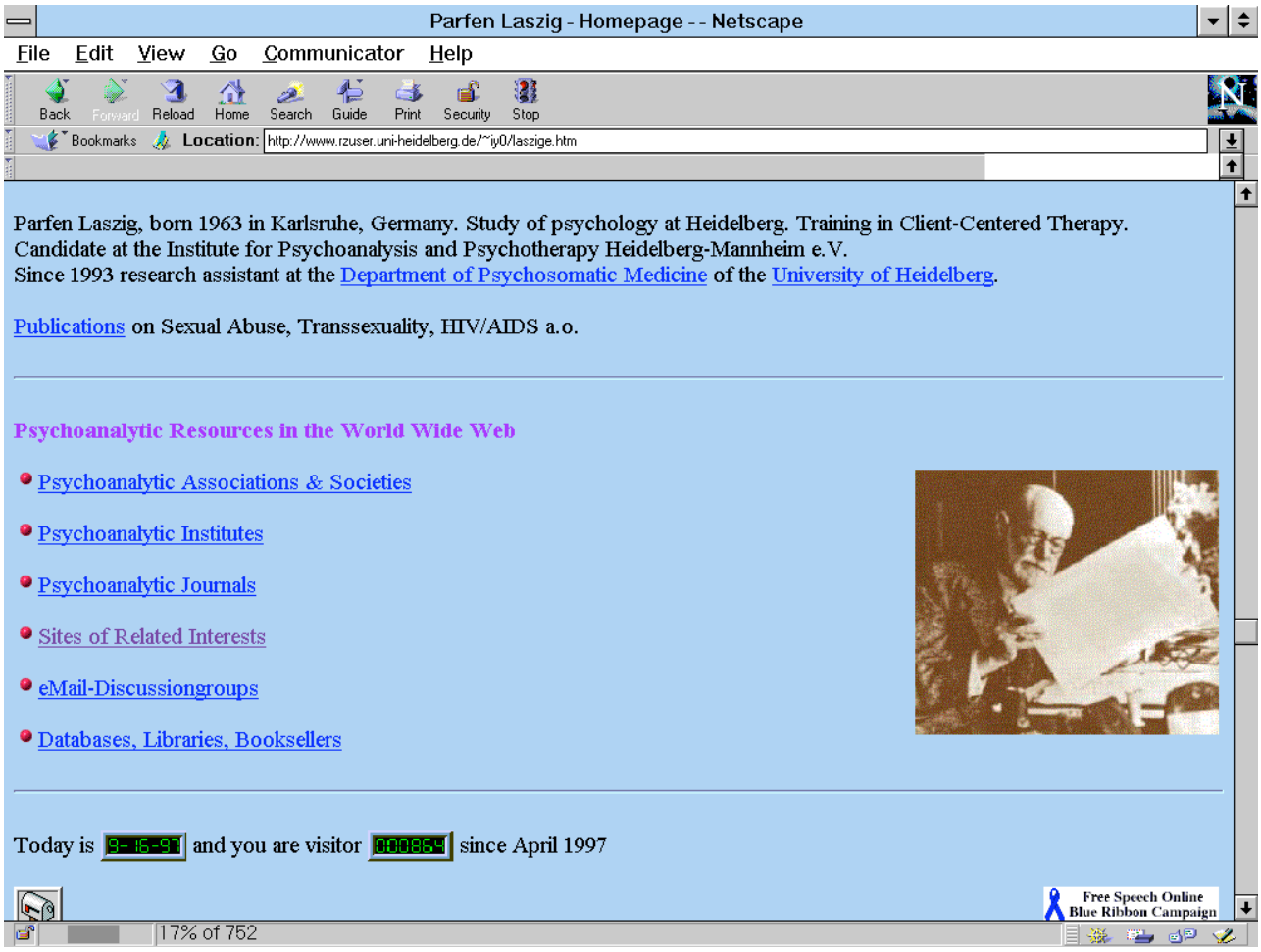

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A comparative study of the CCRT and cycles model methods using a session of psychotherapy

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GENERAL AIMS: The objective of this work is to relate the obtained results by using analysis in a session of Psychotherapy through two narrative analysis methodologies: Cycles Model (CM), and Core Conflictual Relationship Theme (CCRT).

THEORETICAL CONCEPTUALIZATIONS: In this research we combine two study methods that observe patient's narratives, the CCRT (*Luborsky, 1990) and the CM (*Mergenthaler, 1993).

The CCRT is an empirical research method that focuses on the narrative of the patient expressed in Relationship Episodes (RE). In this narrative W (subjects' wishes, needs and intentions); RO (other's responses to W) and RS (subject's responses to RO) are surveyed. The final aim is to arrive at de CCRT (Core Conflictual Relationship Theme) of each patient (i.e, his prevailing interactional pattern usually coinciding with his transference pattern).

Luborsky says "one index of change in dynamic therapy is the extent to which the maladaptive theme becomes less pervasive in the relationships of a patient by the end of treatment"[1]...."this change was related to the self reported change in symptoms and the clinician-rated health-sickness rating"[2]
On the other hand, in the Penn sample, Luborsky et.al, demonstrates that most patients need to increase their self-understanding (insight of their Core Conflictual

Relationship) to improve in psychotherapy. [3]
The Therapeutic Cycles Model is a method able to identify the presence of stylistic patterns in the discourse of the patient. These patterns detect and note the key moments and the Key sessions in the therapeutic process.

The patterns are a combination of the content analysis variables "emotion tone" and "abstraction" allowing a description of therapeutic cycles.

Mergenthaler says "successful patients differ from patients that do not change in a positive way or even worsen by having a higher percentage of the emotion-abstraction pattern D (connecting) (KEY MOMENT = INSIGHT)...Pattern D (connecting) will appear more frequently at the end of a successful treatment"[4] "Defense is strongly connected to abstraction"#[5]

METHODOLOGICAL ASPECTS: The different RE's of one patient were analyzed. The resulting fragmentation (including the blanks provoked by the absence of episodes of the CCRT classification) was matched with the 150 wordblocks fragmentation made by the Cycles Model. The content of these two analysis technics was compared. The aim was to observe if the analysis of these different technics has some degree of relationship. Although the fact that the CCRT doesn't contemplate the therapist speech, the analysis of this speech was made in search of the characteristics of the Therapist Speech, when it provoked a change into the patient pattern.

The next table shows in standard way de structure of the CCRT with the addition of the C.M. components the block numbers and the phases. The use of colors in this table is to be able to see how the patterns and ERO'S match between them.

Here is comparative table showing the CCRT and CM elements (with one color to each phase of the

CM) and all the contents of the CCRT.

CCRT SCORESHEET
AND EMOTION-ABSTRACTION PATTERNS
-Abstract-

Patient: Alfredo **Date:** December 1996
Judges: CS., CMLM. **Sesión Nß** 6 **date:** 5/01/1993
LB., SK.

	CCRT			**CM**	
E.R.	Wish, need or intention	R.O.	R.S.	Block number	Pattern
# 1 girlfriend	(w) to be in control (21) 1 to know what do I laugh about (21) 1	(-) girlfriend misunderstand him (2) 5 (-) girlfriend gets angry (4) 5	(-) I laugh (13) 6 (-) I laugh when I'm laughing(13) 6 (-) My reaction disturbs me (2) 2 (-) I don't know what do I laugh about (2) 2	1	Connecting
# 1 girl-friend (cont.)			(-) When I argue with my girlfriend I laugh and I can't stop it (13) 6 (-) Time ago I use to get angry (13) 6	2 3	
# 2 father	(w) his father carry out his obligation (13) 3 (w) to understand his father (4) 5	(-) his father forgot his obligation (19) 3 (+) His father explains himself (11) 8 (+) It wasn't so serious (11) 8	(-) Recriminate my father (21) 7 (+) I lament (1) 1 (+) I relief(1) 1	4	
# 3 mother	(w) his mother carry out his obligation (13) 3	(-) his mother forgot her obligation (19) 3 (+) mother explains herself (11) 8 (?) mother was surprised (11) 8	(-) Recriminate my mother (21) 7 (?) Inform my mother (7)1	5 6	Reflecting
# 4 pa-rents	(w) He want to understand (4) 5 (w) See his parents to make a fool of (16) 2 parents being alone there (16) 2 to worry because other people doesn't come (16) 2 To avoid seeing his parents arguing(14) 4)	(-) parents don't carry out their obligation (19) 3 (-) parents are wrong (19) 3	(?) I found funny the story (7) 1 (+)I try to understand (1)1 (-) I laugh at this story (21) 7 (+) I would enjoy it (21) 7	7	

# 5 lawyers	(w) to protect his father (12) 8	(-) lawyers attack his father (19) 3 (-) Lawyers aren't trustworthy (19) 3	(+) I defend my father (1)1 (+) Justify my father (1)1	8	
		CCRT			**CM**
E.R.	Wish, need or intention	R.O	R.S.	Block number	Pattern
# 6 mother	(w) His friend not to be use by his mother (3) 6 to be requesting (3) 6 (w) his mother request him (3) 6 People he loves to be protected by him (12) 8 His parents take charge of situation (3) 6 (w) to understand (4) 5	(-) His friend is used by his mother (2) 5	(+) I got very angry (21) 7 (-) There are some things that I don't understand (2) 2	9 10 11	Relaxing
# 7 mother	To be respect by his mother (3) 6 Not to be hurt by his mother (14) 4	(-) They deprived him of attention (6) 5 (-) Mother deprived him of attention (6) 5 (-) Mother isn't trustworthy (19) 3 (+)Mother is trustworthy (11) 8 (-) Mother pretends she agree (8) 4	(+) I ask my mother (7) 1 (+) I ask my mother not to bother my friend (7)1 (+) I complain about my meddling mother (7) 1	12 13	Experiencing
# 7 mother (cont.)		(-) Mother investigate at the back (8) 4			
# 8 conflictive group	His mother not to be contradictory (14) 4	(-) Mother lies (19) 3 (?) Mother doesn't know where he is (19) 3	(+) I complain about the contradictory answer of my mother (21) 7	14	Relaxing
# 8 (cont.)	The lawyers to be more specific (14) 4		(+) I complain about the lawyers (21) 7	15	Reflecting
#8 (cont.)	Justify parents (4) 5			16 17	Relaxing
# 10 self	Stop suffering (14) 4		(-) It hurts me very much (22) 7 (+) I try to get off pain (22) 7 (-) I can't find relieve (22) 7	18 19	Connecting

			(-) It hurts me (22) 7 (+) I try to avoid the subject (22) 7 (-) I remember my father (23)7 (-) I remember my parents being together (23)7		
# 11 parents	(w) To comfort his father (12) 8 (w) To know why parents cry (4) 5	(+) His father read him the letter for the judge (11) 8 (-) Father cry likes a child (11) 8 (+) Father calms down (11) 8 (-) His mother speaks about his father and cry (11) 8	(+) I comfort my father and I cry (9) 1 (-) I don't know why my parents cry (2) 2	20 21	
#11 parents (cont.)	(w) Parents don't cry (13) 3		(-) I feel bad because my parents cry (22) 7	22	Experiencing
				23	Connecting
				24	Reflecting
		CCRT			**CM**
E.R.	Wish, need or intention	R.O.	R.S.	Block number	Pattern
# 14 family (past)	(w) Family wouldn't change (11) 5 He wants his daddy at home (11) 5 (w) He wants his house to be a home again (11) 5	(+) The family used to enjoy music (11) 8 (-) The family don't enjoy music any more (12) 5	(+) I miss homelife(23) 7 (+) I miss my daddy (23) 7 (?) I don't stay home (20) 7 (+) I miss so much (23) 7 (?) I think problems will not solve with house moving (20) 7	25 26	Reflecting
# 15 father	(w) Things wouldn't change (14) 4		(-) I feel daddy didn't make a good change (20) 7 (-) I feel daddy can't move back (20) 7	27 28	Relaxing
# 15 father (cont.)	(w) He wants his daddy at home (11) 5 (w) To be nearer from his father (11) 5 (w) To feel comfortable at his father's home (3) 6	(-) His father replaces him for a woman (8) 4	(-) I cry (22) 7 (-) I feel I have half a father (20) 7 (-) I have not private life in my daddy's house (20) 7		

# 16 Self	He wants his father's wife far from him (18) 2 (w) He doesn't want to be friendly with her(10) 4		(+) I feel she is guilty (21) 7 (+) I don't want my father's wife take advantage (11) 4 (+) I don't want to be friendly with her (11) 4 (+) I dislike exploitation people (21) 7 (+) I feel exploitation my father's wife (21) 7 (+) I reflect about it (2) 2	29 30 31	Experiencing
# 16 Self (cont.)	(w) She should ask him first (18) 2		(+) I don't want my father's wife try to be near (21) 7 (+) I feel my father's wife took me out my father (24) 7	32 33	Connecting
				34	Reflecting
# 18 father's wife (past)	Don't bother him (10) 4	(+)His father's wife interrogate him (7) 5 (+) His father's wife had to shut her mouth (16) 3	(+) I argue with my father's wife (11) 4 (+) She gets angry (21) 7	35	Relaxing

Nß	Cluster	Wishes	Frequency
4,11	5	To be close and accepting	7
10, 14	4	To be distant and avoid conflicts	7
3	6	To be loved and understood	3
12	8	To achieve and help others	3
13	3	To be controlled, hurt, and not responsible	3
16,18	2	To oppose, hurt and control others	3
21	1	To assert self and be independent	1

Nß	Cluster	RO	Frequency
16,19	3	Upset	7
2.4.6.7	5	Rejecting and opposing	6
1, 3, 11	8	Understanding	5
8	4	Bad	2

Nß	Cluster	RS	Frequency
20,21, 22,23, 24	7	Disappointed and depressed	15
1,7,9	1	Helpful	7
2	2	Unreceptive	4
13	6	Helpless	1

11	4	Oppose and hurt others	2

CCRT#
"I want to be closed and accepting, other upset me and I'm disappointed and depressed"

PRELIMINARY RESULTS AND COMMENTS: This pilot study doesn't have a representative character. The results lead to a comparative investigation with multiple cases. Some of the observed issues are:

The therapist´s interventions previous to the Keymomment include the patient´s CCRT elements. This fact could indicate a connecting phase provoked by the therapist´s intervention. Previous to the RE N.10 (word block. 18 and 19) it's possible to observe within the therapist speech : a) A predominant patient W (to be close to others, Cluster 5). b) A predominant patient RO (upset, hurt, angry, CL 3) c) A predominant patient RS, when the therapist says "you are very angry and in pain" (disappointed and depressed, cl7). During the Key moment, the patient expresses his W by saying "pain, go away" and his RS is to express his pain, feel neglected by his parents and confront his parent's divorce alone.

Regarding the analyst's interpretation, two Freudian observations studied in the Penn sample, related de CCRT with therapist's interpretations: "(15) Interpretation hanges the expression of the pattern; (16) Insight into the transference pattern can benefit the patient"[6] "Most striking is the fact that the accuracy on the wish plus response from other scale is the best predictor of outcome"[7] "Accuracy of interpretations... represents the degree of congruence between the contents of the therapist's interpretations and the contents of a patient's CCRT"[8].

Another observation shows an explanation in a relaxing pattern after a therapist's expansion question made by a high level of empathy. In those ERO's it's interesting to observe the presence of the nuclear elements of the patient's CCRT, this could indicate a relaxing phase hold by an accompaniment feeling, more than an evasive action of the conflict situation.

The block one has a Key moment with a W a RO and a RS, which, however are not charactersitics of the patient´s CCRT. For this reason we consider this as a special connecting. Their the patient, focuses and describe his problems and his expectations of understanding, but without going through the defense level. Here the W is "to be in control" (ST 21, CL.1), the RO is "The other are angry" (St. 4, Cl. 5), and the RS is "he feels out of control and not selfunderstood " (ST. 13 Cl. 6 , ST. 3, CL. 2).

New projects are being developing as a result of this first explorative study. These new studies use the preliminary results as hypotheses to be corroborated.

One of the projects is a comparative study of the two technics using 16 single sessions from different non diagnosed Borderline of psychotic patients. The second one is the study of six psychoanalytic treatments, trying to trace in a longitudinal way the results obtained in the present research.

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A cyclic model of therapeutic processes: The flow of Emotion-Abstraction Patterns in a long term psychoanalytic treatment

Erhard Mergenthaler

Introduction

Jones and Windholz in their 1990 paper entitled "The psychoanalytic case study: Toward a method for systematic inquiry" (Jones & Windholz, 1990) conclude that "The psychoanalytic literature is extraordinarily rich in theoretical writings and clinical case studies. There has, however, been very little in the way of reliable, descriptive data about the analytic process" (p. 1014). With the application of the Q-technique to the case of Mrs. C. in that very paper they clearly demonstrated that psychoanalytic case material can be studied in a systematic and formal manner and thus they gave a valuable contribution to a formal and systematic inquiry of psychoanalytic constructs. With the most and least descriptive Q-items for the complete treatment they provided a "static" picture of the analysis. An "in-motion" view was given by statistically comparing the more or less characteristic Q-items in successive years. The study was based on 6 blocks of 10 sessions each roughly covering the six years lasting treatment, or in other words 5,5 percent of all 1.100 sessions. This poor coverage however raises doubts on the usefulness of the findings, whether psychoanalytic constructs really are captured, or whether the psychoanalytic process has been observed at all.

About the same time, Gedo and Schaffer (Gedo & Schaffer, 1989) presented a study of another psychoanalytic case, A2, lasting 2 and a half years with a total of 324 sessions. The authors choose a random sample of 10 sessions each from an early and a late phase and thus covering 6,2 percent of all sessions. The sessions have been rated according to a modified form of the Gill-Hoffman (1982) coding scheme for tracing transference references. The aim of this study was to "systematize the data and to trace process within sessions" (p. 281). Also here the results may be questionable with regard to their representativeness for the full treatment.

Another aspect both studies share is the lack of a process model, or at least of variables that are closely related with a theory of change. Both, the Psychotherapy Process Q-set and the Gill-Hoffman coding scheme are instruments that are inherently bound to clinical psychoanalytic thinking and barely can be connected to a dynamic view of change. An idea of what "Therapeutic Change Agents" could be like Toksoz B. Karasu already gave in 1986 (Karasu, 1986) . In a very profound and theoretically grounded paper he identified three change agents: Affective Experiencing, Cognitive Mastery, and Behavioral Regulation. These aspects of therapeutic processes share the principle of universality and complementary. This means, that "all psychotherapies use some combination of affective experiencing, cognitive mastery, and behavioral regulation as therapeutic change agents" (Karasu 1986, p. 693). From this it can be concluded that schools may not be more than emphasis on one or more of these change agents by preferring certain techniques. This however sounds very similar to what Klaus Grawe in a recent paper (Grawe, 1997) lines out as Research Informed Psychotherapy, based on four "Basic Mechanisms of Change": Problem Actuation, Clarification of Meaning, Mastery/Coping, and Resource Activation. In fact, what is new compared to Karasu's change agents is the aspect of the patient's and therapist's resources that can or can not be activated in a psychotherapeutic process.

But still, the identification of therapeutic change agents is not enough in order to understand and study psychotherapeutic processes and thus processes of change. What needs to be added are models of process that are built on change agents but also take into account the temporal aspects of treatment. A very general process model, or better to say, a model of viewing at therapeutic

processes, is given by Thomä and Kächele (Thomä & Kächele, 1985; Thomä & Kächele, 1987) with their notion of the "Focus Model". This model essentially describes a psychoanalytic long term treatment as a sequence of focal therapies with changing focus. The model does not, however, specify any change agents.

A more specific view of therapeutic processes is given by Stiles (Stiles et al., 1990) in his model on the Assimilation of Problematic Experiences. His variables "Feelings" and "Attention" roughly can be understood as change agents and the Assimilation Model predicts their prototypic change, defining the sequence of phases like: Warded off, unwanted thoughts, vague awareness, problem statement and clarification, understanding and insight, application and working through, problem solution, mastery. The empirical realization of this model is done using a rating scheme to identify the given phase in transcripts or video recordings.

A psychoanalytical oriented and by findings from cognitive psychology grounded process model is given by Wilma Bucci (Bucci, 1997) . Her *Multiple Code Theory* and the Referential Cycle provide a solid theoretical background to describe psychotherapeutic processes not only phenomenological, but also analytical. The notion of the "power of the narrative" opens both a window to an understanding of therapeutic processes in terms of emotion schema and reflecting processes, and to an immediate understanding of the therapist's verbal actions and regulation of such.

The study presented here uses Mergenthaler's approach of measuring therapeutic processes by means of *Emotion-Abstraction Patterns* and the *Therapeutic Cycle* Model (Mergenthaler, 1996) . This approach makes use of two of the above mentioned change agents, Affective Experiencing and Cognitive Mastery measured as "*Emotion Tone*" and "*Abstraction*" in the verbal expressions of patient and therapist in verbatim transcripts. This model describes both: Micro processes within session and macro processes across sessions. Depending on the intensity and duration of a therapy (e.g. psychotherapy vs. psychoanalysis) the various phases of the model can become repeated (repetition), cycles can be repeated (iteration), or one or more cycles can occur within a cycle (recursion). This constitutes the descriptive power of the *Therapeutic Cycle* Model.
Emotion-*Abstraction* Patterns

The quantitative dimension of *Emotion Tone* and *Abstraction* allows to differentiate four classes, the *Emotion-Abstraction Patterns* (Fig. 1). Graphically they will be represented as a combination of the standardized relative frequencies (z-scores) for *Emotion Tone* (black) and *Abstraction* words (grey). The four patterns are defined, labeled, and interpreted as follows:

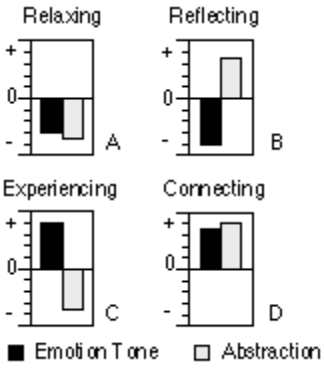

Figure 1: The four Emotion-Abstraction Patterns

Pattern A - *Relaxing*: Little *Emotion Tone* and little *Abstraction*. Patients talk about material that is not manifestly connected to their central symptoms or issues. They describe rather than reflect. Further, it is a state patients return to as often as they feel the need to, thus regenerating both, physis and psyche to prepare themselves for the next step of their «talking cure». *Relaxing* correlated with "Well Being" as rated by a patient on a visual scale (Mergenthaler et al., in prep.) . Furthermore, there is a coincidence with the "Well Modulated" state of mind according to Horowitz (Mergenthaler & Horowitz, 1994) .

Pattern B - *Reflecting*: Little *Emotion Tone* and much *Abstraction*. Patients present topics with a high amount of *abstraction* and without intervening emotions. This may be an expression of defense known as intellectualizing.

Pattern C - *Experiencing*: Much Emotion and little *Abstraction*.
Patients find themselves in a state of emotional *experiencing*. Patients may be raising conflictual themes and *experiencing* them emotionally. *Experiencing* correlates negatively with "Well Being".

Pattern D - *Connecting*: Much *Emotion Tone* and much *Abstraction*. Patients have found emotional access to conflictual themes and they can reflect upon them. This state marks a clinically important moment. *Connecting* correlates with the "Shimmering" sate of mind, according to Horowitz a moment where therapeutic change takes place (Mergenthaler & Horowitz, 1994) .

The therapeutic cycle model

The following model (Fig. 2) is derived from a specific temporal sequence of the four Emotion-Abstraction Patterns. This is introduced as the Therapeutic Cycle Model consisting of five phases. It is based on the assumption that across a psychotherapy or within a psychotherapy session emotion abstraction patterns do not occur by chance. Rather a periodic process for the underlying variables "emotion tone" and "abstraction" is assumed. A periodical change of content analysis variables already has been observed by Hogenraad and Bestgen (Hogenraad & Bestgen, 1989) . They have been analyzing a three-hour monologue for primary and secondary processes using the Martindale regressive imagery dictionary. Within approximately half an hour the initally dominating primary process decreased and the secondary process dominated. Within another two hours the variables again changed dominance. They found similar rhythms in literature like novels. To explain this, not only psychic, but also biological factors may be taken into account (e.g. endorphines).

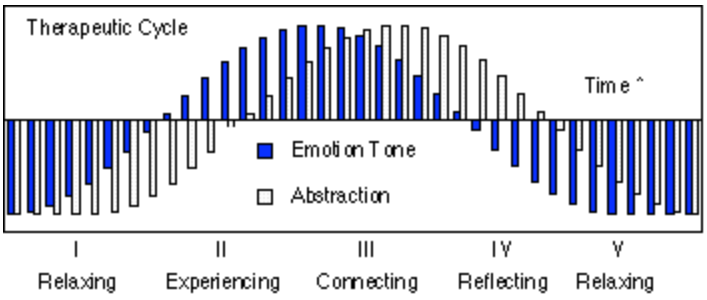

Figure 2: The Therapeutic Cycle Model.

Phase I: Starting point is pattern A (Relaxing), moments where patients do not show much emotion nor abstraction. They find themselves in a "relaxed" state, in a transitional state from one theme to another, or they are associating freely.

Phase II: After a while, emotion increases and pattern C (Experiencing) will show up. This shift can be initiated by having reported a narrative (dream, early memory, episode) or by reporting on the symptoms they are suffering from. Patients at this time are in a state of emotional experience.

Phase III: Ideally here the amount of reflecting will increase, either by patients' own impetus or guided by the therapist. Patients will reflect their recent emotional experience and thus reach emotional insight. They are in a state of connecting Emotion Tone and Abstraction showing up as pattern D (Connecting).

Phase IV: As a consequence of the insight processes the emotional tension will decrease. Patients can reflect upon their new experience without being bound to emotional constraints. Pattern B (Reflecting) will show up.

Phase V: Finally reflection will fade out. The cycle ends with the state of Relaxing (pattern A) which can lead to the emergence of a new cycle.

The Therapeutic Cycle model can be used for both, micro analyses, and for macro analyses. In the macro-analytic perspective the patterns are computed for full therapy sessions. A therapy then can be characterized by a given sequence of these patterns. From clinical experience it is known that in every therapy there are phases in which the patient has more working-through processes like insight but also periods where defence mechanismes are dominating or patients are occupied by emotional states. This experience is what the therapeutic cycle model puts into an ideal and prototypic order.

The microanalysis refers to the analysis of one single therapy session. Here the Therapeutic Cycle model describes the very moments of genesis, effect and end of therapeutic progress. From clinical experience it is well known that the processes of insight do not occur very often within a session and even not within every session. With regard to the Therapeutic Cycle model it is rather expected that the cycle fairly often can be observed partially. From the analyses of several hundreds of therapy sessions it is known already that the variables "emotion tone" and "abstraction" peak two to three times within a session.

Along with the Therapeutic Cycle model three principles should be mentioned that contribute to the descriptive power of this approach. The first one is the principle of *repetition* which means that single phases of the model can become repeated. The second one is called *iteration* when complete cycles are iterated. Finally the princple of *recursion* should be mentioned which can be observed on the macro-analytic level and means that one ore more cycles can occur within a given major cycle. One of the goals of this study will be to show that these principles, repetition, iteration and recursion empirically can be demonstrated with a long-term analysis due to the unique chance that there no sampling has to be employed because every therapy session is transcribed.

It has been shown that improved patients significantly more often show the pattern of connecting compared to not improved ones. Also, in a psychotherapy which was known to have a key session and key momentwithin, both could be idendified by using this technique. In addition the macro-analytic analysis of several short-term therapies ranging from 8 therapy hours to 28 showed an overall change according to the therapeutic cycle model.

Method and Material

This study used transcripts from a fully audio taped analysis conducted between 1975 and 1977 with a total of 324 sessions. The analysis begun with a frequency of 4 sessions a week; the last six months have been conducted with two sessions a week and face-to-face. The patient was a middle-class married woman and housewife in her late 20s. She was complaining about phobic reactions to social outings, which included symptoms of nausea and diarrhea before and after such events. The case was judged to have a good outcome.
The transcripts are on loan from the PRC[1]. The transcripts were done on a typewriter machine and later on became scanned for use with a computer. There have been many errors within the text which have been fixed as far as possible for this study. The most serious problem was the loss of speaker role due to missing markers and thus the mix-up of patient's and analyst's contributions.

The graphical data representation will be done using procedures composed of several smoothing runs. For the microanalyses this will be a moving avarage with a window of three and weights of .25, .50, and .25. For the macroanalysis a technique known as 4253H-smoothing will be applied (Velleman, 1982) . Thus the data are smoothed by a running median with a window of four, then smoothed again with a window of two, then of five and finally of three. Smoothed data may be considered to be closer to the real unfolding of the dimension measured in a given text. Of course for detailed analysis the unsmoothed data have to be used. The amount of variants that the smoothing data share with the unsmoothed ones normally is abough 25 % which means that the smoothed data still have a correlation with raw data of .50 or more.

As an example for a microanalysis with this long-term therapy session 245 was depicted. This is the only instance where both change agents "emotion tone" and "abstraction" are above two standard deviations. This sessions shows two cycles from word block 2 through 7 and 8 through 17. As we can see from the lower graph the therapist's activity in the word blocks 10 through 12 contribute to a more intensive connecting. In the second half of the session no cycle is developing. Although the therapist tries as in word block 17 and in word block 24 with substantial interventions to keep this

process running.

In addition to the application of the Therapeutic Cycle model based on emotion-abstraction patterns the Affective Dictionary developed by Michael Hölzer was applied to the material. From that dictionary two categorizations were used: *positive* compared to *negative* emotions and *self* compared to *object* emotions. From the macroanalysis it becomes obvious that the pattern of experiencing, as can be observed in phase 2, obviously is built up of negative emotions. The positive emotions rather mark the beginning of the intensive working period marked by phase 4. Both dictionaries positive and negative together cover less than 50 per cent of the emotion tone dictionary.

Results

The overall representation of case A2 (Fig. 3) clearly shows that the treatment can be characterized by five phases each represented by a different Emotion-*Abstraction* Pattern. The analysis starts with about 54 sessions classified as *Relaxing*, followed by a phase of 42 sessions marked as *Experiencing*. The third phase of about 30 sessions has little *abstraction* and moderate emotion. Formally this has to be seen as *Experiencing* as well, but it clearly differs from the second phase. Then follow 24 sessions *Experiencing* which directly leads into a long period of 78 sessions with *Connecting*. The last phase it characterized by the pattern *Reflecting*. The beginning of this period coincides with the strong wish of the patient to no longer lay on the couch and, in fact, refusing to do so. The second half of this phase was then conducted on a twice-a-week basis face to face. The *Therapeutic Cycle* partially can be observed twice. The first instance starts in phase 1 with *Relaxing*, followed by *Experiencing* in phase two. The next two steps, *Connecting* and *Reflecting* are missing however. The second instance is an almost complete *Therapeutic Cycle* and starts in phase 3 with *Relaxing*, followed by *Experiencing*, *Connecting*, and *Reflecting*. What is missing is the final *Relaxing*. This should however be considered in connection with the change in the setting from couch to face-to-face.

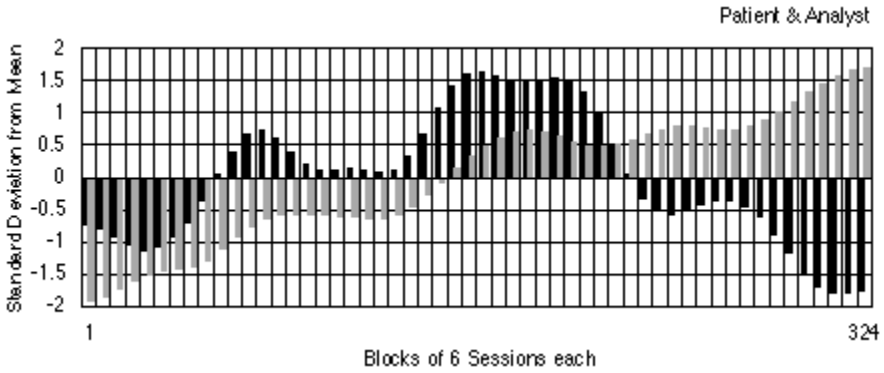

Figure 3: A2 - complete case (Emotion Tone = black, Abstraction = grey).

A macro analysis of the last phase which is characterized as *Reflecting* in the overall view reveals the recursive properties of the method. Standardizing just across the last 54 sessions reveals new cycles taking place on a "lower" level.

The longitudinal distribution of the Emotion-*Abstraction* Patterns over all 324 sessions (54 blocks) showed highly significant changes for all four patterns (Pearson r; $p < .001$). While *Relaxing* ($r = -.64$) and *Experiencing* ($r = -.52$) decreased, *Reflecting* ($r = .70$) and *Connecting* ($R = .55$) clearly increased. These changes mainly took place during the first 267 sessions (45 blocks) when the analysis was four times a week. The last 56 sessions (9 blocks) did not show significant change except for *Experiencing* ($r = -.40$, $p < .05$).

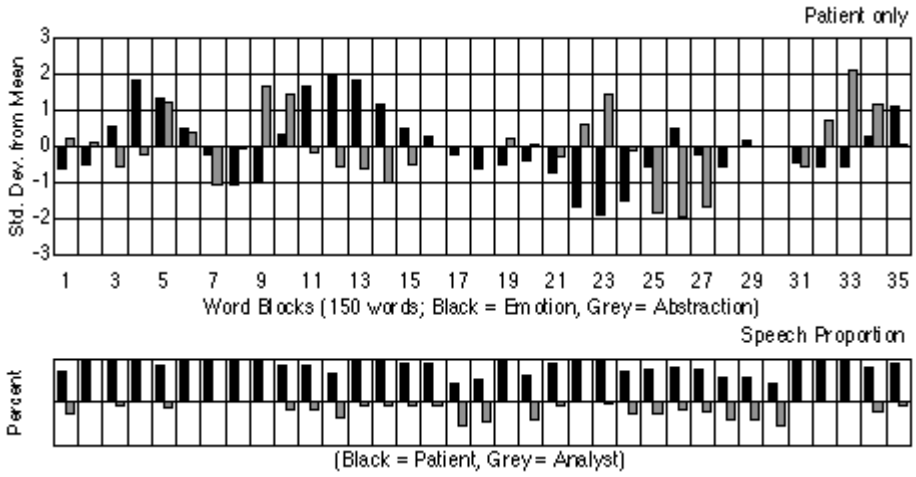

Figure 4: A2 - Session 245

From the micro analysis of session 245 (Fig. 4) it becomes obvious that there are two instances of the Therapeutic Cycle

Discussion

The findings support the notion of *Emotion Tone* and *Abstraction* as change agents under the principle of complimentary. The recursive power of the *Therapeutic Cycle* Model was demonstrated from a very general macro-analytic level, through a medium level analysis down to the mirco analysis within sessions. As to my knowledge this is the first time that a complete analytic treatment became analyzed in a systematic and formal way and theoretically grounded.

The results of the *Therapeutic Cycle* analysis also demonstrate that findings based on sampling techniques might be crucial when to describe long term change. The sample chosen by Gedo and Schaffer can be located in the transient area between the first and second phase for the early sessions, and the beginning of the fifth phase for the late sessions group. It is not astonishing from the *Therapeutic Cycle* point of view that they did not find as much significant findings as they had expected. Just to give an example, Gedo and Schaffer hypothesized, that within late sessions "the patient should be more able to follow up one transference insight with another" (p. 280) and they found a suggestive trend in the predicted direction. Using the same sample this also can be shown by counting the number of complete *Therapeutic Cycles* which in fact is higher in the last sessions sample. Had they chosen the late session samples within the range of phase 4 they could have expected much clearer results. Another example is their hypothesis that "transference insight will increase across the treatment" (p. 280). This prediction did not approach statistical significance, although the mean probability changed in the predicted direction. For the same sample the pattern *Connecting* increased significantly ($M_e = 18.9$, $SD_e = 6.4$, $M_l = 30.0$, $SD_l = 6.6$, $t = -4.40$, $DF = 9$, $p < .01$) which indicates a significant increase of insight.

The findings clearly are against the myth of uniformity. We can not expect the psychotherapeutic process to start from a given level and then to continuously increase or decrease. More likely and supported by the findings with the *Therapeutic Cycle* Model is a cyclic behavior with, in an ideal case, findings at the end that rather compare to those at the beginning and the extreme changes within the therapy.

Clearly, many steps are still left to do. One of them includes to trace the major topics this analysis is about in the disparate phases. This can be done by using the characteristic vocabularies which will give hints on thematic topics.
Another interesting step will be the analysis for transference using Spence's measures (Spence et al., 1994; Spence & Owens, 1990) .

Finally, this analysis will be expanded including Bucci's Referential Activity measured as Computer Referential Activity CRA (Mergenthaler & Bucci, in print) . Combining the three language measures

CRA, ET, and AB will allow for an even more powerful model, the Cycles Model (Bucci & Mergenthaler, in prep.) that makes fully use of the *Multiple Code Theory* and computer assisted measures in order to describe not only change effects but also to explain why changes take place.

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[1]Psychoanalytic Research Consortium, directed by Sherwood Waldron, New York

A Research Strategy for Measuring Structural Change in Psychoanalytic Psychotherapies

Gerd Rudolf, Tilman Grande & Claudia Oberbracht

Summary

The paper presents a research strategy which can be used to identify structural change. This strategy makes it possible to add to the measurement of symptomatic or behavioral changes a specifically psychodynamic level of investigation. The goal of long-term psychoanalytic psychotherapies is to induce changes at the structural level. Our assumption is that it is only by including this level that the important effects of such therapies can be depicted adequately.

Introduction

In what follows we present a research strategy which we developed to conduct the "Practitioners' Study in Analytic Long-term Psychotherapy (PAL)." In 1993 the DGPT (Confederation of German Psychoanalysts) decided to support research on long-term psychoanalysis. The DGPT's plan was to study highly frequent long-term analyses as compared with one hour/week psychotherapies. In calling for research proposals the DGPT's was on the one hand pursuing a legitimately interest, one directed toward outside addresses such as health insurance funds and political institutions; on the other hand, however, it also encountered an existing interest on the part psychoanalytic organizations in evaluating their own work and gaining a deeper understanding of it with the aid of systematic research. Aside from the question of effectiveness, the call for projects was thus also guided by the inside interest in an investigation of processes and the specific effective mechanisms of psychoanalysis.

In working on the DGPT's invitation, our considerations soon centered on the fundamental question whether the demands formulated there for a research project on psychoanalyses could, in view of the present state of research and methodology, be met in the first place. The most important problem emerged from the circumstance that, against the background of the so-called dose-effect models (Howard, Kopta, Krause & Orlinsky 1986), the research instruments used so far identify significant changes in the early phases of psychotherapeutic treatment but only slight effects in the further course of treatment. This means that the potential for mapping the beneficial effects of therapy is limited to about the first 50 hours of treatment (Grawe, Donati & Bernauer 1994). Thus, only up to the 50th hour such methods can be used to represent therapeutic effects so convincingly that the benefits of therapy become manifest; the effects then recede, and, for instance, after the 200th or 300th hour, are only weakly detectable and can thus, at best, be demonstrated only with references to large numbers of cases.

These results led us to conclude that the specific effects of psychoanalyses, which, as experience shows, materialize only following long and intensive treatment, cannot be detected with the aid of conventional research instruments. These instruments measure close to the surface by capturing above all symptomatic or behavioral characteristics. On the other hand, from the psychoanalytic point of view, the essential changes proceed at the level of personality structure, i.e. in the course of the reliquification of pathological structures that have emerged in the course of a biography and the reorganization or reintegration of the intrapsychic conflicts and vulnerabilities imbedded in them. Such processes of restructuring, which are in all probability reached only by means of long-term analytical processes, can apparently not be registered by the customary measures of change. It is as though, having turned on the cellar light, one were to measure the light on the first floor. These considerations led us to conclude that a project dealing with the effectiveness of long-term analytic therapies might meet with success only if a standardized method were available to assess central personality-structure data from a psychoanalytic point of view.

In fact, 1992 saw the constitution of a working group consisting of 40 scientists and clinicians with a psychoanalytic background and from 12 universities; the group developed, in the framework of the project on an Operationalized Psychodynamic Diagnosis (OPD), instruments that close this gap. Four years of work led to a classification system for research, teaching, and practice that is based on psychoanalytic constructs and thus goes beyond the descriptive approach of existing systems (Arbeitsgruppe OPD 1996). The instruments of the OPD thus assume a central position in our research concept, which, toward the end of 1993, was presented to the DGPT as a project proposal (Rudolf & Grande 1997). The plan was evaluated by several independent experts and classified as suitable for answering the questions posed in the DGPT's call for projects. A review committee agreed in 1995 to support our concept with a

grant.

Toward the end of 1996 we started with data collection in 3 centers (Heidelberg, Berlin, Zürich). We decided in favor of a naturalistic research design, that is to say, the patients are accepted for the study after they, together with their analyst, have opted either for a psychoanalytically oriented psychotherapy (one hour, seated) or a higher-frequency psychoanalysis (3-5 hours, reclining). This type of comparison is used to create, with regard to the therapeutic setting, a sharp contrast which, as clinical experience indicates, will render observable the specific effects and modes of impact of the two forms of therapy. Meanwhile a growing number of reputable scientists from all schools of therapy share the view that randomizations pose insuperable difficulties in the filed of psychotherapy research in that they create artificial realities, thus failing to give rise to valid results (Seligman 1995; discussion in Waldvogel 1997). In studies it has been demonstrated time and again (overview in Orlinsky, Grawe & Parks 1994; see also Rudolf, Grande & Porsch 1988; Rudolf 1991; Rudolf & Manz 1993) that the initial encounter between therapist and patient and the "relationship work" continuing after the beginning of therapy constitute a crucial factor the realization of therapy in the first place and for the course of psychotherapeutic treatment.

The study will include a total of 72 cases, a further 30 cases are being investigated in the Swiss parallel study. The research experience available thus far indicates that this number of cases is perhaps somewhat small to arrive at a statistical demonstration of differential therapeutic effects. This meant that in selecting the patients care had to be taken to ensure that the anticipated differences between groups were clear-cut. To create a marked contrast, we thus restricted the study to severely disordered patients. The differences between the two forms of therapy were expected to emerge more clearly for this selection of patients, assuming that it is precisely with severely disordered patients and low-frequency therapy on the one and a psychoanalytic therapy on the other hand that qualitatively and quantitatively different results could be sought for and, according to clinical experience, achieved as well (the options can be summed up in the alternatives of "coping" versus "structural change"). The study thus deals with a section of the patient spectrum in which the specific effects of psychoanalyses are particularly marked. This selection is additionally reached with the aid of a homogenization of the patient group aimed at improving the detectability of differential therapeutic effects for purely statistical reasons (Grande & Jakobsen, forthcoming). Our study regards as severely disordered patients who show on the structural axis of the OPD a moderate or low integration level and furthermore display clear-cut symptoms. With an eye to ensuring continuous comparability of the differential effects in the two groups, each of the participating analysts brings with him/her to the project two cases, one psychoanalysis and one psychotherapy. In this way possible influencing factors associated with the person of the analyst is are compensated for in both groups (overview in Grande, Rudolf, Oberbracht 1997).

The Operationalized Psychodynamic Diagnosis is geared to those relationship patterns, conflicts, and structural characteristics that, in the view of psychoanalysis, make up the latent basis of a patient's symptoms and are thus the object of treatment. This means that the assignment of a patient to an OPD diagnosis at the same time implies a definition of his central problems, which also makes it possible to indicate the type and direction of the restructuring processes required for any substantial change. The isomorphy thus realized in the definition of the disorder in need of treatment, the focus of treatment, and the criteria of therapeutic success corresponds to the problem-treatment-outcome congruency pointed to by Strupp, Schacht & Henry (1988; see also Schulte 1993). The Operationalized Psychodynamic Diagnosis is thus, for many reasons, eminently well suited to detect structural changes.

Instruments for registering structural change

The clinical material required to assess an OPD finding can be obtained with the aid of an interview developed especially for the purpose; the interview is initially in free form and is then focused on given areas important to judging the axes "relationship," "conflicts," and "structure." The interview framework is described in Janssen, Dahlbender, Freyberger, Heuft, Mans, Rudolf, Schneider & Seidler (1996) (see also Arbeitsgruppe OPD 1996). In our project we conduct the interview in the research institution; the patient is invited to attend at the beginning of treatment, after three and six months have elapsed, and then every six months. The interview is conducted and evaluated by scientifically trained staff members.

The Operationalized Psychodynamic Diagnosis conceptualizes a set of psychodynamic findings as a combination of five axes:

- experience of illness and treatment preconditions
- relationship
- conflicts
- structure
- ICD-10

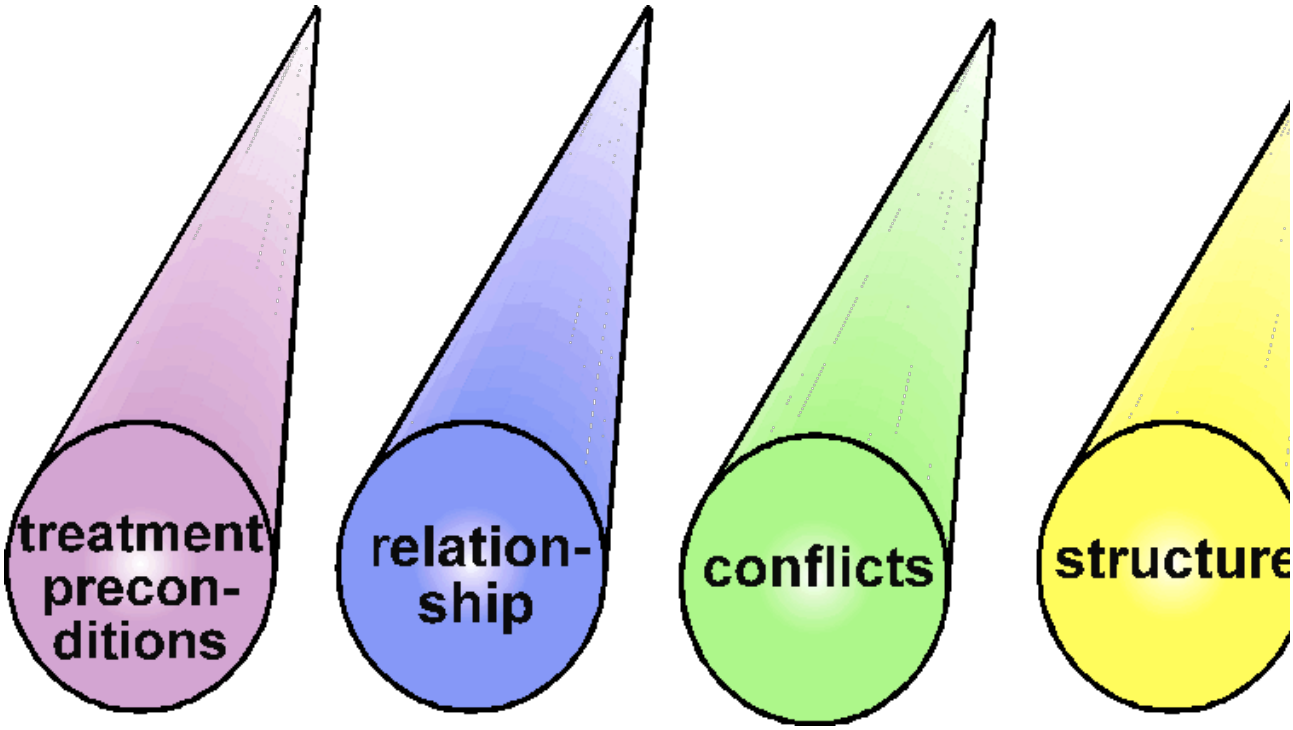


Figure 1: Operationalized Psychodynamic Diagnosis

This conceptualization registers object and goal of therapy. This does not apply to axis I and V, and for this reason these axes were not included in our study. The Operationalized Psychodynamic Diagnosis is thus well suited to deal with questions of both diagnostics of state and diagnostics of change. To be sure, structural changes are described at the level of the Operationalized Psychodynamic Diagnosis only after some time has elapsed, the reason being that the concepts operationalized here are related to personality features which are stable across time. In other words, if the goal is a differentiated picture of phases of change - and this is our goal - the Operationalized Psychodynamic Diagnosis is in need of an additional, more subtle measuring instrument. And so in the last two years we have developed a procedure that makes just this possible. The procedure consists of 3 steps.

First step: assessment as per OPD

The first step consists of assessing the patient, following an interview, with regard to relationship, conflict, and structure. The OPD manual sets out the criteria and principles according to which such judgments are to be formed.

To conceptualize the relationship axis, we note the patient's central habitual, dysfunctional relationship pattern. The elements of this pattern include the interpersonal positions habitually assumed by the patient and his objects in the dominant relationship constellation. The quality of these positions is depicted on the basis of a given list of 30 items. We differentiate here between the experiential perspective of the patient and the examiner. Both perspectives are integrated to form a concise relationship figure.

The conflict axis depicts the patient's enduring and life-defining conflicts. The eight conflict types defined here are rated on a four-stage scale in terms of their presence and significance. The types are:

- Dependency versus autonomy conflicts
- submission versus control conflicts
- need for care versus autarky conflicts
- self-esteem conflicts
- super-ego conflicts
- oedipal-sexual conflicts
- identity conflicts
- deficient awareness of conflicts and feelings

The structure axis describes six different structural capacities and likewise assigns them, in terms of their level, to a four-stage scale. The following capacities are defined:

- self perception
- self regulation
- defenses
- object perception
- communication
- attachment

Several studies have already shown that OPD findings show good reliability when assessed by independent raters. In an initial practicability study in which 134 diagnosticians from 16 centers participated, reliability levels were found that were satisfactory and moved within the range of what may be expected for complex diagnostic assessments (as compared to ICD and DSM) (Freyberger, Dierse, Schneider, Strauß, Heuft, Schauenburg, Pouget-Schors, Seidler, Küchenhoff, Hoffmann 1996). The reliability of the ratings made by the members of the OPD Working Group (a subgroup of the 134 diagnosticians within the study) proved to be "good." A further reliability study conducted with 24 patients of the Psychosomatic Clinic of the University of Heidelberg showed for the relationship axis a weighted kappa of 0.59, for "conflicts" a value of 0.61, and for "structure" a value of 0.75 (Rudolf, Grande, Oberbracht, Jakobsen 1996). A more recent - but not yet published - study conducted with 64 patients of our clinic turned up values of 0.61 for "conflicts" and 0.71 for "structure". Against the background of comparable complex clinical ratings, these values must, on the whole, likewise be termed "good" (Landis & Koch 1977).

The usual concepts used for measuring change define improvements in the course of therapy as the gradual alleviation of a pathological (symptomatic) finding. In the case of the Operationalized Psychodynamic Diagnosis, however, this model can have no more than limited significance in that structural factors change not in the sense of "more" or "less" but more along the lines of a qualitative reshaping or an enhanced integration. A patient's central conflicts are not neutralized in the successful course of an analytic process; id would be better to say, that they are constructively modified and better integrated in the important spheres of life. Nor does the central problematic relationship pattern become "less" in the course of a successful therapy; it instead loses more and more of its compulsive character and is reshaped in qualitative terms. The best way to put it would be to say that certain structural vulnerabilities (of the type registered in the "structure" axis of the OPD) become less marked; but here, too, it often seems clinically more appropriate to speak, in the case of a therapeutic success, of an enhanced integration of certain vulnerabilities, which by no means implies that the latter have simply vanished as a topic of life.

In our study we grasp change as restructuring in the sense of a growing integration of specific "central problems" that are of central significance for a patient's psychodynamics. We assume that it is possible to define for every patient a limited number of such specific "problems" that can be used to observe structural changes. This procedure implies two further methodological steps.

Second step: Individualized definition of central problems

In a second step, five central problems of the patient from the spheres "relationship", "conflicts", and "structure" are selected. This choice is based on a spectrum of findings encompassing a total of 30 areas, which are listed in Figure 2. These areas result from the core dysfunctional relationship pattern, 8 conflicts and 21 points from the structure axis. The 21 points of the structure axis constitute in turn a more detailed breakdown than the 6 dimensions of the structure axis.

Operationalized Psychodynamic Diagnosis OPD ß		Heidelberg Set of Central Problems based on OPD ß
I. Relationship	Identification of patient's core dysfunctional relationship pattern	1. core dysfunctional relationship pattern
II. Conflicts	Rating the significance of conflict types for patient; see list opposite **=>**	2. dependency versus autonomy
		3. submission versus control
		4. need for care versus autarky
		5. self-esteem conflicts (narcissistic conflicts)
		6. super-ego and guilt conflicts

		7. oedipal-sexual conflicts
		8. identity conflicts
		9. deficient awareness of conflicts and feelings
III. Structure	Rating the patient's level on the following structural abilities (well integrated, moderately integrated, poorly integrated, disintegrated):	
	IIIa. Capacity for perception and experience of the self	10. self-reflection
		11. image of self
		12. identity
		13. differentiation of affect
	IIIb. Capacity for self-regulation	14. tolerance of affects
		15. regulation of self-esteem
		16. regulation of impulses
		17. anticipation
	IIIc. Capacity for defense	18. intrapsychic defenses
		19. flexibility of defenses
	IIId. Capacity for object perception and object experience	20. self-object differentiation
		21. empathy
		22. awareness of total objects
		23. object-related affects
	IIIe.Capacity for communication	24. contact
		25. decoding others' affects
		26. encoding one's own affects
		27. reciprocity
	IIIf. Capacity for attachment	28. internalizations
		29. detaching
		30. variability of relationships

Figure 2: Heidelberg Set of Central Problems

From this set of potential problems we select those five problem areas that are of central significance and that can be used to observe changes in the course of therapy. We refer to these problem areas as "nodes" as a means of illustrating our concept, which entails selection from a nexus of dynamically interlinked features a limited number of points that assume a central position; we further imagine that they are interlinked with other features in such a way as to allow us to use the movement of the nodal points in the course of therapy to draw conclusions on the movement of surrounding structural areas or aspects. Defining them has the character of a case-related psychodynamic hypothesis specifying a patients' change-relevant characteristics.

With regard to the selection of the five central problem areas, what is intended is an expert assessment on the part of

the examiner: the problem areas rated here as central are those that are presumed to sustain the patient's psychic and psychosomatic symptoms as well as his interpersonal problems. One problem area of the OPD spectrum is judged for "central", against this background, when, in the examiner's view, something would have to change in it if the patient's problems are to be alleviated or dispelled.

The habitual dysfunctional "relationship" pattern constitutes one problem area here in any case. The remaining problems are selected from the areas "conflicts" and "structure," with the proviso that at least one problem area be selected from each of these axes. The therapist view is not considered here because the concern here is explicitly not to define a therapeutic goal from the dyad of the therapeutic working relationship, in the sense of a focus formulation, but to establish an observer framework for research purposes, from, as it were, an outside perspective.

Third Step: Heidelberg Structural Change Scale (HSCS)

In a third step we note what restructuring processes have taken place in the patient with regard to these problem areas. For this purpose we use a modified form of the "Assimilation of Problematic Experiences Scale (APES)" of Stiles, Meshiot, Anderson & Sloan (1992). This scale permits us to describe more subtle changes in a patient's dealings with given structural problems. The term "assimilation" here designates, with reference to Piaget, a process in which difficult experiences are acquired, integrated, and reshaped. The authors themselves conceptualize this process as free of theoretical school implications and without any reference to a specific therapeutic orientation. In our view, however, the scale systematically describes several important phases of change. We have revised APES with an eye to more closely assimilating it to the exigencies of psychoanalytic therapies. The revision is in line with the logic set out in Freud's 1914 study "Remembering, Repeating and Working-Through". The modifications of APES made by us are extensive, and hence we refer to this instrument as the "Heidelberg Structural Change Scale." (HSCS).

		Examples from the Manual ß
1. Problem warded off	1	no awareness of conflicts; problematic behaviors ego-syntonic; for the patient
	1 +	there is "no problem" at all
2. Unwanted occupations with the problem	2 -	unwanted thoughts and feelings regarding the problem area; collisions with outer reality;
	2	patient behaves defensively and tries to avoid problematic experiences
	2 +	
3. Vague awareness of the problem	3 -	the patient is aware of a problem which cannot be warded off; has an idea that
	3	this problem could be related to him/herself; nevertheless the attitude is mainly defensive
	3 +	
4. Acceptance and exploration of the problem area	4 -	the difficulty is acknoweldged as a problem which can be formulated; the patient seeks xplore
	4	to explore the problem area actively; now a working alliance related to the problem is

	4 +	possible
5. Deconstructions in the problem area	5 -	destabilization in concepts of self and other persons; the patient is aware of his/her
	5	limitations and injuries; efforts alternate with resignation
	5 +	
6. Reorganizations in the problem area	6 -	the patient owns up to his/her new situation and has dismissed the old; he/she tries to
	6	find new solutions in respect to the problem; there is a change in concepts of self and other
	6 +	persons
7. New integration of the problem, solution	7 -	problem solved; in the problem area the patient behaves in a self-confident way; the
	7	problem is remembered as something past

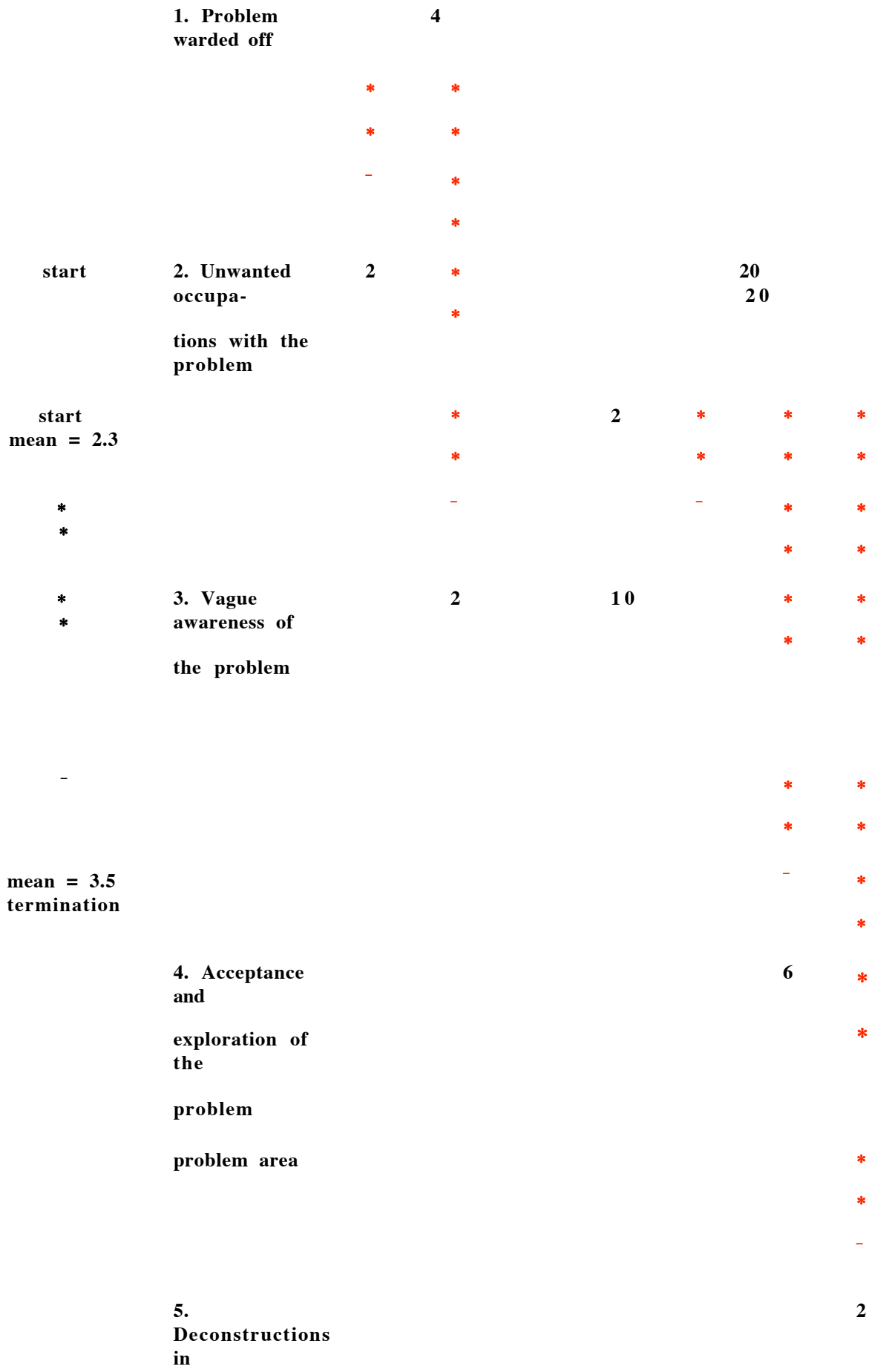
Figure 3: Heidelberg Structural Change Scale (HSCS)

Each stage marks a therapeutically significant step, beginning with the increasing awareness of a problem area not perceived until then, extending through the therapeutic working-through of the aspects and experiences associated with it, and down to the restructurings resulting from it in the patient's experience as well as in his concrete external behavior. Patients are assessed with the aid of the Scale as to the degree of structural change they have achieved. An assessment is made of the restructuring reached for each problem area defined. In our preliminary study to the "Practitioners' Study in Analytic Long-term Psychotherapy" we found an interrater agreement on the Heidelberg Structural Change Scale of 0.64 (weighted kappa; N=40).

Results

The following results derive from the preliminary inpatient study referred to above. A sample of 40 patients out of 100 were measured twice, when they were admitted and when they were released, on the basis of the methods just described. We have at the beginning three assessment steps (OPD rating, problem selection and assessment of structural change) and at the end two steps (OPD rating and the assessment of structural change). This means that at the end there is a new OPD rating, but no new selection of problems. Instead, the initial selected set of central problems is rated again with the HSCS. Normally the OPD-profile changes only slightly in inpatient therapy, so that the patient's progress can be seen better in the HSCS-profile changes.

The preliminary study indicated that at the beginning of therapy patients display average restructuring levels of 2+ for the five problem areas selected for them. This indicates that the patients are "unwantedly" confronted with their central problems at the beginning of therapy. This can result from unconscious enactments, unpleasant thoughts and feelings, or confrontation with difficulties in their social environment. We can, however, observe a tendency (+) toward the level "vague awareness of problem". This finding is in line with the clinical experience that for most hospitalized patients the primary initial concern is to build a motivation for psychotherapy, which appears to be achieved by the patients we have investigated at the end of therapy (HSCS average of 3.5, see Figure 4). According to the HSCS, this means that the patients have on average reached the threshold of "acceptance and exploration of the problem area" - a good condition for the start of an outpatient therapy after the inpatient treatment. The individual courses of the patients with regard to their therapeutic success is shown on the right side of Figure 4.


1. Problem warded off
4
start
2. Unwanted occupa-
tions with the problem
2
20
20
start
mean = 2.3
2
3. Vague awareness of
the problem
2
10
mean = 3.5
termination
4. Acceptance and
exploration of the
problem
problem area
6
5. Deconstructions in
2

the problem area

6. Reorganizations in

the problem area

7. New integration of

the problem, solution

Figure 4: Patients' progressions on the Heidelberg Structural Change Scale (HSCS)

Another method of evaluation likewise delivers informative indications on the validity of the HSCS. First we grouped all patients with respect to two different criterias; i.e. on the one hand the patients are divided in two groups, depending whether they have reached level 4 or not (see the marked column to the left in Figure 5), on the other hand all patients who showed improvement of more than one stage on the scale between the beginning and end of therapy were assigned to one group, the rest to the other group (see marked column to the right in Figure 5). We found high correlations between these two dichotomic measures and the global assessments of success made by various raters (therapeutic rounds, therapist, staff, patient), which is all the more surprising as the assessments made by the external researchers were completely independent of the ratings made by the therapeutic team, i.e. the researchers knew nothing of the assessments of the clinicians, nor were they informed on the patient's therapeutic course.

	Level of structural change at the end of the psychotherapy **levels 2 to 3 versus levels 4 to 5**	❷ **Assessment** ❹ **of external rater**	**Difference between the levels of structural change at beginning / end** **less than 1 stage versus more than 1 stage**
Global assessment of **outcome** by			
1. therapeutic rounds	**.44** p<.05		**.40** p<.05
2. therapist	**.41** p<.05		**.63** p<.001
3.staff	**.62** p<.001		**.54** p.<.01

4. patient	**.14** n.s.	**.31** p<.10
retrospective assessment of the **therapeutic alliance** at the end of the treatment		
1. by the patient	**.35** p<.05	**.42** p<.05
2. by the therapist	**.12** n.s.	**.44** p<.01

Figure 5: Correlations between level of structural change and several outcome measures

In a last step we examined the extent to which the restructuring processes registered by us are associated with symptomatic change. We found that there is no connection whatever between these two levels of change: in the period of inpatient treatment structural changes do not regularly lead to symptom alleviation, and improvements of symptoms can take place without any structural change occurring at the same time (an exception is a depression scale). These results indicate that with the HSCS we have in fact been able to register a very important level of therapeutic success different from that observed by conventional "near-surface" (i.e. symptomatic, behavioral) measures.

Conclusions

Therapeutic success in inpatient treatment means that the patient becomes able to accept, explore and formulate his or her significant difficulties, which are summed up in the five problem areas. This ability is represented by level 4 of the HSCS "acceptance and exploration of the problem area" This kind of therapeutic success is highly correlated with global outcome assessments derived from very different sources: therapist, staff, therapeutic rounds. It also correlates with the retrospective assessment of the therapeutic alliance by the therapist and the patient (see Figure 5). Based on these results we conclude that attaining level 4 of the HSCS indicates very significant progress in therapy. On the other hand, reaching level 4 of HSCS is *not* a precondition for symptomatic change; symptomatic change can take place without structural change. Although symptomatic change is independent of structural change, the latter could be a precondition for the *stability* of symptomatic improvement. This hypothesis will be tested in our preliminary study with follow-up data. Finally, we suggest that level 4 of the HSCS is a precondition for the *ability to cope* successfully with the significant psychological difficulties formulated in the five selected problems. The higher levels of the HSCS represent further steps toward a genuine structural change of personality in the sense of new conflict solutions and integration. We assume that such progress is most likely to be reached in long-term psychotherapy. This hypothesis will be tested in our main outpatient study, the "Practitioners' Study in Analytic Long-term Psychotherapy".

On the whole we can conclude that the first application of the procedure in the study presented may be regarded as a provisional indication of the usefulness and validity of our research strategy. It appears to register clinically significant dimensions of change. We expect that the method will prove suitable to demonstrate the specific effects of psychoanalysis that are more likely to emerge in longer-term treatments than in "near-surface" (symptomatic and behavioral) changes.

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A comparison of frames with core conflictual relationship themes and computerized referential activity

Mark Sammons & Paul Siegel

ABSTRACT

FRAMES and Core Conflictual Relationship Themes (CCRTs) are reliable measures of the themes of a patient's discourse as manifested in psychotherapy transcripts. While CCRTs have been employed in a range of psychotherapy process and outcome studies, FRAMES is a potentially more useful instrument given its variable plot structures (in contrast with CCRT's fixed structure) and because its structural elements are emotion expressions that are explicitly derived from an application of Dahl's emotion theory. Computerized Referential Activity (CRA) is an independent index of stylistic aspects of speech which may be useful in identifying the location of central themes in therapy sessions as well as their relationship to other important aspects of the therapeutic process. In this paper, we investigate the relationships between FRAMES and these other measures by examining whether they identify similar segments of text. Early, middle and late phase sessions from the case of Mrs. C and cases A2 and V4 selected by researchers from the Collaborative Analytic Multisite Project (CAMP). FRAMES and Core Conflictual Relationship Themes (CCRTs) are reliable measures of the central themes of a patient's discourse as manifested in psychotherapy transcripts. Which Multisite Project were analyzed using each measure. Segments were identified from which FRAMES or Relationship Episodes (4) had been derived, and a binomial test for independence was used to determine the extent to which these segments coincide. The thematic contents of FRAMES and CCRTs were heuristically compared. Mean ratings of CRA were computed for those segments of text in which FRAMES have been identified and compared to the means for the remaining portions of the transcript using a Wilcoxon test. Substantial overlap between the location and content of FRAMES and CCRTs provides important cross-validation of the FRAMES measure. A significant relationship between the location of FRAMES and the mean level of CRA provides further cross-validation for these two measures and underlines the potential importance of their joint application in process research.

INTRODUCTION

The central questions of psychotherapy process research involve an investigation of the nature of therapeutic change. To understand the process of therapeutic change, it is necessary to have an idea of what it is, about a patient, that changes in the course of psychotherapy, as well as what kinds of events bring about any changes that may occur. The idea of change necessarily entails a concept of stability: to speak of change implies that something that is relatively invariant has somehow been altered. 'Relative invariants' are commonly referred to, in a range of disciplines, as 'structures'. Structures can be schematized. Thus, one can represent them by describing their constituent parts, and the manner in which those parts are organized. Structural change can be meaningfully described either by indicating the alteration of parts of a structure, or differences in the way in which such parts are ordered.

Thematic content analysis, a principal avenue of psychotherapy process research that makes use of structural concepts, involves the detailed examination of therapy transcripts in a manner analogous to studies in literature and linguistics (5), wherein texts are analyzed according to various criteria in order to abstract the central themes of a portion, or portions, of text. At present, the most widely employed measure of thematic content is the Core Conflictual Relationship Theme (Luborsky, 1990). The basic structure of the CCRT consists of three elements, a wish, the response of the self, and the response of the other arranged in that sequence. Change processes can be investigated using the CCRT by examining whether any alterations of these elements has occurred, yet, the ordering of the elements remains invariant.

The FRAMES measure (Dahl, 1988; Dahl & Teller, 1994) shares some of the features of the CCRT in that it also consists of a sequence of discrete elements. However, there are important structural differences between CCRTs and FRAMES. In the CCRT, the individual sequence of events as they occur may be violated, while in FRAMES, the order of the elements is not pre-determined. Rather it is derived from the text through inferring the logical sequence of events from the manifest content of a patient's discourse. The number of elements that make up a FRAMES sequence is not restricted, while the CCRT is limited to three. FRAMES has certain potential advantages over the CCRT with respect to studying the process of change in psychotherapy. In the FRAMES measure, changes can be represented not only as alterations in the number and content of structural elements, but also the way in which they are put together in a sequence.

A second aspect of FRAMES that recommends it over the CCRT is the nature of its constituent elements. While the elements of the CCRT are conceptualized in terms of patterns of interpersonal interactions ('wish', 'response from other', 'response of self') which have been abstracted from portions of a transcript identified as 'relationship episodes', there is some conceptual vagueness concerning what exactly constitutes a wish or a response. In contrast, the elements of FRAMES are unambiguously defined as emotion expressions, and expressly linked to a categorization scheme that has been empirically validated (Dahl & Stengel, 1978), and reliably applied to therapy sessions (Silberschatz, 1978; Seidman, 1988; Sharir, 1991). Furthermore, the rationale for the categorization scheme is an explicit (psychoanalytic) theory of emotions as a fundamental information processing system (Dahl, 1978). In Dahl's theory, emotions are understood as functioning essentially like appetitive wishes (IT emotions) or beliefs about their fulfillment (ME emotions). The elements of FRAMES and CCRTs are therefore similar in certain respects, since both may take the form of wishes, and in many instances the 'responses' of the self and other in the CCRT contain emotion expressions (6), which facilitates comparisons of the two measures.

Although the present study is essentially exploratory, the aforementioned observations regarding the different methods for deriving CCRTs and FRAMES led to some expectations about the results of a comparison of the two measures. Since the FRAMES measure has no 'completeness' criterion which might lead to certain text segments being excluded, its application should result in a larger proportion of text being identified. Thus, we predicted that, when comparing the relative proportion of text identified by each measure, FRAMES should exceed REs. As the elements of the CCRT are nearly always expressions of emotion, although not explicitly identified as such, the FRAMES measure should also identify these elements. Therefore, we predicted that there should be significant overlap between the two measures, both in terms of location and content.

While measures of thematic content provide an essential research tool in that they may represent 'what' it is that changes in psychotherapy, in and of themselves they are insufficient to fully characterize the process of therapeutic change. For although such measures may allow us to understand the nature of the changes that may have occurred, and roughly when in the course of treatment such changes are evidenced, they provide limited information concerning how change is effected. FRAMES allows for a relatively precise specification of the elements of emotion schemes and their interrelations, that is, it can answer the question, "What has changed?," but leaves unanswered the equally important question "How did the change come about?"

In order to study how change comes about a theory of the process of sychoanalytic treatment is needed, a theory that is expressed in terms compatible with empirical investigations, and ideally, a theory that regards emotions schemes as centrally important. Bucci's (1997b)

'Multiple Code Theory' fulfills all of these criteria, and has the added virtue of being linked to a reliable and widely validated measure, Computerized Referential Activity (Mergenthaler and Bucci, 1993). The Referential Cycle Model is an explicit application of multiple code theory to the psychoanalytic situation which conceptualizes therapeutic change as the result of linkages between subsymbolic and symbolic non-verbal information processing systems with the verbal system through a process of 'referential activity'. Referential activity is a dimension of psychological functioning that involves the integration of affect, imagery (in a full range of sensory modalities), and verbal expression. Measures of referential activity index not only the presence of links between non-verbal and verbal systems, but the extent of their integration as well. The central idea is that therapeutic benefits arise not only from a patient being able to give verbal expression to affective

experience, but by doing so in an immediate and evocative manner.

The Referential Cycle Model offers a description of the process of referential linking as a sequence of phases unfolding in an analytic session. The cycle begins with a phase of subsymbolic activation of emotional schema. While such activations are an on-going concomitant of psychic life, psychoanalytic treatment facilitates the emergence of these schemas into symbolic expression through the requirement of free association and the developing relationship with "a new symbolic object, "the analyst. In the second "symbolizing phase," the emerging schema stimulates the "production of prototypic images" which, through a process of associative links generates a series of thoughts that may be related to "an event, a memory, a dream that may seem trivial or irrelevant," (p.231) and eventuates in a narrative. The patient's narrative opens up possibilities for the alteration of the emotional schemas in a variety of ways, and becomes a focus for the analyst's interventions (Bucci, 1995).Typically, analysts remain silent during the recounting of a patient'snarrative, but upon its completion will, equally typically, offer interpretations (Dove & Bucci, 1997), which inaugurate the next phase of the referential cycle. This final phase is a period of "reflection and verification" in which the patient and the analyst make use of the organizing properties of the verbal system in order to allow "reconstruction of the schemas to occur" (Bucci, 1997b, p. 233).

CRA, a computerized language measure that models referential activity (Mergenthaler & Bucci, submitted for publication) provides a graphic representation of the phases of the referential cycle as it manifests in actual therapy sessions (Bucci, 1997a). In principle, it should be possible to use CRA to identify the location within a transcript of those portions of a text containing expressions of emotion schemas. Ina study of the relationship between CRA and CCRTs, Doyle (doctoral dissertation, submitted; Bucci, in press) found a significant association between the mean level of CRA and REs, with the CRA level in text segments identified as REs generally higher than the remaining portions of the text. Given our expectations concerning the overlap between FRAMES andCCRT, we were curious to investigate whether Doyle's findings would hold for the FRAMES measure as well, and indeed, this was the result we anticipated. In her study, Doyle found a few examples wherein the predicted relationship between RE and CRA failed to manifest. Upon detailed examination she noted that REs not associated with CRA peaks were frequently instances in which the object of the relationship was the analyst. In such cases, rather than the RE taking the form of a narrative, as is most usual, instead the episode represented an enactment. Since FRAMES are always associated with an object, it is a simple matter to identify FRAMES associated with the analyst, and therefore we examine the data on the relationship between CRA and FRAMES while taking the object into account. It is our expectation that, in accordance with Doyle's findings, the CRA mean for FRAMES instantiated with the analyst will be lower than the mean for other instantiations of FRAMES.

The present study was initially designed as a component of a larger study conceived under the auspices of the Collaborative Analytic Multi-Site Project (CAMP, 1996), an organized program of research spanning nearly two decades. In the course of their investigations, various CAMP researchers (including Drs. Bucci, Dahl, and Luborsky) have developed a range of measures that can be applied to psychotherapy transcripts .During the past few years, coordinated efforts to assess the interrelationships between various of these measures have been conducted. To facilitate this work CAMP researchers identified a number of therapy sessions which could provide a common corpus of data to allow for comparisons of different measures. The sessions which form the focus of the present study were selected from this CAMP data set.

METHOD

Three previously transcribed sessions, one each from an early, a middle, and a late phase of treatment, were selected from each of three fully recorded analyses; the case of Mrs. C, and cases A2 and V4. These sessions were: in the case of Mrs. C, hours 5, 766 and 943; for A2, hours 4, 162, and 312; for V4, hours 4, 312, and 654.

FRAMES were derived independently by two raters, using a 5 step procedure outlined by H-lzer and Dahl (1995). For the details of this procedure, along with the corresponding reliabilities for various steps, the reader is referred to Siegel and Sammons (1997) which forms a companion piece to the present study.

Relationship Episodes and the corresponding CCRTs were identified by two raters in a previous study on the relationship between CCRTs and CRA (Doyle, submitted). For details of this procedure the reader is referred to Ms. Doyle's dissertation. FRAMES raters were blind to the CCRT data prior to the completion of the FRAMES derivation.

A statistical comparison of FRAMES and CCRT was conducted on the basis of the location of the text segments in which each of these measures had been identified. In the case of the FRAMES measure, an object map, which is constructed as part of the procedure, identifies the beginning and ending paragraph and sentence numbers in which to search for FRAMES. These segments provided the basis for comparison. Similarly, CCRTs were derived on the basis of a combination of data from a number of REs, each of which is highlighted in the transcript, and can be similarly identified on the basis of beginning and ending sentence numbers.

The percentage of text containing FRAMES was computed by counting the total number of sentences in those sections of text from which FRAMES had been derived and dividing by the total number of sentences. A similar procedure was applied in the case of REs. A third percentage, the observed coincidence of FRAMES and CCRTs, was calculated by counting the sentences which were used in deriving both measures and dividing by the total number of sentences. The observed coincidence was compared to the expected coincidence of FRAMES and CCRTs based on chance. For each session it was noted whether the observed coincidence exceeded or failed to exceed the expected occurrence, and the pattern of findings thus obtained was subjected to statistical analysis using a binomial test for independence.

CRA was calculated using computerized procedures as outlined in Mergenthaler and Bucci (1993), using the Text Analysis System (TAS) software package. The texts were initially segmented automatically into 150 word units. TAS analyzes each wordblock, essentially by comparing the words in the text to customized dictionaries, and the results of this analysis permit the derivation of a mean rating of CRA for each wordblock.

Analysis of the relationship between FRAMES and CRA involved calculating a mean value of CRA for wordblocks in which FRAMES had been identified and comparing this to the mean CRA for the remaining wordblocks for each session. A binomial test for independence was used to assess the statistical significance of the relationship between the sets of means which were organized into three groups: wordblocks without FRAMES ("No FRAMES"), wordblocks with FRAMES in which the object is the analyst ("Analyst FRAMES"), and the remaining wordblocks with FRAMES ("Non-Analyst FRAMES").

RESULTS

Insert TABLE 1 about here

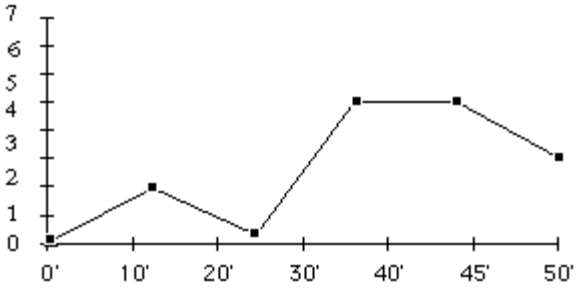
Table 1 presents the results of the comparison between the location of text segments identified as containing FRAMES and those containing REs.Note first that the FRAMES % ranges from a low 21.1% to a high of 98.9% (mean of 60.2%, standard deviation of 23.3%), whereas the RE% ranges from 25.8% to 85.8% (mean=36.5%, standard deviation=18.9%). The FRAMES measure appears to have a higher mean and be more variable than the CCRT with respect to the proportion of text represented. While our prediction, that the FRAMES measure would result in a higher proportion of text being identified than the CCRT method, appears to be generally confirmed by the data (7 out of 9 cases), statistical analysis fails to confirm this as more than a trend (binomial test, $r=0.5$, $p< 0.1$, one-tailed). However, observed FRAMESxRE % exceeds expectation in 8 cases which indicates a statistically significant coincidence in the location of the text segments identified by the two measures (binomial test, $r=0.5$, $p< 0.02$, one-tailed), a confirmation of our main hypothesis.

The large number of instances in which FRAMES and REs coincide in this data set (over 30 examples) prohibits a comprehensive heuristic comparison in this presentation. Instead a few examples of 'good' and 'bad' matches (as judged by the authors) are presented for consideration.

Figure 1 presents examples from two of the three cases which were considered to be "good"

matches. The elements of the FRAMES consist of emotion code category labels, e.g. '1A', or '2,4N', a precise specification of their significance can be found in Dahl, Hölzer, and Berry (1992). While this way of representing FRAMES has a number of advantages, for the purposes of heuristic comparisons an examination of the summary predicates which appear alongside the emotion codes is sufficient. Thus the reader who is unfamiliar with this method of representing emotion expressions can simply ignore the codes, and attend to the predicates.

GRAPH 1



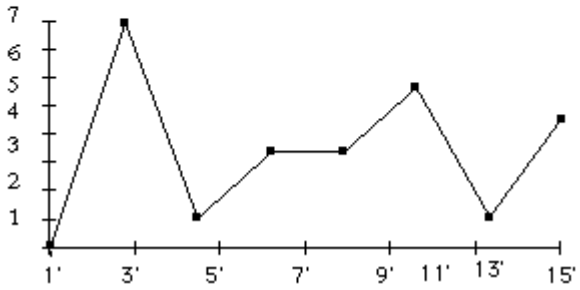
The similarity in content between the two measures is immediately apparent from an examination of Figure 1. In each case, the FRAME contains emotion events which directly correspond to the elements of theRE, for instance, the first event in each FRAME finds its parallel in the 'wish' of the corresponding RE. In the RE from case A2, the 'response from other' ("to be rejecting, disapproving") corresponds to the third event in the FRAME ("he rebukes me"); whereas in V4, the 'response from other' ("to be dull, disappointing") can reasonably be connected to the second FRAME event ("but my excitement fades"). Note that, for V4, in the actual transcript the patient confines himself to a description of his reactions, that is, the "response from other" doesn't appear explicitly in the text but must be inferred, and this accounts for the difference between the two representations.

The 'response of self' in V4 ("to lose interest and withdraw") corresponds to the second event ("but my excitement fades"), and to the third event in the FRAME ("I want to escape the relationship"), as well. The CCRT is constrained by its categories and therefore the patient's response, when there is more than one, must be represented by a complex predicate. The FRAMES measure generally differentiates between the various elements of a complex response, particularly, as in this instance, when there are categorical differences in their emotional content. In the case of A2, the 'response of self' ("to feel irritated; angry") corresponds to the final event on one branch of the FRAME ("I feel angry"), the other branch ("I feel bad") is missing from the RE. the FRAMES measure allows alternative outcomes to be represented by a branching structure when they are articulated as such by the patient, as in this case.

Finally, in each example, there is an element that occurs in the FRAME which is not represented in the RE. In the case of A2, the second event, "but I fall short" ("in my attempts to please my father"), is a significant aspect of the patient's story from a clinical point of view, in that it may potentially indicate a passive-aggressive, or masochistic, component to the patient's actions. In V4, the final event of the FRAME ("I look for another exciting relationship") indicates the repetitive, cyclic nature of the particular relational dynamic the patient is articulating.

Figure 2 presents two examples, one each from A2 and V4 of instances where, although much of the same portions of the text were used, the authors considered the relationship between FRAME and RE to be a "bad" match.

GRAPH 2



First, consider the example from A2. The only clear correspondence is the similarity between the second element of the FRAME ("She screams at me") and the 'response from other' ("To be angry"). While it is conceivable that the 'wish' might be inferred from the same aspects of the text that gave rise to the second and third events of the FRAME, nowhere does A2 make explicit her desire to be "seen accurately" or "be understood." As with the 'wish', the 'response of self' appears to require an inferential leap, as nowhere in this portion of text does the word "guilt[y]" appear, nor does A2 talk of "expressing herself;" she does however explicitly say that she tries to "reassure her [mother]."

In the example from V4, the dissimilarity of the two representations is largely due to the way in which the events are sequenced. The 'wish' ("To be cared for") can reasonably be inferred from the third event of the FRAME. Similar close correspondences exist between the first FRAME event and the 'response from other', and between the first and second FRAME events and the 'response of self'. The final FRAME event, a crucial element of V4's emotional schema is missing from the RE.Indeed, reading the relationship episode gives the impression that the patient is describing a harmonious and conflict free interaction with his analyst, while the text indicates explicitly that V4 feels "[un]willing to let . . . [him]self get away with" paying a low fee (the issue under discussion). The FRAME captures this aspect of the patient's dynamics, which arguably plays an important role in understanding this case.

Next, we examine the results of our comparison of the FRAMES measure and CRA. Table 2 summarizes our findings. Binomial tests (r=0.5) were used to compare these three groups of means. Mean CRA for Non-Analyst FRAMES was found to be significantly different from Analyst FRAMES ($p < 0.01$); a trend toward significant difference between mean CRA for Analyst FRAMES and the portions of the text where no FRAMES were identified was observed ($p < 0.1250$); while the difference in mean CRA between Non-Analyst FRAMES and the No FRAMES group was non-significant. When the data are analyzed in terms of two groups, FRAMES and No FRAMES, the difference is also non-significant, which fails to confirm our hypothesis that CRA should be higher for FRAMES in general.

Insert TABLE 2 about here

DISCUSSION
FRAMES and The CCRT

An elusive goal of process research finds expression in a proposition first articulated a decade ago by Strupp, Schacht and Henry(1988) , that process measures increase in terms of their overall scientific utility to the extent to which they can effectively represent a patient's problem, the focus of treatment interventions, and the nature of the therapeutic outcome (PTO, or, problem-treatment-outcome congruence).

Because it makes no sense to talk of "change" without reference to something which is relatively enduring, a necessary ingredient of an adequate empirical articulation of change processes is some kind of structural measure that can represent what it is about a patient that changes in psychotherapy. Indeed, the idea of something rigid, maladaptive, and resistent to change is at the heart of psychoanalytic conceptualizations of psychopathology, so it seems quite logical to represent what is pathological about a patient in structural terms. Maladaptive psychological structures are, at least implicitly, the foci oftherapeutic interventions: psychotherapeutic treatment aims, first, at undoing some of their rigidity, and next, in reducing their maladaptive aspects. Furthermore , in contrast to indirect measures which may track the consequences (secondary gains) of therapy, any direct measure of psychotherapeutic outcome must necessarily be structural as well (Bucci,1997b).

A number of structural measures of thematic content have been developed (for other comparisons, see Luborsky, 1988; Luborsky, Popp &Barber, 1994) which satisfy two aspects of PTO congruence: description of patient pathology and assessment of treatment outcome. Luborsky's CCRT is the most widely adopted of these measures, but FRAMES is arguably a more useful measure for examining the process of structural change for a number of reasons. FRAMES more accurately reproduces the manifest themes of a psychotherapy session, given its "bottom-up" procedure. It produces a differentiated representation of the central themes of psychotherapy session given its variable plot structure, and is readily susceptible to formal comparisons due to its use of emotion code categories as structural elements. It is more sensitive because its format is not limited to a fixed sequence (wish, response from other, response of self), but can readily represent other expressions of patient themes, which results in a greater proportion of text being represented.

Schematizing the structure of a patient's stories as a sequence of emotion expressions, as in the FRAMES measure, suggests that emotion schemas are a salient measure of the central issues in psychoanalytic treatment, whereas the CCRT would appear to be more explicitly linked to an "object relations" perspective. Certainly the two positions are not incompatible, especially when one considers that the elements of the CCRT, or one familiar with Dahl's emotion theory, are readily seen to be emotion expressions for the most part (Dahl, in press). Indeed, contemporary theorists who appreciate the need for empirical study (Stern, 1985, Bucci, 1997b) talk about object relations in terms of schema. It is but a small step to recognize the centrality of affect as the principle invariant element of relational schemas, indeed, it is an established tenet of object relations theory that object relations take the form of self and other representations with a linking affect (Fairbairn, 1954; Kernberg, 1976; Scharff & Scharff, 1987), an idea that preserves the structural elements of drives, while freeing itself from the accompanying energic meta psychology. FRAMES has the virtue of making the affective nature of relational schemas explicit and available for empirical study.
FRAMES and Computerized Referential Activity

What is striking about the findings we reported is the apparent strength of the relationship between CRA and FRAMES instantiated with the analyst. Although the sample size is quite small, a statistically significant result was achieved. Furthermore, in every case the CRA mean for the Analyst FRAMES was notably lower than the mean for the Non-Analyst FRAMES, and this relationship held for all but one session when Analyst FRAMES were compared to No FRAMES segments. Interestingly, this session (V4 Hour 652) appears to be somewhat unusual (as can readily be seen from Table 1), in that a strikingly high proportion of the text was identified as containing both FRAMES and REs (indeed with 85.5% of the text comprising REs, it is the lone outlier in which REs exceed 37.5%) Interestingly, Analyst FRAMES differ from most other FRAMES in that the portions of the text do not correspond to narratives, but to here and now enactments of emotional schemas. This finding is especially important considering the central role the concept of transference plays in psychoanalytic clinical theory. Given the observed relationship between CRA and Analyst FRAMES, there is evident potential for using the computerized measure to efficiently identify portions of the text which contain transference enactments.

A microanalysis of the interaction between the two measures in a single session, hour 943 of the case of Mrs. C provides some intriguing observations concerning the potential joint application of FRAMES and CRA for studying detailed aspects of the psychoanalytic process. Figure 3 graphs the variations in CRA across the wordblocks that make up this session; wordblocks containing FRAMES are also identified.

In this session, Mrs. C begins by relating a series of short vignettes having to do with her recent experiences at work, involving herco-workers and clients, with the CRA measure above its mean throughout. Although a number of emotion schemas might be identifiable in this portion of the text, in general her stories are fragmentary and none of the potential schemas that

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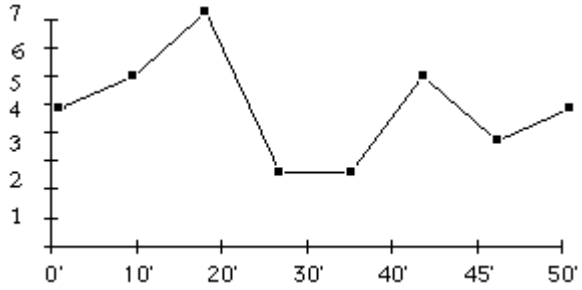
GRAPH 3



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emerge satisfies the requirements for a FRAME (in particular, that it be instantiated elsewhere). She then stops talking for over two minutes, immediately following which she produces a short narrative relating her wishes concerning a baby-sitter in relation to her husband, the first appearance of a FRAME in the transcript, and this narrative occurs in a CRA peak, as predicted. Following is a short series of exchanges with the analyst in which he encourages Mrs. C to reflect upon her feelings and wishes, and ends by making a transference interpretation. The ensuing section is characterized by a relatively long sustained drop in CRA which remains below its mean for the middle third of the hour. In this section she articulates two distinct emotion schemas, each of which is instantiated with the analyst which is followed by a period in which Mrs. C reflects on the significance of what she has just related. She is again silent for over two minutes, but then produces a narrative that begins in a small CRA peak, in which the very FRAME which appeared earlier is reinstantiated with her husband, but with new elements apparently introduced as a result of her interaction with the analyst.

What remains to be demonstrated concerning whether or not the FRAMES measure satisfies the PTO congruence principle is how successfully it can be used to investigate what occurs in treatment. For this a detailed longitudinal examination of the incidence and evolution of FRAMES is necessary. The FRAMES measure provides a precise specification of thematic content that preserves much of what is unique about a patient's discourse. Since FRAMES are derived in a "bottom up" fashion from therapy transcripts, they permit the data to "speak for itself." The FRAMES measure allows for investigations of thematic content in a manner that doesn't sacrifice the depth and complexity of clinical material, while providing a sufficiently abstract representation so as to facilitate formal assessment.

Footnotes

1 FRAMES (Teller and Dahl, 1986) are defined as Fundamental Repetitive And Maladaptive Emotion Structures
2 Paper presented at University of Ulm, Germany, June 20, 1997 and 28th Annual Society for Psychotherapy Research Conference, Geilo, Norway, June 26, 1997
3 The authors gratefully acknowledge the advice and assistance of Dan Pokorny (University of Ulm, Germany) on the statistical analyses.
4 'Relationship Episodes' (REs) denotes the text segments from which CCRTs are derived.
5 Note however, that the analogy holds for biochemistry as well, if, as is commonly done, we extend the idea of a 'text' to include molecules, as in 'reading' the genetic code.
Because these elements must all be present to some degree, judges rating a transcript for REs are

instructed to assess an RE's 'completeness', with REs receiving a low completeness rating generally excluded for the purposes of deriving the CCRT.
6 Indeed, slightly more that half of the words used to characterize the responses of self and other in Luborsky's (1990) CCRT manual appear in Dahl and Stengel's (1978) list of emotion words. Most of the remaining words in the CCRT list are close synonyms of Dahl's emotion words.

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"Process patterns" drawn from theories of complexity as a means for tracing long-term change in psychoanalysis

Henri Schneider, Markus Fäh-Barwinski & Rosmarie Barwinski Fäh

Abstract. In psychotherapy research, as well as in psychoanalysis, there is a striking lack of concepts allowing processes of change to be described as they unfold in time. In this paper, we consider possibilities for tracing long-term developments offered by theories of complexity. Typical ways in which change occurs in complex systems are represented as *process patterns* which can be used as heuristics for identifying courses of change in therapeutic material. The process pattern developed on the basis of the "epigenetic landscape" is presented, and a methodological procedure for investigating long-term change processes is sketched out. Our research approach is illustrated by tracing change in a nine-months segment taken from a psychoanalysis.

How should we investigate long-term processes of change in psychoanalysis? In this paper, we would like to outline our research approach, which is based on theories of self-organizing processes (e.g. Haken, 1992; Prigogine, 1996; Prigogine & Stengers, 1979, 1988), or theories of complexity as they are preferably called in the U.S. (Waldrop, 1992). Theories of self-organizing processes provide new concepts (such as instability, fluctuation, or attractor) relevant to the description of change processes. The importance of these theories for psychotherapy research is being increasingly recognized by leading researchers in the field (Elliott & Anderson, 1994; Stiles, Shapiro & Harper, 1994). In psychoanalytic literature, a lively interest in "nonlinear" concepts is indicated by a growing number of articles and book reviews (e.g. Galatzer-Levy, 1995; Hoffman, 1992; Moran, 1991; Quinodoz, 1997; Spruiell, 1993; Stolorow, 1997; Wurmser, 1989). The assumption underlying our approach is that the psychoanalytic process is not a linear development; rather, it is characterized by leaps, breaks and a variety of parallel and superimposed developmental lines and themes. Thus, with regard to the debate on case history in psychoanalysis (Meyer, 1994), our approach may add a new perspective to the way we describe change processes occurring in long-term therapy.

Our research approach owes much to the *Significant Event Paradigm* (Rice & Greenberg, 1984; Greenberg, 1991; Greenberg & Foerster, 1996). However, while the *Significant Event Paradigm* confines itself to making explicit the clinical knowledge of experienced psychotherapists, our approach takes an additional step by drawing upon the domain of research on complexity. Stengers (1987, 1991, 1992, 1996) comments on the methodological issues to be considered when dealing with complex phenomena. She points to the fact that hard sciences came into being where the definition of an experimental object (i.e. an object which can be isolated and purified) turned out to be possible. Such coincidences are rare compared to the large number of phenomena that escape experimental procedures. We are optimistic that our research approach will be considered an example of a "rational practice", as advocated by Chertok and Stengers (1992, p. xvii) when they write: "How can we turn what resists purification or what submits to it only in a deceptive manner into a positive problem [...]? [...] we believe that the answer to the question belongs to history and to the eventual creation of different rational practices, practices that will doubtless be even more exacting than those permitted by experimental reason."

Process patterns describe "typical ways" in which change occurs in complex systems and can be used as heuristics for identifying courses of change in therapeutic material. Up to now, two process patterns have been developed. In an earlier paper we proposed a process pattern based on the B,nard phenomenon (Schneider, Barwinski & F"h, 1995; Schneider, F"h & Barwinski, 1997). In this paper we shall present the process pattern based on the epigenetic landscape (see also Schneider, F"h & Barwinski, 1996).

The process pattern based on the epigenetic landscape

The "epigenetic landscape", visualizing the developmental system of an organism, has been

introduced into developmental biology by Waddington (1940, 1974). Later, this "conceptual aid" (Saunders & Kubal, 1989) has been taken up by Piaget (1967) to conceptualize cognitive development (see Schneider, 1983). The epigenetic landscape graphically depicts the development of attractors in the course of time (Waddington, 1974, p. 258). An *attractor* corresponds to a preferred behavioral mode sought by a complex dynamic system as a function of the interactions of its internal components and its sensitivity to external conditions (Thelen & Smith, 1994, S. 60). With respect to tracing change in psychotherapy, we distinguish between an *old* (i.e. "problematic") and a *new* attractor (i.e. a more progressive inner attitude, a different behavior towards a significant other, etc.).

Change is made possible by a *control parameter* assuming higher values. In the B,nard phenomenon, to which we refer in order to illustrate some of the theoretical concepts (Prigogine & Stengers, 1988, p. 52), it is the supply of heat - which results in a temperature difference between the lower and the upper surface of the liquid layer - that is the control parameter. At a certain value of this control parameter, a new kind of activity arises in the system: liquid currents start to form, developing from microscopic fluctuations into a regular arrangement of convection cells appearing at the macroscopic level. In psychoanalysis, the control parameter is not applied from the outside, but emerges from the psychoanalytic process itself. Thus, the term "control parameter" (cf. Schiepek, Strunk & Kowalik, 1995, S. 105) may be circumscribed as: the patient-therapist "system's" activity (i.e. what is happening here and now between patient and analyst), as experienced by the patient. The nearer the patient's experience of the therapeutic relationship is to the new attractor, the higher the value we assign to the control parameter. Whereas the patient initially experiences the therapist in terms of an old pattern (= low value of the control parameter), he or she gradually becomes able to experience the therapist as a new object (= increasingly higher value of the control parameter).

Fluctuations may be characterized by a patient's deviation from what he is used to and exploration of new possibilities, and may be recognized by his enactment of internal patterns in an increasingly active manner (with the analyst becoming increasingly aware of these patterns by way of his or her countertransference feelings).

When the control parameter assumes higher values, parameters may take on meaning which, at or close to equilibrium, are negligible. In the B,nard phenomenon, this is true for the gravitational force, which starts to exert an influence on the molecules as soon as liquid currents are forming, that is, as soon as there is some noticeable activity in the system. Thus, the meaning of this parameter depends on the system's activity! (See Prigogine & Stengers, 1988, p. 179.) When transferred to the psychoanalytic process, this means that, when something "gets under way" with respect to the transference relationship, a patient may become aware of *inner parameters* underlying the *separatrix* between the old and the new attractor. An inner parameter may thus be thought of as a negatively toned feeling which prevents the patient from getting into the new attractors. See Fig. 1.

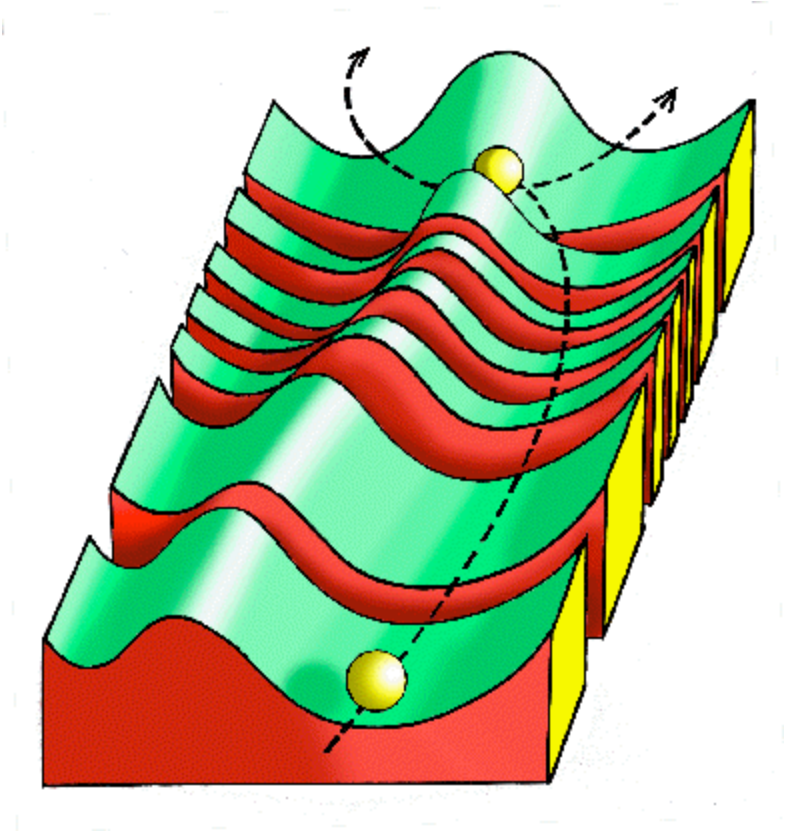

Figure 1: Graphic illustration visualizing the process pattern based on the epigenetic landscape.

In Fig. 1, the process pattern based on the epigenetic landscape is graphically visualized. The landscape is partitioned into "situations" of variable duration (i.e. from parts of sessions to a few sessions). The state of the patient is represented by a ball. The increase in control parameter values is rendered by the rise of the landscape. The valley which symbolizes the old attractor becomes flatter, so that stronger fluctuations may gradually arise. A second valley is indicated which represents the developing new attractor: at particular moments during a session (i.e. when the control parameter assumes the required value), the ball may jump into this new valley, meaning that the patient is able to experience the new state just for a short moment. Little by little, this new state becomes more distinctly recognizable to the patient, rendered by the new valley becoming as deep as the old one. Through flattening the old valley and deepening the new valley, the separatrix (i.e. the dividing line between the old and the new attractor) becomes surmountable. At the bifurcation point, the patient will be able to recognize the old and fully experience the new attractor.

Compared to the process pattern based on the B,nard phenomenon (Schneider, Barwinski & F"h, 1995), which captures the change processes taking place in a specific situation (i.e. at a bifurcation point), the process pattern based on the epigenetic landscape corresponds to a bird's-eye view, in that it visualizes the values of selected parameters as they gradually change in the course of time, thus allowing situations to be described (i.e. "still pictures" to be taken) at different moments. See Table 1.

Methodological procedure: the "10-point program"

A segment selected from a psychoanalysis is analyzed using the guidelines schematically sketched out in Table 1 (cf. Schneider, F"h & Barwinski, 1993). This work is preferably carried out in a *research group*, consisting (in our case) of the analyst in charge, a second analyst, and a "researcher" whose task is to continually support the reference to the theoretical concepts (i.e. the process pattern).

The investigation of a segment selected from a psychoanalysis is based on the analyst's report to the research group. This means that we dispense with video or audio recordings of therapy sessions. (In

a sense, one might say that one of us, namely the analyst, has seen the video and summarizes the pertinent passages to the other members of the research group.) The analyst's report, however, is audiotaped and transcribed, and it may later be extended by detailed descriptions of the situations selected for further investigation based on his or her process notes. We are struck by the proximity of our procedure to the methodology developed by Stiles (1996) which, although being based on transcripts of audiotaped therapy sessions, analyzes the material in similar steps.

The process pattern based on the epigenetic landscape is summarized as a "frame" containing, as its "slots", catchwords for the specific aspects of the process pattern (see below: Table 2). By filling in the frame, increasingly precise and consistent references are established between the process pattern and the clinical material. As a result, the theoretical concepts and the description of the material are interrelated in a transparent way. This "frame procedure" (Schneider, Barwinski & F"h, 1992; Schneider & W*thrich, 1992) draws on *competitive argumentation* (VanLehn, Brown & Greeno, 1984), which has been developed in Cognitive Science for the discussion of "deep" theories (i.e. theories which, in their explanations, refer to many layers of unobservables).

Our aim was to develop a methodological procedure which would allow change to be traced over an extended period of time (meaning several months at 4 to 5 weekly sessions). Drawing on a passage from Hofstadter's latest book (1995, p. 488), we came to think of our 10-point program as an *imaging device*. To take one example: when using ultrasound, it is the computer which converts the scattered, high-frequency sounds reflected off a fetus into a vivid television image; in a similar manner, in our procedure, we make use of the psychoanalysts' ability - which may be supported by the discussion taking place in the research group - to convert the multiple aspects of their realizations about a patient into a meaningful picture. This will depend on their psychoanalytic knowledge and the theoretical concepts (i.e. in our case, the process pattern) used for generating ("computing", as it were) this picture (cf. Friedman, 1997, p. 35, for a similar use of the term "imaging technique for mind"). Thus, what we can demonstrate from our analysis of a segment taken from a psychoanalysis using our 10-point program, is a *picture of the changing internal structure of the patient as generated by the analyst and based on his or her psychoanalytic knowledge and the process pattern*. This picture will be described in the subsequent sections.

The psychoanalysis from which the nine-month segment was taken

Using the process pattern based on the epigenetic landscape, we shall sketch a particular aspect of change in the course of a nine-month segment of the analysis of a 37-year-old man. This patient came to see his analyst because of massive depressive disorders, psychosomatic complaints, relationship problems and a compulsive desire to present himself as better and bigger than he really is. The analysis of this patient posed a variety of problems, since the treatment of the neurotic conflicts was under constant jeopardy from the narcissistic disorder and related defense maneuvers.

The particular aspect of change to be described consisted of the patient being able to give up his controlling behavior in relation to persons with whom he was involved, which in turn created a sizable obstacle for satisfactory loving relationships. This change was expressed in his ability on the one hand to experience loving feelings and attitudes toward peers who were not under his control, and on the other to deal with the related feelings of worthlessness stemming from his history by being able to initially tolerate these feelings, to subsequently understand them and their roots, and eventually to largely overcome them.

The frame summarizing the process pattern

As a search heuristic, a process pattern suggests what we should look for in a passage under investigation: what might be the control parameter? Are there fluctuations? What kind of feeling may constitute an inner parameter underlying the separatrix, preventing the patient from getting into a new attractor? The frame shown in Table 2 establishes this link between the process pattern based on the epigenetic landscape and the section taken from a psychoanalysis. See Table 2.

The *old attractor* (i.e. the patient's problematic attitude) can be described as follows. The patient can only have a loving attitude towards a love object when he controls the person he loves. For example, it was always the patient who decided on which evenings during a week he was "free" from other

obligations and could therefore meet his girlfriend. Financially, he was overwhelmingly generous to her, urging her to quit her job in order to have her dependent on him and be more in control of her. When his girlfriend showed signs of autonomy, stating that she didn't want his "gold" but his love, he reacted furiously and with cold anger, or retreated into depression. In the daydream of the first situation (i.e. the *Sarajevo Fantasy*; see below), he was expressing the same attitude towards the analyst. For the patient to be able to feel and express warm, tender and caring feelings towards him, the analyst had to be in a very unpleasant situation.

The initial value of the *control parameter* (i.e. the patient-therapist "system's" activity, as experienced by the patient) is indicated by a worthless, ridiculous self, libidinally attached to a devaluing, contemptuous and castrating love object. The final value of the control parameter is indicated by a positive, attractive self, worthy of love, in a relationship with a loving, caring, estimating and limit-setting good object.

The *fluctuations*, characterized by the patient's deviating from his usual patterns of feeling and relating to people, can be viewed as subtle "attempts" to experience new parts of his self. For example, in the fourth situation (i.e. the *Session Postponement Episode*; see below), he is able to risk expressing a wish to the analyst. These "major" fluctuations, which helped us to identify the six situations, are preceded by smaller ones pointing in this direction, namely showing warm feelings and love wishes towards the analyst more openly and without controlling the situation (see section on fluctuations below).

The *inner parameter*, which underlies the separatrix between the old and the new attractor, consists of the patient's feelings of shame and ridiculousness when feeling attached to a love object which is out of his control.

The *new attractor* can be recognized from the patient's feeling of being able to love the analyst, his girlfriend or other people, without having to control them. This change was connected with his insight into the determinants of the old attractor; in other words, his self-image of being worthless.

Six situations in a nine-month segment from a psychoanalysis

Following the "10-point program" (see Table 1) we identified six situations in the change process of the nine-month segment under investigation:

(1) *The "Sarajevo Fantasy"* (July 20). The patient describes his fantasy that he is coming to save the analyst and his family, held captive by the Serbs in Sarajevo.

(2) *The "Volcano Dream"* (September 12). The patient dreams of a volcanic eruption. He is crouching at the crater edge to avoid being hit by flying rocks.

(3) *The "Amputation Dream"* (November 8). The patient dreams that he is asleep on the couch, wakes up, and turns around to see the analyst sitting in a hospital bed, amputated and urinating.

(4) *The "Session Postponement Episode"* (December 14). The patient feels sadistically ridiculed by the analyst, since his request to postpone a session was not met. He thinks that the analyst doesn't "give a shit" about his injured feelings.

(5) *The "Parking Lot Episode"* (January 10). The patient parks his car in front of the analyst's practice in a reserved parking spot, becomes afraid of punishment by the analyst, and experiences himself as absolutely ridiculous.

(6) *The "Contract Episode"* (March 29). The patient would like the analyst to read a contract that is important to him and his business, and confirm that it is a good contract. When his wish is not fulfilled, he feels deep disappointment about the fact that the analyst cannot be, for him, the supporting father he is still seeking.

Tracing a change process unfolding in time

We shall now trace the process of change over a period of nine months, using the terms *control parameter*, *inner parameter* and *separatrix*. Fig. 2 shows a longitudinal section through the "old valley" of the epigenetic landscape, which has been turned 90 degrees with respect to Fig. 1. While the control parameter assumes higher values, the inner parameter underlying the separatrix takes on meaning. (Thus, the assumption is made that the *value* of the inner parameter remains constant whereas its *taking on meaning* depends on the value of the control parameter. This assumption is based on the analogy we draw between the inner parameter and the gravitational force in the B,nard phenomenon.) The picture may also be read as a diagram rendering estimated values of the control parameter for the situations one through six.

The value of the control parameter indicated for the first situation (i.e. the *Sarajevo Fantasy*) relates to the old attractor. This value can be estimated only indirectly on the basis of psychoanalytic considerations. There is a role reversal in that the analyst is helpless whereas the patient is a powerful rescuer. We take this as a fantasy of grandiosity which is used to ward off feelings of worthlessness. Therefore, we assign a low value to the control parameter. The inner parameter (i.e. feelings of shame) is not experienced by the patient, the separatrix thus remaining an insurmountable obstacles. See Fig. 2.

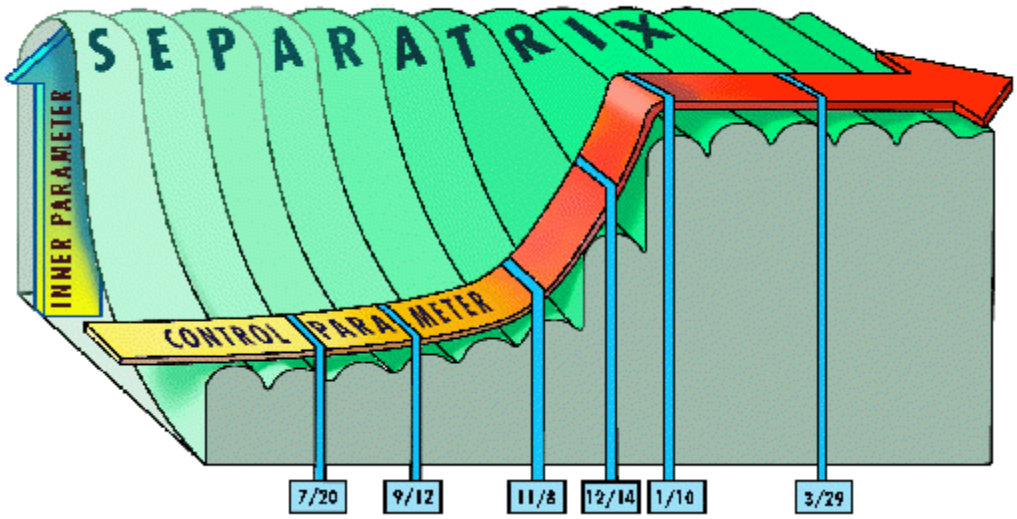

Figure 2: Longitudinal section through the "old valley" of the epigenetic landscape, turned 90 degrees with respect to Fig. 1. Estimated values for the control parameter at the time of situations one through six.

In the second situation (i.e. the *Volcano Dream*), the volcano is taken to stand for the power of the drive and the rocks for the patient's anxiety in the relationship with the analyst. This dream is an expression of a change in the control parameter. However, the wishful fantasies of the dream are not connected with the patient's feelings, since neither the desire for a loving relationship with the analyst nor the anxieties connected with this wish are experienced by the patient. This means that the control parameter has increased only by a small amount. The conditions have not essentially changed, therefore, neither with respect to the inner parameter.

In the third situation (i.e. the *Amputation Dream*), the analyst is a castrated and ridiculous object. The patient, however, is no longer an omnipotent rescuer as in the first situation. In this third situation, the control parameter can again be inferred from a role reversal as the feeling of worthlessness is projected onto the analyst. But this projection is a first step in the patient's acceptance of this feeling as his own. A slight increase in the control parameter's value may thus be inferred. In addition, the devaluation makes the analyst undesirable as an object. This means that, for the patient, there is no "danger" of feeling ridiculous when rejected. Due to this devaluation, the patient does not experience the inner parameter underlying the separatrix. (By the control parameter assuming higher values, the patient is induced to take an additional measure in order to avoid experiencing the dreaded shame and ridiculousness. Interpreting this defense further promotes the

analytic process.)

In the fourth situation (i.e. the *Session Postponement Episode*), the patient is asking for a rescheduling of a session. For the first time, he exposes himself with a wish, thus risking a rejection. That it was possible for the patient to ask for a session postponement is taken as an indication that the value of the control parameter has considerably increased. Up to now, the expression of a wish was connected with the fantasy that the object would reject him in an unloving way and make him feel ridiculous by not caring about his feeling of being hurt by this rejection. For the first time, this constellation, which had been warded off, is enacted in the transference. Because the analyst does not meet his request, the patient feels ridiculous. In other words, the inner parameter starts to take on meaning for him. Subsequently, it was possible to work through the feelings of ridiculousness and shame. That the patient is aware of a wish and is not compelled to experience the analyst as a sadistic and castrating object means that he is at this moment in the new attractor, having temporarily surmounted the separatrix. Even when he experiences a wish towards the analyst and the analyst does not grant this wish, he is able to feel that the analyst is not rejecting him in a cold and ridiculing manner.

In the fifth situation (i.e. the *Parking Lot Episode*), the patient parks his car in a reserved parking space which, he claims, is his to use if no other car is parked there. (In not occupying his parking space, the analyst is experienced as having given up his rights, like the father of the patient who was absent in his childhood and "didn't defend his rights".) At the same time, the patient is afraid of punishment and feels ridiculous when caught by the analyst returning from an errand. On the basis of the increasing stabilization of his self-esteem (i.e. the higher value of the control parameter), it is possible for him to feel oedipal wishes and to become aware of a new facette of the inner parameter: the feeling of being ridiculous not only when he shows loving feelings, but also when he is aware of anxiety based on oedipal rivalry.

In the sixth situation (i.e. the *Contract Episode*), the patient is able to accept his disappointment that the analyst does not praise his new business contract. He can tolerate feeling ridiculous when the wishes he directs onto the object are not granted by the object. The inner parameter is felt, the separatrix thus no longer constituting an insurmountable obstacle. This development has become possible because of the change of the control parameter. The patient has reached a new inner attitude; in other words, a new attractor.

What are the change processes that we tried to clarify? By estimating the value of the control parameter for the individual situations and working out the relationship between control parameter and inner parameter, we could delineate how:

(1) a *control parameter* has to emerge and reach a certain threshold value before any development with respect to the inner parameter becomes possible. In other words, a specific characteristic of patient-therapist interaction which emerges from the psychoanalytic process is a necessary condition for intrapsychic change;

(2) based on the control parameter assuming increasingly higher values, an *inner parameter* gradually takes on meaning. A negatively toned feeling underlying the *separatrix* which prevents the patient from getting into a new attractor gradually becomes accessible to the patient's experience.

Thus, in terms of the "epigenetic landscape", it is the development of the control parameter which fosters the awareness and change of the inner parameter.

Fluctuations preceding the Session Postponement Episode

As pointed out, in the fourth situation (i.e. the *Session Postponement Episode*) an important step in the patient's change process becomes evident. How was this development made possible? In this section, we pass to a more detailed level, and look for fluctuations in the sessions preceding the *Session Postponement Episode*.

We identified a *first* fluctuation in the fourth session preceding the *Session Postponement Episode*. The patient stated that the analyst's private life was on his mind, but that he withheld the many

questions because the analyst, being very strict, wouldn't give an answer to him anyway, and that he didn't want to feel ridiculous again, and ashamed by not getting an answer from the analyst. He ended up by asking a question, although in a somewhat intricate manner. In the subsequent session, the analyst had the impression that the patient was emotionally withdrawn, and he saw this as an indication that the patient felt hurt. The analyst ventured the possibility that the patient may nevertheless have felt rejected, in that he was expecting something, but didn't clearly say so, and now felt hurt. The patient reverted to this situation and told the analyst of the thoughts he had: if he asked the analyst about his private life and the analyst didn't answer, and if he then said that he felt hurt, the analyst would just say that he didn't care about the patient feeling hurt.

A *second* fluctuation caught our attention, which occurred in the session immediately preceding the *Session Postponement Episode*. The patient greeted the analyst in the waiting room as well as in the consulting room. In other words, they shook hands twice. However, the patient commented on this by saying: "I'm still in the ritual!"

Both sessions are characterized by an attempt by the patient to show to the analyst that he loves him. This thrust, however, is immediately wrapped up into a withdrawal. But by asking the analyst about rescheduling a session, the patient exposes himself without a safety net. Our assumption is that, in the preceding session, "something" (i.e. an aspect of the control parameter) has accumulated that prepared the way for the enactment in the *Session Postponement Episode*.

The concept of fluctuations helps identify such courses of change in the material. In a future project, a closer look could be taken at the way in which the analyst "excavated", as it were, the question that the patient hadn't really asked, and how both analyst and patient dealt with the patient's fantasies of the analyst not caring about his feeling of being hurt. At this level of detail it would then be possible to identify characteristics of productive versus non-productive courses of change. An initial question may be: what are the processes that facilitate the formation of an enactment such as the *Session Postponement Episode*?

Discussion

In the two preceding sections we described what can be "seen" when looking at change processes using the process pattern based on the epigenetic landscape. Certainly, this process pattern picks out a small number of "threads" from an intricately woven "texture". However, only by this kind of simplification may strands of change be identified in the material (see Stengers, 1987, 1996, for comments on using simple models in view of complexity). In this sense, process patterns constitute a restriction that we accept in order to be able to "tell a story" along pre-set lines, borrowing from Stengers (1991a) the term "narrative principle" as a characterization of a process pattern.

Using this process pattern, other research groups may describe courses of change which are similar with respect to the features of change processes highlighted by the process pattern. These descriptions may then be collected, and accounts of productive and non-productive segments may be compared (cf. Greenberg & Foerster, 1996). In this way, the process pattern based on the epigenetic landscape may contribute to the identification of additional starting points for change (such as fluctuations in the patients experience) in treatments with difficulties similar to the psychoanalysis described in this paper.

Process patterns may be considered as a source of inspiration with regard to conceptualizing change. Gradually, it will become clear which aspects of these process patterns will turn out to be pertinent for the description of long-term change processes in psychoanalysis. Our methodological procedure is geared to producing a picture of change processes that covers an extended period of time with a minimum of expenditure. Our hope is that this proposition will contribute to the discussion within psychotherapy research about how to investigate processes of change which are typical of long-term psychoanalysis.

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Table 1. Tracing long-term change in psychoanalysis by means of process patterns: guidelines for investigation.

(**1st research session**:)

(1) *Matching of a segment* (i.e. a part of a psychotherapy) *to a process pattern*: which segment from which psychoanalysis should be investigated by means of which process pattern? (The "epigenetic landscape" is here used as an example.)

(2) *Report* on the selected segment by the analyst in charge.

(3) *Questions* related to the understanding of the treatment process by other members of the research group:

- *from a psychoanalytic perspective*, and

- in terms of *the process pattern* being used.

(4) *Transcript* of the tape recording of the research session.

(Before and during the **2nd research session**:)

(5) Establishing a *provisional relationship* between *particular concepts* of the process pattern and the *material* (as reported by the analyst in charge). Extraction of a "*problematic*" *strand* and identification of *particular situations*.

(After the session:)

(6) The analyst in charge reviews his or her notes with the aim of getting a *more detailed description* of the particular situations in the selected segment.

(In the **3rd** and **subsequent research sessions**, the other members of the research group having read the detailed description:)

(7) Clarification of further aspects of the material.

(8) Analyzing the selected segment in terms of the process pattern by filling in a frame and carefully describing particular situations,

(9) thus establishing an *increasingly precise and consistent relationship* between process pattern and clinical material.

(10) Drawing *conclusions*, e.g. by comparing the investigated segment with "ideal" courses of

change (as compiled on the basis of the investigation of a large number of segments).

Table 2. Frame for the process pattern based on the "epigenetic landscape", establishing the link between the process pattern and the section from a psychoanalysis taken as an example. The passages printed in italics relate to the visualization of the epigenetic landscape (Fig. 1).

Old attractor

The patient can have a loving attitude only when he controls the person he loves

The **control parameter**...
(i.e. the patient-therapist "system's" activity, as experienced by the patient)
... assumes higher values. *(The landscape rises.)*

Initial value:
Negative self-image (worthless, ridiculous) and related image of an indifferent, devaluating and castrating object
Final value:
Changed self-image (worthy of love) in connection with the image of a loving and limit-setting good object

The **fluctuations** in the patient's experience are becoming more pronounced. *(The valley, representing the old attractor, becomes flatter.)*

... (see description of individual situations)

The **inner parameter** underlying the **separatrix** receives meaning. *(The separatrix, based on the inner parameter, becomes surmountable.)*

The patient feels ridiculous and ashamed when he expresses a wish towards a person he loves

A **new attractor** *is showing*:

- Experience of a (new) feeling: ability to have a loving attitude without having to control the object
- Insight into the determinants of the old attractor: the patient's self-image of being worthless

Structural change in self reference during inpatient therapy
A Study from the Psychosomatic Clinic of Heidelberg University

Günter H. Seidler & Thorsten Jakobsen

Abstract

This paper reports on a project conducted at the Psychosomatic Clinic of Heidelberg University and designed to identify structural changes during inpatient psychotherapy centering around individual and group psychotherapy. All patients admitted for a duration of at least three months are included in the survey, which extends across a period of one year. The rating instrumentarium used is one developed by the authors and termed "Changes of Self-Relatedness" ("CSR"). The observations drawn upon are taken from group sessions recorded on video. For the assessment of social, physical and psychic symptomatology, the project makes use of an expert rating system recording the severity of the symptoms from the point of view of the patient and the expert. In addition, the "Inventory of Interpersonal Problems - German Version (IIP-D)" (Horowitz, Straus & Kordy, 1994) and a German modification (SAM) (Filipp & Freudenberg, 1989) of the "Self-Consciousness Scale" developed by Fenigstein, Scheier and Buss (1975) is also employed. No reference is made here to other instruments.

The category used as an indicator of structural changes is that of self-relatedness. This extends both to the capacity to make oneself the object of perception, observation and judgment (self-referentiality) and to changes in the experience of relations with self and others. These two indicators are measured via part-instrumentalities of the CSR, these being "Clinical Rating of Self-Referentiality" ("RSR") and "Changes in the Experience of Relations" ("CER"). The findings demonstrate that increased self-referentiality goes hand in hand with greater awareness of changes in relations. It appears that patients displaying a strong increase in self-referentiality also show relatively greater improvement in their social and somatic symptomatology. Also, there is a highly significant decline in interpersonal problems as measured by IIP, a highly significant rise in the private self-consciousness scale, and a significant decline in the public self-consciousness scale as reflected in SAM. All in all, the findings point to increased self-referentiality as an essential component of structural changes during inpatient psychotherapy.

Previous Understandings of Structure

The concept of "psychic structure" goes back to Dilthey (1894). In the course of an attempt to determine the precise locus of psychology within a theory of science, he asserts that the task of "descriptive psychology" is "...to delineate the structural organization of ... the life of the soul. Analysis here is concerned with the architectural layout of the finished edifice, it inquires into the internal structure holding the parts together" (p. 176, English translation by the authors).

In his book on Dilthey, Bollnow (1936) inquires into the relationship between the form and content dimensions of structure, and defines the term "structure" as a "boundary concept" largely determined by formal considerations but devoid of meaning without at least some reference to content.

In the index to Freud's Collected Works in German (Veszy-Wagner, 1968), we find three references under the headword "**Struktur** [-verhältnisse d. Psychischen]" (p. 592). Harsch (1980) lists a number of further uses of the term that he has detected in Freud's works. In the somewhat differently organized "General Subject Index" in the final volume of the English-language Standard Edition of Freud's works (Richards, 1974) we find no reference to "structure" whatsoever. In fact, however, the term "structure" actually appears more frequently in the Standard Edition than its German cognate does in the original, the reason being that the German word "*-bildung*" is sometimes rendered as "formation" and sometimes as "structure". We may perhaps legitimately surmise that the impression in German-speaking countries that the term "structure" is of central significance in Freud's works is a fruit of the reception of studies written by English-speaking authors. Freud makes no mention of the term "structure theory". Nagera (1967) mentions what was obviously an oral communication by A. Freud

suggesting that this term was coined by E. Kris (p. 88). In the literature, the term "structure theory" is used to refer to Freud's theoretical notions of the make-up of the personality based on the id-ego-superego model. Drawing on Glover's (1948) concept of microstructures, Gill (1963) proposes designating these three systems as macrostructures and describing their internal constitution microstructurally. In addition, he suggests making a distinction between "mode of function" and "mode of organization" (p. 2) in order to represent the difference between dynamic and static aspects of structure. Beres (1965) goes a stage further and advocates replacing the concept of "structure theory" with that of a "functional theory of psychoanalysis" (p. 58), with a view to adequately reflecting the fact that the three anthropomorphically described control centers id, ego and superego are in fact functional systems. This controversy about correct terminology is an expression of the difficulty of achieving appropriate conceptualization of the relation between processual dynamics and static organization in the psychic sphere. The proposal put forward by Rapoport (1957) has been accorded a high degree of acceptance: "A distinction between cognitive processes on the one hand and the structured (patterned and persisting) tools of cognition and their organizations on the other can possibly be made by the criterion of rates of change: the processes may be defined as showing a high rate of change, the tools and their organization as showing a low one. In other words, the processes are temporary and unique, the tools and their organizations permanent and typical" (S. 634). Although Rapoport here restricts his purview to cognitive structures, the "slow rate of change" feature has been widely acknowledged as a defining criterion for psychic structures in general.

Hartmann (1927, 1964) is particularly notable for his emphasis on the degree to which the genesis of structures may be seen as evolving in conflicts. In the first of his studies he insists that "...the analysis of drive and affect processes down to their subtlest ramifications in memory, perception and action" is the indispensable foundation for "...studying the reciprocal conditioning taking place between character and experience" (p. 42; translation by the authors). Later, however (Hartmann, 1939), he suggests that there are "apparatuses" of "primary autonomy" (e.g. the perceptual system, the memory system, motility) which unlike those of "secondary autonomy" do not develop from a drive-defense process.

Although Freud makes sparing use of the term "structure", he appears to give it three different shades of meaning, one relatively general and referring to "internal organization", one in connection with what was later to be called "structure theory", and a third, different sense manifesting itself in his later references to the "structure of neurosis". In a letter to Fliess dated 2.5.1897, he writes that he now has "...a sure apprehension of the structure of hysteria" (1985c, p. 253; translation by the authors). Here he uses the term "structure" to designate the internal organization of a form of neurosis. Notably Schultz-Hencke (1931) draws on this idea and describes a variety of neurosis structures.

Starting in the early 1960s, a number of American publications discuss the problems bound up with the "structure" concept (e.g. Sandler & Rosenblatt, 1962; Gill, 1963; Beres, 1965; Schafer, 1968). Criticism is leveled above all at the tendency to derive "real" reified structures from the fact that ordered functional processes display recognizable internal organization. With his distinction between metapsychology and clinical theory, Gill (1976) is notably instrumental in placing these criticisms on an organized conceptual basis. Examining the use of the term "metapsychology" in Freud and later authors, he identifies - in analogy to Klein (1970) - "the physical substrate of psychological functioning" as the domain of metapsychology, contrasting this with clinical theory and its focus on "intentionality and meaning" (p. 85). Metapsychology, he claims, is not just a more abstract form of clinical theory, it is an entirely different domain of discourse. In the way it thematizes such things as "structure" and "energy", metapsychology avails itself of a terminology loaned from the natural sciences, and this terminology cannot be legitimately employed to discuss structures of intentional meaning. Stolorow (1978) utilizes this distinction between two different forms of discourse in advancing a concept of psychic structure reflecting a "metapsychology-free conception of psychological structure" (p. 317). In this he draws on a study by Sandler & Rosenblatt (1962) and their "concept of the representational world". This refers to the sum of the "*representations*" of self and objects, the condensed basic patterns of the experience of one's own person and the experience of others, actualized in the form of self- and object-*images*. These images are situation- and person-related concretizations of the affective-cognitive generalizations underlying the representations. Thus, the father-*representation*, for example, may be *concretized* in the form of individual remembered images of one's own father. With this approach, Stolorow (1978) takes the systems of id, ego and superego from traditional metapsychological structure theory and recasts them in experiential terms by linking them with a theory of representation and demonstrating that they are in fact elements that belong squarely in the domain of clinical theory: "...the term 'structure' always refers to the representational world. ... Stable, recurrent representational configurations constitute the experiential referents for such terms as 'character' and 'personality structure'" (p. 316). In this approach the traditional id-ego-superego systems lose their status as metapsychological entities, and are replaced

by a concept of the self in its relations to others. This is the view also underlying the "Operationalized Psychodynamic Diagnosis" approach (Arbeitskreis OPD, 1996), whereas other authors such as Holder & Dare (1982) and Kernberg (1982, 1990) still occasionally draw on elements of structure theory. But by attributing to the self the status of a structure, Kernberg too has in fact already turned away from the "tripartite model of drive theory" (Greenberg & Mitchell, 1983, p. 336).

Conceiving Structure as Observable Behavior: Three Stages of Self-Relatedness

The approaches to a conceptualization of structure that have come down to us are venerable. From a present-day viewpoint they must however be considered provisional, for as metapsychological concepts they are hardly susceptible of empirical verification. Thus in a large-scale preliminary theoretical study (Seidler, 1995a), an attempt was undertaken to describe self-relatedness as the central structural configuration and to conceptualize this construct in such a way as to make it empirically verifiable. This self-relatedness construct takes up the self-perception aspect to be found in the OPD, differentiates it and elaborates on it. It also has points in common with the concept of "objective self consciousness" developed by Duval & Wicklund (1972). But in the elaboration of their construct these authors make no attempt to distinguish different stages of maturity. Clinically, however, these are of major interest.

The present approach distinguishes three materializations of the way in which a person self-relates. At an unreflected stage, there is no reflexive relation to the individual's own intentionality. Patients largely organized in terms of this stage have neither a self-image nor any awareness of how they are perceived by others. Their central anxiety is that of being perceived as an individual at all. If they experience themselves as perceived and judged, then their self-judgment will concur with the judgment by the other(s). Their affects are largely global; the signal quality of affects is something largely or entirely unavailable to them. Their tactlessness and inability to relate makes them violate boundaries and intrude on the intimacy of others. - The median stage of self-relatedness is externally reflected. Patients displaying this kind of structural organization confront their vis-à-vis with the identity question ("Tell me who I am!"). They experience themselves as delineated and defined in the real presence of an other and are configurated by the perception of themselves evinced by that other. Their central anxiety is that of being *condemned*. The reality of other persons is perceived by them, their own individuation and the failure to accord entirely with their vis-à-vis is experienced as a state of rejectedness for which they are bear the guilt. - The third stage of self-relatedness is self-reflected; the subject is able to relate to itself as an object of perception, observation and judgment. It is here that we encounter the structure termed "objective self awareness" by Duval & Wicklund (1972). At this stage, the perception function of the vis-à-vis is appropriated and is available to the subject in the form of a capacity to develop a self-image and a regulation of self-esteem. The subject is capable of assessing its activities in terms of personal responsibility; psychodynamic "guilt-capacity" is only fully established at this level. - These three self-relation modes are not advanced here as alternatives but as progressive stages. When the next-higher stage is reached, certain functions of the next-lower stage will remain operative, depending on the situation. - The self-relatedness construct is part of a broader theoretical approach involving an attempt to conceptualize reciprocal processes. We call this "alterity theory". One of the things it sets out to do is to reformulate the traditional biographically oriented concept of oedipality. Central to this approach is the assumption that whenever a hitherto undisturbed intentional process is interrupted by the intrusion of experiential contents from an outside source, the subject is thrown back upon itself. The resulting "breach" is not itself susceptible of symbolization as such. But the encounter with this breach manifests itself as a boundary of the self and the self emerges from this encounter endowed with reflexivity. In therapeutic situations, for example, the act of "inter-vention" represents such an interruption: for the patient, the therapist becomes susceptible of being experienced as an other or confronts the subject with an interpretation which points up contents hitherto denied or fended off via defense. Clinical experience shows that inpatient psychotherapy is a domain that provides an abundance of opportunities for such experiences. This is due to the fact that in this context patients can - and indeed must - oscillate between the possibility of abandoning themselves to their experiences and the contact with real others and with the institutional parameters of a psychotherapeutic ward or department.

These stages of self-relatedness manifest themselves in interpersonal behavior. Accordingly, we make extensive use of videographed group-therapy sessions for our observations. During the period at the clinic, each patient is rated four times by trained raters. The rating instrumentarium we use consists of three lists of items developed to assess "changes of self-relatedness (**CSR**)". For measuring changes in the extent of self-referentiality we first developed 34 items. Taking into consideration the judgment of an expert, 14 out of these 34 items were chosen to be worked with further. These 14 items are sufficient to assess the extent of self-referentiality. Let us give you an example of these items:

3. The IP fears to hurt others, to be a burden on them or disturb the group:

no clue or no more no Undecided more yes yes

7. In speaking with the IP, a topic becomes subject. This can be, in an objective speech, the IP himself:

no clue or no | more no | Undecided | more yes | yes

This instrument is called "Clinical rating of self-referentiality (**RSR**)". Here the interrater reliability was 0.75. The internal consistency (Cronbach`s Alpha) was 0.86 and 0.80, depending on the rater. For patients on a high structural level - i.e. whose structural changes are not their main problem - 7 items were added to RSR inquiring into "Changes in experiences of relations (**CER**)". As an example, we show you the following items:

4. The IP reports to have regained a previously known ability or characteristic, which he thought to have lost:

no clue or no | more no | Undecided | more yes | yes

5. The IP reports to have previously not known perceptions with others:

no clue or no | more no | Undecided | more yes | yes

The interrater reliability was 0.62. The internal consistency (Cronbach`s Alpha) was 0.75 and 0.68, depending on the rater. This result is in an acceptable range. As we were also concerned to examine the connections between structural change in self-relatedness and clinical symptomatologies, we developed a list of items of our own (10 items) to assess symptomatology and experience of illness. The first three items refer to the assessment of physical, social and psychic symptoms from an objectifying external viewpoint. The next three items refer to the extent patients suffer subjectively from their symptoms. Another three items refer to the insight and the psychodynamic comprehension of the patient. The last item analyzes the extent of the patients' therapy motivation from the raters viewpoint. These assessments are done by two raters in an additional round. The interrater reliability for the first group - the assessment of physical, social and psychic symptoms from an objectifying external viewpoint - was 0.85, for the second group - patients' view of the significance/severity of their symptoms - 0.78 and for the third group, the gaining of insight, the interrater reliability was 0.82. The assessment of therapy motivation was more difficult; here, interrater reliability was 0.65. There is a detailed manual for each of the instruments.

Translating a Theoretical Concept into a Naturalistic Study

The main hypothesis up for validation in this research project is the assumption that during a course of inpatient psychotherapy of three months there will be demonstrable changes in self-relatedness broadly corresponding to a development from the first towards the third of our stages. The observational setting for validating this hypothesis is the material from videographed group-psychotherapy sessions attended by the patients on 33 occasions (3 times a week) during a three-month period at the clinic. Assessment of structural changes takes place via the rating instruments described earlier. These are employed by trained raters to assess each patient at the beginning of therapy, after four and eight weeks of therapy, and shortly before discharge. The scales in the "changes of self-relatedness (CSR)" instrumentarium are encoded on the basis of the videographed group sessions. The instrumentarium for the assessment of symptomatology and subjective experience of illness is encoded during a special interview conducted jointly by a doctor and a doctoral intern. The encodings are carried out independently on the basis of the joint interview. Subsequently, difficult situations are discussed in the light of future rating.

Given the insufficient degree of standardization for our own instruments, we also included in our study a variety of internationally established instruments conceptually close to our own. Among these are a German modification (by Filipp & Freudenberg, 1989) of the "Self-Consciousness Scale" developed by Fenigstein, Scheier & Buss (1975). The instrumentarium includes two sub-scales. One images "public self-consciousness", the other "private self-consciousness". The first maps the degree to which a subject addresses its consciousness to the way it is perceived by others, the second charts the degree of the subject's occupation/engagemnent with its own self. Our hypothesis was that the scale of public self-consciousness might correlate with the externally reflected stage in our own approach, and the scale of private self-consciousness with the self-reflexive stage. For the assessment of interpersonal problems we use the German short version of the "Inventory of Interpersonal Problems" (Horowitz, Strauss & Kordy, 1994). The routine diagnostic procedure encompasses both a documentation with the "Psychic and Social-Communicative Result " (Rudolf, 1981) and a survey with parts of the

"Narcissism Inventory" (Deneke & Hilgenstock, 1989) at the beginning and the end of the inpatient psychotherapy setting. Assessments with the above-mentioned instruments take place at 4 points during the 12-week course of therapy. For reasons of time, we shall not be able to present the results obtained with all these instruments.

The present survey took place in the 22-bed ward of the University Psychosomatic Clinic in Heidelberg. Here treatment is given to patients with chronic neuroses, psychosomatic disorders, personality disorders and eating problems. There are various therapy programs, and the settings suitable for individual patients are agreed upon with them in an outpatient interview prior to hospitalization on the basis of the indications present. The study presented here encompasses all patients admitted for a 12-week course of therapy in the period between 1 February 1996 and 31 January 1997. They took part in psychoanalytically oriented individual therapy, psychoanalytic/interactional group psychotherapy and two therapy programs from the range of body therapy, music therapy and creative therapy.

The constitution of the group of patients included in the study is as follows:

At the evaluation stage for this presentation, sets of data were available for some 100 patients. Only complete sets of data were included. Three-quarters of the patients are female, one-quarter male. Median age is approx. 30, this applies to both sexes alike. Most of the patients are between 21 and 30 years of age, only a small minority over 40 (Figure 1 & 2). One-third of the patients completed their secondary education with the "Abitur", which qualifies students to attend university; a further third have qualifications corresponding to a junior high school diploma or the British O-Level examinations. Most of the patients are single (61%), 14% are either divorced or separated, approx. 25% are married.

In diagnostic terms, the population breaks down into about one-quarter each with eating disorders, depression-related disturbances, anxiety or compulsion disorders, and psychic illnesses with a somatic component. In addition, almost 30% display personality disorders. The varying percentages in the two diagrams are a result of double diagnoses (Figure 3 & 4).

Results

We first describe changes observed in then individual scales and then indicate some connections between them.

Figure 5 shows a significant difference between the first and fourth timepoint in the ratings pertaining to experiences of relations. On average, there is a highly significant rise in in the capacity for self-perception and other-perception as imaged by the "Changes in experiences of relations (CER)" instrument.

Figure 6 shows a steady rise in self-reflexivity between the first and last timepoint, as measured by the "Clinical rating of self-referentiality (RSR)" scale. In other words, patients display an increasing incidence of behaviors in which they make themselves the objects of their own perception. In terms of the theoretical approach at issue here, this must be regarded as the central therapeutic change.

In symptomatology there is a general drop in clinical abnormalities.

This statement is based on an assessment of physical, social and psychic symptomatologies undertaken at four different timepoints in the context of the interviews mentioned earlier. The results show a highly significant decline in symptomatology in these three areas (all 3 p=.000).

In Figure 7 we see that the IIP rating also shows a highly significant drop in interpersonal problems over the four timepoints. A striking feature here is a significant rise in the first quarter - the first four weeks - of therapy. Here we require more precise analysis to determine whether this progression is to be found in all patients or only in part of the group.

Limiting ourselves to the changes in the various scales between therapy commencement and therapy conclusion, we see a general shift away from over-protectiveness and lack of self-assurance (Figure 8). By contrast, if we look at the prevalent problem area for individual patients as reflected in the maximum rating in a given scale, then we see that this tends to remain constant over time. For 50% of the patients, our figures show that the prevalent problem area remains fundamentally constant, whereas there is a decline in the totality of problems, as we have seen.

Rates for private self-consciousness rise to a highly significant degree (p=.004) between the first and fourth measuring points, wheras those for public self-consciousness decline across the same period (p=.039). We may tentatively interpret this progression as a confirmation of the suggested correlation between the public self-consciousness scale and our externally reflected stage, and between the private self-consciousness scale and our self-reflexive stage.

In conclusion, we should like to point to three instances of connections between the changes observed. The observed reduction in interpersonal problems goes hand in hand with a decline in public self-consciousness (Figure 9). A particularly marked decline in public self-consciousness is bound up with a particularly pronounced drop in interpersonal problems (r= .41**). While there is also a demonstrable rise in private self-consciousness, this stands in no relation to the reduction in interpersonal problems. The interpretation of the SAM is not straightforward. Two possible readings suggest themselves. It seems conceivable that the interpersonal problems of these patients diminish because they withdraw their self-consciousness from the public sphere. In this case it is not to be expected that an outside assessment will register any reduction in their interpersonal problems. The possible alternative is that the reduction in interpersonal problems effects a decline in the necessity for public self-consciousness. At the same time, we see that there is a connection between the reduction of interpersonal problems and more differentiated experience of relations (Figure 10). Our interpretation is that an increase in the structural capacity for diffrerentiated experience of relations brings about a decline in interpersonal problems.

The main line of inquiry informing this study is the question of the development and describability of structural changes during inpatient psychotherapy and the way this correlates with interpersonal problems and other aspects of patient symptomatology. Our findings here (Figure 11) show that a rise in self-reflexivity is associated with a highly significant symptomatological decline both in the somatic and the social dimensions. In other words, those patients with a particularly pronounced increase in self-reflexivity also display a particularly marked decline in both these symptom areas. By contrast, no such connection reveals itself in connection with psychic symptomatology, although this too shows a general decline in the group over time.

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Figures

Figure 1: Gender distribution, whole group

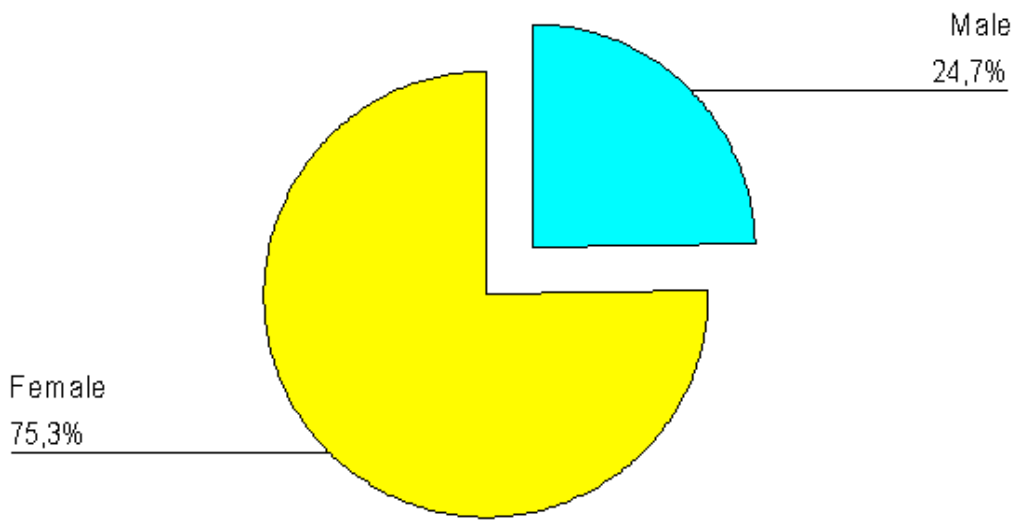


Figure 2: Age distribution in groups (percentages). Mean age 30 years.

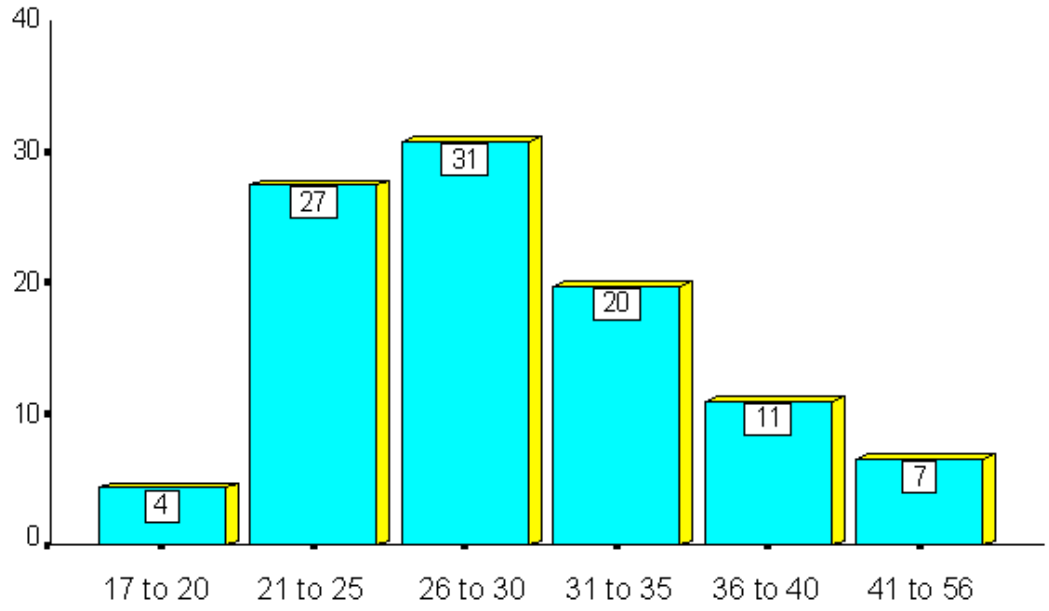


Figure 3:Diagnoses excluding the patients with double diagnoses.

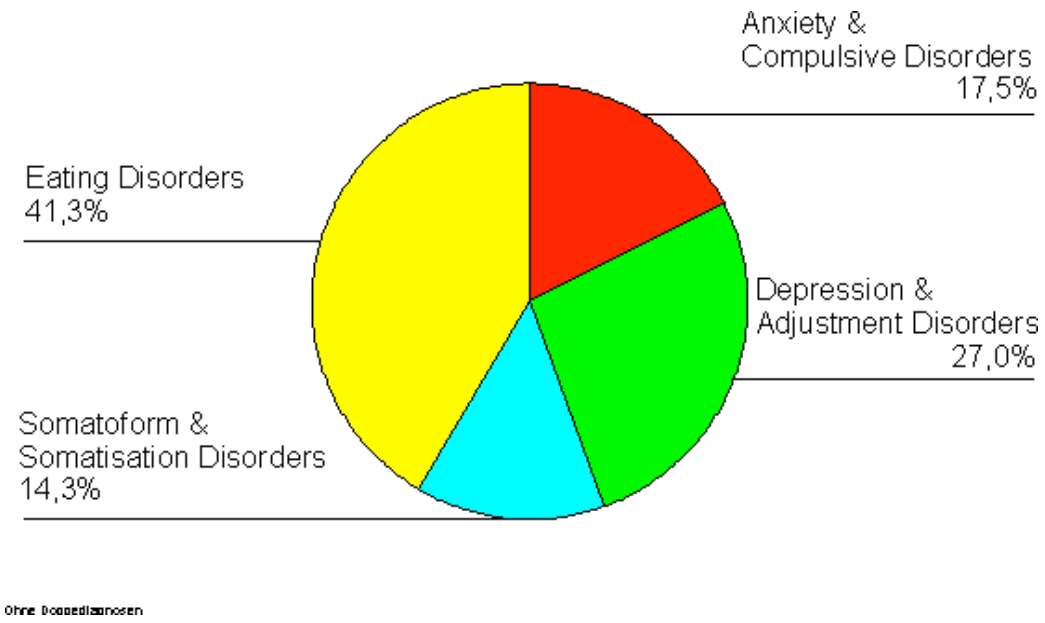


Figure 4: Diagnoses including the patients with double diagnosis.

Figure 5: Progression in the CER scale. Significant differences from t1 to t4 (p=.007; group means of row values).**

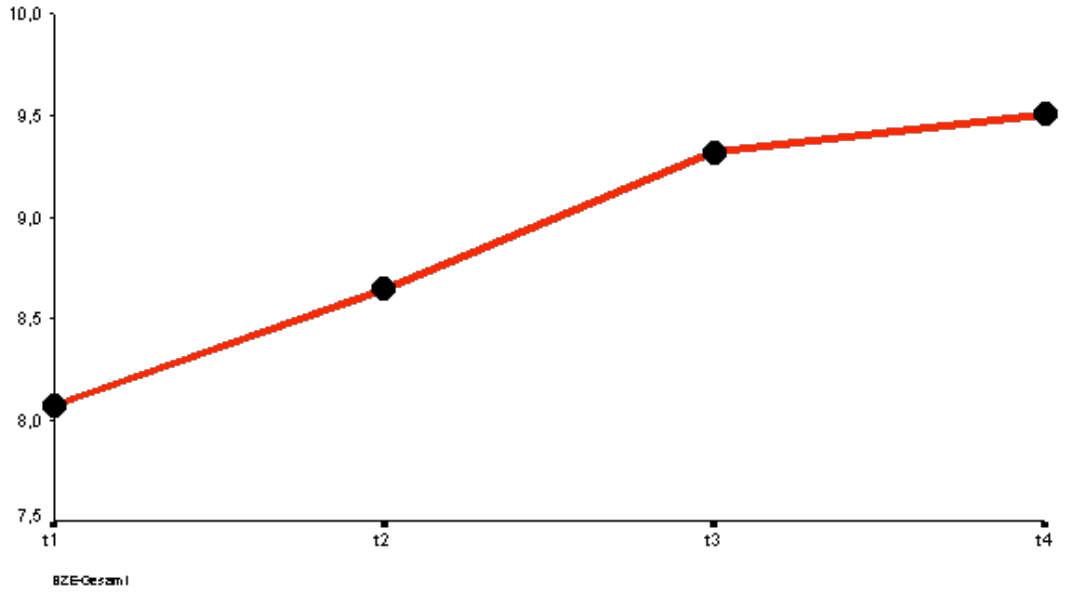


Figure 6: Progression of the RSR scale. Significant differences from t1 to t4* (p=.048; group means of row values).

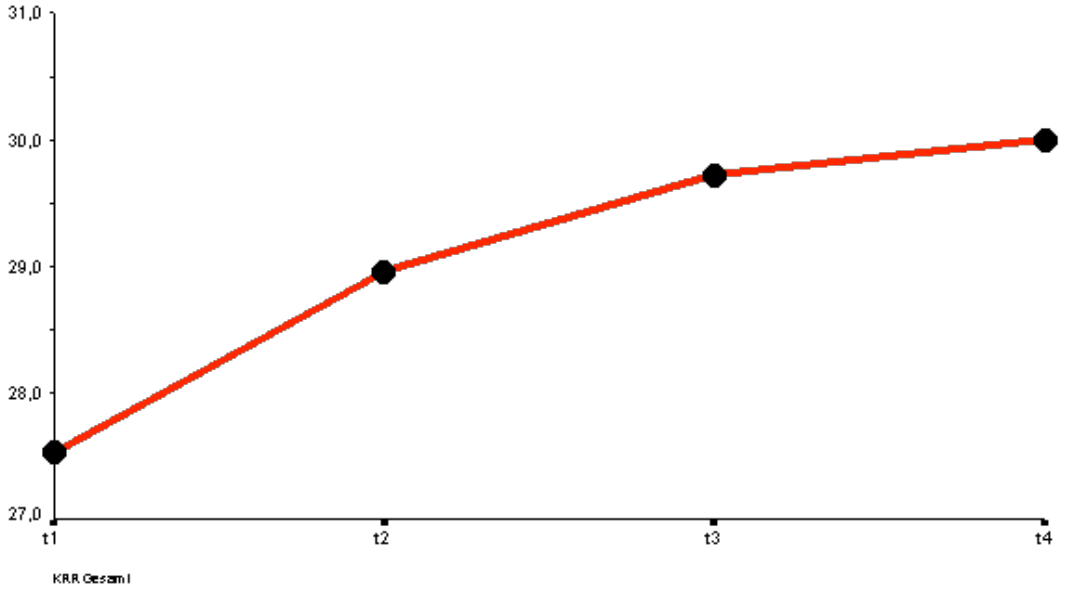


Figure 7: Progression of overall IIP ratings. Significant differences from t1 to t2* (p=.034) and from t1 to t4 (p=.000; group means of row values).**

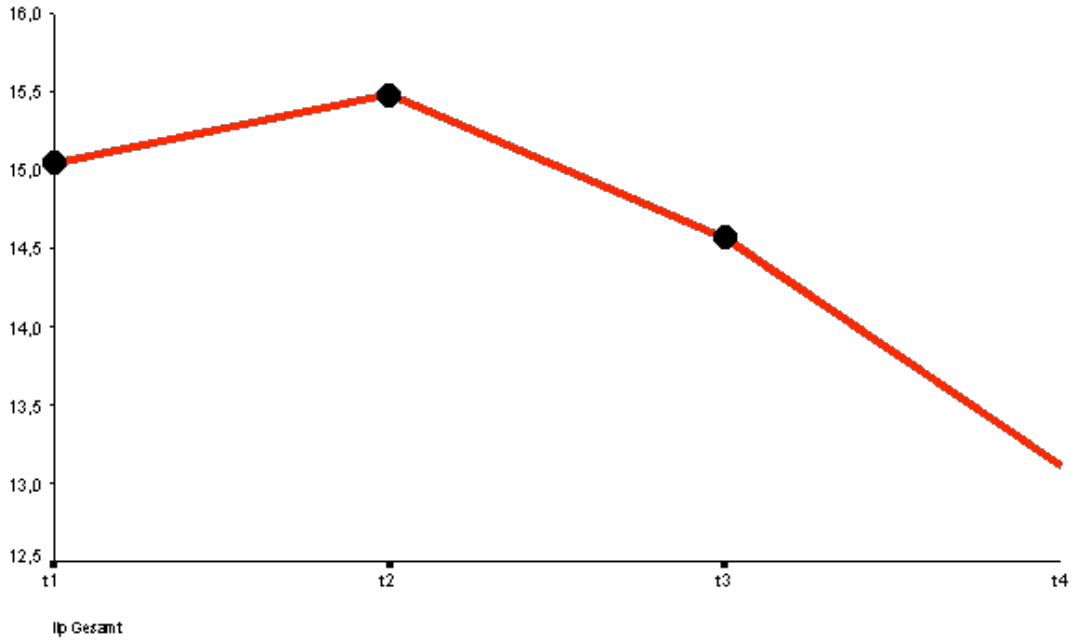


Figure 8

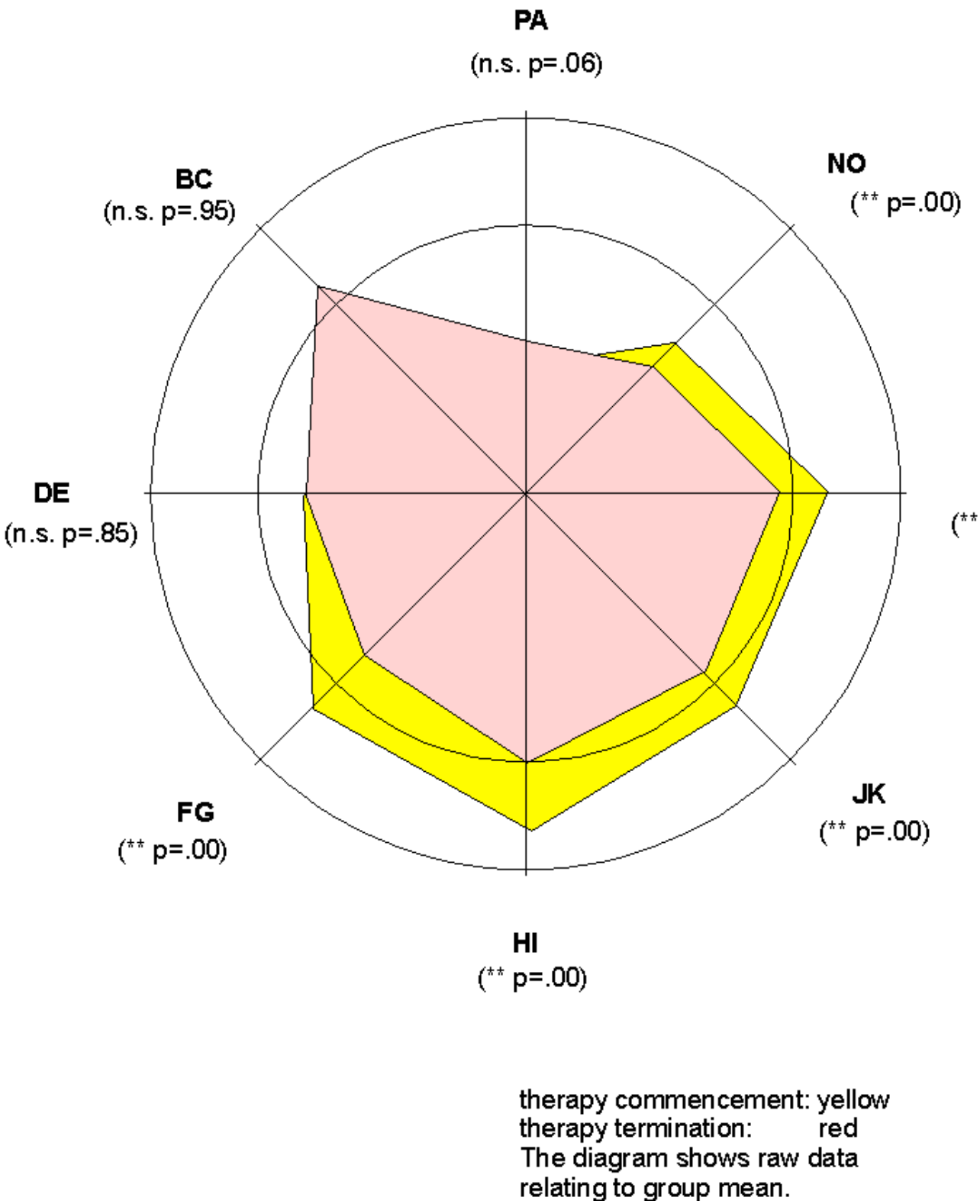

Differences in individual IIP scales
from therapy commencement to therapy termination
PA
(n.s. p=.06)
NO
(** p=.00)
BC
(n.s. p=.95)
DE
(n.s. p=.85)
(**
FG
(** p=.00)
JK
(** p=.00)
HI
(** p=.00)
therapy commencement: yellow
therapy termination: red
The diagram shows raw data
relating to group mean.

Figure 9

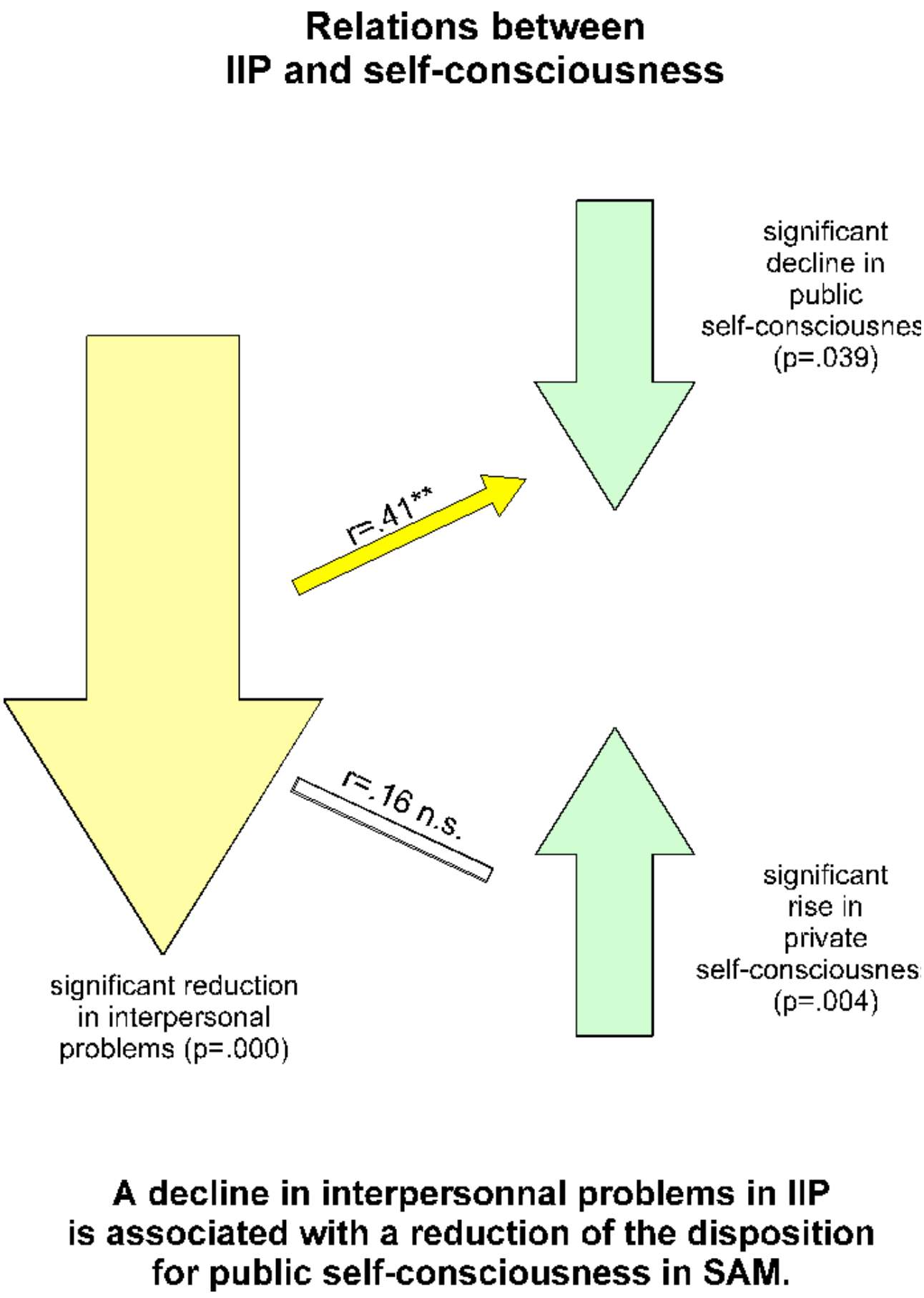

Relations between
IIP and self-consciousness
significant
decline in
public
self-consciousnes
(p=.039)
r=.41**
r=.16 n.s.
significant reduction
in interpersonal
problems (p=.000)
significant
rise in
private
self-consciousnes
(p=.004)
A decline in interpersonnal problems in IIP
is associated with a reduction of the disposition
for public self-consciousness in SAM.

Figure 10

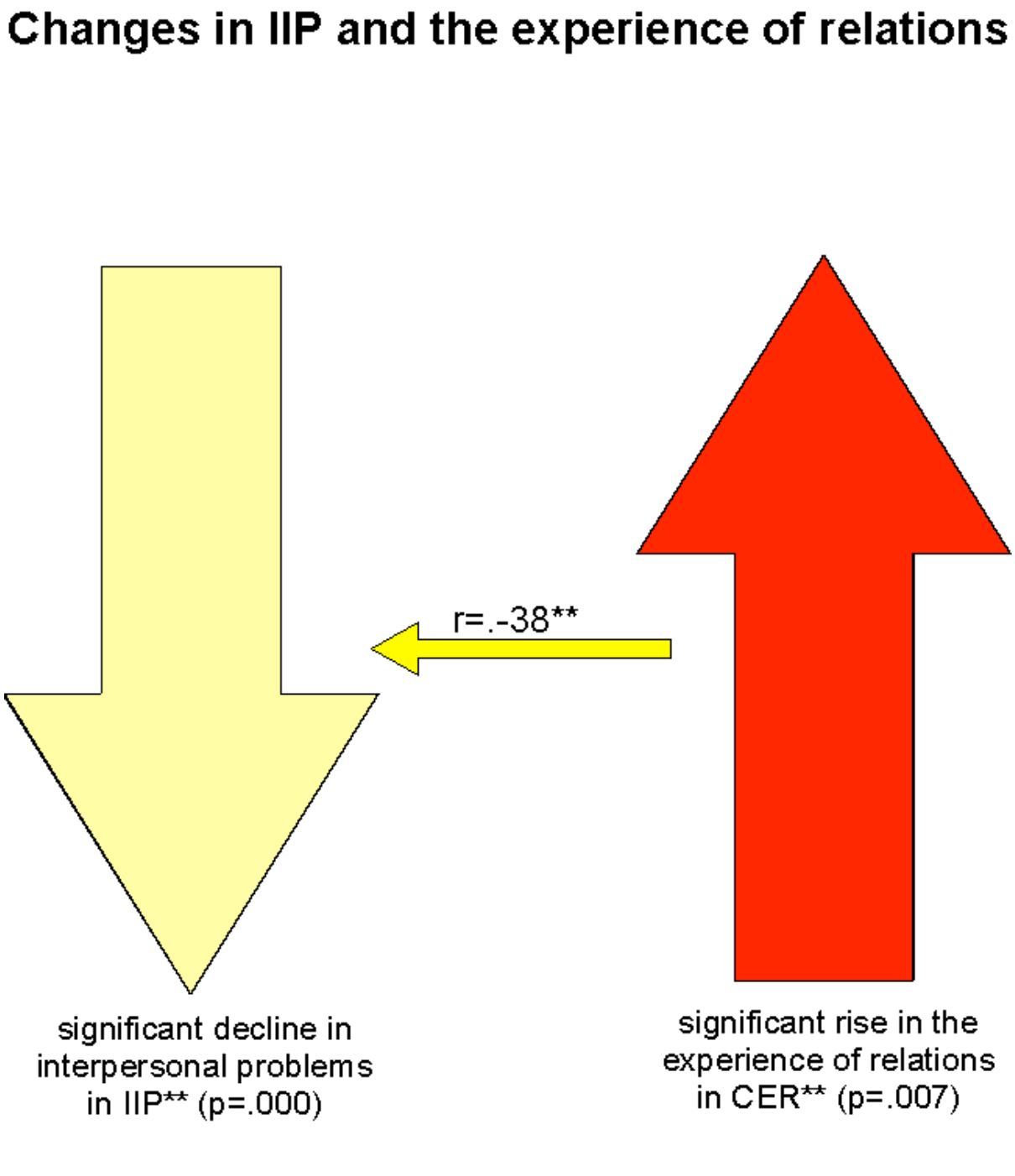
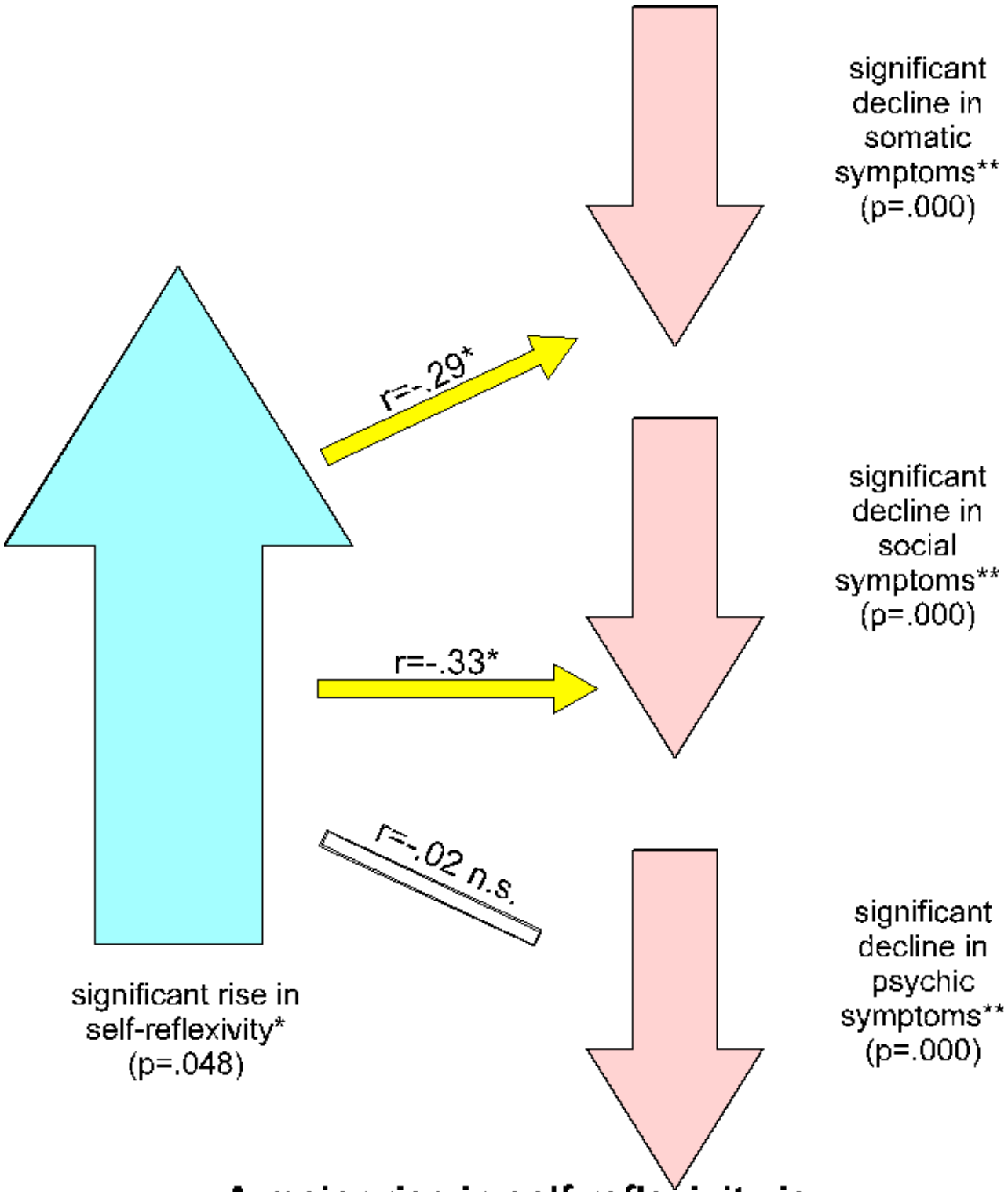

Changes in IIP and the experience of relations
r=.-38**
significant decline in interpersonal problems in IIP** (p=.000)
significant rise in the experience of relations in CER** (p=.007)
A major rise in the experience of relations is associated with a pronaunced drop in interpersonal problems in IIP.

Figure 11

Relations between reflexivity and changes in symptomatology



A major rise in self-reflexivity is connectet with a major drop in somatic and social symptoms in the expert rating.

Changing Problems, Changing Aims: The development of change in psychoanalytic psychotherapy evaluated by PATH, a tool for studying longterm treatments

Hermann Staats, Joachim Biskup & Falk Leichsenring

Abstract:

The **"Goettingen Study on the effectiveness of psychoanalytic psychotherapy"** started in 1992; by now five patients have had their 1 year catamnestic interviews. Part of this study is "**PATH**", a method of investigating the development of **P**roblems and **A**ims in **Th**erapy and their changes.
We illustrate PATH using a case example and present PATH data from five patients. First results lead to the impression that reduction of suffering occurred mostly in the last 80 sessions of therapy. Patients' aims seemed to be achieved mostly in the time directly following their formulation. Aims and problems did change during longterm psychoanalytic treatment; and gains were substantial in later parts of treatment for some patients.

1. The Goettingen study on the effectiveness of psychoanalytic psychotherapy

- is a naturalistic study
involving now about 20 psychoanalysts, mainly in private practice.

- investigating the effects of
psychoanalytic psychotherapy (2 to 3 sessions weekly for 2-4 years) and
analytically orientated psychotherapy (1 session weekly for 1-2 years)

- assessing outcome referring to symptoms, interpersonal problems, emotional well-being, quality of life and individual problems and aims.

and using a combination of well-normed (mainly self-report) diagnostic instruments (e.g. SCL 90, IIP, VEV) with a diagnostic approach tailored to the specific conditions of longterm psychoanalytic psychotherapy: **PATH**.

Points of measurement are before therapy (T1), at 50 sessions (T2; in a pre-study: 80 sessions), 160 sessions (T3), end of therapy (T4) and one year after termination of therapy (T5).

In our study, we expect quantitative differences between psychoanalytic psychotherapy and psychodynamic therapy. We expect qualitative differences, too, and assume, that during psychoanalytic psychotherapy problems and aims arise which patients did not before experience as such: new problems and new aims. This is in accordance with the description of psychoanalysis as a focal therapy with shifting foci (Thomä and Kächele 1985).

2. "PATH" is a method of investigating change in Problems and Change in Aims during THerapy.

Several instruments are used for studying change in psychotherapy. One of these is goal attainment scaling (Kiresuk and Shermann 1968).
At least in Europe, the idea of a "goal" somehow looks like a metaphor transferred from the football (or soccer) grounds: Goals are set up before the start, a time period is fixed - twice 45 minutes - and in the end you hit it or you did not. For short term psychotherapy this is a useful concept. However, we think it is not well suited for long term psychotherapies:

Problems and aims change - in life and during therapy. Problems usually stay; they rarely end, they often change. So we modified goal attainment scaling in order to evaluate individual problems and aims in therapy **and their changes**. We included the development of new problems and aims arising during therapy and do not confine ourselves

to studying problems and aims presented at the beginning of therapy. This way, we hope to ensure that the effects of working on problems which emerge later in the course of therapy will not be lost .

With PATH, at each point of measurement we ask for problems and aims as they are experienced now. Patients describe their problems and aims in their own words. They rate, on a five point scale, how much they suffer from these problems. From T2 onwards they are then given photocopies of the problems and aims they described at previous points of measurement in the study and rate how much they now suffer from these "previous" problems and in how far they have achieved these "previous" aims.

Using PATH, with each new problem arising during therapy a new scale is opened. This way we hope to avoid ceiling effects and effects of adaption to change.

Suppose, for example, a patient has rated his anxiety on a five point scale (0 = not at all; 1 = little; 2 = somewhat/moderate; 3 = severe; 4 = could not be worse) as 3 = "severe" and experienced relief during the first sessions of therapy. He may now experience his anxiety as 1 = "little". Perhaps, he has rarely been so free from anxiety during the last months as he is now. It is for this reason, he considers his symptoms as "little". This is the expected great change between T1 (beginning) and T2 (50 sessions) for problems described at the beginning of therapy and between T2 (50 sessions) and T3 (160 sessions) for new problems first described at T2. If - further on in therapy - symptoms decrease as much as they did during these first sessions, the patient could only rate his anxiety as "not at all" at later parts of therapy - what he may be unwilling to do. The amount of change in symptoms will not be depicted on the scale; people may - falsely - conclude, that later parts of therapy do not lead to considerable change anymore. Indeed, with adaption to progress, progress may become less impressive; and if there is no further progress, adaption to what has been gained may cause patient ratings of achievement to fall.

3. Case example: Mr. U:

We shall explain PATH by using a case example from our pre-study, a 40 year old male patient with problems at work, problems with friends and in his familiy, a promiscous sexual life and a long history of stomach ulcera, having caused life threatening bleeding and surgical intervention. Let us call him Mr. U.

Mr U. sees himself as a person always prepared to help, and deeply disappointed with others, who do not help him. He does not see, that he **forces** his ideas on **how** he wants to be helped on others and so makes them retreat.

Fig. 1: Mr. U.: Problems - Part I

T1 (Start)	T2 (80 sessions)	T3 (160 sessions)	T1	T2	T3
1. Too much stress, time pressure			3	3	3
2. To mark limits in contact with other people			3	2	3
3 Unhealthy eating and drinking habits			2	2	2
	1. Too little opportunities to relax			3	2
	2. Financial burdens			2	1
	3. Conflicts with my wife			2	1
unexpected change:	- Friendships have improved a lot: +3: - How I see myself has				

	changed for worse: -2:		
		1. Conflict with my father and sister	3
		2. Too little time for myself	3
		3. At times I feel lonely	3
unexpected change		Passing feelings of loneliness: -2 Sometimes felt as pleasant inner peacefulness: +2	

He describes his problems at the beginning of therapy as:

"Too much stress, time pressure" - rated "3" = severe

"mark my liDiskettenlaufwerk Diskettenlaufwerke" - rated severe

and "unhealthy eating and drinking habits" - rated as suffering moderately

After eighty sessions the patient describes his most urgent problems anew, rates how much he suffers from them and once again describes his aims for treatment.
He then gets photocopies of what he has written at the beginning of treatment. He rates again how much he is suffering under the problems described at that time and in how far he has reached the aims described at that time.
He is also asked to describe changes in areas, where he did not expect change before. After 80 sessions - at time T2 - Mr. U notes: "Friendships have improved a lot" and " how I see myself has changed for worse".

This is repeated at 160 sessions, at the end of therapy and one year after therapy.

Fig. 2: On this sheet you can see all the data for change of problems during treatment of Mr. U.

T1 (Start)	T2 (80 sessions)	T3 (160 sessions)	T4 (240, end)	T5 (catamnesis, one year after treatment)	T1	T2	T3	T4	T5
1. Too much stress, time pressure					3	3	3	0	0
2. To mark my limits in contact with other people					3	2	3	2	1
3. Unhealthy eating and drinking habits					2	2	2	3	1
	1. too little opportunities to relax					3	2	1	1
	2. financial burdens					2	1	0	2
	3. conflicts with my wife					2	1	1	2
	friendships have improved a lot: +3 how I see me has changed for worse: -2								

	1. Conflict with my father and sister	3	0	0
	2- too little time for myself	3	0	0
	3. at times I feel lonely	2	1	1
	passing feelings of loneliness: -2 sometimes felt as pleasant inner peacefulness: +2			
Problems Mr. U.:	1. my professional career		3	1
4.: "could not be worse"	2. my health: back, stomach, eating habits		2	0
3.:"suffer severely"	3. handling anger		3	1
2.: "suffer somewhat"	other men's woman are less important now: +3 friendships have improved much: +3			
1.: "suffer little"				
0.: "suffer not at all"	1. too little sex			3
	2.too little sun, I often feel cold			2
	3. too many wars			4
	I feel more self-possessed and calm: +3 I face problems now and feel that I can tackle them successfully: +3			

What do we see as results of a treatment judged as successful both by the patient and the analyst?

Looking just at the ratings for suffering at the beginning and the end of therapy you may think:

- Mr. U. is suffering more under his problems at the end of therapy ("severe", "somewhat", "could not be worse") than he did at the start ("severe", "severe", "somewhat").

- The problems he suffers from at the end are different from those he suffered from at the beginning of therapy.

- Impressive change occurred in areas, where Mr. U. did not expect change to occur: After 80 sessions - at T2 - you find "Friendships have improved a lot" - a +3, "much improved" - and "how I see me has changed for worse" -something he rates a - 2, a "moderate" setback. "How I see myself has changed for worse" may not look like progress. In this case, however, it describes the early focus of treatment: Mr. U. now realizes how he forces others to do as he wants them to do and no longer sees himself as a "hero helper". His image of himself has become worse. In consequence, he is no longer as disappointed as he used to be: his friendships have become much better.
After 160 sessions - at T3 - passing feelings of loneliness arise and are sometimes felt as "pleasant inner peacefulness". Other mens' women have become less important at the end of therapy with friendships improved - at T4. One year after therapy ended Mr. U. describes that he feels more self-possessed and calm (+3) and that he faces problems now and feels that he can tackle them successfully.

- A last point can be noted: Problems can change in content. "Too much stress" at T1 changed to "too little opportunities to relax" at T2 and into "too little time for myself" at T3 before completely disappearing at the end of treatment. You may argue, though: no more therapy three times weekly - that greatly reduces the problem of "time pressure"!

4. Evaluating PATH data:

You have seen part of the PATH data - the "problems", not the aims" - for one patient, Mr. U. These data can be evaluated in different ways:

- One way is their use as a basis for empirically validated case studies.

- Another possibility, reducing the complexities of the data, is the use of content categories, enabling the statistical

evaluation of content changes in patient groups. Content categories for problems and aims have been developed by Faller and Goßler (1998). Larger samples of patients are needed to obtain interesting results - we hope to report on these in a couple of years.

- In this contribution we try to evaluate these data using quantitative indices. **Reduction of suffering** and **achievement of aims** are assessed in form of numerical data.

If you want to follow Mr. U., have a look at the line marked with crosses. He is a patient with a psychosomatic disorder, stomach ulcera, (ICD-10: F54) and a character neurosis (ICD-10: F60.9)
Two patients suffered under panic disorder (ICD-10: F41.0), one of them with additional diagnosis of a narcissistic personality disorder (ICD-10: F60.8) and a somatization disorder (ICD-10: F45.1).
One patient was diagnosed as dysthymic (ICD-10: F34.1), with sexual dysfunction and a character neurosis.
Diagnosis of the patient marked with triangles is a narcissistic personality disorder.

4.1 A look at the "problems"

4.1 The following figures show the reduction of average suffering under problems first described at various times of therapy (Mr. U. marked X):
T1 (beginning of therapy)
T2 (80 sessions of therapy)
T3 (160 sessions of therapy,if therapy had 210 sessions altogether)
T4 (End of therapy, after 160 or 240 sessions of therapy)
T5 (12 months after end of treatment, catamnesis)

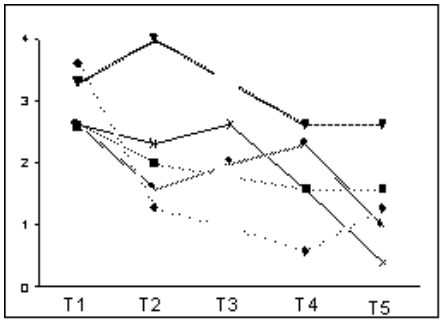


Fig. 3: Problems described at T1

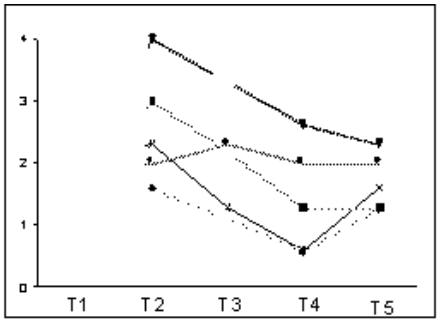


Fig. 4: Problems described at T2

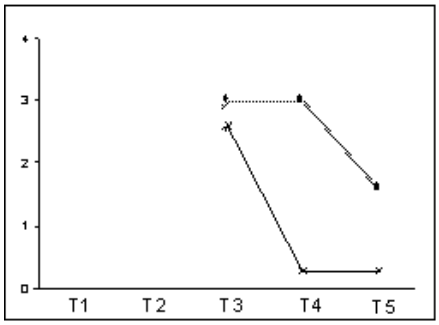


Fig. 5: Problems described at T3

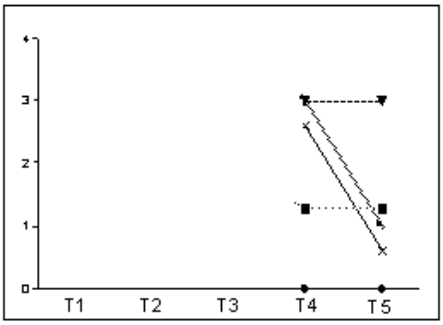


Fig. 6: Problems described at T4

0 = not at all; 1 = little; 2 = somewhat/moderate; 3 = severe; 4 = could not be worse)

Comment:
The patient diagnosed as suffering from a narcissistic personality disorder experienced little reduction of suffering under his problems during therapy. He restarted working during therapy and has been keeping his job up to now; but his interpersonal problems and somatic complaints have changed little.

Two patients with anxiety disorder have experienced a lot of reduction of suffering.

For Mr. U. suffering under problems that only appear in the course of therapy or at the end of therapy seems to be reduced faster as compared to suffering under problems he began with.

4.2. The average reduction of suffering under problems for treatment intervals.

This index uses **average** values for change in problems. Here it becomes necessary to distinguish between "old" problems, that come up repeatedly in new words during the evaluation, and new problems. Problems are rated but once. For Mr. U. the problems "too little opportunities to relax" (at T2) and "too little time for myself" (at T3) are considered "old" problems, repetitions of "too much stress, time pressure" (at T1).
Problems and aims are rated "old" (= repeated) if they are:

- equal in content **or**
- similar in content and equal in their first rating.

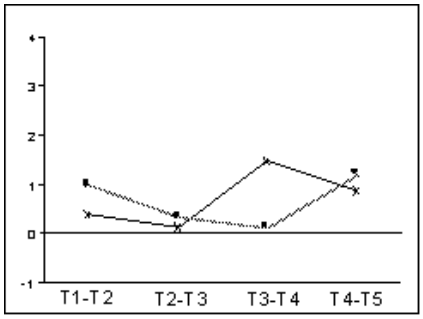


Fig. 7

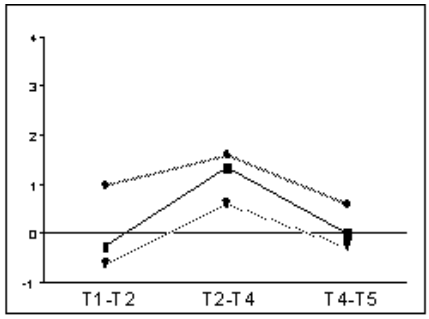


Fig. 8

On the left you find treatments lasting 240 sessions. That makes five points of measurement and thus four treatment intervals. On the right you find treatments lasting 160 session, with four points of measurement and three treatment intervals. T4-T5 is the catamnestic interval.

Comment:
Suffering under problems - that is the area under the curve - is in most patients strongly reduced in the final 80 sessions of therapy - between 160 and 240 sessions in Mr. U. and 80 to 160 sessions in other patients.
Maybe patients stop therapy, once they have "solved" a lot of their problems.

4.3 A look at the aims and their changes

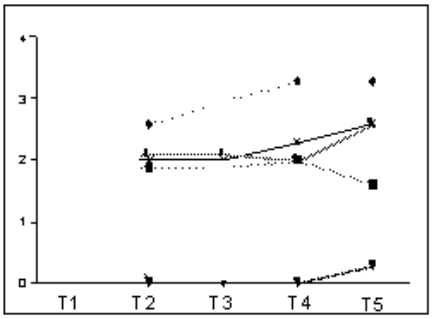


Fig. 9: Goal attainment for aims described at T1

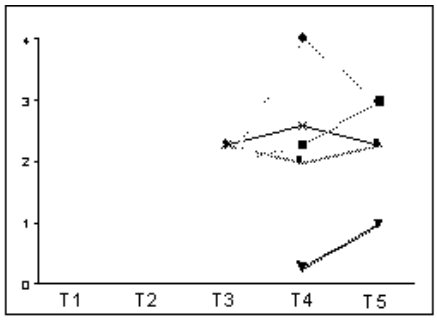


Fig. 10: Goal attainment for aims described at T2

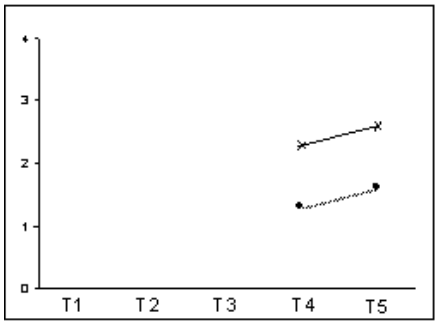


Fig. 11: Goal attainment for aims described at T3

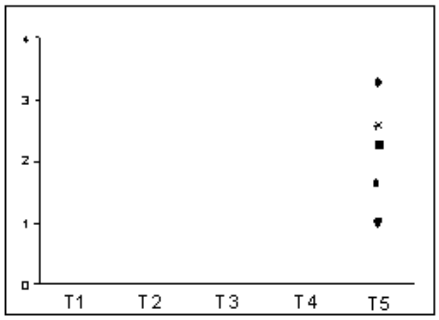


Fig. 12: Goal attainment for aims described at T4

(Goal attainment: 0 = "not at all", 1 = little, 2 = moderate, 3 = much, 4 = completely).

You can see goal attainment scores starting at about 2 = "Moderate" goal attainment. There is not much increase after this first interval. This seems to hold true for goals early and late in therapy.

Comment:
Aims seem to be achieved to a considerable extent in the time directly following their formulation.
"Simple" goal attainment may thus lead to the impression, that there is little change in later parts of therapy - contrary to clinical knowledge and to our PATH data.
The impression of little change in later parts of therapy may be considered an artifact of the method used. If this finding holds true for a larger number of patients, unmodified Goal Attainment Scaling may not be well suited to evaluate long term psychotherapies.

5. Some standardized self report instruments and the change they show during treatment

In these five patients it looks as though change in subjective feeling of well-being (Bf-S) may precede reduction of suffering under problems in some patients but not in others. Well-being may decrease in therapy. Symptom reduction is not well shown by GSI, PST and PSDI (SCL-90-R).

6. Discussion

Remembering all these lines leads to the impression that reduction of suffering seems to occur mostly in the last 80 sessions of therapy. Aims seem to be achieved mostly in the time directly following their formulation.

Possibly with some irony we have been warned: "Never generalize from one patient - always wait for two". We do not know **who** said so; if any reader should know the quote, please let us know!
Keeping this in mind, our approach may be able to show that

- aims and problems do change indeed during longterm psychoanalytic treatment; and that

- gains may be substantial in later parts of treatment for some patients.

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The interactive production of resistance

U. Streeck

Resistances are attitudes and behavioral patterns of a patient in treatment which contradict the aims of the psychoanalytic process: "...whatever disturbs the continuation of analytic work is a resistance" (Freud 1900, 521). Even the first version of this concept describes resistance as an interactive event between patient and analyst, although there was the idea of an aggressive and belligerent therapeutic relationship about Freud's view (1895). Freud considered the analyst, whose aim is the surrender of resistance, to be an opponent of the patient, who defiantly resists the analyst's aim with 'psychic force' (Thomä, Kächele 1985; Mertens 1990). Today many psychoanalysts, Gill (1993) for example, stress the interpersonal character of all resistances - as well as the whole therapeutic process - as joint creations of analysand and analyst.

Psychotherapy and conversation analysis

As resistances are co-productions, the question emerges, how analysand and analyst jointly produce resistances while interacting with one another. Up to now psychotherapy research has hardly adressed this question. This is the reason Wolff (1994) says psychotherapy research is chiefly concerned with the effects of psychotherapy but does less research on psychotherapy itself.

Conversation analysis is a research program that very well suits the aim of examining the interactive character of psychotherapy and its microstructures. Conversation analysis, coming from interactive sociology (c. Sacks 1992; Heritage 1984; Schegloff 1993), examines methods and procedures that participants in social interaction apply to arrive at intersubjectively coordinated constructions of reality (Bergmann 1991) and to produce the characteristic structural features of their situation. Related to resistances, conversation analysis examines the means and procedures that analysand and analyst use in the therapeutic situation while interacting to produce, step-by-step, those phenomena that in a psychoanalytic view we call resistances. It is assumed in this context that every patient-analyst-pair create their own 'local culture', their own types of interaction patterns and by this their own specific resistances (c. Kantrowitz 1995). For conversation analysis, every last detail of the participants' spoken language and of their nonvocal behavior is important as it contributes towards the production of the local situation. For this reason, conversation analysis requires specified and detailed transcription systems (c. Jefferson 1978). The detailed transcription notations reflect the view of conversation analysis, that participants in social situations produce their social reality by detailed means of their verbal and nonverbal behavior, i.e. how they make visible and audible to one another what is going on.

As far as psychoanalysis is concerned, many case studies give evidence that psychoanalysts have an intuitive knowledge of the interactive function - even of minute details - of verbal and nonverbal behavior (c. Eagle 1993; Jacobs 1994; Klüwer 1995; Mahl 1977; McLaughlin 1992; Renik 1993; Sandler 1976; Treurniet 1996).

Conversation analysis applied to the examination of resistance

All of the psychotherapy sessions in the study are face-to-face therapies. The sessions were videotaped. For the aim of this study, a clinically experienced psychoanalyst rated the session under investigation from a clinical psychoanalytic viewpoint, marking the sequences which seemed to him to be important. Those sequences, which in his view showed manifestations of resistance, were transcribed using the transcript notations developed by Jefferson (1978), including nonvocal activities such as gaze or gestures which are commonly noted in conversation-analytic research.

In the case examined here, resistance phenomena are manifested in the activities of patient and analyst in their organization of turn taking. Usually the change of speakers occurs quite smoothly,

overlapped speech is seldom and brief, and transitions from one turn to the next occur with very little pause and no overlapped speech (Psathas 1995).

In contrast, there occurred about thirty more or less extended overlaps and interruptions during one half hour in the psychotherapeutic session under investigation. When these disorganized turn-takings are examined in detail under conversation-analytic aspects, it is clear that they do not occur incidentally, but are produced jointly by patient and analyst and are highly complex and elaborate activities requiring considerable interactive competence on the side of the patient.

At first glance patient and therapist seem to start speaking at the same moment purely by chance. In fact the patient uses different, elaborated strategies to win the 'turn fights'. He seizes his turn in hidden ways, for example by making it seem as if he were only continuing his own turn, or as if it was the analyst who interrupted *him*, or as if the overlapping happened by chance. A conversation-analytic examination can reveal that none of these is the case, but rather that the patient is making use of highly developed interaction competence, exploiting interaction mechanisms that participants use in everyday interaction:

P.: Würde mich schon intressiern das von einem Fachmann zu hörn

(2.5)

T.: Das könn ten Sie

{

P.: weil so die Erfahrung hab ich ja auch gemacht daß (..) wird draußen doch oft (...) sind da gewisse Ressentiments (.) daß man also doch nicht das sagt so demjenigen

(P.: I'd be interested hearing that from a specialist

(2.5)

T.: You could

P.: because it's been my experience that there're often resentments in the outside world things that people don't tell you)

P.: Wenn ich das Gefühl hab (..) seis bei mir oder bei andern auch speziell bei andern (..) da iss irgendwo:: nn gewisser Mass (.) Machtmißbrauch dann reagier ich schon en bißchen=

T.: =Mmhh!

P.: °allergisch gegenüber oder° (.hh)

T.: Also meine Macht

{

P.: versuch ich meine ich ss es iss ja das Problem auch immer wieder ich sehs ja jetzt auch so im (..) vielleicht nn bißchen aus ner andern aus ´nem andern Blick (..9 oder aus nem ja::ah aus ner andern Sicht

(P.: If I have the feeling be it in me or with others also especially with others that there is a certain abuse of power then I react a little bit

T.: Mmhh

P.: allergic to that or

T.: Well my power

P.: I try, I mean it's always the same problem I can see it now a little bit from a different point of view or from a different perspective)

After having regained the turn, the patient in this example needs some time to reorganize his speech ('ich meine ich ss es iss ja'). In using these fillers, he keeps the floor and prevents the therapist from taking a turn in the pause that would otherwise emerge.

Sometimes the spoken utterances of patient and therapist seem to start exactly at the same moment so that the overlapping appears to be purely accidental. But analysis of the nonvocal interaction reveals that the patient exploits signals of the therapist with which interaction participants usually and unconsciously make each other visibly aware of their intention to take the next turn:

P.: Meistens hatt ich dann hinterher den Schwarzen Peter ne (...) dass ich dann halt zu Hause derjenige war der (..) also immer für Unruhe so sorgte ne und (...) aufmüpfig war

T.: Hmm

(0.3) (T. looks up slightly showing that he is going to take the turn)

T.: Ja: da

{

P.: spezielle Fälle (..) gut (..) ähh ich will jetzt (...) kann (..) will ich jetz nich dazu nennen

(P.: Mostly the buck was passed to me then 'cause at home I was the who caused disturbances and who was rebellious

T.: Hmm

(0.3)

T.: Yes there

P.: special cases yeah well I don't want to talk about it now).

Conclusions

Conversation-analytic studies of the microstructures of therapeutic interaction reveal that phenomena of resistance - as well as other events in the therapeutic process - can be highly complex performances which patient and analyst jointly enact by subtle vocal and nonvocal means. These means are basically the same as those used by participants in everyday life in 'natural' social situations, when they interact and construct their local social reality. Here, in therapy, these means are merely used in a special manner to create resistances and are part of the local therapeutic culture.

Mimic reactions after a passed and a failed test in psychotherapy. A pilot study based on the process theory developed by Weiss, Sampson and the San Francisco Psychotherapy Research Group

Reto Volkart & Brigitta Walser Zalunardo

Introduction

Ladies and Gentlemen, I'm pleased to be here today reporting the results of a pilot study which was conducted by Brigitta Walser Zalunardo under my supervision at the Department of Clinical Psychology at the University of Zurich, Switzerland. As you notice from the title, our study refers to *test situations* in psychotherapy. These tests are part of the theory of the psychoanalytical process of *Joseph Weiss* (Weiss et al, 1986; Weiss, 1993a). The theory, also known as *Control-Masterytheory*, has been empirically investigated by *Harold Sampson*, *Joseph Weiss* and the *San Francisco Psychotherapy Research Group*, previously known as the *Mount Zion Psychotherapy Research Group*. To give you the theoretical background I'll first describe the main ideas of Weiss theory. Next I will tell you about the questions and methods of our empirical study. Then I'll show you the two video sequences of a passed and a failed test which were under investigation. As a last step I would like to present some results of the study before we have time for questions and discussions.

Control-Mastery theory emphasizes a patient's ability to exercise *control* over his mental and unconscious mind. It also emphasizes a patient's wish to *master traumatic experiences* which have inhibited his development. The theory is based on special parts of Freud's later writings which Thomä & Kächele (1988, p. 8) have called "the neglected assumptions". It assumes that the patient's problems and psychopathological symptoms stem from maladaptive and constricting *pathogenic beliefs*. These pathogenic beliefs are typically acquired in childhood *after traumatic experiences* and may be unconscious. They reflect the child's most important motivations to *maintain ties to his parents* and to *master the helplessness* associated with traumatic experience.

An example: A child observes his mother becoming worried and depressed. This happens at a time when the child becomes more independent and displays more strength. The child may causally relate these events and develop the *pathogenic belief* that his mother would be worried and depressed if he was to become still more independent or feel even stronger. Later on this person might develop the *symptoms of a phobia* which would require him to stay close to home. This could count as an example of *separation guilt* (Modell, 1971). Maybe this child has siblings which also suffer from mother's depression. They all experience that their mother is no longer able to respond to their normal needs. Their mother's attention is a very rare event for them. Some of them may develop the belief that if they get it from their mother they would take it away from the other siblings. This is an example of *survivor guilt* (Modell, 1971). Pathogenic beliefs are strongly related with feelings of guilt, shame and other negative emotions (Friedman, 1985; Silberschatz & Sampson, 1991). *The function of the pathogenic belief is to warn the child that if he would not repress important wishes, needs, behavior, emotions and goals then further trauma would happen.*

Patients in psychotherapy develop specific but often unconscious *plans* to have experiences by which they may *disprove their pathogenic beliefs* and master their problems in order to reach some specific and concrete *goals* which their beliefs warn them against. A plan also includes a simple *order* which problems to tackle first and which to defer. These plans are of a very simple quality, they just point the patient in a particular direction.

The patient is motivated to master and overcome his pathogenic beliefs. But he cannot be sure that these pathogenic beliefs are not reliable explanations of traumatic experiences. Therefore the patient has to *test* his pathogenic beliefs in his relationship to the therapist. *Tests aretrial actions*. There are two possibilities of testing: In *transference tests*, the patient reproduces behavior similar to that by which, in his opinion, he had provoked the parental behavior he had experienced as traumatic. The second way of testing is called *passive-into-active testing*. The patient changes the roles involved in the traumatic experience. He takes the role of a traumatizing parent and puts the therapist in the position he once was in as a child (Foreman, 1996).

The patient unconsciously hopes that the therapist will not react as his pathogenic beliefs predict. If the patient perceives that the therapist does not react in this way the therapist has *passed* the test. This would help the patient to take a small step toward disproving the pathogenic belief. On the other side, the therapist may react similar to the parental behavior. This would confirm the pathogenic belief, and the therapist would have *failed* the test.

There are two broad ways a therapist can help a patient: 1) *passing the patient's tests* and 2) *offering "pro-plan interpretations"*. Pro-plan interpretations are interpretations that the patients can use in their effort to carry out their plan. These interpretations help the patients to gain insight how their pathogenic beliefs arised, what purposes they originally served and how they now obstruct their goals. These pro-plan interpretations help the patients to disprove their pathogenic beliefs and to persue their goals. The therapist's approach is therefore highly *case-specific*. He attempts to help each patient to disprove his *particular pathogenic beliefs* and to pursue his *particular goals*. He does this by passing the patient's tests, by offering him pro-plan interpretations and by his *overall approach* and *attitude* (Weiss, 1994; Sampson, 1994).

The *empirical studies* of the San Francisco Psychotherapy Research Group (see Weiss, 1993 b) show that patients *react immediately with positive behavior changes* when they perceive a test as passed or an interpretation as pro-plan oriented (Silberschatz, Fretter & Curtis, 1986; Silberschatz & Curtis, 1993). They are more involved with what they were saying and so demonstrate a higher level of experiencing. They are bolder, feel more relaxed and less anxious, they can lift their repressions and therefore can remember specific memories and show more insights (Broitman, 1985). There are also studies that demonstrate long term effects of pro-plan interpretations. For example Norville, Sampson & Weiss (1996) found a correlation of 0.7 between plan-compatibility of therapist interpretations and a case specific outcome measure in seven cases of brief psychotherapy.

Until now the empirical studies of the San Francisco Psychotherapy Research Group were based on *verbal data*, I.e. transcripts of audio-taped therapy sessions. There is one exception: Kelly (1989) used the *Voice Stress Measure* and showed that in two out of three cases the patient reacted to a passed test by demonstrating an immediate decrease of tension.

Goal of the study

The *goal of our pilot study* was to expand the research with verbal data to the maybe most relevant nonverbal channel: *facial or mimic behavior*. Facial movements enable the most distinguished nonverbal expressions of emotions (Ekman, 1993). The idea to rely on facial expressions as an indicator whether a patient perceived a test either as passed or as failed was motivated from my clinical work. I had a patient who used to do much passive-into-active testing. He used to criticize me and our therapeutic work and made strong demands in a very authoritarian way. It seemed to be helpful for him that I was not put down by his criticism and took an explicit stance against his arguments. However the patient didn't react with positive verbal behavior after a passed test. Instead he made an even more aggressive demand or would argue even stronger against me. This kind of behavior shows that the passed test enables the patient to test even more vigorously because he feels safe enough to do so and he hopes that the therapist can pass an even more difficult test. But for the therapist this kind of behavior is hard to take and sometimes difficult to interpret. Every new test includes aggressive and negative behavior and the therapist may worry that he has failed the last test. However in the course of this therapy I realized that the patient *smiled very quickly* before he went on to a new test. I learned to read this short nonverbal sign as a positive evaluation of my intervention before new verbal attacks followed.

So the main question underlying our pilot study was: Are there facial expressions which indicate whether a patient perceives a test either as passed or as failed? For our pilot study we used sequences of a videotaped therapy with a patient called "Jane".

The data: Jane's case

Presenting problem: Jane called our counselling service and explained that she had planned for a long time to discuss her problems with someone. Her decision to call was released by a conflict with her boy-friend. I liked Jane from the beginning of our first session. She seemed to me a vivid, spirited, attractive and attentive woman. She was 28 year old and had an academic education and degree. She was working in a scientific research project and her professional career was very important to her. She had a boy-friend, let's call him Carl, with whom she was involved for two years. Carl was living in another town so Jane was living single most of the time. The relationship with Carl seemed to be quite difficult. He used to withdraw suddenly from her without speaking about his reasons. Nevertheless Jane was working hard for this relationship. In the first session Jane describes her main problem as her "uncontrolled, exaggerated outbursts of emotions". This *symptom* consists of *two bodily aspects*: First she is *bursting into tears*. Second her *voice* becomes very tense, high and even stops for short times. Jane consequently did *not* connect this symptom with her *feelings*. It was just something that happened and that she could not control. The symptom did already occure in the first minutes of the intake interview *(video sequence)*.

Jane's symptom seemed strange to me and did not affect me at all. Later on in therapy the emotional quality of her crying changed markedly. The symptom was very disturbing for Jane, in her professional as well as in her private life. It usually occurred when she was the only woman in front of one or several men who are of importance or of interest for her. She made very clear that this symptom has nothing to do with restricted exhibition because she often speaks at conferences, did very well and had proofed herself as a very competent expert in her field.

History: Jane's parents separated when she was two years old. She grew up in the country with her mother and her two years older sister. Her grandmother also lived very near. Jane left home and moved to town when she began to study. Her father hardly cared for her after the divorce. He remarried quickly and has another two daughters. Jane's mother had only a few transitory relationships with men after the divorce, stayed single and was working in a social profession. Later on in therapy Jane described her mother as a rebellious woman, proud of her independence, but also as cynical and bitter. At the end of the therapy she could establish a good relationship with her father and saw him in a much more positive light.

Course of therapy: I offered Jane five sessions to evaluate her problems and whether she wants to undergo a therapy. After that initial phase the weekly sessions were continued as therapy. At the beginning of the 7th session Jane already decided to stop therapy because the symptoms had disappeared already after the first session and she said that she could handle the relationship with Carl much better. We stopped therapy after the 8th session. After that I discussed the case with *Steven Foreman*, another member of the San Francisco Psychotherapy Research Group. We made an outline of a plan-diagnosis and formulated hypothesis why she had left therapy. One year after she left I asked Jane whether she would participate in a catemnestic interview. After that interview she decided to continue with therapy which was going on for 50 more sessions and was considered successful.

Jane's main pathogenic beliefs

Let me now summarize Jane's main pathogenic beliefs that are important to understand the meanings of the tests which we investigated.

1. Jane believes that she is "emotionally incontinent" and therefore has to control her emotions and feelings.
2. Jane believes that she is disgusting, awful and detestable when she is expressing her emotions, feels ashamed and therefore has to hide or hold back her feelings.
3. Jane believes that she is chaotic, a mess and disgusting like a pig and therefore she should stay with animals, she should not be treated in a friendly way, or has to find people contemptible

who are nice to her.
4. Jane believes that her uncontrollable feelings are the reason that her father had left the family and has looked for new and clean daughters.
5. Jane believes that her positive feelings for her father and her wish to speak with him are the reason for her mother's staying alone and therefore she is not to speak anymore with her father or a man she likes.
6. Jane believes that she would betray her mother and would be illoyal if she had a good relationship with a man, and therefore she has to terminate such relationships or find them "boring".

Two key tests

For this study we choose two *key tests*, I.e. two tests of central importance for Jane's problems. The sequence of the *passed test* is from the very beginning of the second session. Jane presents herself as chaotic, thinking that the therapist couldn't follow her disordered and messy explanations. The therapist took a skeptical attitude against this self presentation and said that he didn't consider her chaotic and that she was explaining her problems rather straightforward. After that intervention Jane said that the symptoms had vanished and that she was feeling well *(video sequence)*.

The *failed test* was from the beginning of the 7th session. The therapist wants to fix a next meeting but Jane wants to stop therapy. She said she was feeling fine, the symptoms had vanished and she now could handle her problems in the relationship with Carl. The therapist put away his agenda, indicating that he no longer expected to fix a meeting and asked about what was happening in the meantime. He said it was possible to stop now and maybe to come back later if she wanted to do so (*video sequence)*.

The passed test sequence consists of 132 seconds, the failed test sequence consists of 130 seconds. We divided the sequences as follows: There is a first part called the *testing sequence* of the patient. It follows the first *intervention* of the therapist which indicates whether the test is failed or passed. The part after the therapist's intervention is called the *reaction sequence* of the patient. Each testing or reaction sequence approximates one minute in duration.

Method

To study the facial expressions we used the *Facial Action Coding System (FACS)* from Ekman & Friesen (1978). FACS is based on the muscles in the face which can be moved independently. These are called *Action Units (table 1)*. The intensity of the activation was also coded. The video material consisted of 282 seconds altogether. Each second has 50 frames, and each single frame was FACS-coded. Only the facial expressions of the patient were coded by a trained and reliable FACS-rater. These FACS-codings could be visualized in 57 so-called *micro-plots* (Bänninger-Huber, Moser & Steiner, 1990).

Table 1: Action Unit Legend (Ekman & Friesen, 1978)

1 *Inner Brow Raise*	***22*** *Lip Funnel*	***42*** *Slit*
2 *Outer Brow Raise*	***23*** *Lip Tight*	***43*** *Closed*
4 *Brow Lower*	***24*** *Lip Press*	***44*** *Squint*
6 *Cheek Raise*	***25*** *Lips Part*	***45*** *Blink*
7 *Lids Tight*	***26*** *Jaw drop*	***46*** *Wink*
8 *Lips Toward*	***27*** *Mouth Strech*	***51*** *Head: Turn Left XYZ*
9 *Nose Wrinkle*	***28*** *Lip Suck*	***52*** *Head: Turn Right XYZ*

10 *XYZ Upper Lip Raise*	***29*** *Jaw Trust*	***53*** *Head Up XYZ*
11 *Nasolabial Deepen*	***30*** *Jaw to Sideways*	***54*** *Head Down XYZ*
12 *XYZ Lip Corner Pull*	***31*** *Jaw Clench*	***55*** *Head: Tilt Left XYZ*
13 *Cheek Puff*	***32*** *Bite*	***56*** *Head: Tilt Right XYZ*
14 *Dimpler*	***33*** *Blow*	***57*** *Head: Forward*
15 *XYZ Lip Corner Depress*	***34*** *Puff*	***58*** *Head: Back*
16 *Lower Lip Depress*	***35*** *Cheek Suck*	***61*** *Eyes: Left XYZ*
17 *Chin Raise*	***36*** *Tongue Bulge*	***62*** *Eyes: Right XYZ*
18 *Lip Pucker*	***37*** *Lip Wipe*	***63*** *Eyes: Up*
19 *Tongue Show*	***38*** *Nostril Dilate*	***64*** *Eyes: Down*
20 *XYZ Lip Strch*	***39*** *Nostril Compress*	***65*** *Walleye*
21 *Neck Tighten*	***41*** *Lids Droop*	***66*** *Cross-eye*
		74 *Unscorable*

(Please insert table 1 about here)

As a second step we used the affect predictions of Friesen & Ekman (1984), which they proposed in their *Emotional Facial Action Coding System (EMFACS)*. These affect predictions consist of combinations of action units which are seen as prototypes or major variants of seven emotions: *surprise, fear, happiness, sadness, disgust, contempt and anger* (see table 2 as an example for contempt). We didn't use the EMFACS procedure in its original form, which is done in real-time coding and only with a limited number of action units. Instead we used the affect predictions to give an emotional meaning to our original FACS-codes, which are strictly descriptive.

Table 2: EMFACS Indicatory for Contempt (Friesen & Ekman, 1984)

1.	1 and	2 and	5B	(U 10 or U 14)
2.	1 and	2 and	5B and	14
3.	1 and	2 and	5B and	
4.	1 and	2 and	5C/D	
5.	1 and	2 and	5C/D and	7
6.	1 and	2 and	5C/D and 7 and	(U 10 or U 14)
7.	1 and	2 and	5C/D and 7 and	14
8.	1 and	2 and	5C/D and	(U 10 or U 14)
9.	1 and	2 and	5C/D and	14
10.	4 and	*5*		
11.	4 and	(5B or 5C/DE)	And 7	

12.	4 and	5 and	7 and	(U 10 or U 14)
13.	4 and	5 and	(U 10 or U 14)	
14.	4 and	5 and	14	
15.	4 and	7		
16.	4 and	7 and	(U 10 and U 14)	
17.	4 and	7 and	14	
18.	U 10 or U 14			
19.	14			
20.	23 and	(U 10 or U 14)	And other lower face AU	
21.	23 and	14	And other lower face AU	

(Please insert table 2 about here)

It was important to distinguish between *felt happiness* and *phoney smiles* as indicated in table 3. There are many different kind of smiles with many different functions (Steiner, 1986). Only felt smiles can be seen as indicators for happy emotions, while other kind of smiles serve social or defensive functions.

Table 3: Indicators for "Felt Smile" and "Phoney Smile"

(Steiner, 1986)

Felt Smile:	*Between 2/3 sec. And 4 sec.*
12 and (6 or 7)	
Phoney Smile:	*Less than 2/3 sec. Or longer than 4 sec.*
12 and (6 or 7)	
12 and no other AU	

Results

We evaluated the density of the different single emotions which are indicated by the EMFACS predictions. The density is defined as the percentage of time one emotion is predicted compared with the time of the whole sequence. The results are shown in figure 1. There were no indicators of fear or surprise. Happiness is divided into felt smiles and phoney smiles as explained above. The first column represents the density of the testing sequence of the passed test, followed by the reaction sequence of the passed test. The third and fourth columns represent the testing and reaction sequence of the failed test.

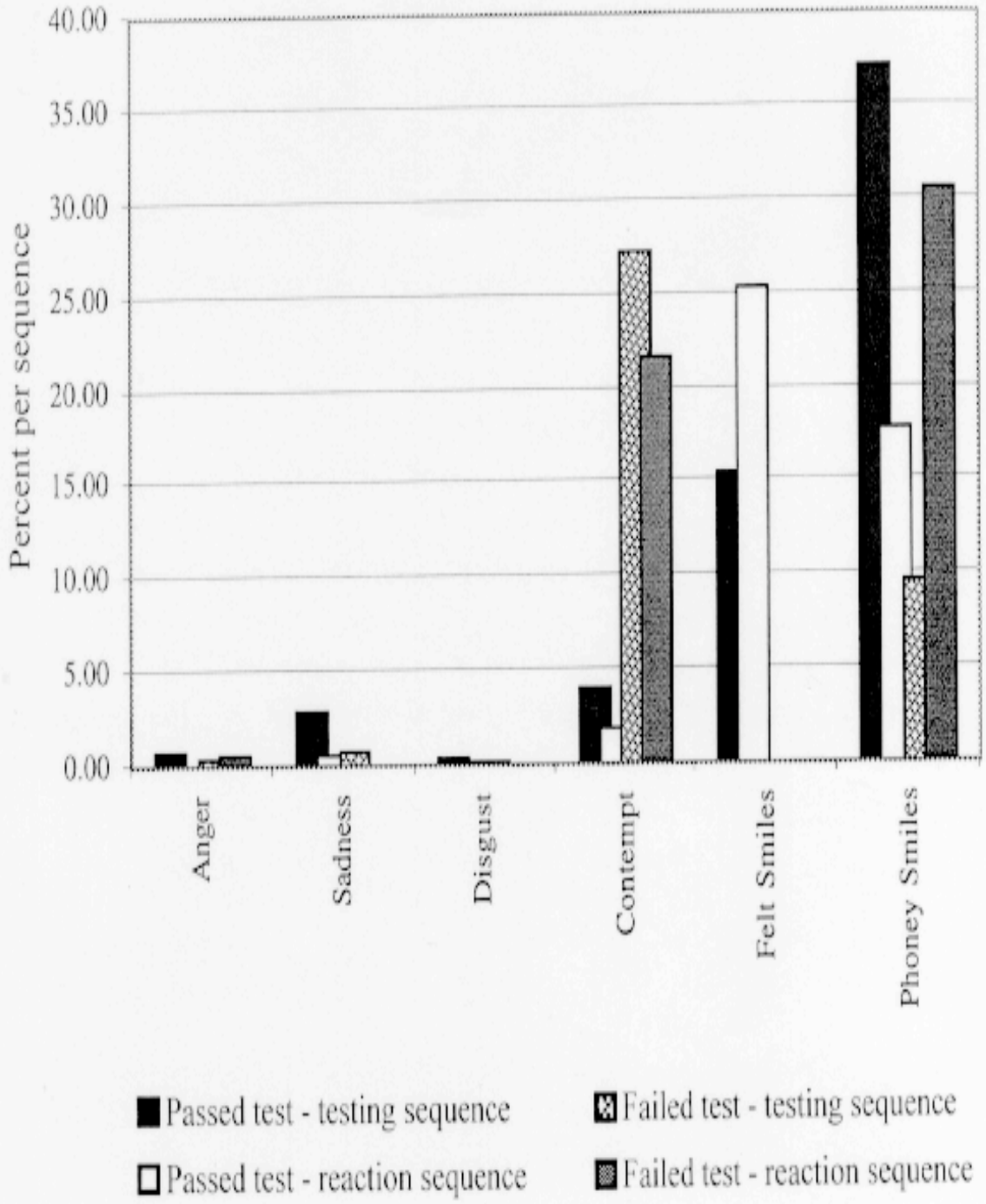

Figure 1: Emotion densities

(Please insert figure 1 about here)

Discussion

Passed test: Jane begins the testing sequence of the passed test with a high proportion of smiles. There are both felt smiles indicating happiness and phoney smiles which can be interpreted as a kind of flirtation. So it seems that Jane's nonverbal behavior already is expressing her well-being although she verbally states a kind of dissatisfaction with herself. These contradictory signals seem to make it easy for the therapist to contradict Jane's self-presention as chaotic and therefore to pass the test. There are also short signals of contempt, sadness, disgust and anger in the testing sequence. Disgust and contempt can be interpreted as *referential emotions* (Ekman, 1993). They may represent an emotional commentary of the verbal content of the test: "How disgusting and how contemptible to be such a mess!". Sadness and anger are probably related to issues Jane wants to work on in this session, i.e. to get down with problems of her childhood. However she first has to test the therapist to see whether the relationship is save enough to do so. When she perceived the therapeutic intervention as disproving her pathogenic belief (that she is a mess and chaotic), she responds immediately with a very strong felt smile. She verbally states that she is feeling well and that the symptoms have vanished after the first session. During the whole reaction sequence the felt smiles increase indicating joy and happiness, while the phoney smiles decrease. All other negative emotions are lower compared with the testing sequence or even absent. After the test is passed Jane tackles her most painful experiences in childhood in a very straightforward manner. Her therapeutic work includes experiencing and reflecting on feelings of disappointment, anger and sadness. The sequence of this session can be seen as another example of the touching process that Weiss (1952) called "*Crying at the happy ending*".

Failed test: In the failed test however, there are no positive emotions at all, neither in the testing nor in the reaction sequence. There is a high amount of contempt that the patient is expressing both in the testing and reaction sequence. In the reaction sequence Jane shows more phoney smiles then in the testing sequence, indicating defense or coping mechanisms. The emphasis on contempt during the failed test may be interpreted as a sign of Jane's strong identification with her mother which she described as cynical and bitter. This interpretation is supported by Jane's general appearance and look of dressing which seems to be very rigid and austere and very different to how she presented herself in other sessions. Jane was probably turning passive into active: She identifies with her mother and puts the therapist in the role she once had as a child. The lack of positive emotions emphasizes the seriousness of the maternal behavior and may also indicate that Jane did not really *expect* the therapist to pass this test although she might have the *unconscious hope* that he would do so. This fits the verbal data because Jane was not really asking to stop, she already had decided to stop therapy. Nevertheless her increased phoney smiles in the reaction sequence may indicate her attempt to overcome her disappointment about the therapist's intervention. A helpful intervention of the therapist would have required a very strong and explicit stance against Jane's decision. The lack of other signals, especially of positive emotions may have contributed to the therapist's difficulty to resist Jane's decision; another reason was that the therapist felt obliged to respect her autonomy. The ongoing session after the failed test also sharply contrasts with the process after the passed test. While there was a intense shift of behavior after the passed test, Jane's behavior after the failed test didn't change any more and was in fact very restricted and rigid during the hole session, with high amounts of contempt and phoney smiles.

Interestingly Jane reproduced this test twice at the end of the therapy. But having the failed test of the seventh session in mind, this time the therapist strongly argued against stopping the therapy earlier then the fixed date and Jane's very positive reactions showed that she evaluated this kind of intervention as disproving her pathogenic beliefs.

Further research is needed to see how other patients react, and how these reactions develop over time in therapy. To do this kind of research with the FACS procedure would be too time consuming. Alternative research procedures are needed. Most helpful would be sensitive and reliable clinical ratings. One important question is how long the reaction time for those nonverbal comments should be. If we evaluate sequences that are too long we might loose the most important information which is maybe expressed most clearly during the first seconds. Our pilot study suggests that the patient's reaction after a passed test can be identified much better than after a failed test. This may be

especially true for passive-into-active testing where there are high proportions of expressed negative emotions during testing: Those emotions may change even for a very short time after the patient experiences the intervention of the therapist as disproving his pathogenic beliefs, but they stay at a high level in the case of a failed test.

Those nonverbal cues can be very short, but they give important information, especially in passive-into-active testing. In our pilot study there was the *felt smile* indicating happiness which was the most important cue. Other patients probably use slightly different signs, for example they may react with *positive surprise* or *bodily movementsthat indicate relief*. Our pilot study indicates that nonverbal cues, especially mimic expressions can be very helpful for the therapist to distinguish between patient's reactions and therefore to see whether his interpretations were perceived as pro- or anti-plan-oriented.

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Jakob - a Tool for Narrative Analysis in Process Research

Res Wepfer, Agnes von Wyl & Brigitte Boothe

Abstract

In psychotherapy research there has been an increasing attention to everyday stories. They contain important data concerning diagnosis, psychodynamics, indication and method of treatment. Moreover they can provide evidence of the progression and outcome of therapy.

It has been suggested that everyday stories change past situations into what the client wished would happen. They can serve the function of subsequent wish-fulfilment. But narration can also be seen as an attempt of the narrator to come to terms with his fears. Everyday stories hold a reorganizing function, too. In retrospect, suffered shocks, psychological destabilization in a negative, traumatic or in a positive, euphoric direction can be integrated by telling a story again and again. Everyday stories carry intrapsychic conflicts of the narrator (the patient) with wishes and fears, demands and conditions, rules and resistance. The everyday story contains implicit offers of relationship inviting the audience (the therapist) to resonate, to show sympathy, to help, to witness - all relevant to the psychotherapeutic process.

We will introduce parts or a narration analysis system called Jakob that has been developed and applied at the Clinical Department of the University of Zurich (Boothe 1992-1997). Jakob is based on psychoanalytical theory. It describes and interprets the psychodynamics that underlie the telling of everyday stories. Using the same terminology as stage directors, Jakob investigates how clients put their experiences "live" on stage.

Introduction

Within psychotherapy the term narrative has an increasing importance and it is used in various contexts. Especially indicated is the relevance of narrating in a general sense in therapeutical conversations. I would like to mention among others Labov & Fanshel (1977) and Flader & Giesecke (1980).

Various research-approaches offer themselves for dealing with everyday stories. To be mentioned in particular are the narrativistics coming from linguistics, the science of literature and cognitive psychology. They deal with the structures of everyday stories in the way they are remembered but also with the way the narrators work up personal experience.

From psychoanalysis we also know various concepts which can be connected with narrating. Let us take for example the one of the psychoanalytical stage-model. Here the psychoanalytical room is understood as a stage, where everything can and should happen *as if* and which makes possible a continuous experimental action (Thomä & Kächele, 1985, p.96f). In therapy narrated episodical stories can be understood as stage-productions as well. The narrator as a stage director develops a kind of imaginary stage-room. The stories are performed (Wolfson, 1978). Or in the terminology of Goffman (1959) they are *replayed*. Finally Gülich and Quasthoff (1986) say: "To extend Goffmans's metaphor: The event is put on stage, the narrator acts it out."

There is another connection to the concept of scene and stage-production (Argelander, 1979; Lorenzer, 1977). Scenes that take place between analyst and the person to be analyzed can be interpreted as stage-productions of unconscious conflicts. In these scenes aspects of transference can be seen, that means imitations of motions and fantasies, which originally were meant for another person.

Unconscious conflicts are enacted in everyday stories as well. An event is not only re-narrated. Everyday stories don't want to inform of a situation; they don't represent the reality, they mainly reshape it in a process of adaptation. An event is put on stage and with it the inner conflict and the psychical working up. In the narrated scene, the narrator develops aspects of his own experience. Aspects of transference are shown as well, similar to the ones that were postulated in the concept of scene and stage-production.

In this sense it is less a question of whether an everyday story is authentic or credible, but of how the everyday story is.

In therapy everyday stories have various functions (e.g. Eisenmann, 1995). We focus on four functions which can be achieved by the specific forming of an everyday story:

1. The everyday story forms identity of its own in the presence of its social vis-à-vis. We call that social integration.

2. The everyday story has the tendency to form conflictful situations in the direction of wish-fulfilment. It's similar to Freud who said the same thing about dreams.

3. The everyday story repairs disintegration and destabilization in the direction of an organized available whole. So it's possible for the narrator to transform passivity to activity.

4. The everyday story actualizes a past experience and therefore produces a relation to the present situation. We call that function actualization.

So it is worthwhile to make the everyday story analysis systematically effective for psychoanalytical purposes, too. The point is to examine everyday stories in psychoanalytical perspective. We understand them like dreams as containers. Everyday stories serve the emotional experience. We focus on the structures produced by fantasy. Not the event itself is of interest. The story is interpreted as a process of dramatic placement sequentially connected and oriented towards a result.

First to our terminology: Our original material consists of narratives, as the name "narrative analysis" says. But we found that the term narrative has various meanings. So we have decided for the term "story". Here story is defined as a narrative of a usually self-experienced episode that actually happened. This episode the speaker - consciously or unconsciously - rates highly. Usually such stories begin with expressions like "For example, I once had to...", "This is what once happened..." or "I know one other example...".

Here, in opposition to CCRT, it is a question of not only extracting and defining a structure of relation but of the dramatic form as a whole.

The narrative analysis Jakob can be understood as reading of dramatic stage-productions. We not only take an interest in the material reality of the event. We are interested in elements of the process, which form a subjective wish dramatically and develop it as wish. We understand every element as a motivated placement as well as the specific dramaturgy, as every specification, as every leaving out.

If you understand an everyday story as a stage-production, the comparison with a drama makes sense and is very expressive for the discussion and therefore helpful. A drama is distinguished by the fact that a hero has a certain motivation wherefrom a certain sequence of action results. In the narrative analysis Jakob the everyday story is understood as a drama. The analysis tries to work out this dramaturgy, to reconstruct it. It is asked how the hero presents himself in the drama, how he constellates relations. And furthermore which wish-fulfilment could the drama offer, which anxiety urges the drama on? Finally it is always supposed that there is a conflict that reveals itself in the drama.

In a next step the presented method shall be compared to others briefly. It is typical for the narrative analysis Jakob that short talk-contributions are examined thoroughly according to their linguistical placement. Thus we focus on the detailed reconstruction of the evocative process of forming.

Concerning the exactness of detail Jakob could be compared to conversation analysis. Conversation analysis looks at the communicative structure and meaning, whereas Jakob focusses more on content. So far a comparison with the metaphor analysis makes sense. Similar to metaphor analysis the narrative analysis Jakob accentuates the choice of words in its semantics. We do not examine the substance of individual metaphors, but little scenes in their dramatic placement.

Next we present our method of narrative analysis Jakob (Boothe, 1992a, 1992b, 1994; Boothe et al., 1997; von Wyl et al., 1995, 1997). It has been developed by Brigitte Boothe and it shows a priority of research of the Department for Clinical Psychology in Zurich. Various research-studies are dealing with its revision and application. Here we present parts of a project supported by the Swiss National Foundation for Scientific Research.

The narration analysis Jakob has several steps of preparing and analyzing. Here we want to describe just one step of evaluation. It is called rules. We have chosen this one, because it works with the dramatic stage-production.

Rules

So far we postulated the dramaturgic stage-production as characteristic of a story. We will now describe how this drama can be presented and interpreted. You can describe a story in the most general way as tension-loaded sequence. Tension is a reception-related term. Tension is produced in the listener. The listener is engaged as an emotional participant. The story evokes participation. We are trying to show systematically how a story produces tension, develops tension and leads tension towards a final or resting point.

We subdivide a story in

a) initial sequence

b) the arising of a situation that presses towards change

c) the carrying-out of an event and

d) the result or completion of the activity regarding it's success or failure.

The wish-anxiety-events and the conflict can be identified by looking in particular at the initial sequence as well as at the arising of a situation that presses towards change.

Each narrator has to introduce his own narrated world. Situative characteristics like place, time, actors, stage-properties, constellations have to be named more or less exactly. This is necessary for the transfer, meaning that the listener must be able to orientate himself in the imaginary room. But this is not all it needs to set off conflictful, purpose-orientated movement. For this at least one impulse of action is needed. As a consequence not only possible worlds are set, but also possible actions or strands.

Summing up it may be said that the specific, tensionloaded starting conditions result from these situative characteristics in their specific, linguistic presentation. Because of them the drama has to develop further. The starting situation includes certain compulsion to set. What should happen and develop is set out on the basis of the starting. The starting conditions open a free room. As the audience you may wonder what will happen and you also imagine how it could go on and what kind of ending the story will have.

The narrator, proceeding from this free space necessarily makes a decision in the course of the everyday story. Within the limits of the free space, meaning a spectrum of possibilities to produce narrative dynamics, to create tension, he chooses one out of several get effective. We find out which it is and so we try to determine the dynamic moment of the plot.

With this moment we have looked at the specific purposes of the everyday story. We can now concretize two hypotheses. We can produce hypotheses along the disclosed purpose-orientation of

the everyday story. That means we try to find out what is the ending or the optimum. We call it SHOULD BE. And we try to find out what is the negative ending. That we call ANTI-SHOULD BE. In other words: on the basis of the starting conditions plus dynamic moment of the plot we ask what would be the optimum and what the catastrophe? Of course the practically realized ending of the everyday story is taken into consideration, too. We capture it in the label BE and formulate it such a way that a comparison with SHOULD BE and ANTI-SHOULD BE is possible.

Survey of the Rules

Starting Conditions

From the beginning of the story we extract those elements as starting conditions, which are important for the whole story. Such elements can be figures, actions, backgrounds like time and place and props. Not always all the elements occur. The setting is created by the positioning and the constellation. The setting fixes the perspectives of the further plot.

Dynamic Moment of the Plot

We call the dynamic moment of the plot that particular combination of the elements of the starting conditions which hypothetical cause the main mental tension. This dynamic starting situation provokes a change of arrangement. The audience wonders empathically: What has to happen? What should not happen?

From here the additional hypotheses of SHOULD BE and ANTI-SHOULD BE can be developed. What would, measured against the starting conditions, be the optimal ending and what the disastrous one?

SHOULD BE

model-like constellated optimum

ANTI-SHOULD BE

model-like constellated catastrophe

be

The realized result of the story is called BE. In order to express explicitly the character of result we compare SHOULD BE with ANTI-SHOULD BE.

Examples

What has been said so far shall now be illustrated by two examples. In our research project we have collected everyday stories of 6 patients. All these 6 patients came for 5 sessions to an intake procedure at our department. All in all we extracted 104 everyday stories. A detailed narrative analysis of this material is in process and will soon be published under the title "The initial everyday story in psychotherapy" (Boothe et al., 1997).

Our first example comes from a woman-narrator we call Suzy. Suzy was a young student. She followed medical advice to attend psychotherapy. She was already suffering chronically from reappearing bodily complaints in the area of genitals (flux, inflammations, misperceptions), which according to the estimates of the treating doctors were psychically conditioned or superimposed. Suzy told the therapist about these estimates with skeptical distance, but at the same time she declared herself to be in need of help. She gave the following everyday story in the second session:

Suzy-6: Wherein lies my strength?

[1]	I went to see a woman, a vocational counselor

[2]	and actually I would have liked to do such a test
[3 III 2]	wherein lies my strength, really
[4]	and this she denied, simply for the reason, too
[5]	because she thinks
[6 III 5]	I should know this myself
[7 III 5]	a test wouldn't show this, either

What is narrated? Narrated is - as we have heard - what makes Suzy insecure in a positive or negative direction, what has been experienced subjectively conflictful. The narrator describes an episode, where she surrenders to an examination by a female person of authority. This surrender seems to be connected with insecureness. A desired positive ending of the episode is faced by an anxiety-releasing negative one.

Which is the desired positive ending (SHOULD BE)? The narrated I wants a specialist to measure her competencies by a standardized measuring instrument (test). Thereby the narrator indicates in which direction she would like to see the results of the measuring: In the direction of strength. The narrated I wants to see this strength proved objectively. Therefore we could suppose that by the everyday story the narrator wants to create something like a self-controlled integrity. A narrated I who feels insecure regarding the choice of profession goes to see an advising person of authority. This person of authority - at first interestingly enough introduced by the narrator as a person of her own sex and only afterwards equipped with a professional function - should provide the client with strength. The strength is assumed to be already there, but hidden, and it has to be brought out by the person of authority. So the narrated I wants to become equipped by a maternal person. The wish-fulfilment should be established so to speak from the outside by a parental authority.

Which is the anxiety-releasing negative ending (ANTI-should be) of the everyday story? With the surrender to an authority of judgement the narrated I exposes herself to danger. Namely she exposes herself to the judgement of a powerful, competent stranger. This person, at whose mercy the narrated I seems to be, has the power of judgement. So a situation of unequal power-proportions arises: A person of authority of the same sex as the narrator faces an I-figure who is insecure (in the choice of profession). Promptly the female person of authority denies the narrated I the instrument, which could have located the strength, and so retains it in the weak condition.

Why narrate? It is narrated in order to change a destabilization into a stabilization. How does the narrator deal with the tension between the desired positive ending and the anxiety-releasing negative one? She quotes the person of authority. The end of the story is concluded with the final explanation of the specialist (vocational counselor) which opposes to the desire of the narrator. By the way the narrator does not comment further on the quotation. So the narrator goes in submission opposite the person of authority. Submission feigns cooperative willingness and efficiency by manipulating the person opposite into the role of initiator and director and keeping her there. At the same time the unseizability of the impenetrable subject is maintained.

Suzy's everyday story shows the following rules: The end of the story (BE) is formed in a way that the desired positive ending (SHOULD BE) is not achieved, but neither is the catastrophe of the anxiety-releasing negative ending (ANTI-SHOULD BE). Quoting a declaration keeps the story in a strange way open for judgement. However looked at it closely, the feeling arises that in the process of narrating the same thing is manifested again that has just been the theme of the everyday story: namely the self-controlled integrity. For the narrator it seems to be clear how the person opposite (therapist) should understand the quotation: as a denial of the vocational counselor. So by enacting cleverly the narrator presents herself again as upright. The everyday story seems to be designed that way, the mentioned events seem to be especially selected for that purpose. In the process of narrating the narrator again observes the same demand for control that was the theme of the everyday story.

By the way this example is in a specific way typical of the narrator Suzy, how she presents herself in the first 5 sessions. Some patterns of experiencing that are expressed in this everyday story can also be found in other stories of the same patient. So for example in 12 of 14 stories self-controlled integrity (as SHOULD BE) is a theme. The surrender to an extraneous disposal (as ANTI-SHOULD BE) is even mentioned in all the 14 stories of Suzy.

From the analysis of all the everyday stories of Suzy results on the whole the following picture for the patient: Suzy sees her own intactness and integrity in danger. She cannot trust her own competencies and functions (in other stories especially the bodily functions). That's why she sees herself as in need of help. The anxiety to become affected in her own intactness leads in Suzy's case to the fact that she has to keep the therapist at a distance, that she cannot react to his interventions. She does this very clearly in the everyday stories in which she repeats the reports of the doctors as quotations. She herself does not comment on the quotations. A permissive I-figure keeps itself distant from an authority of powerful restitution. Thereby the person of authority stays in control of the quoting I. The narrated I avoids interactive tension, but it keeps the interest in the participation. It is not hard to imagine that such a constellation has far-reaching consequences for the therapeutic process.

Contrasting with this I want to present a second example of an everyday story. It is from Jane. Jane was a young woman scientist who came to our counseling service of her own initiative. She had the impression of herself that she was not able to decide in a calm, composed, sensible, unerring, realistic way in her relation to her partner and in other friendly and companionable relations. Thereby the anxiety of separation and of being abandoned played an important role. She felt dominated by pessimistic presentiments, unhappy and in the personal relations with others very weak. The following everyday story was given in the first session:

Jane-5: He is like frozen

[1]	and then, afterwards, a week later, he comes and says
[2 III 1]	now he'd rather be on his own again
[3]	then I thought
[4 III 3]	no, really
[5 III 3]	this isn't possible
[6]	and then I tried to discuss it with him
[7]	but it didn't work
[8]	he was like, like frozen
[9]	so you couldn't, absolutely couldn't reach him
[10]	then he just left
[11]	and then I thought
[12 III 11]	no
[13 III 11]	I don't believe this, yes

What is the desired positive ending of this story (SHOULD BE)? A male opposite person whose role as an intimate partner is probably going through a time of upheaval, steps in front of the narrated I and declares intentions of withdrawal. The narrated I does not share these intentions. It tries by discussion to put the male opposite person off his intentions. That's why the desired positive ending of the story is probably the one where the narrated I can soften up, warm up, bend up its male opposite person, where it can feel near him, reach him. The male opposite person should stay available.

From this we can derive the anxiety-releasing negative ending (ANTI-SHOULD BE) of the everyday story: The male opposite person withdraws from the narrated I. This happens totally

independent from whatever efforts the narrated I makes. So the desires, intentions, efforts of the narrated I seem to remain without resonance with the male opposite person. The narrated I is left alone unheard.

How does the narrator deal with the tension between the desired positive and the anxiety-releasing negative ending? After all in this story the "feared catastrophe" happens. The male opposite person does not let himself become touched and withdraws without responding to the narrated I. The narrated I gets upset and protests ("I don't believe this"). This indignation however, in the therapeutical context wherein the story is given, can at the most reach the listening therapist. The male opposite person of the narrator doesn't hear it.

So Jane's everyday story shows the following rules: Desired is the availability of the object (SHOULD BE). Feared is the self-withdrawal of the object (ANTI-SHOULD BE). The story ends with the anxiety-releasing negative variant (BE). The narrated I remains in indignation and protest.

Again the above example of an everyday story is in a specific way typical of the narrator Jane, how she presents herself in the first 5 sessions. Some patterns of experiencing that are expressed in this story can also be found in other stories of the same patient. So for example in 8 of 25 stories the availability of the male opposite person is mentioned (as SHOULD BE). Opposite to this availability there are 8 stories that mention the self-withdrawal of the object (as ANTI-SHOULD BE). This ANTI-SHOULD BE occurs in 4 cases. In 9 stories the narrated I is left behind unheard and resorts to protest.

According to her everyday stories the following picture arises for Jane: In her everyday stories Jane outlines dynamics of female capitulation. This is probably the consequence of a wishful oedipal fantasy and at the same time keeps the anxiety of becoming rejected within limits. An I-figure sees a male opposite person on the run.

After the intake procedure Jane had two other sessions with the same therapist. The therapist offered her the possibility of a consecutive therapy. However in an impressive sequence of interaction Jane refused it. For this she used sensible, well-chosen, calm words and referred to the already resulted improvement of symptoms. While she formulated this, her face expressed great sadness. It seemed as if she renounced beforehand the continuation of the contact that emotionally meant a lot to her. One year later Jane on her own initiative resumed the relationship with the same therapist. Over the period of one and a half year a very productive and intensive cooperation developed. Thematically in the centre were Jane's conflicts with her erotic desires, her fantasies and her anxiety ideas. Now she could use the therapeutical cooperation extraordinarily productively.

Summary and Prospects

In our opinion, out of the comparison of several such everyday stories you can find a differentiated, dynamical structure of conflict for every narrator - such as we tried to indicate in the case of Suzy and Jane. With Suzy the "feared catastrophe" is often averted by the quotation of an extraneous opinion. With Jane however it sometimes occurs. So Suzy and Jane create specific conditions that influence the ending of their everyday stories. Often Suzy presents herself as submissive and withdrawn at the end of an everyday story. Jane however shows herself as protesting. In her situation other narrators would perhaps want to present themselves as resolute, sociable or robust.

The analysis of everyday stories leads us to the conflict- and relation-model of the narrator. The psychodynamics of our patients manifest themselves in their everyday stories. Therefore everyday stories supply sound clinical material for diagnosis and treatment. According to our impression the dynamics of conflict and relation are reflected very clearly in the interaction between patient and therapist. In our opinion the analysis of everyday stories proves to be helpful in order to get indications about the progress of treatment and the therapeutic process.

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Qualitative Analysis of Therapists' Process Notes (1)

Stefanie Wilke

Introduction

This study is part of the multi-method, multi-perspective Practitioners´ Study on Analytic Long-term Psychotherapy (Rudolf, Grande, Oberbracht, see this volume).

The focus here is the investigation of highly subjective data: the therapists' process notes of the psychoanalytic treatment process.

The project is located in the tradition of Ramzy's paper on psychoanalytic inference *How the mind of the psychoanalyst works* (1974), Peterfreund's *Working models* (1975), Meyer's question *What makes psychoanalysts tick?* (1988), furthermore *Psychoanalysts´ individual theories and their tacit assumptions* (*Hintergrunderwartungen*, U. Streeck 1986, 1995), and Moser's *Pchoanalyst as an on-line researcher* (1991).

Our design is a non randomized naturalistic one that proceeds directly from the therapeutic practice and aims at making the following processes transparent:

- what's crossing the analyst's mind in certain sessions?
- how does the last session or how do the last three months influence the therapist's interpretation of what is happening right now and what happened in retrospect?
- how do psychoanalysts evaluate what's going on without knowing about the outcome?

This paper will include the outline of our project and first results of a pilot study done with a single case (see Appendix) and we would like to see it as Work in Progress. At this point it is important to mention what the study is not about:

We are not interested in socalled vignettes which are condensed and do not mirror the steps of the process any more. The outcome of the treatments is not the major issue but only one of the interesting aspects, since this study is basically process oriented. Furthermore; we do not aim at 'objectively' finding out what really happens in the treatments, we do not wish to test psychoanalytic theories, and we do not replicate studies on 'psychoanalytic components' (cf. Boesky 1990).

The Issue

Our basic goals are

- the reconstruction of psychoanalysts' clinical assessments
- the understanding of the process of 'making sense' of what happens in psychoanalytic sessions: the back and forth between observation, participation on various levels, and theories
- the description of evenly suspended attention and the actualization of clinical knowledge for the construction of hypotheses
- the investigation of which theoretical models (also mini-models, Meyer 1988) for the clinical understanding are actually being applied at different stages of the treatments and how they are individually modified
- the comparison of therapists' descriptions of which kind of material occurs when and how

during the therapeutic process and how it is being worked through
- the comparison of clinical assessments of high and lower frequency long term psychoanalytic treatments

The Data and the Sample

Our primary data consists of the notes the psychoanalysts take down in a questionnaire under the following conditions: 15 experienced psychoanalysts each select two beginning treatments, one high frequency psychoanalysis and one lower frequency psychoanalytically informed therapy for the study. For each treatment and over its entire duration the therapists are asked to select up to three 'somehow relevant' sessions every three months and to freely comment on

- what happened in this session?
- what do you think it means?

These comments should be written directly after the sessions and in a personal style, including examples or quotes, illustrating the atmosphere felt by the therapist as closely as possible (cf. Meyer's *retro-reports*, 1981 and Heimann's *running commentaries*, 1969). Only for the interpretation of what it all means they should focus on theoretical implications.

Additionally, every three months the therapists write one assessment of the process including free comments on what happened in retrospect and semi-structured evaluations on

- the therapeutic relationship
- transference and counter-transference
- regression
- resistance
- unconscious fantasies, and
- psychodynamics

It is important to add that it should also be commented if there is no change at all or if the process itself cannot be sufficiently understood at that stage of treatment.

For the first three years of the project we will be able to analyze 240 to 360 notes on selected sessions and 90 comments on the psychoanalytic process.

The Basic Research Questions

Since no such data has ever been systematically obtained before we are initially interested in answering the following questions

> How do psychoanalysts describe selected sessions?
>
> How does the data look like?
>
> Are the notes characterized by certain or typical topics or text units like the description of events, dreams, and interaction sequences?
>
> How do psychoanalysts reconstruct the therapeutic process within the process itself?
>
> What makes selected sessions meaningful, i.e. what are the markers in the texts that indicate the relevance of the material for the process?
>
> Is there a difference in the assessments of high and lower frequency psychoanalytic treatments regarding the above mentioned topics?

More detailed questions concern 'change' in psychoanalysis:

What are the individual criteria for indicating change and which type of change is described how and when during the treatments?

The Method

For the text analysis we use a qualitative content analytic method which is based on the principles of the *Grounded Theory* by Glaser and Strauss (1968). It implies the development and systematization of a so called discovery oriented open category system: the texts are initially broken down into themes and text units and are later condensed into categories and types of category patterns. These are strictly data based, i.e. the categories are derived directly from the material (in the terms of Glaser and Strauss they 'emerge') and no preformed system is applied (Wilke 1992, 1994).

Beginning with single session and single case analyses we use the *Constant Comparative Method* (Glaser 1969) for the development of a typology of clinical assessments in different psychoanalytic settings. The steps of the analysis are the following:

1. First, we define broader *text units* like ´descriptions of events´, ´negotiation of setting and fees´ to get an initial idea of the texture of the data. The fine grained coding process continues as follows:
2. On the basis of single sessions we start with an *open coding*. All themes of each session are categorized on a basic level. No psychoanalytic terminology is used at that stage of coding. But there is an extra category for psychoanalytic terminology when the analyst uses it (e.g. splitting, cruel superego). The category system can be called 'saturated' (Glaser, Strauss 1968, 61) when it contains all topics of all sessions of the whole sample.
3. The next step is the *temporal coding* which systematizes the development of the categories over time during the process of each treatment.
4. A *selected coding* integrates the material and defines a *core category* which is essentially related to most of the other categories and can be regarded as the headline or story line of the treatment.
5. The *theoretical coding* introduces clinically and psychoanalytically relevant terminology and interprets the material on a higher and specific theoretical level.
6. For the comparison of all treatment processes of the whole sample we use the method of *contrasting* the assessments by *'maximum similarity' and 'maximum difference'*. As a result we gain a typology of clinical assessments.
7. Finally, the results of the presented study are systematically related to those of the quantitatively oriented Practitioners´ Study.

Credibility

There is a need for strict validation criteria in qualitative research. In this paper we do not wish to extensively focus on that matter, but we would like to introduce the term *credibility path* (cf. also Flick 1995) which implies the explication of each step of the analysis and the publication of the original notes as the data for the category system.

Furthermore, socalled *triangulation processes* are crucial: triangulation has become increasingly important for the discussion around validity in qualitative research. It is defined as the *systematic* comparison and correlation of various points of view and of the researchers themselves. In our study the triangulation of *researchers´ perspectives* will play an important role: the coding is being performed by different members of different research groups of the project. After having finished the textual analysis of the notes we will introduce a triangulation as well of *data* as of *methods*: the therapists' notes and the results of the Practitioners´ Study with various quantitatively oriented designs and research interviews are systematically related.

The most important aspect is that the results and the processes of gaining them can be evaluated by others by making them *intersubjectively transparent*.

Hypotheses

We expect a great variety of data.

We expect that the assessments of the psychoanalytic processes will illustrate some dependency between frequency and setting and the occurrence of specific and psychoanalytically relevant components like the depth of the transference neurosis or regressive processes.

It is however important to add that we do not expect a linearity of the treatment courses but cycles which, at first glance, may sometimes even seem chaotic. To a certain extent we expect to be able to analyze an underlying order of these nonlinear cycles.

We proceed from the assumption that 'treatment phases' are to be detected which can be defined as well qualitatively by their contents (what happens how on the various levels) as quantitatively (how often is a topic being mentioned and worked on) and by their very individual temporal occurrence (when do themes come up, disappear or are being transformed into other issues). Thus a 'treatment phase' will be seen as a complex matter which differs from analysis to analysis.

Results

We hope to be able to present the following results:

I The reconstruction of the descriptions of psychoanalytic sessions
a) single sessions
b) typification of assessments

II The structure of the assessment of the psychoanalytic process
a) single case
b) typification of processes

III A comparison of the assessment of high and lower frequency psychoanalytic treatments
a) for each therapist
b) for each treatment type

IV The comparison of the results with the Practitioners´ Study on Analytic Long-term Psychotherapy

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Appendix

Single Case Analysis of the First Year of a High Frequency Psychoanalytic Treatment

Data: Notes of 15 selected sessions (from 136) and 5 assessments of the treatment process

Results (excerpts):

1. *Analysis of text units* (examples):

description of interaction sequences:
"the patient told Mr. X that she wouldn't take it any more and she wanted more of a respect from him, he then replied that he didn't see the point at all ... she left in a desperate mood and"

description of therapeutic interaction:
"when I told her that she is to be liked and deserves respect and love she didn't say anything for a long time and seemed to be very surprised and thoughtful"

description of explicit fantasies:
"she imagines her boss as a person who will eventually fully accept her and love her. ...She pictures herself being with that young man ...."

description of therapist´s verbalization of patient´s fantasies:
"I tell her that she probably imagines herself ... that she probably has the fantasy of ..."

therapist´s hypotheses of patient´s fantasies:
"I think... it occurs to me that.. she must have the fantasy .. she unconsciously has the fantasy ..."

naming of patient´s dreaming:
"the patient told me that she had a dream but didn't elaborate on it..."

explicit description of dreams:
"she told me a dream where she lived in a very cold room without any furnitures where ..."

description of dreams and interpretation sequences, including patient´s insight

2. O*pen coding: basic categories*

TIME

Dimension	quality	text example
Now	for the first time	the P is able to accept other aspects than being worthless and shielded against others
		the P is able to work on her fixation: she sees the boss as an overwhelmingly powerful father figure
	new is	that she now struggles with her boss and is able to explicitly tell him that she doesn't want to ...
Beginning of treatment through now	still	she still enacts her core relationship conflict within the relationship with her boss
	up to now	she hasn't really had the wish to get in touch with reality
	more and more	there is a development of a stable self-representation
Future		I don't see any development ... yet; a process has been started; she will be able to integrate ...
Biography	like in her childhood	when she was being left alone with her desires to be accepted and loved
	back then	when the mother had the accident
Duration	long	for several sessions she has been being occupied by this topic; she thinks about ... for a long time
	short	she touches ... only shortly and switches back to ...

RELATIONSHIPS

Persons	in general	men
	specific	her boss
Form	love relations	she has never had a close relationship to a man of her own age before; she now is interested in a young man; she wants him to fully accept her and lives for her fantasies for him

AS WELL AS

	at the same time,	she is able to experience her boss as s.o. who accepts her and is overbearing, too
	as well as	she sees herself as well as a brave woman with a sword and a shield as having softer sides and female aspects like ...

	not only but	she is not only the disadvantaged one and a poor thing but also a grown up woman who makes people like her

EMOTIONS

Persons	patient	she says that she is so happy about having discovered ...; she laughs as is she were relieved
	from biography	the father was very scornful towards her
	present time	he was very disappointed by her; she now flirts with him
	psychoanalyst	I can't concentrate any more and I'm getting bored. This is going to become a problem
Contents	aggression	her father was very scornful towards her; she felt such a rage
		she can't feel her rage yet, for it would be too dangerous for her
	fear	she is very afraid of telling him; I can feel her anxiety
	sorrow, pain	it is very painful for her to become aware of the attempted suicide of her mother and that she also was in great danger; she is in deep sorrow about ...
	love	she is deeply in love with that man
	relief	she laughs with relief and says how much she can enjoy ...
	boredom	I am getting bored by her now
Form	explicit	she says that she can now enjoy ... so very much; she tells me all of her love fantasies
	hypothesis	she can't feel her rage yet, for it would be too dangerous for her; for the 150. time she tells me about her boss!

List of all categories for single case:

Time

Relationships

Dosage (*more and more, increasingly, deeper*),

As Well As

Actions *(slams the door)*,

Job *(wants to quit, is overworked, her boss)*,

Dreams

Emotions

Biography

Symptoms

Way of Communicating *(she talks a mile a minute, she remains silent for a long time)*,

Process *(so far we have reached a point in analysis where she is now able to ...not even after one year of treatment we have reached ...)*,

Therapeutic Relationship *(I feel touched by her ... she is now much more confident and can see me as someone who will support her)*,

Emotional Attitude of Patient *(she is very suspicious towards me and expects to be left alone like her mother did when she was ...)*,

Emotional Answer of Therapist *(I now feel superfluous and like I would disturb her. This has a connection to the scene in her bedroom when her mother ...)*,

Involvement *(she increasingly loses her mistrust and opens up)*,

Setting *(vacation, fees)*,

Appearance *(she looks more female now)*,

Body *(she says that her body feels more female now .. is hard)*,

Metaphors *(shielded like a knight with sword and harnish)*,

Interpretations

Psychoanalytic Terminology

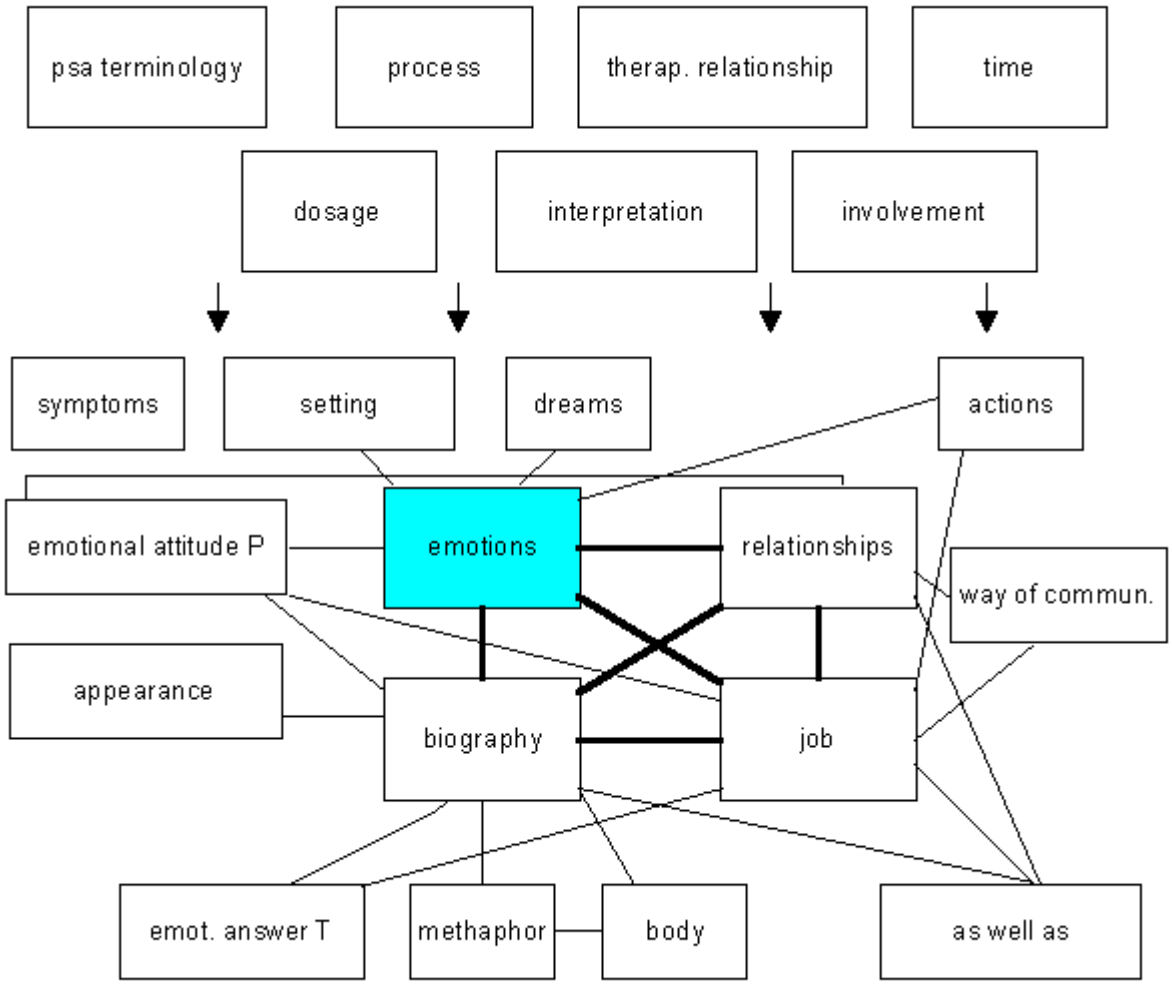
3. T*emporal coding* (examples):

The category JOB is relevant from session 1 on. EMOTIONAL ATTITUDE OF PATIENT only becomes explicit from session 93 on and is being discovered at that stage of therapy. INTERPRETATIONS also become increasingly important in connection with PROCESS and METAPHORS from session 93 on: The patient discovers her transference as a result of the analyst's interpretations and the patient herself comments on the therapy process now via metaphors "Well, it seems that our therapy has been sort of a train ride, me and you traveling together".

4. S*elected coding: Core Category*

Emotions turned out to be the core category of this treatment so far, followed by relationships, biography, and job.

The figure illustrates the categorial pattern with the connections of themes over 136 sessions.



A first look at another case of our sample indicates that symptoms seems to be the core category for the first half year of this treatment. The patient consistently focusses on his somatic symptoms and the therapist follows him so far. It is however to be expected that emotions will play an important part over the course of the treatment, too.