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.

References

Arbeitskreis OPD (Hg.) (1996). *Operationalisierte Psychodynamische Diagnostik*. Bern: Huber (English edition in press).

Beres, D. (1965). Structure and function in psychoanalysis. *International Journal of Psychoanalysis*, *46*, 53-63.

Bollnow, O. F. (1936). *Dilthey. Eine Einführung in seine Philosophie*. (4. Aufl.). Schaffhausen 1980: Novalis.

Deneke, F. W. & Hilgenstock, B. (1989). *Das Narzißmus-Inventar*. Bern: Huber.

Dilthey, W. (1894). Ideen über eine beschreibende und zergliedernde Psychologie. In W. Dilthey (Hg.), *Gesammelte Schriften, Bd. 5: Die geistige Welt. Einleitung in die Philosophie des Lebens* (S. 139-240) (5. Aufl.). Stuttgart 1968: Teubner.

Duval, S. & Wicklund, R. A. (1972). *A theory of objective self awareness*. New York: Academic Press.

Fenigstein, A., Scheier, M. F. & Buss, A. H. (1975). Public and private self-consciousness: assessment and theory. *Journal of Consulting and Clinical Psychology*, *43*, 522-527.

Filipp, S.-H. & Freudenberg, E. (1989). Der Fragebogen zur Erfassung dispositionaler Selbstaufmerksamkeit (SAM-Fragebogen). Göttingen: Hogrefe.

Freud, S. (1923b). *Das Ich und das Es. Gesammelte Werke, Bd. 13, S. 237-289.. Frankfurt am Main: Fischer.*

Freud, S. (1985c*). Sigmund Freud. Briefe an Wilhelm Fliess 1887-1904. Edited by J. M. Masson. Frankfurt am Main 1986: Fischer.*

Gill, M. M. (1963). *Topography and systems in psychoanalytic theory*. New York: International Universities Press.

Gill, M. M. (1976). Metapsychology is not psychology. In M. M. Gill & P. S. Holzmann (Hg.), *Psychology versus Metapsychology: Psychoanalytic essays in memory of George S. Klein* (S. 71-105). New York: International Universities Press.

Glover, E. (1948). The future development of psychoanalysis. In E. Glover (Hg.), *On the early development of mind* (S. 333-351). New York: International Universities Press.

Greenberg, J. R. & Mitchell, S. A. (1983). *Object relations in psychoanalytic theory*. Cambridge, Mass.: Harvard University Press.

Harsch, W. (1980). *Der Begriff der psychischen Struktur in der Psychoanalyse*. Freie Universität Berlin: Med. Dissertation.

Hartmann, H. (1927). *Die Grundlagen der Psychoanalyse*. Stuttgart 1972: Klett-Cotta.

Hartmann, H. (1939). *Ich-Psychologie und Anpassungsproblem*. (3. Aufl.). Stuttgart 1975: Klett.

Hartmann, H. (1964). Ich-Psychologie. Studien zur psychoanalytischen Theorie. Stuttgart 1972: Klett.

Holder, A. & Dare, C. (1982). Narzißmus, Selbstwertgefühl und Objektbeziehungen. *Psyche*, *36*, 788-812.

Horowitz, L. M., Strauß, B. & Kordy, H. (1994). Inventar zur Erfassung interpersonaler Probleme - Deutsche Version (IIP-D). Weinheim: Beltz Test.

Kernberg, O. F. (1982). Self, ego, affects, and drives. *Journal of the American Psychoanalytic Association*, *27*, 793-819.

Kernberg, O. F. (1990). New perspektives in psychoanalytic affect theory. In R. Plutchik & H. Kellerman (Hg.), *Emotion. Theory, research, and experience. Vol. 5: Emotion, psychopathology, and psychotherapy* (S. 115-131). San Diego: Academic Press.

Klein, G. S. (1970). Two theories or one? *Bulletin of the Menninger Clinic*, *37*, 102-132.

Loch, W. (1967). Grundriß der psychoanalytischen Theorie (Metapsychologie). In W. Loch (Hg.), *Die Krankheitslehre der Psychoanalyse* (S. 1-49). Stuttgart: Hirzel.

Mertens, W. (1992). Kompendium psychoanalytischer Grundbegriffe. München: Quintessenz.

Nagera, H. (1967). The concept of structure and structuralization. *Psychoanalytic Study of the Child*, *22*, 77-102.

Rapaport, D. (1957). Cognitive structures. In M. M. Gill (Hg.), *The collected papers of David Rapaport* (S. 631-664). New York: Basic Books.

Richards, A. (1974). *The Standard Edition of the complete psychological works of Sigmund Freud. Vol. 24: Indexes and bibliography. London 1986: Hogarth.*

Rudolf, G. (1981). *Untersuchungen und Befund bei Neurosen und psychosomatischen Erkrankungen. Materialien zum psychischen und sozial-kommunikativen Befund (PSKB). Weinheim: Beltz.*

Sandler, J. & Rosenblatt, B. (1962). The concept of the representational world. *Psychoanalytic Study of the Child*, *17*, 128-145.

Schafer, R. (1968). *Aspects of internalisation*. Madison, Conn. 1990: International Universities Press.

Schultz-Hencke, H. (1931). *Schicksal und Neurose*. Jena: Fischer.

Seidler, G. H. (1995). *Der Blick des Anderen. Eine Analyse der Scham*. Stuttgart: Verlag Internationale Psychoanalyse (American edition: In Others' Eyes. An Analysis of Shame. Madison, Conn.:International Universities Press - in press).

Stolorow, R. D. (1978). The concept of psychic structure: its metapsychological and clinical psychoanalytic meanings. *International Review of Psychoanalysis*, *5*, 313-320.

Veszy-Wagner, L. (1968). *Sigmund Freud. Gesammelte Werke. 18. Bd.: Gesamtregister. Frankfurt am Main: Fischer.*

Dr. G. H. Seidler & Dipl.-Psych. Th. Jakobsen

Psychosomatische Klinik der Universität Heidelberg

Thibautstr. 2

69115 Heidelberg

e-mail: guenter_seidler@krzmail.krz.uni-heidelberg.de

thorsten_jakobsen@krzmail.krz.uni-heidelberg.de

Figures

Figure 1: Gender distribution, whole group

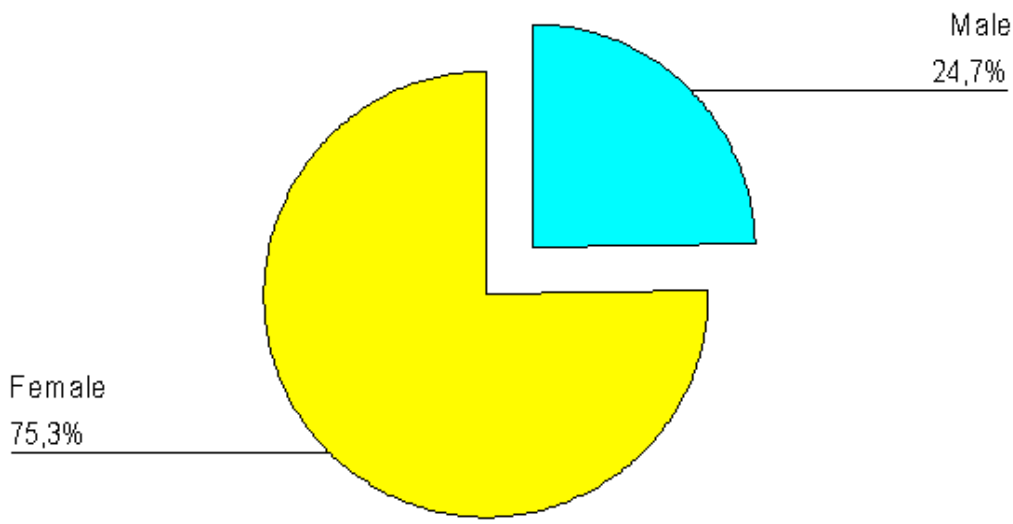


Figure 2: Age distribution in groups (percentages). Mean age 30 years.

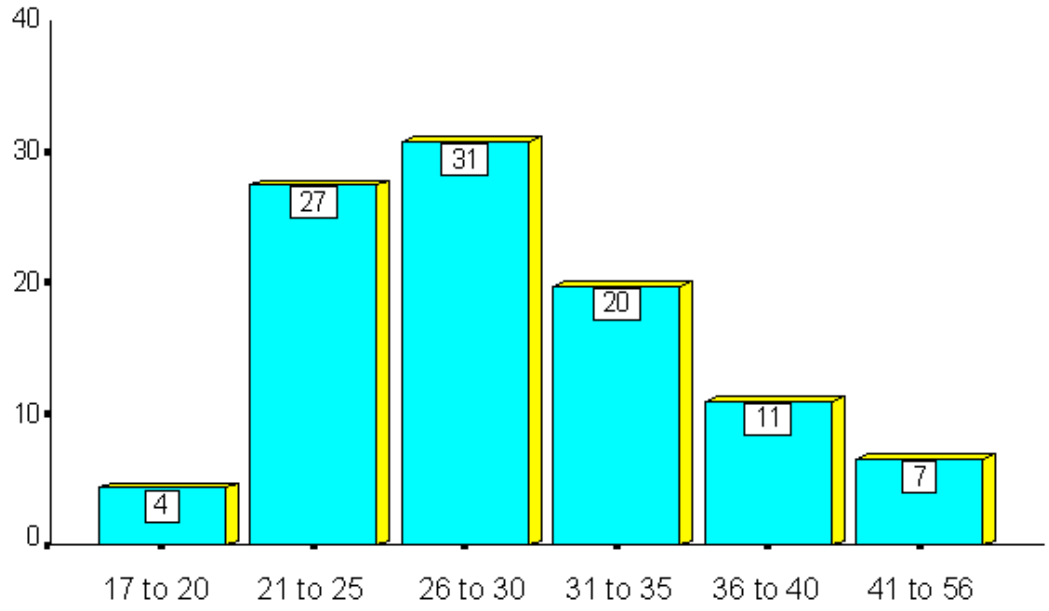


Figure 3:Diagnoses excluding the patients with double diagnoses.

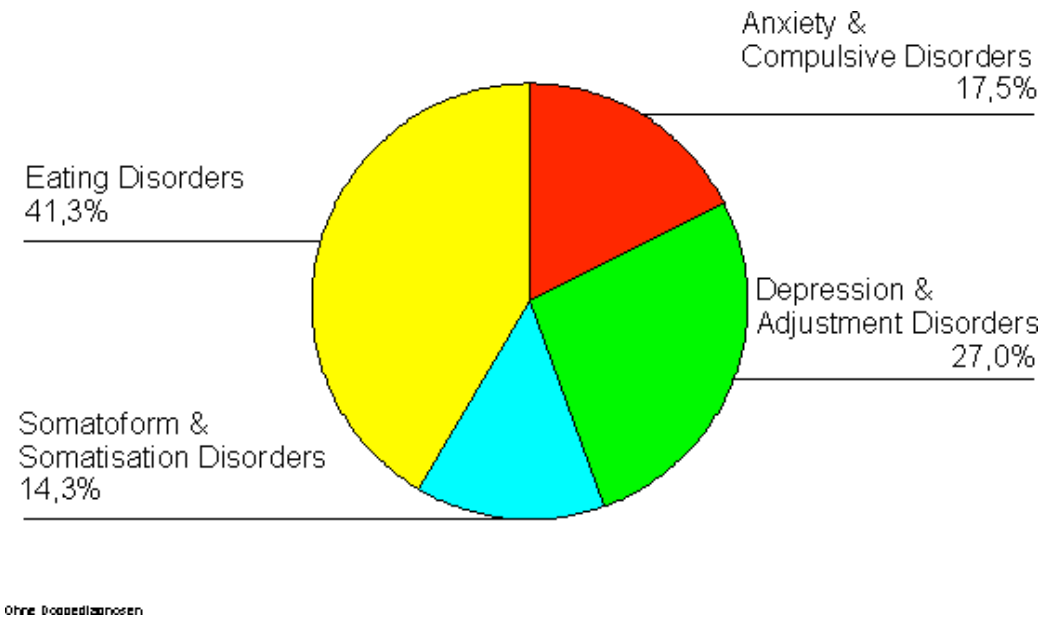


Figure 4: Diagnoses including the patients with double diagnosis.

Figure 5: Progression in the CER scale. Significant differences from t1 to t4 (p=.007; group means of row values).**

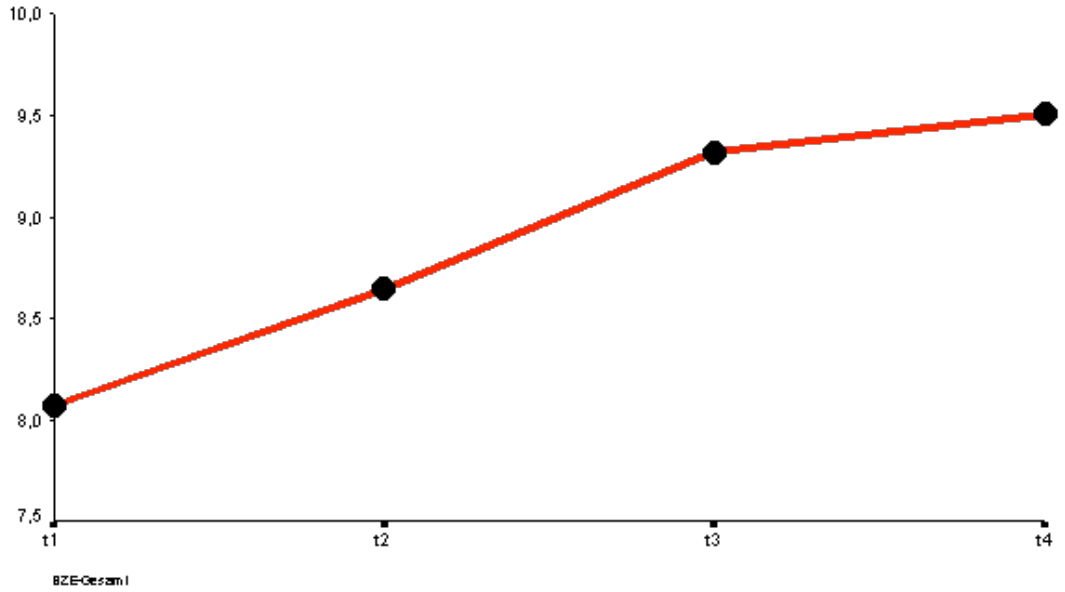


Figure 6: Progression of the RSR scale. Significant differences from t1 to t4* (p=.048; group means of row values).

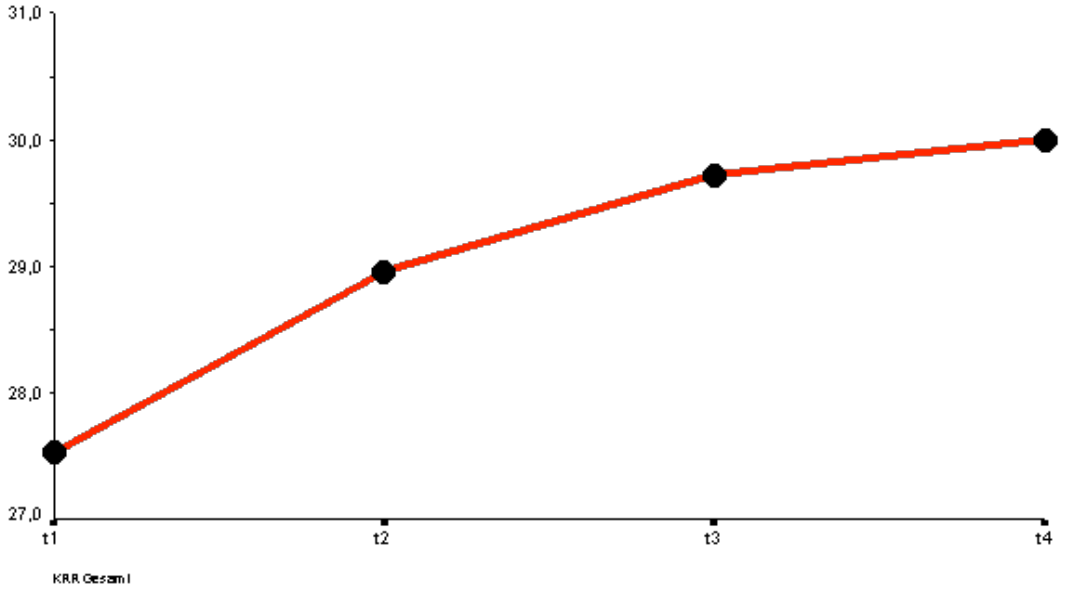


Figure 7: Progression of overall IIP ratings. Significant differences from t1 to t2* (p=.034) and from t1 to t4 (p=.000; group means of row values).**

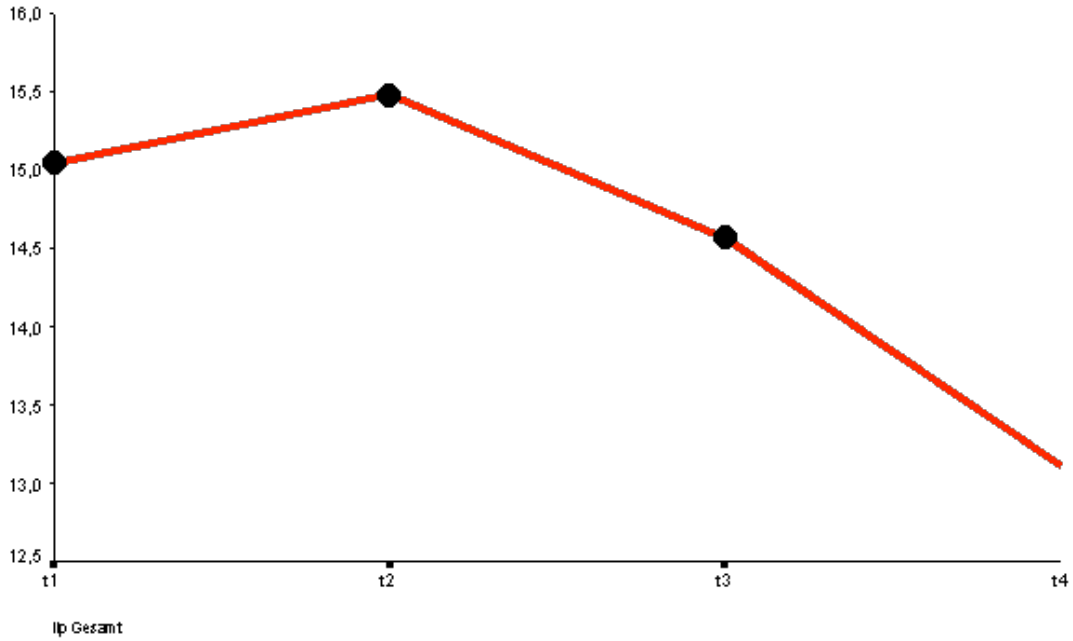


Figure 8

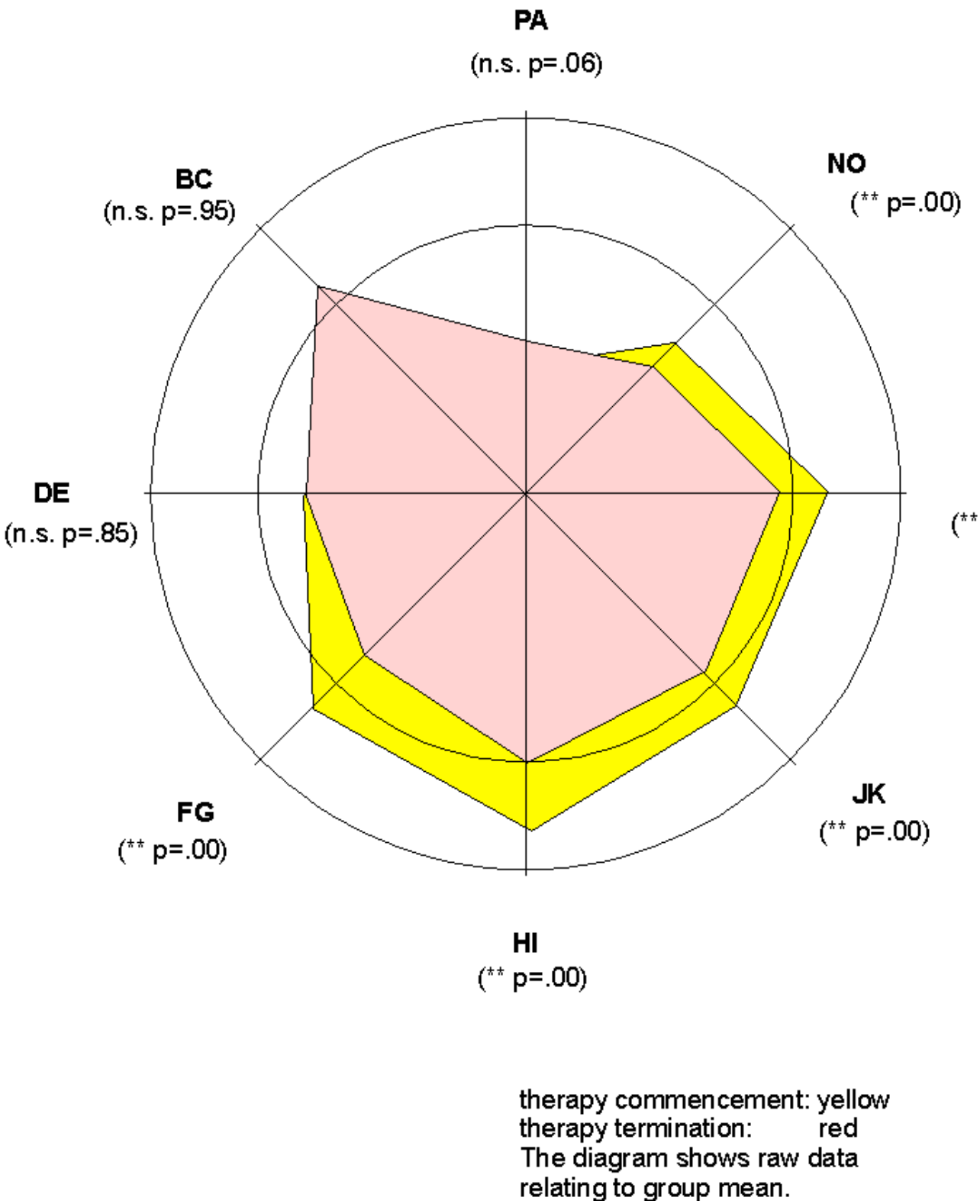

Differences in individual IIP scales
from therapy commencement to therapy termination
PA
(n.s. p=.06)
NO
(** p=.00)
BC
(n.s. p=.95)
DE
(n.s. p=.85)
(**
FG
(** p=.00)
JK
(** p=.00)
HI
(** p=.00)
therapy commencement: yellow
therapy termination: red
The diagram shows raw data
relating to group mean.

Figure 9

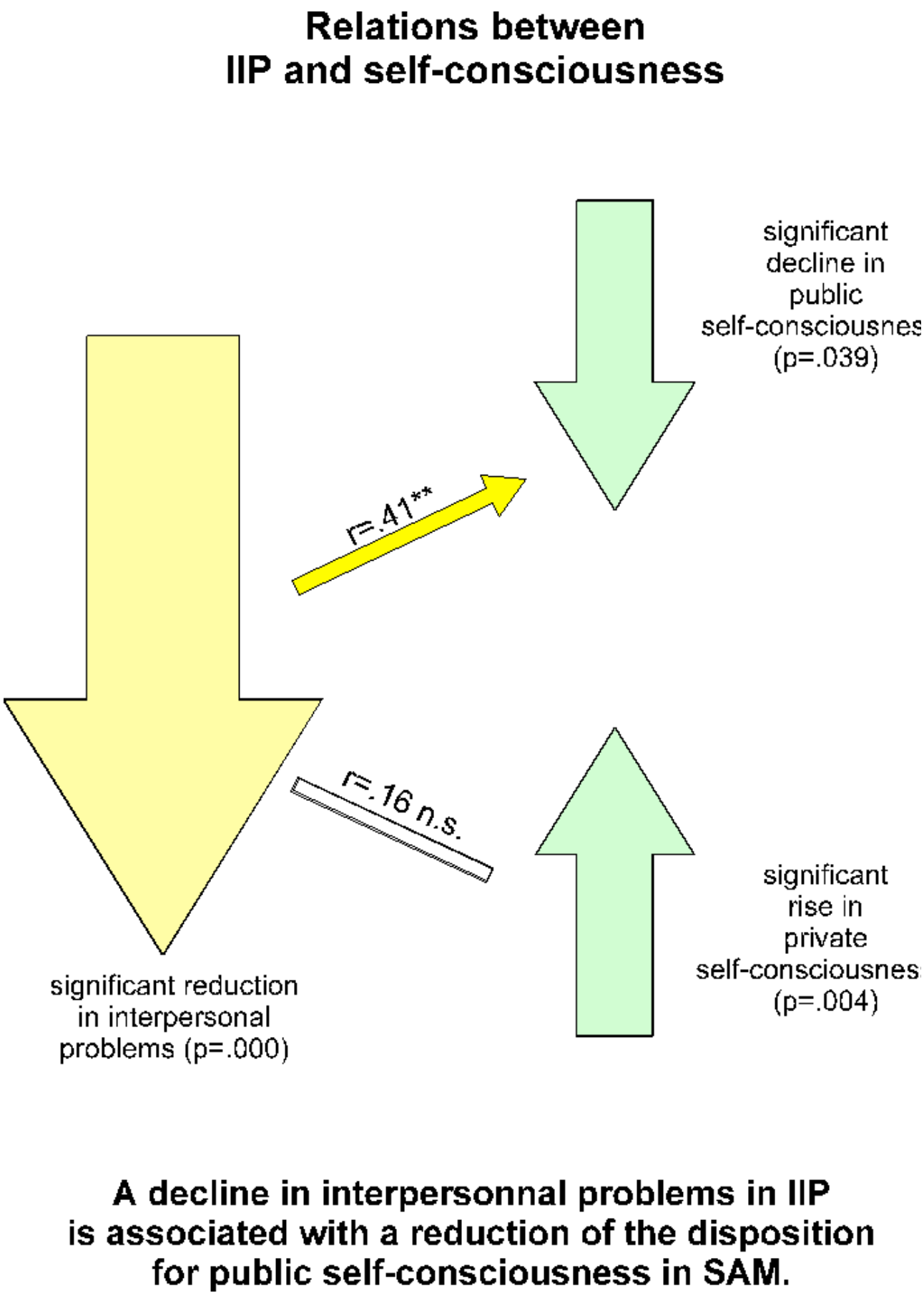

Relations between
IIP and self-consciousness
significant
decline in
public
self-consciousnes
(p=.039)
r=.41**
r=.16 n.s.
significant reduction
in interpersonal
problems (p=.000)
significant
rise in
private
self-consciousnes
(p=.004)
A decline in interpersonnal problems in IIP
is associated with a reduction of the disposition
for public self-consciousness in SAM.

Figure 10

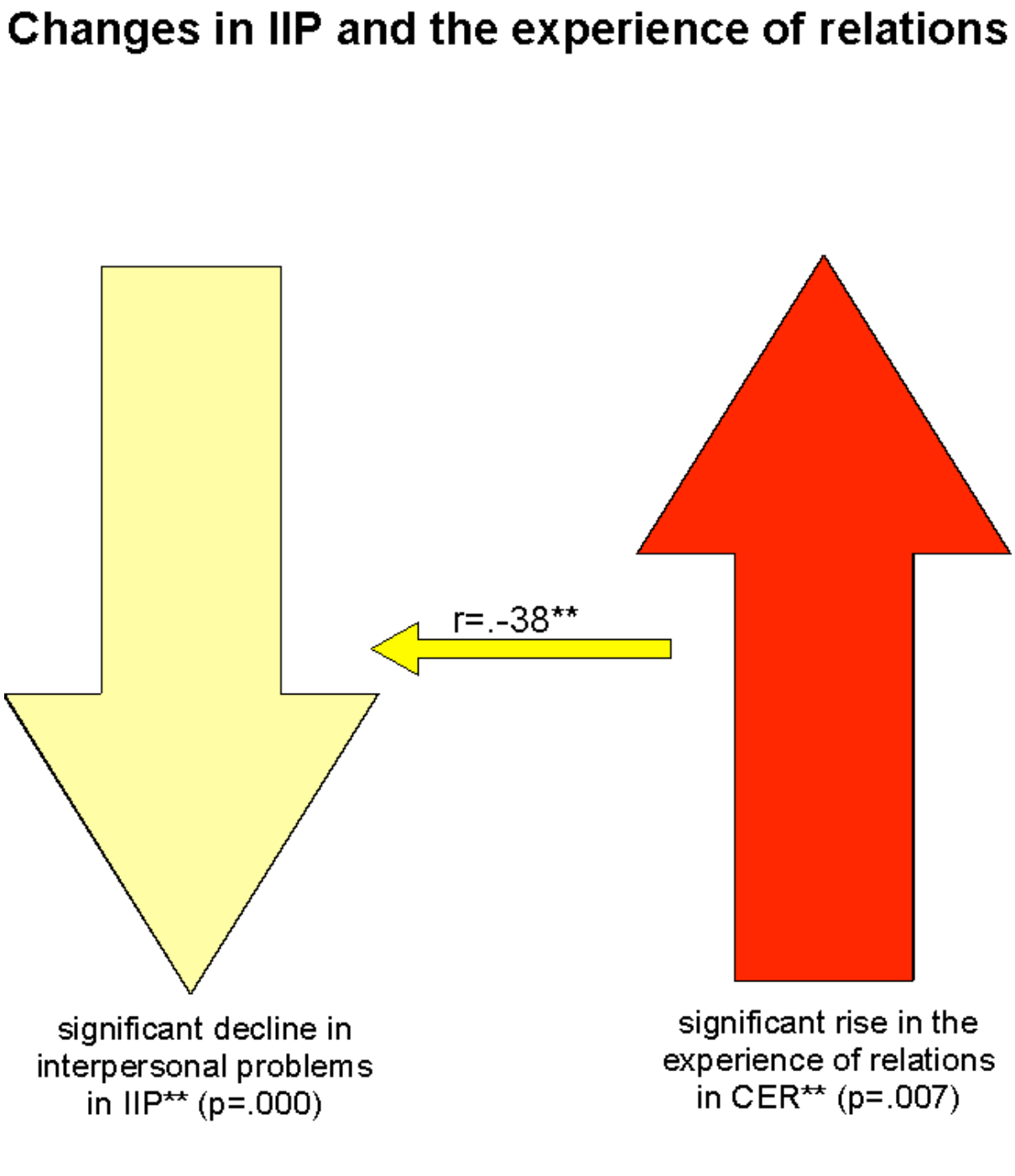
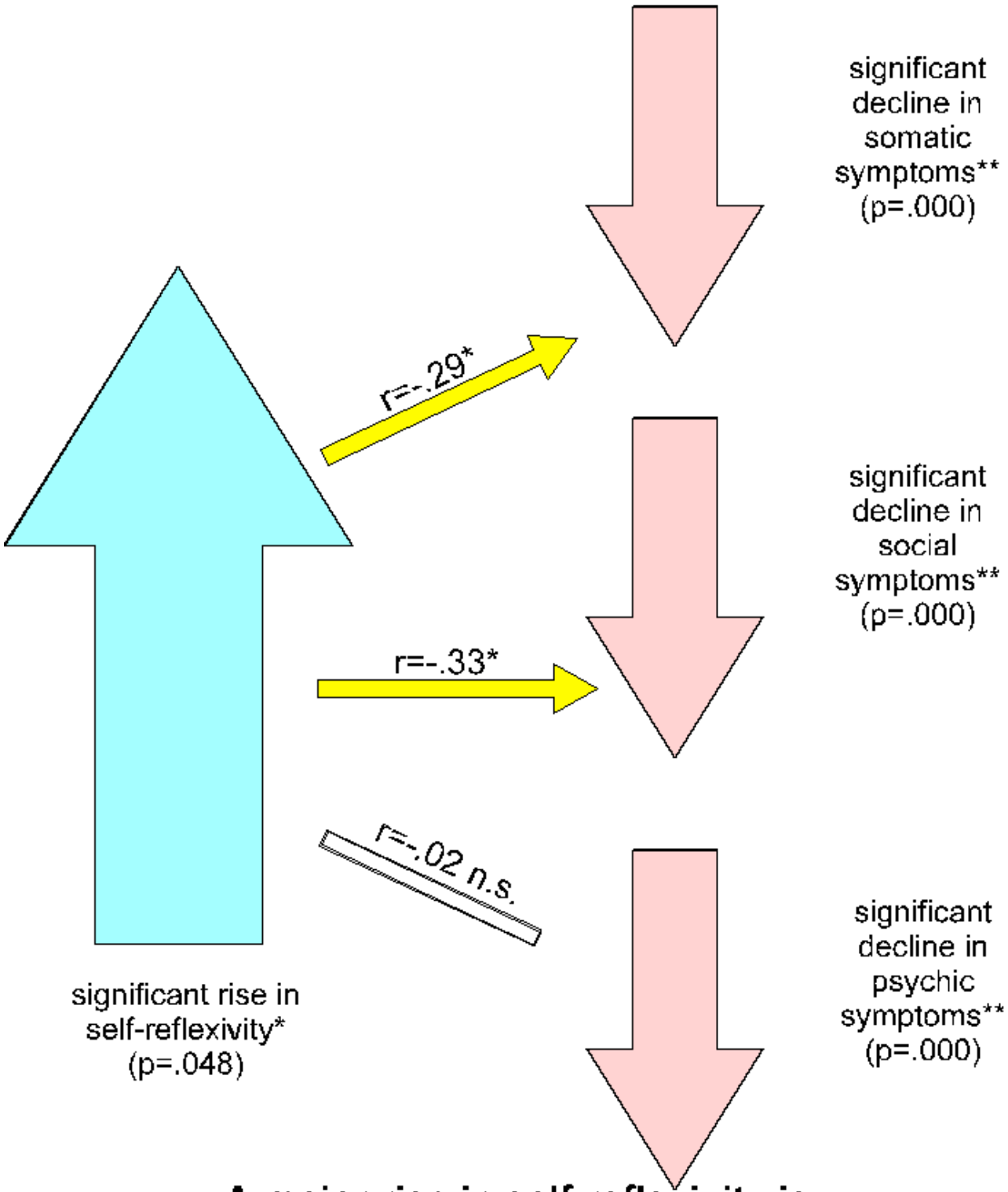

Changes in IIP and the experience of relations
r=.-38**
significant decline in interpersonal problems in IIP** (p=.000)
significant rise in the experience of relations in CER** (p=.007)
A major rise in the experience of relations is associated with a pronaunced drop in interpersonal problems in IIP.

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.