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

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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.

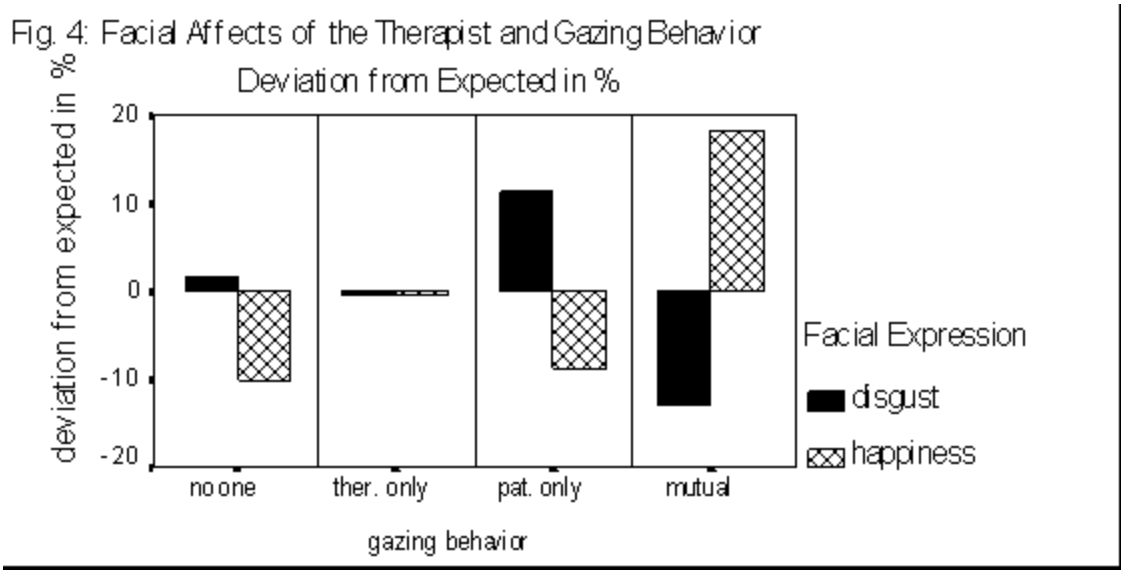
There are 4 possible states of dyadic **gazing behavior** at one specific moment: 1) no one is looking at the other, 2) therapist is looking at the patient while the patient is not looking at the therapist, 3)

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.

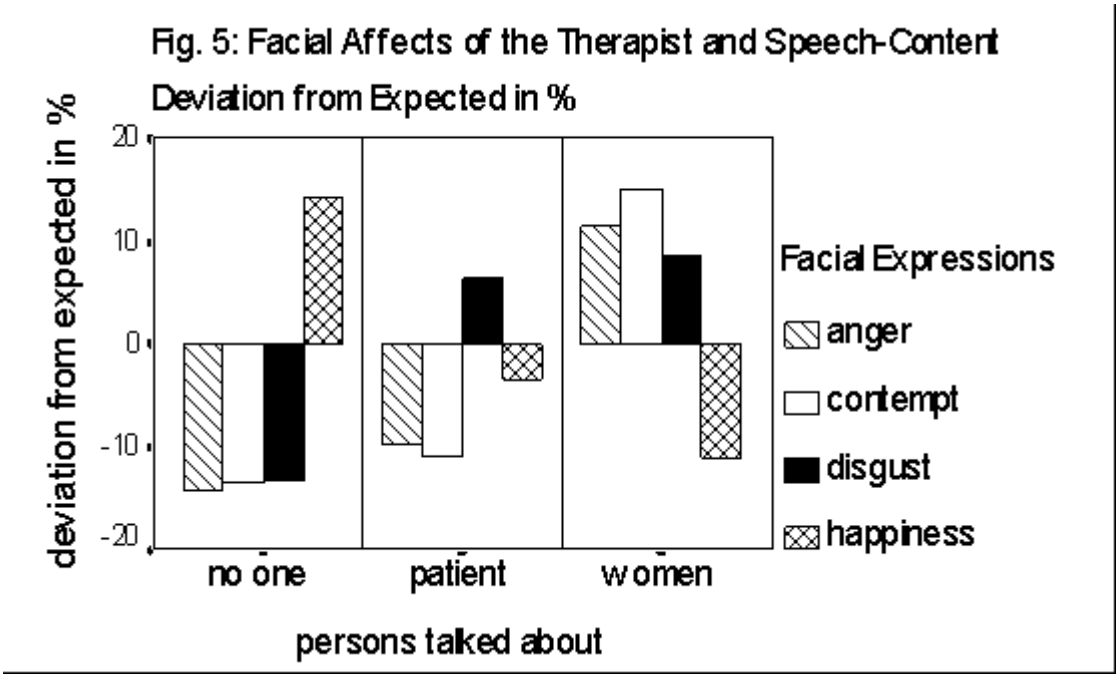


Figure 5 contains deviations from the expected of the therapist's facial expressions in the context of different speech-contents (here: a selection of the persons therapist or patient are talking about at the same moment of the therapist's affective facial expression). The therapist's expressions of 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.

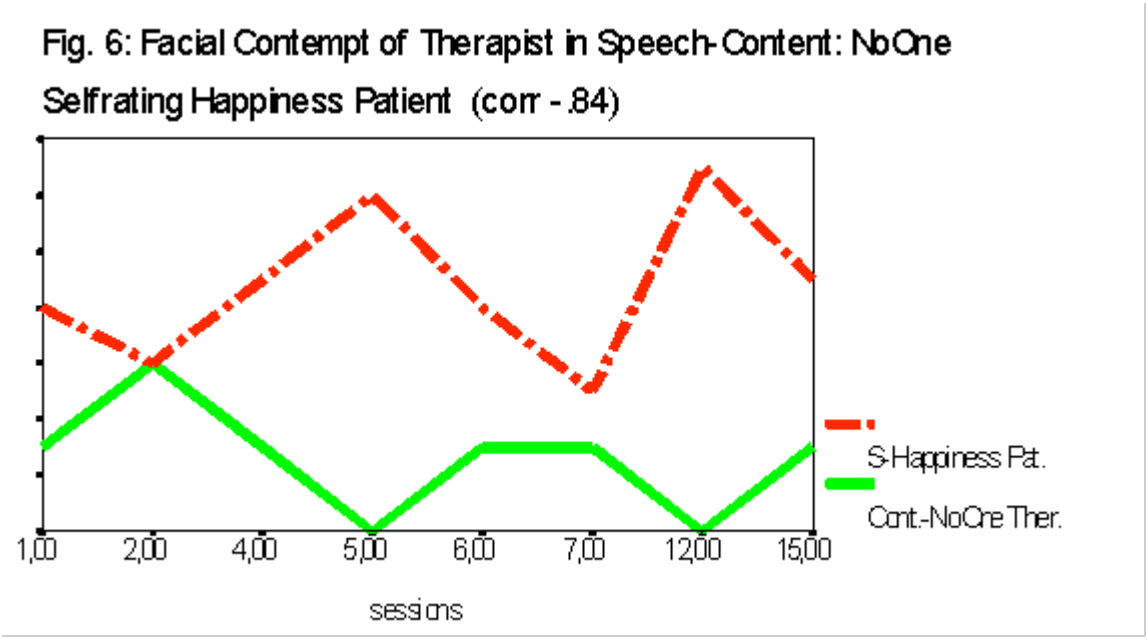
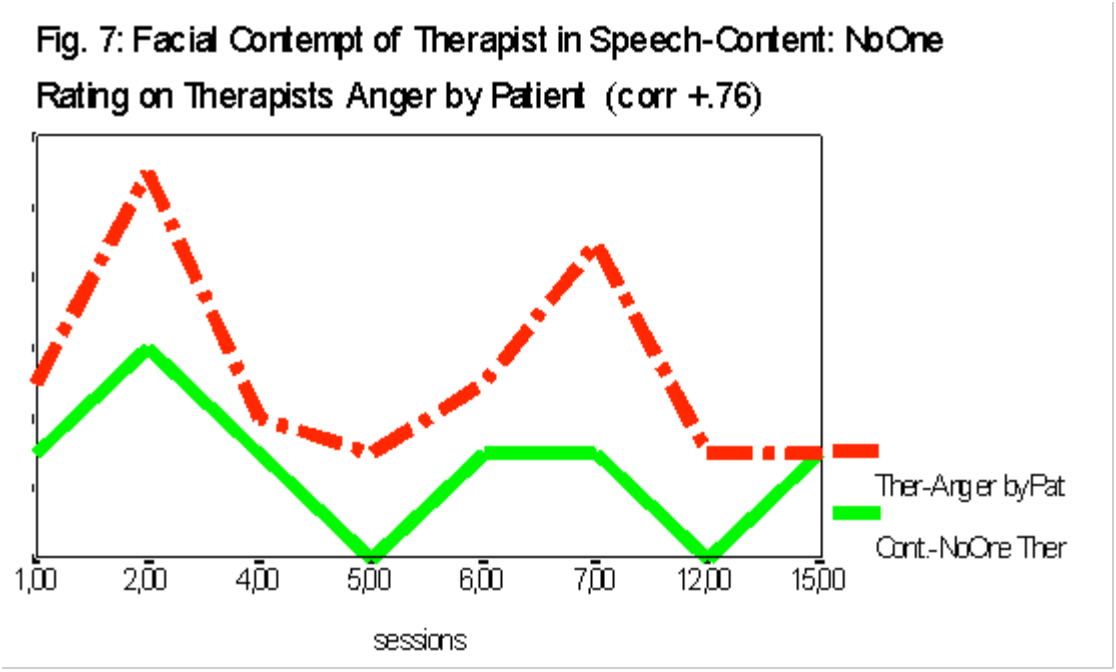
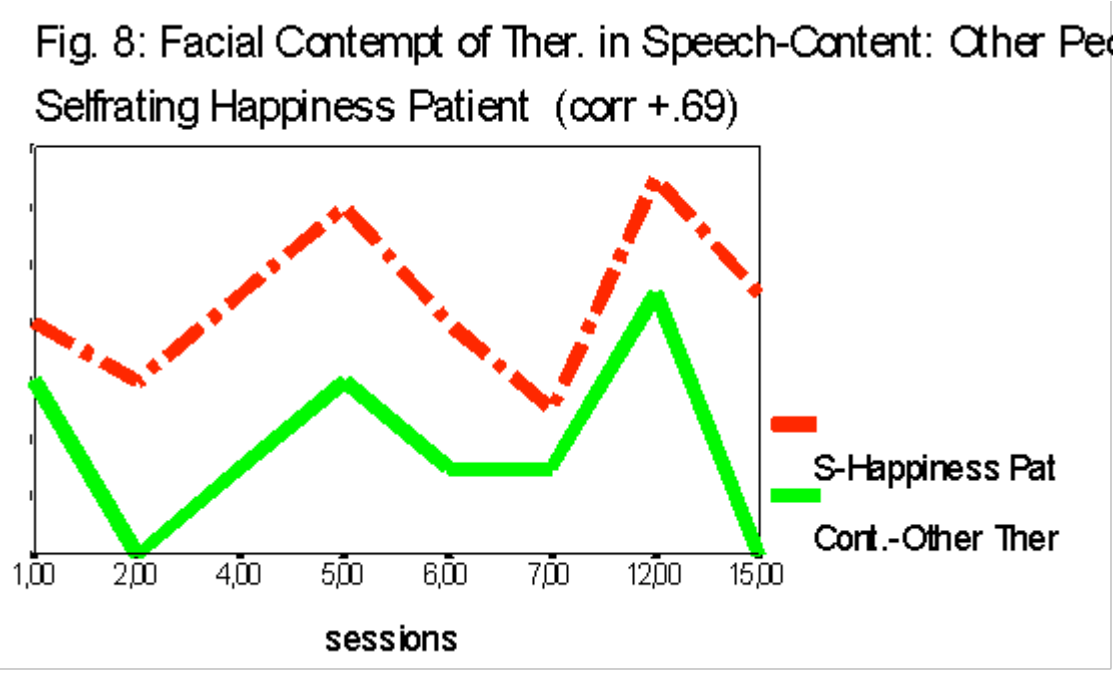


Fig. 6 shows the negative correlation between the frequency of the therapist's contempt-expressions which are not placed in a codable speech-content (Cont.-NoOne Ther.) and the patients selfrating of happiness after the session (S-Happiness Pat.). The more "interactive" contempt the therapist shows in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