

INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

UMI

A Bell & Howell Information Company
300 North Zeeb Road, Ann Arbor MI 48106-1346 USA
313/761-4700 800/521-0600

PATTERNS OF CHANGE IN THE SYMBOLIZATION OF OBJECT RELATIONS
AND NARRATIVE OVER THE COURSE OF SHORT-TERM PSYCHODYNAMIC
TREATMENT WITH PSYCHIATRIC INPATIENTS

by

PATRICIA CRISTINA

A dissertation submitted to the Graduate Faculty in
Psychology in partial fulfillment of the requirements
for the degree of Doctor of Philosophy,
The City University of New York

1996

UMI Number: 9630453

**Copyright 1996 by
Cristina, Patricia**

All rights reserved.

**UMI Microform 9630453
Copyright 1996, by UMI Company. All rights reserved.**

**This microform edition is protected against unauthorized
copying under Title 17, United States Code.**

UMI
300 North Zeeb Road
Ann Arbor, MI 48103

© 1996

PATRICIA CRISTINA

All Rights Reserved

This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

16 April 1996
Date

Vera Paster
Professor Vera Paster, Chair of Committee

4-25-96
Date

Kay Deaux
Professor Kay Deaux, Executive Officer

Professor Norbert Freedman

Professor Michael Berzofsky

Professor Steven Tuber

Professor William King

Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK

Abstract

PATTERNS OF CHANGE IN THE SYMBOLIZATION OF OBJECT RELATIONS AND NARRATIVE OVER THE COURSE OF SHORT-TERM PSYCHODYNAMIC TREATMENT WITH PSYCHIATRIC INPATIENTS

by

Patricia Cristina

Advisor: Professor Vera Paster

The focus of the present study is on patterns of change in symbolization over the course of short-term psychodynamic treatment with psychiatric inpatients. The aim is to shed light on some specific dimensions of symbolization and to propose that using measures of symbolization is a useful way of measuring change in psychotherapy.

This study consisted of two parts. In the monologue study, three different groups, determined by their scores on the Level of Associative Organization (LAO), were compared: symbolizers, non-symbolizers changers and non-symbolizer non-changers. A total of 14 subjects were used; all were psychiatric inpatients from an urban medical center. The central measures used were the LAO, the Gottschalk and Gleser Hostility Scale, the Symbolization of Object Relations Scale (SORS), and the Symbolization of Narrative Scale (SONS), all applied to five minute monologues, before and after treatment. The SORS and SONS

were developed to further operationalize the concept of symbolization as defined by the LAO. In the therapy study, there was an indepth examination of two additional non-symbolizer changers by applying the SORS and SONS to five minute segments of initial and peak therapy sessions.

In the monologue study it was hypothesized that at pre-treatment, patients identified as symbolizers, non-symbolizer changers and non-symbolizer non-changers can be distinguished along specific lines of symbolizing activity, and that at post treatment, patients will show changes in the level of symbolization independent of initial trait characteristics. In the therapy study it was hypothesized that the non-symbolizer changers will improve in their capacity to symbolize object relations, narrative and affect, within an optimal treatment session.

As predicted, at pre-treatment, the symbolizers were significantly different from both groups of non-symbolizers and demonstrated higher levels of symbolization of object relations and narrative. As predicted, there was a significant main effect at post treatment; the non-symbolizer changers were distinguished to have a significantly higher level of symbolization of object relations and narrative than the non-symbolizer non-changers. As predicted, a comparability of change was found in the therapy study; the non-symbolizer changers displayed the inability to symbolize at the beginning of

treatment, but, at change sessions, demonstrated the capacity to symbolize object relations and narrative.

On the basis of these findings it can be concluded that different patterns of change occur over the course of short-term inpatient psychotherapy for symbolizers, non-symbolizer changers and non-symbolizer non-changers on the dimensions of symbolization of object relations and narrative. It can be concluded that the labels of symbolizer and non-symbolizer are not static entities impermeable to change. Finally, the findings from the therapy study have implications for being able to determine change from the therapy session itself, rather than relying on a secondary method such as a five minute monologue.

This study has been able to further elaborate the LAO measure which is a global measure of symbolization and has offered a more clinically descriptive and useful way to access change using the dimensions of object relations and narrative. Accordingly, any clinician, no matter his or her theoretical orientation, can use measures of symbolization to describe change or progress in psychotherapy and therefore, can engage in a more "common ground" approach in exploring the process of change.

TO

Kyran, whose narrative discourse has provided me with
much inspiration during the past twenty years
and will, no doubt, continue to do so.

ACKNOWLEDGMENTS

There are many people I would like to thank for their help and support. First I would like to express my gratitude to Vera Paster, Ph.D., the chair of my committee, whose steady support and availability throughout the entire dissertation process enabled me to get through it. Her thoughtful reading of every draft provided valuable editing, criticism and encouragement. Her challenging questions helped me to clarify essential concepts.

I can not say enough to express my gratitude for the Downstate experience and to Norbert Freedman, Ph.D. and Michael Berzofsky, Ph.D. who were both so generous in their support of my project and their very real assistance in all aspects of this dissertation. Norbert Freedman's generosity of spirit, excitement for ideas and depth of wisdom fostered my development as a clinician and researcher. Michael Berzofsky was wonderful for his unending support, thoughtful collaboration, gentleness and sense of humor. I also want to express thanks for the use of the LAO for the inspiration to explore the symbolization process. A special thanks goes to Reuben Margolis for his essential help with the data input and data analysis. I would like to thank Ken Feiner, Psy.D. and Gill Katz, Ph.D. who were my clinical supervisors at Downstate.

I wish to thank the faculty of CCNY's Clinical Psychology Doctoral Program for the solid foundations they

gave me. I would like to thank Steve Tuber, Ph.D. and William King, Ph.D. for being outside readers and for providing thoughtful criticism and praise.

I would like to thank Laura Pontrelli, Ph.D. for her participation as a therapist and for her general support as a colleague during the fellowship at Downstate. A special thanks goes to Julie Lewis, Carol Ahuna, Ph.D. and Linda S. Murphy for their help with coding and scoring and to Jordana Skurka for data transcription.

I would like to thank my parents, my father for his patience, kindness, and intelligence, and my mother for her strength and organizational expertise.

Last of all, I would like to express my gratitude to Kyran Cassidy to whom this dissertation is dedicated. His reading and editing of early drafts was more than helpful. His love, support, sense of humor and encouragement were invaluable.

TABLE OF CONTENTS

Abstract.....	iv
Dedication.....	vii
Acknowledgments.....	viii
List of tables.....	xi
List of appendices.....	xii
Chapter 1. Introduction	1
Chapter 2. Literature Review.....	7
Symbolization of object relations.....	22
Symbolization of narrative.....	26
Symbolization of affect.....	33
Chapter 3. Methodology.....	37
Subjects.....	37
Measures.....	40
Procedures.....	55
Chapter 4. Results.....	64
Chapter 5. Discussion.....	87
Appendices.....	116
Bibliography.....	134

LIST OF TABLES

Table

1	List of Alpha Reliability Coefficients for the SONS.....	51
2	Means and SDs for symbolizers, non-symbolizers and non-symbolizer changers on the SORS at pre-treatment	63
3	Means and SDs for symbolizers, non-symbolizers and non-symbolizer changers on the SONS at pre-treatment	64
4	Means and SDs for symbolizers, non-symbolizers and non-symbolizer changers on the Gottschalk and Gleser Hostility Scale at pre-treatment	67
5	Means and SDs for symbolizers, non-symbolizers and non-symbolizer changers on the SORS at post treatment	68
6	Means and SDs for symbolizers, non-symbolizers and non-symbolizer changers on the SONS at post treatment.....	70
7	Means and SDs for symbolizers, non-symbolizers and non-symbolizer changers on the Gottschalk and Gleser Hostility Scale at post treatment	72
8	Means and 95% confidence intervals for the non-symbolizer changers on the SORS at pre, post and peak treatment.....	75
9	Means and 95% confidence intervals for the non-symbolizer changers on the SONS at pre, post and peak treatment.....	79

LIST OF APPENDICES

Appendix

A	The Symbolization of Object Relations Scale and Scoring Manual.....	116
B	The Symbolization of Narrative Scale and Scoring Sheet.....	121
C	Berzofsky and Freedman's LAO Scale and Scoring Manual.....	127
D	Patient Characteristics.....	132
E	The Consent Form.....	133

Introduction

The purpose of the present study is to contribute to an understanding of some of the dynamic processes of change in psychoanalytically informed psychotherapy. The change that is the focus of the present study is the process that occurs in a patient's ability to symbolize, to create symbolic meaning in progressing towards a "cure" and/or a patient's struggle towards integration. What does symbolization, in a psychoanalytic sense, mean and what constitutes a patient's ability to symbolize? Do patients show differing abilities in their ability to symbolize and how does this effect their capacity to receive benefits from psychotherapy? How does one determine a patient's ability to symbolize, and is this an ability that can change, become more developed, with psychotherapy? These are the questions this present study is concerned with.

One of the goals of therapy is to help patients create symbolic representation and to develop an emotional meaning of themselves in relation to others and their environment. This study will further define symbolization as it applies to psychoanalytic thinking and proposes that symbolization can be a way to arrive at a common ground in being able to describe change in patients regardless of what theoretical orientation one adheres to.

The present author equates the capacity to symbolize to being able to gain from the therapeutic experience.

This is an ability that can not be predetermined because there are those patients who are described as symbolizers, who can benefit from psychotherapy treatment initially; and those patients who are described as non-symbolizer changers, who give no evidence of being able to symbolize initially; however, they subsequently develop the capacity to symbolize during the treatment process. These patients are of great interest in this study, and are compared to the non-symbolizer non-changers, those patients who do not show the capacity to symbolize initially, nor do they develop the capacity subsequently, and therefore do not seem to benefit from psychotherapy treatment.

This study will demonstrate that these two groups do exist, the symbolizers and the non-symbolizers. And that among the non-symbolizers there are two types, those who do develop the capacity to symbolize and those who do not. This study will delineate the patterns of change associated with psychotherapy among patients who have been identified as symbolizers, non-symbolizer non-changers and non-symbolizer changers. These designations were determined by a measure called Level of Associative Organization (LAO) created by Berzofsky and Freedman (1988). The LAO is a global scale which gives a broad estimate of a patient's capacity to symbolize and has been found to differentiate symbolizers from non-symbolizers (see methods section). This study will elaborate the concept of symbolization offered by LAO.

The significance of such a study is to arrive at a better understanding of the process of symbolization as it applies to the psychotherapy process; to harness a more concrete definition of what symbolization is, and to apply this more concrete definition of symbolization, with its components of object relations, narrative and affect, to assess change in a more descriptive way, regardless of psychoanalytic orientation.

Objectives of Study

The main objective of this study is to further elaborate the process of symbolization and non-symbolization originally based on the Level of Associative Organization (LAO) (Berzofsky and Freedman, 1990). This study aims to specify changes associated with the psychotherapy process as these changes may be represented in a patient's narrative; more specifically, changes in symbolization of self object representations, of a cohesive narrative, and of ownership of affect. Symbolization and non-symbolization will be analyzed in terms of three major components critical to the change process which will be designated 1) symbolization of object relations, 2) symbolization of narrative, and 3) symbolization of affect.

The second objective of this study has to do with the challenge offered by the phenomena of non-symbolization and resymbolization. The inability to use symbolic construction offers a major challenge to the understanding

of processes leading to mental health. Non-symbolization is a phenomenon which occurs not only in psychopathology but also in various kinds of stressful situations such as in the regressive transference. It is the earmark of that aspect of conflict based on disavowal, in contrast to symbolization, which is the ability to establish psychic links or linking connections. It has been shown that non-symbolization cuts across the boundaries of psychopathology (Bach, 1985). Nonetheless, non-symbolization may be viewed as that which impedes successful analytically informed treatment.

Is non-symbolization a cognitive stylistic attribute or is it a process that can be altered with treatment? If non-symbolization were only an attribute of style then clinicians could only be led to therapeutic pessimism. Thus, a prevalent comment in the literature of the efficacy of psychotherapy is that the rich get richer and the poor get poorer. That is, those who have the cognitive capacity for symbolization will improve while those who do not have the capacity, tend not to respond and do not show changes in treatment (Whitkin, 1968). Clinical observation contradicts this. Frequently we find reports of patients who, for a variety of reasons, have difficulty engaging in the treatment initially and yet, show significant clinical changes subsequently.

So, the second objective is to seek to delineate the patterns of change associated with psychotherapy among

patients initially identified as symbolizers and non-symbolizers, and within the group of non-symbolizers to delineate those who reveal changes (non-symbolizer changers or resymbolizers) and those who do not reveal changes (non-symbolizers proper) in the symbolic process.

This study will be carried out in 2 stages. Part one involves delineating patterns of changes in symbolization over the course of treatment in three groups: symbolizers, non-symbolizers and non-symbolizer changers. In part 2, there will be a closer fundamental analysis of non-symbolizers who change using two treatment cases.

The first part of this study is to establish patterns of change over the course of short-term inpatient psychotherapy based on an associative monologue given at the beginning and at the end of treatment. One of the most challenging questions raised by the first part of the study is whether a patient identified from the associative monologue as a non-symbolizer will show resymbolization, and furthermore, to investigate such psychic change in the course of a psychotherapy treatment.

The purpose of the second study is to clinically validate the observations of the earlier associative monologue study by using actual psychotherapy transcripts. Looking more closely into the nature of change of two non-symbolizer changers, in a case study approach, will shed some light on the process of resymbolization. Freedman and Berzofsky (1995) conclude that the most challenging

phenomena is the transition from non-symbolization to symbolization.

"It is this transition which marks the shift from deadness and destructiveness to aliveness in construction of meaning or, as we prefer to call it, from the destruction of psychoanalytic space to the creation of psychoanalytic space. It is this transition which marks the psychological birth of the conflicted patient" (pp. 372 - 373).

This study will contribute to an understanding of the construct of symbolization not only as a trait but involving specific dimensions of change in the course of treatment. By documenting that it is possible for the poor to become rich, allows us to have therapeutic optimism and has implications for psychotherapy being a process that can promote symbolization.

Literature Review

The empirical literature on the quality of change associated with psychoanalytic therapy is caught in a dilemma: according to the Smith and Glass (1977) report, all changes in psychologically related treatment are non specific in their efficacy. For instance, if we consider criteria such as symptom reduction, behavioral, psychoanalytic or psychopharmacological indices of change, each group can claim equal incidence of improvement without regard to quality of change. In fact, on the basis of these broad non-specific changes, psychoanalytic therapy does no better; it actually does worse than other forms of therapy in terms of yielding benefits (Luborsky, 1993).

In contrast, the psychoanalytic literature on change is very specific. In the analytic literature, the evidence of change is presented through clinical vignettes. The changes are assumed to reflect particular theoretical orientations. In self psychology we speak of, among other things, changes in self object, self cohesiveness, mirroring and idealization (Kohut, 1978). In Object Relations theory, we talk of changes in the representation of the internal object (Mahler, Pine, & Bergman, 1975). In neoclassical theory, we speak of changes in the drive and defense balance (Brenner, 1982). In Attachment theory, we speak of changes in the internal working model (Bowlby, 1980; Ainsworth, 1979). There is no systematic examination

of what the changes are, no objective way to categorize the changes that occur. It often seems that each theoretical orientation is describing a different patient. The patients may be similar, however, but appear to come from different cultures depending on which theory is used to describe them. What is needed are criteria specifically appropriate to account for changes that apply to all the various psychoanalytic theoretical assumptions, thus providing a common measure for comparative outcome purposes.

An alternative is the notion of common ground within the domain of psychoanalytic treatment suggested by Wallerstein (1992) who states that there might be a consensus at the level of clinical description when talking about patients, although there is diversity at the level of interpretation. While there are a finite number of discrete psychoanalytic models, both the models and the practice have much in common in contradistinction to non-analytic approaches.

One way such a common process manifests itself has been through the use of symbolization. Symbolization has been defined as the use of symbolic vehicles to represent objects, concepts and thoughts (Werner & Kaplan, 1963). Symbolization, which consists of culturally shared resources to represent private experience, has been the focus of anthropological, sociological, philosophical, and linguistic study (Jakobsen, 1960; Malinowski, 1938).

Loewald (1988) bemoans the fact that symbolization has received little attention from psychoanalysts.

Jones' paper (1948) was the first early attempt to define a psychoanalytic theory of symbolism (Loewald, 1983). Jones considered that a symbol stood for something hidden and unconscious, and that the symbolic linkage is repressed and the symbolic function unknown. That which is symbolized depends on the maintenance of repression. For Jones, a symbol is an item that can represent in conscious thought something that is repressed and hidden. Consider that for a patient the symbolization of money is represented by feces. When money is given out by the patient, he does not think of giving out feces because the linkage is repressed. The symbolic image depends on a repressed idea. Jones believed that the forming of a symbol is necessitated by repression.

Loewald (1988) challenges Jones' ideas of symbolization as disguise and states that this is a very limited way to conceptualize symbolization. Loewald suggests that many other disciplines, like Jones, conceive of symbolization as a "wishful disguise and distortion" (p.50). Loewald (1988) argues that a more psychoanalytic way of conceptualizing symbolization is to view symbolization as the linking of distinct spheres of the mind. Loewald believes that the relationship between the symbol and the symbolized can be consciously recognized and when this is accomplished the

connection becomes a true symbolic relationship for the patient with richer meanings. He states:

Words are not symbols merely in the sense that they are objective units that can be heard or read and that represent things; more important, they are themselves symbolizing links that establish or reestablish connections between items of experience. The prime function and intention of words is to provide, to be, bridges between items of experience other than themselves and to bring out connections between them (1988 p. 58).

Loewald, unlike Jones, believes that once repression is lifted the symbol does not cease to be symbolic. According to Loewald, when a patient becomes conscious of the symbolic linkage, the patient can deepen his understanding of the linkage and re-establish connections in conscious thought. He believes that the goal of therapy is to lead a patient from repressed symbolism to "actualizing and verifying live symbolic connections between two hitherto disparate items of experience and thought" (1983 p. 13).

Other psychologists who have made significant contributions to the study of symbolization are Piaget (1962); and Werner and Kaplan (1963). Symbolization as a specific developmental phase was highlighted by Bion (1967), Langs (1978-79) and Melanie Klein (1975). Bion (1959, 1962a) describes how the mother's ability to accept the infant's projective identification is essential for the symbolization process to develop in the infant. When a mother can not accept her infant's projective identifications, the infant will internalize the mother's "attack on linking" and will generate self-directed attacks

on linking which hinder his ability to link thoughts and to create emotional connections to others.

Melanie Klein, according to Loewald (1983), was one of the most valuable psychoanalytic thinkers on the topic of symbolism. Melanie Klein (1975) highlights how the beginnings of symbol formation begin to take place in the depressive position. It is in the depressive position that the child is able to integrate the good and the bad and view the mother as an integrated object. At this point, the child begins to use reparation. As the child strives to protect the mother from his/her destructive drives it partially inhibits his/her instincts and displaces them on to substitutes. This process marks the beginning of symbol formation. The process of giving up an instinctual aim involves loss and mourning and evokes the original giving up of the breast. According to Hanna Segal (1964) these repeated renunciations, if successful, can be assimilated in the ego and become symbols. Symbol formation is viewed as the outcome of a loss and involves working through the pain through mourning.

It is during the depressive position that abstract thought and the capacity for linking develops. When a person is stuck in the paranoid-schizoid position, his/her capacity to symbolize is limited and can be described as making "attacks on linking." Thus, in the paranoid-schizoid position "any function or organ that is perceived

by the infant to link objects together is violently attacked" (Segal, 1964. p. 57).

Ogden (1990) expands Klein's ideas on symbol formation. He describes how the self exists primarily as an object in the paranoid-schizoid position where the infant can not think or feel, rather, the infant is "lived by his experience" and experiences his thoughts and feelings as happening to him. Ogden develops the idea that in the paranoid-schizoid position there is no interpreting subject to mediate between the symbol and the symbolized, therefore the infant does not have the capacity to create meaning. Since the infant cannot create meaning, he cannot understand and is forced only to act: to get rid of, to cling to, to conceal, to hide from, to put into someone else, to shatter, to destroy. The infant views everything very concretely; the symbol is what it represents, events are what they are. Ogden states "When everything is the thing itself, everything is what it is without the potential for understanding that it could be other" (p. 212). The infant in this stage has no sense of himself as having a continuous personal history.

In the depressive position Ogden (1990) explains how a sense of "I-ness" develops and the infant becomes a subject. Things are no longer what they appear to be, rather, things are interpreted according to how the infant makes meaning. The infant can have thoughts and feelings about his perceptions and can create meaning. The infant

begins to develop a personal history. In the depressive position a person's thoughts, feelings, perceptions and behavior can be viewed as constructions rather than as facts. Ogden states "Only when one's behavior is viewed (at least in part) as a personal symbolic construction can one be curious about why one does what one does, how one does it, with whom one does it, and when one does it" (p. 117).

Is symbolism considered to be a process, a relatively stable one, or one that changes over time? There are those who believe either you have it or you do not, and there are those who believe it is a process that can be affected by treatment. In cognitive and linguistic literature (Werner and Kaplan, 1963; Cassirer, 1957; Langer, 1942), symbolization involves the linkage of rather distinct entities such as words, the symbolic vehicles, and their referents, the objects the words represent. The word book is considered to be the symbolic vehicle for its referent, the actual book. This view adheres to the use of symbolization as a relatively stable process that does not alter much over time. Alternatively, if one views the ability to symbolize in Kleinian terms then one can say that the ability to symbolize can be affected by treatment. As a patient works through the paranoid-schizoid position the patient's ability to symbolize will increase.

More contemporary psychoanalytic thought (Green, 1986; Ogden, 1990; Barratt, 1990) suggests that there is a

tertiary organizing force, either an interpreting subject or ego, that is essential for the linking of ideas and experiences in the symbolizing process and that this process can transform within the treatment setting. Ogden (1990) states:

The symbolic function always involves the threeness of the interrelationship of three distinct entities: 1) the symbol (the thought); 2) the symbolized (that which is being thought about); and 3) the thinker (the interpreting self), who is creating his thoughts and who stands apart from both the thought and the thing being thought about" (p. 225).

Freedman and Wilke (1994) further consolidated various psychoanalytic theories and have defined 3 major dimensions of symbolization: verbalization, spatialization and interpretation. The theories of many psychoanalytic thinkers (Shapiro, 1992; Rosen, 1969; Bucci, 1985; Loewald, 1988; Werner and Kaplan, 1963; Dahl and Teller, 1995) tend to fall into the category of verbalization where symbolization is considered to be an ego function. Symbolization conceptualized in this way is seen as a relatively stable psychological structure over time. In verbalization, a symbolic vehicle is linked to its referent, i.e., a word is linked to an image, a thought, an experience or an emotion. As when Helen Keller links the word WATER to the sensation of coolness and wetness.

Verbalization is not just talking, rather, it is "what can only be called a process of interpenetration between the spoken language and inner experience" (Freedman and Wilke, 1994 p. 7). Verbalization speaks to the process

linking the symbolic vehicle, the word such as water, with its referent, the thing itself such as coldness and wetness. It is the process by which a patient defines his/her subjective world to him/herself and to others (the therapist). It is the immediate correspondence between a word and a subjectively felt state. For the most part, verbalization bespeaks a conscious or preconscious process and does not address symbolization of unconscious thought or fantasy.

The second dimension of symbolization is called Spatialization, which refers to the process by which there is a linkage between images occurring in different psychic spheres. The theories of Kris (1956), Gill and Hoffman, (1982) and Jones (1948) fall into this category. These different spheres can consist of different times: past and present; different spaces: in the office of the therapist with the emphasis on the here and now relationship or events outside the therapeutic setting such as at work; different realms of consciousness: dream, fantasy and reality; and different objects: therapist, husband and father. The patient can make use of the many different spheres to illustrate similar issues and themes. This process speaks to a more coherent experience of self and increases a patient's sense of consistency of psychic reality in multiple contexts.

The third dimension of symbolization offered by Freedman and Wilke (1994) is symbolization as interpretive

activity where "meaning is not discovered, it is being constructed" and unconscious fantasy is revealed. Once a patient can verbalize a certain theme, and is able to spatialize, to represent the theme in various contexts, the patient then proceeds to present the themes in "contradictory and often paradoxical contexts." Through the process of interpretation, unconscious wishes are exposed by the interpreting ego and conflicts are resolved. For this process to occur the conflict must be ripe and present in the here and now, and has entered the therapist's subjectivity. It involves a triangular process which involves the patient's conflict (his/her positive and negative longings), and the analyst's interpreting ego. The tertiary force is the interpreting ego.

It is both symbolization as spatialization and as interpretation that lend themselves to change over time; they are viewed as processes that can be altered by treatment. The quality of verbalization is fairly constant over periods of time, nonetheless, this does not preclude the possibility that certain patients may show an increment over the course of treatment. Whether symbolization is a stable process or a process that changes over time is precisely one of the issues to be explored in this study.

The psychoanalytic theories of symbolization are plentiful, but the applicability of psychoanalytic theory regarding symbolization as a treatment process has not been

done by many. The following is a more extensive review of the research that has been done on symbolization.

Freedman and Berzofsky (1990) studied the ability of patients to symbolize in psychoanalytically informed treatment by looking at the associative process in language. They believe that the ability to symbolize is the basis of the "talking cure" and they developed the Level of Associative Organization (LAO) which reflects a patient's ability to symbolize or to cope with ambivalent promptings. The LAO measure can be applied to any verbal sample to measure the associative quality of language. The LAO has four scales: (A) self and object differentiation as seen in pronoun use; (B) capacity for symbolization; (C) tolerance for ambivalence ; and (D) level of self-experience (Berzofsky and Freedman, 1988).

The Level of Associative Organization (LAO) is considered to be a measure of verbalization. In a study "Alterations in associative organization during brief hospitalization" (Berzofsky, Freedman, and Passik, 1988) the LAO was compared to the Brief Psychiatric Rating Scale (BPRS). A total of 48 subjects was used. The LAO does not purport to measure changes in symptomatology as defined by prevalent psychiatric nosology, rather, it reflects a patient's ability to symbolize or to cope with ambivalent promptings. The BPRS (Overall and Gorham, 1962) is a measure which reflects changes in level of symptomatology.

The LAO was applied to 5 minute speech samples obtained at admission and at discharge and identified a group of patients called integrators (N=12) and a group of patients called nonintegrators (N=20). They found that there were no discernible demographic or diagnostic differences which accounted for the differences between integrators and nonintegrators.

BPRS scores were obtained from independently scored records obtained at admission and discharge. This process was independent of the 5 minute monologues which were scored using the LAO. The records were scored for a total score on the BPRS and also for psychotic symptoms and nonpsychotic symptoms, (mainly anxiety). Analysis of covariance evaluated the BPRS scores as a function of integrators versus nonintegrators, (between groups) as well as a function of change, pre treatment versus discharge, (within groups).

It was found that all subjects, whether they showed associative integration or not, showed a decrease in terms of overall level of symptom intensity. A total score yielded a significant f value for pre/post score, $f = 36.18$, with no significant difference in regard to integrator/nonintegrator status. They obtained the same finding in separate analysis of psychotic and nonpsychotic symptoms.

The authors conclude that the LAO does not reflect changes in indices of psychopathology as the BPRS does.

According to the BPRS everyone gets better, however, according to the LAO, this is not the case. Similarly, change on global measures of adjustment, specifically the Global Assessment Scale (Endicott, Spitzer, Fleiss, and Cohen, 1976) was poorly correlated with reintegration of the associative process, ($R = 0.27$). The authors conclude that this finding suggests that reintegration is not a target symptom improvement or an overall improvement in terms of adjustment level. The LAO is a more discriminating evaluation of change and attempts to measure a process the authors call symbolization.

Freedman and Berzofsky (1995) further elaborated the concept of symbolization to include the type of symbolization that occurs in the transference. They state that "it is possible to give a relative theory-neutral account of transference phenomena in a clinical situation" (p. 364). Freedman and Berzofsky believe that it is the symbolized transference which is the basis for analytic and therapeutic work. Symbolization refers not just to talking i.e. spoken language, but the use of language through which the patient is able to communicate his transference wishes on to or into the therapist's consciousness. A symbolized transference occurs in relatively "not so difficult patients." A desymbolized transference may be characteristic of a more difficult patient.

This symbolization dimension of the transference was also given empirical support. Based on an empirical

approach to the study of the communicated transference (1992) Freedman and Berzofsky established an entity called a "difficult and not so difficult patient" regardless of diagnostic category. They concluded that the "not so difficult patients", the symbolizers, were able to articulate their message in a readily comprehensible fashion; they were able to communicate ambivalence, achieve narrative coherence by inserting a specification of intent, explicitly invoke the therapeutic relationship, use language which reflected attunement to inner promptings, were able to articulate aggressive promptings, and abstained from derailing by fragmented use of language. The "difficult patients", the non-symbolizers, lacked a coherent transference theme, were unable to communicate ambivalence, were unable to articulate aggressive promptings, had low specification of narrative intent, could only describe the therapeutic relationship implicitly or remotely from the events of the treatment situation, and had many instances of derailing or destructive use of language. Freedman and Berzofsky (1992) state that:

In having delineated a dimension of symbolization and desymbolization of the transference, we believe we have identified the specific treatment effect which characterizes the psychoanalytic form of treatment, and it is an effect which is shared by all major current analytic models" (p. 18). 1

The present study takes as its departure the notion that psychoanalytically informed therapy is concerned with symbolic construction. Symbolization is the process of connecting items of experience, of linking

ideas, thoughts and experiences to create meaning, a process that is common to all psychoanalytic approaches (Loewald, 1983). In the spirit of the foregoing contributions of Loewald, Jones, Klein, Ogden, Freedman, Berzofsky and others, the present author proposes that the process of symbolization is that psychological process which is shared by all major dynamic viewpoints and therefore, is a proposed vehicle to arrive at a common ground. Symbolization can be the language of common ground since making links is the goal of any psychoanalytic enterprise. To objectify this process is the aim of this present study.

There is a danger that symbolization is rooted in cognitive psychology (Werner and Kaplan, 1963) and linguistics (Jakobsen, 1960) with insufficient relevance to the clinical encounter. The term symbolization has been vaguely defined and has not been harnessed with a definition that makes it clinically useful. It is still broadly defined by clinicians as a way to form links between experiences. One of the tasks of the present study is to provide a more detailed definition of symbolization, to further elaborate the process of symbolization as defined by Freedman & Berzofsky, (1990), who developed their concepts using the Level of Associative Organization (LAO).

To arrive at a clinical and a more analytic conception of symbolization we must ask what are the components of

symbolization? What is being symbolized and how does the process occur? In order to respond to these questions, three components of symbolization will be addressed: symbolization of object relations, symbolization of narrative and symbolization of affect. These three components are critical to the change process and provide a more descriptive way of conceptualizing symbolization.

The term symbolization is chosen in preference to a word such as representation or experience because the concern is with the translation of the inner life into shared communicated speech, i.e. a shared symbolic code. In contrast, representations or experiences may be conscious or unconscious, private or shared, and do not specify if the phenomena are being communicated to another person. It is the process in which links are not only formed but also communicated that creates the foundation of the symbolization process. The process by which a patient uses language to create links and to communicate them in a clinical setting constitutes the symbolization process. The concepts of symbolization of object relations, symbolization of narrative and symbolization of affect will be further elaborated and explored in the following sections.

SYMBOLIZATION OF OBJECT RELATIONS

It is within the therapeutic encounter that the symbolizing transference as described by Freedman & Berzofsky (1995) occurs. It is in the clinical encounter

that a patient develops the ability to impart to the therapist the desire to be understood. The wish to be known by another is what creates the possibility for change. The importance lies in how patients translate their inner experience into a verbal code. It is the symbolizer who seeks to create meaning, as opposed to the non-symbolizer who wards off or destroys meaning, that fuels the clinical encounter, making it a vehicle for change.

What is being symbolized is not mathematics or world politics, rather, the material that is symbolized is representations of self, and representations of self in relation to objects. As many clinicians have proclaimed, internal object relations are a central constituent of any psychoanalytic process. The internalization of object relations has been central in psychoanalytic theory (Loewald, 1988; Greenberg & Mitchell, 1983). Through the process of internalization, object relations form intrapsychic structures that regulate and direct behavior. Freud wrestled with the question of how identifications with objects were internalized (1917, 1921, 1923). More recent psychoanalytic theory and research has focused on the role that early formative interpersonal relationships have on the formation of intrapsychic structures that form the representational world. The representations of self and other that are internalized are seen to shape and direct subsequent interpersonal relationships (Blatt and Lerner, 1983). Initially, a child's representations of

self and others are vague and undifferentiated. Such representations only gradually develop into consistent, enduring and relatively realistic representations that provide organization and coherence to the child's, and subsequently the adult's, experience and, thereby, provide a sense of identity (Mahler, Pine, & Bergman, 1975; Stern, 1985; Winnicott, 1965).

Most of the research that has been done to assess the quality of object representation has focused primarily on Rorschach responses, early memories and the manifest content of dreams (Blatt & Ritzler, 1974; Blatt, Brenneis, Schimek, and Glick, 1976; Blatt, Schimek, & Brenneis, 1980; Krohn, & Mayman, 1974; Mayman, 1967; Urist, 1977; Tuber, 1989). Blatt and his colleagues (1976) constructed measures to determine the quality of differentiation, articulation, and integration of human and human-like responses on the Rorschach. These measures have been used to demonstrate that patients with different types of psychopathology have consistent differences in the structure and content of their object representations (Blatt & Lerner, 1983). Mayman (1967) found that the quality of human responses on the Rorschach predicted clinical ratings of relative health or psychopathology depending on the complexity, differentiation and affect of the response. Urist (1977) developed the Mutuality of Autonomy Scale (MOAS), a seven point Rorschach scale that determines the degree of autonomy and differentiation

between self and other. Weston and his colleagues (1990) have developed the Object Relations and Social Cognition Scale to determine the quality of object relations from TAT stories.

These studies have all contributed support to the construct validity of object representations as a theoretical dimension that aids in our understanding of the developmental quality of individual interpersonal relationships and the experience of the self and the object world. Krohn and Mayman (1974) conclude that the "level of object representation appears to be a salient, consistent, researchable personality dimension that expresses itself through a relatively diverse set of psychological avenues ..." (p. 464), and stress the importance of assessing object relations in clinical research and practice.

Blatt, Wein, Chevron, & Quinlan (1979) were the first to use nonprojective measures to assess object relations. They analyzed open-ended descriptions of significant figures, particularly parents, and concluded that representations of parents lacking in nurturance, support and affection were related to depression in normal young adults. They conclude that it is necessary to study the changes that occur in qualitative and structural dimensions of representations in psychotherapy and that subsequent research should be concerned with investigating changes in representations of object relations in treatment. Leigh, Weston, Barends, Mendel & Byers (1992) have expanded

Weston's Object Relations and Social Cognition Scale to apply it to interview data. However, thus far, there has been a lack of application of their scales to psychotherapy transcripts or patient monologues.

A question that this dissertation is concerned with is what is the state of a patient's current state of internally experienced object relations as manifest in spoken language. Since all of the object relation scales thus far have been developed for projective material, early memories and the manifest content of dreams, with only limited application to structured interviews, it was necessary to develop the Symbolization of Object Relations Scale (SORS) to assess a patient's object relations from patient monologues and psychotherapy transcripts. The SORS is a 13 point scale which is a direct way to glean the quality of a patient's object relations from patient speech. The SORS is sensitive to changes within the internalized representations of object relations and not limited to a general stylistic dimension. The central idea is to determine the extent to which the patient can represent him/herself and others within the framework of relationships. The adaptation of the scale is presented in the method section.

SYMBOLIZATION OF NARRATIVE

Psychotherapy involves telling a coherent story, the revealing of one's inner dialogue. Narrativization of experience is an essential element of psychoanalytically

informed treatment. This often involves a patient's ability to transform a profound motivational system, including unconscious fantasy (Langs, Bucci, Udoff, Cramer, & Thomson, 1993), into spoken language.

How is narrative symbolized? Analytic psychotherapy is concerned with establishing continuity with experience whether past or present, conscious or unconscious, inside, or outside the consulting room of the therapist. Narrativization refers to the process by which a patient describes his/her subjective world (Essig, 1989; Bruner, 1986). More meaning can be generated through a narrative which is continuous and cohesive. The concept of narrativization of experience, creating a coherent story of one's mental life, has been a pivotal way of describing the therapeutic process and changes in a patient's clinical state (Shaffer, 1992; Spence, 1982). In general terms, narrativization refers to a narrative about one's biography, or the memory of one's past, or a narrative of one's current object representations. However, what we have in individual therapeutic sessions is not the whole biography, only a little window of discourse of the here and now.

This interest in narrative has led many clinicians and researchers to look at various aspects of how language is used to create a more complete picture of the subjective inner landscape. Researchers and clinicians have examined the content, form and structure of the narrative. Areas of

inquiry have focused on the meaning of the narrative, how the ideas are connected, how specific and clear the ideas are expressed, how the themes are organized and how much the speaker and listener are involved. There has been a great deal of research on the content of narrative.

Luborsky, (1977) developed the core-conflictual relationship theme method (CCRT) to describe patterns of wish, relationship, and conflict as it appears in the patient's narrative. Bruner (1986) describes how language functions in narratives with a special interest in how narrative discourse is not only a passive experience that guides readers, but it also provides an active experience as it invites readers to construct their subjective meaning of the text. Bruner (1986) applied a descriptive system developed by Todorov (1977) to demonstrate how one's understanding of a text is influenced by the subjective lens through which one views the text. Todd Essig (1989) adapted Bruner's method and applied a revised version to clinical transcripts to gain a better understanding of how patient and therapist struggle to gain access to the subjective experience and point of view of the other. Essig (1989) elaborated Todorov's concept of simple and complex transformations, and developed a coding system for classifying subjective relations between subjects and events in discourse, using the concepts of specification and predication. Essig's method will be adapted for use in the current study and is presented in the methods section.

In contrast to the focus on the content of narrative, there has been a great deal of interest in the structure and form of the narrative discourse. Steingart and Freedman (1972) examined the structural aspects of discourse and found that schizophrenic patients were more likely to speak in simple sentences of less hierarchical complexity of syntax than depressed patients. Singer & Wynne (1963, 1965) identified several structural problems such as disruptions, vagueness, irrelevance, and lack of closure as contributing to the difficulty in comprehending the discourse of schizophrenic speech. Gilani, Bucci, and Freedman, (1985) and Mahl (1987) were interested in the speaker's subjective experience by examining silences and pauses in psychotherapy. Bransford (1979) and Russell (1987b) investigated how entire fields of text were organized to create narrative discourse.

There are various other aspects of analyzing a discourse; however, the one that is most interesting, besides what has been described thus far, is the concept of "cohesive ties." Rochester and Martin (1979) used Halliday and Hasan's (1976) method for structural analysis of discourse, and found that narrative discourse seemed more incoherent when the discourse failed to contain semantic linking devices called cohesive ties. The "tie" is the link between one thought and another, and an important component of symbolization since symbolization is concerned with the process of linking.

According to Halliday and Hasan (1976), textual cohesion is obtained by semantic linking among structurally unrelated elements of discourse. Cohesion refers to the connection between different ideas within a text and occurs when the interpretation of one idea is dependent on information about another idea. An example is presented.

A. Did Karen take the car to the store?

B. No, she drove it to school.

The second sentence only makes sense in relation to the first sentence with "she" referring to "Karen" and "it" referring to "car."

It is the tie or link between the different elements which provides the cohesion. Ties allow for the listener to understand without unnecessary repetition of the referent. Instead of saying "Karen took Karen's book and put Karen's book on the shelf" a speaker, with the use of pronoun ties, can say "Karen took her book and put it on the shelf."

Linking ties provide for a continuity of ideas and create a flow of the narrative in which there are connections between words, sentences and themes. Halliday and Hasan's (1976) model for coding propositional cohesion suggests that certain types of usage can illustrate cognitive structuring and internalized representations. Their model, or Berman's (1985) adaptation to their model, can thus provide a method for examining the connection

between discourse structure, internalized representations and differing levels of symbolization.

Berman (1985) adapted Halliday and Hasan's (1976) method to make it more suitable to interactional analysis. Berman's method will be adapted for use in the current study and is presented in the methods section.

Cohesive linking devices have a quantitative and qualitative function. There could be a change in the overall quantity of cohesive ties used in a segment of text as well as a change in the quality of cohesive ties used. The different forms of linking devices include repetition, substitution and conjunction, which all reflect different levels of complexity. A tie used as repetition is the most simple of linking devices and based on the earliest acquired symbolic function of imitation (Piaget, 1962). Infants develop the capacity for imitation during the first year of life and apply it even before a real understanding is acquired (Bates, 1979). Steingart & Freedman (1972) found that repetition is more notable in thought-disordered patients who tend to have the most fragmented language and ego states. Conversely, Ragin & Oltmanns (1986) found that a decrease in repetition corresponded to a decrease in thought disorder.

A tie used as substitution is a more complex process and requires the ability to use an abstract vehicle such as a pronoun, demonstrative or comparative, to replace the referent. Pronoun use is usually acquired in the second

year of life when some degree of identity is achieved (Sharpless, 1974). The use of substitution implies some form of psychological differentiation and experience of separateness (Mahler et al., 1975).

A tie used as a conjunction implies an even more complex process since a conjunctive tie joins words, clauses, phrases, and sentences, and allows for more complex narratives involving causality, contrast and sequence to be constructed (Halliday & Hasan, 1976). This more complex process indicates an even greater differentiation between self and object (Steingart & Freedman, 1972).

Within the limits of an empirical study the notion of narrative will be further evaluated in the present study. To evaluate the quality of narrative, both the content as well as the form and structure of the narrative, the Symbolization of Narrative Scale (SONS) was developed (see methods section). The SONS measures a patient's ability to tell a coherent story and evaluates a patient's ability to shape his or her experience into a coherent form situating him/herself in a past and present context, reflecting specification, relating specific ideas of content and containing connective ties and links. All of which are prerequisites for symbolization or a dialogue which aims at a shared subjectivity. Furthermore, the ability to tell a coherent story is an ability that is likely to undergo

relative changes during treatment and thus might be a reflection of a patient's progress in treatment.

The development of the SONS was based on the idea that narrative has various sources. The scale consists of 4 components: linking structures, specification, narrative coherence and sentence structure. One part of the scale, specification, depends on Essig's (1989) work and includes an adaptation of his concepts of predication and specification. Another aspect of the scale, linking structures, depends on the work of Berman (1985) and includes an adaptation of her scale. In each case there has been an important adaptation. The manner in how both scales were adapted will be presented in the method section. Narrative coherence and sentence structure were created by the present author.

SYMBOLIZATION OF AFFECT

Finally symbolization, the creation of links, is important because it has bearing on the ownership of an experience, which is particularly significant in one's ability to experience and represent affect. In the clinical process, what matters is not just that an idea is symbolized but that the affect connected with the idea is symbolized, which will be referred to as the symbolization of affect. Ownership of affect is an important aspect of clinical prognosis because it involves the capacity to create links between an experience and feelings concerning the experience. Since it would be a formidable and impractical

task to undertake an adequate study of all affects, a decision was made on practical and theoretical grounds, and on earlier empirical research, to focus on the affect of aggression. The importance of aggression has best been pronounced by Hartmann (1953), who contends that the capacity to neutralize or deneutralize aggression has been a primary source of pathogenesis.

The focus on aggression in the present study is on the manner through which aggressive impulses can find their way in symbolized linguistic form. According to Gottschalk & Gleser (1969a), it is possible to distinguish empirically between aggression which is overt, covert or ambivalent, and whether it is turned inwards or outwards. It is proposed that in direct and overt aggression the aggressive wish is closer to consciousness and is owned, whereas in covert aggression, this is not the case. It is suggested that overt aggression is more closely related to the ownership of aggression, and therefore, is more closely linked to the symbolizing process.

Gottschalk and Gleser (1969a) have developed a method for the codification of aggressive affect with the Scale for Hostility, which examines various dimensions of hostility and which can be applied to the five minute monologue. It is expected that symbolization is most associated with the ability to own affect which will be reflected by the degree to which overt hostility is directed outward, or to the degree to which ambivalent

hostility is revealed. Non-symbolization is associated more with hostility directed inward and covert hostility directed outward. These concepts will be further explained in the method section.

Statement of Hypotheses

The mental functioning of a group of psychiatric inpatients will be evaluated in a paradigm study and in an in vivo study. It is hypothesized:

1) At the beginning of treatment, patients identified as symbolizers, non-symbolizers and non-symbolizer changers can be distinguished along specific lines of symbolizing activity.

1.1 At the beginning of treatment, symbolizers will demonstrate higher levels of symbolization of object relations than both groups of non-symbolizers.

1.2 At the beginning of treatment, symbolizers will demonstrate higher levels of symbolization of narrative than both groups of non-symbolizers.

1.3 At the beginning of treatment, symbolizers will demonstrate higher levels of symbolization of affect than both groups of non-symbolizers.

2) In the paradigm study, patients will show changes in the level of symbolization independent of initial trait characteristics.

2.1 At the end of treatment, the non-symbolizer changers will improve in their capacity to symbolize object relations.

2.2 At the end of treatment, the non-symbolizer changers will improve in their capacity to symbolize narrative.

2.3 At the end of treatment, the non-symbolizer changers will improve in their capacity to symbolize affect.

3) It is expected that in the "in vivo" case study approach, patients who are non-symbolizer changers will improve in their capacity to symbolize and will demonstrate increased symbolization of object relations, symbolization of narrative and symbolization of affect, within the therapeutic hour of an optimal treatment session.

Notes

1 Desymbolization was the term Freedman and Berzofsky (1992) used initially. Subsequently, they redefined their terms stating that "non-symbolization" is the inability to symbolize or to create meaning whereas "desymbolization" is a more active process of destroying meaning.

Methodology

Part I: Patterns of Change in the Symbolization of Object Relations and Narrative Over the Course of Short-term Psychodynamic Treatment.

Patients and Treatment Setting

All subjects used in the first part of the study were drawn from an existing archive of clinical data collected on an unlocked inpatient service of an inner-city acute inpatient psychiatric unit. Subjects were 2 males and 12 females admitted to the inpatient service between 1980 and 1987. The diagnosis of these patients included schizophrenia and major affective disorder. All patients were acute admissions and spoke English as their primary language. They ranged in age from 18 - 59 years. Patients diagnosed with Organic Brain Syndrome were excluded. Patients were from American and Caribbean Black, Caucasian, and Hispanic sub groups.

There were two subjects used in the second part of the study, one male and one female, who were hospitalized at the acute inpatient psychiatric unit during the Fall of 1992 and Spring of 1993. Both had the diagnosis of paranoid schizophrenia.

The inpatient psychiatric service, which is part of a larger medical center, is a 32 bed unit organized as a therapeutic milieu. Major treatment modalities include

some form of pharmacological intervention, group therapy, community meetings and three, 30 minute, individual psychotherapy sessions a week. The entire milieu of the treatment program is viewed as offering the patient a stabilizing context within which the individual psychotherapy takes place. The attitude of the nursing staff and the atmosphere of the community meeting are designed to convey an expectation that the patients participate in all aspects of the program. As they improve, patients are rewarded with assigned off-unit passes and privileges, and with responsibilities on the unit.

Individual treatment begins within a few days after admission. The duration of treatment ranges from four to eight weeks so that each patient receives approximately 12-24 psychotherapy sessions. The type of therapy that is conducted is psychodynamic psychotherapy. All therapists are advanced psychology trainees, either at or near the post-doctoral level, who receive supervision from supervising psychologists throughout the duration of each treatment. All experimenters who collected the battery of psychological measures, pre and post treatment, were trained graduate students, at the extern level, who received on-going supervision from trained supervising psychologists.

Once assigned to a research therapist, patients were asked to participate in a study of how people talk about

their problems. If they agreed, informed consent was obtained. Patients were allowed to stop participating in the study at any point. A copy of the consent form is in the Appendix E.

Primary Data Base: The Associative Monologue

A five minute monologue was the primary data of the first part of the study. Language samples obtained from the patients in the form of five minute monologues were administered at the beginning and at the end of treatment. The associative monologue, often referred to as the Gottschalk task (1969a), has been used in numerous studies in the past two decades as a technique to assess a patient's state of mind, (1969a). The Gottschalk method involves a five minute audio-recorded speech sample in which the subject is asked to speak about whatever comes to mind. The subject does so in the presence of an interested listener who does not respond other than to encourage continuation with the task. The monologue is then transcribed. The methodology has the advantage of being easy to administer and is independent of the therapy process itself. Nonetheless, it comes as close as possible to the natural communicative process which is vital for psychotherapy.

The five minute associative monologue is considered to be an estimate of the patient's state of mind at the beginning and end of treatment. Previous studies (Essig, 1989) have shown that the 5 minute monologue is an estimate

of the patient's state of mind as it is revealed in the therapeutic hour.

Measures

Four different instruments were used for this study. Two of them, the Symbolization of Object Relations Scale (SORS) and the Symbolization of Narrative Scale (SONS) were developed for the current study by the present author. The Gottschalk and Gleser Hostility Scale is a well established clinical rating scale. The Level of Associative Organization (LAO) is a measure developed by Berzofsky and Freedman (1988). In the first part of the study the LAO was used to determine the three groups: symbolizers, non-symbolizers and non-symbolizer changers. The SORS, SONS and the Gottschalk Scale were applied to the monologue data which was collected between 1980 and 1987. In the second part of the study the SORS and SONS were applied to the psychotherapy data collected between 1992-1993.

Adaptation of Scales

1) The Symbolization of Object Relations Scale

Symbolization of object relations were inferred and judged from the five minute monologues by using the Symbolization of Object Relation Scale (SORS). The scale was developed by the present author to assess the quality of object relations within the therapeutic mode. The questions are geared to determine how well a patient can represent others, how well a patient can represent

him/herself in interaction with others, how well a patient can represent an interaction between others, whether the relationship is cast in the past or present, and whether the patient can articulate conflict towards the other.

Validity was established by two trained psychologists trained in the study of communication in psychoanalysis and psychotherapy. The scale items were developed based on the literature and the judgement of the present author of how people convey object relations. Validity was established in the following way. The initial scale of 6 items was presented to the two senior clinicians who were authorities in defining and evaluating symbolization of object relations and who have had experience evaluating 5 minute monologues and therapy sessions. The two senior clinicians and the present author worked to further define and elaborate the items which resulted in an expanded scale which contained 9 items. These items were applied to a protocol by the clinicians, which resulted in disagreement over the scoring. This was processed and items were further elaborated. Approximately four such revisions took place and resulted in a final scale of 13 items. Both the present author and the two senior clinicians reached an agreement that each of the 13 items on the scale reflected an aspect of a patients ability to symbolize object relations and that the scoring accurately reflected differing levels of symbolization of object relations. A high score reflects a high level of symbolization of object

relations and a low score reflects a low level of symbolization of object relations.

Reliability was established by 1 psychologist and 2 psychology fellows who were trained as coders for the Symbolization of Object Relations Scale. Initially two coders rated a subset of monologues using the SORS. Discrepancies in scoring between the two judges were resolved through a discussion to reach consensus. The consensus scores were subsequently used as the scoring criteria and were used to obtain interrater reliability with a third coder. An Alpha co-efficient obtained by the coders for reliability was 0.97. Coders were blind as to the patient identity and the pre and post status of the transcripts. The scale consists of 13 items which can receive either a score of 1 or 0. The highest score obtained is 13. A higher score reflects more development in a patient's ability to symbolize object relations. See Appendix A for the scale and scoring manual.

2) The Symbolization of Narrative Scale

Symbolization of narrative was inferred and judged from the five minute monologues by using the Symbolization of Narrative Scale (SONS). The scale was developed by the present author to assess the quality of narrative within the therapeutic mode. The questions are geared to determine how well a patient can translate his/her experience into a coherent narrative.

The four components of the scale are 1) Linking Structures, 2) Specification, 3) Narrative Coherence, and 4) Sentence Structure. Linking Structures is composed of an adapted version of Berman's scale (1993), which was an adapted version of Halliday and Hasan's scale (1976). The present author's adaptation is presented below.

Specification consists of an adaptation of Todd Essig's (1989) coding system and is explained below. Narrative Coherence addresses the general quality of the narrative. The narrative coherence is reflected by a summary statement which determines the quality of thematic cohesion within the narrative as being either good, fair or poor. Good cohesion reflects a coherent narrative with few developed themes. Fair cohesion reflects a loosely connected narrative with many themes that are not developed. Poor cohesion reflects a barren, tangential narrative without any development. Sentence structure addresses the general quality of the sentence. The sentence structure is reflected by a summary statement that determines the quality of the sentence structure within the narrative as being either good, fair, or poor. Good sentence structure reflects a narrative with grammatically correct and complex sentences. Fair sentence structure reflects a narrative with a mixture of grammatically correct, fragmented and run on sentences, and a mixture of simple and complex sentences. Poor sentence structure reflects a narrative

with fragmented, run on sentences with poor grammar, and mostly simple sentences.

Adaptation of Essig's Coding System

Essig's (1989) coding system and the use of specifications and predications was adapted as part of the Symbolization of Narrative Scale. Since both specifications and predications function as a way to elaborate a subjective relationship between a subject and an event, the present author has combined both concepts under the category of specification: which consists of two subgroups: A) specification of intent and B) specification of predication.

A. Specification of intent requires the presence of a grammatical subject, an event and some linguistic link, either an adverb, auxiliary verb or a prepositional phrase that specifies the relation between the subject and event. These links provide for a richer narrative by highlighting the subjective, intentional state of the subject. For example, consider the statements 'She went to school' and 'She wanted to go to school'. The later statement contains the specification of intent wanted and specifies more clearly the subject's relation to the event.

The following list defines each of the four specification of intent subtypes. The present author combined Essig's categories of aspect, result, initiation and duration into one category labeled temporal

perspective. The category that was deleted from Essig's list was manner. The category he called intent was changed to "desire."

Mode. The event is contingent on the idea of possibility and recognized by the auxiliary verbs might, must, could, would, or should.

The examples are - She might go away. She should go away.

Desire. The event is presented as the subject's intention, will or desire recognized by the verbs want, hope, plan, try.

The examples are: She hoped to go away. She tried to go away.

Degree. The subject's degree of participation is specified by adverbs and adjectives such as really and kind of.

The examples are: She really wanted to go away. She kind of wanted to go away.

Temporal perspective. The event is described in a temporal sense by specifying the action as beginning, finished or happening in the present.

The examples are: She is going away. She started to go away. She finished going away.

A temporal perspective not measured by clocks or calendar is demonstrated by the use of adverbs such as never and occasionally.

The examples are: He never went away. He occasionally went away (1989, p. 45-46).

B. Specification of predication involves the addition of a verb phrase so that there is always more than one grammatical subject. These are more complex statements that contain the agent of the event being talked about and the subject of the added verb phrase whose subjectivity is being commented upon. In these more complex statements, there is a greater interplay between events, actors and the actors' subjective experience or point of view. It is a way to comment on or to relate the actions or experiences of one person to him/herself or to someone else. A subject relates the actions of him/herself or of another person to him/herself or to another person by using a direct quote, or speculating on his/her performance in the present, past or future. A subject is usually reflecting or commenting on the action or experience of him/herself or another person and considering what kind of effect it has had on him/herself or on someone else.

Essig's seven categories, (Appearance, Knowledge, Description, Supposition, Subjectivation, Attitude, and Entreaty) have been combined by the present author into one category called "inner reflections of self and other." This category embraces the principle that all

predications represent some form of inner dialogue of the speaker, or state of reflection, where the speaker is, or is becoming, aware of himself or another person and communicates this information. For example, consider the statement "I realized that she wanted to go away". The addition of the new verb phrase "I realized that" to "she wanted to go away" indicates that the speaker gained an awareness of the "going away" event. This statement emphasizes the speaker's acquisition of awareness of the event, rather than the simple fact that it took place. The following list contains examples of predication subtypes of the category "inner reflections of self and other".

Inner reflections of self and others

a) There can be distinctions between being and seeming. Examples are: I pretended to love him. She pretended to love him.

b) The subject learns, does cognitive work to acquire knowledge or awareness of some other event. Examples are: She learned that he never loved her. His frown showed her how sad he was.

c) The subject transmits knowledge of an event to him/herself or to another subject. Examples are: She said to herself 'I do not love him'. She told him that she did not love him.

d) The subject has an awareness of knowledge of a perspective towards an event located in the future. Examples are: She thinks she will win. She thinks he will win.

e) The subject has an opinion about an event that is happening in the present. Examples are: She thinks she is winning. She thinks he is winning.

f) A perspective towards an event is formulated and the content of that perspective is the result of the event. (enjoyed, disliked). Examples are: I was confused when he left me. He thinks that he was confused when she left him.

g) A subject expresses an intention, wish, desire that is linked to the action of some other subject. Example: I want you to go to the store (1989, p. 47-48).

Adaptation of Berman's scale

For reasons of simplification, the present author combined many of Berman's categories into more general categories which contained a unifying principal. Since the categories of Lexical Reiteration and Lexical Collocation contain the principal of repetition, the present author

combined them into the category of repetition. The principal of repetition is when the speaker uses the same word, a synonym, or a near synonym, to represent the subject. The example is "I bought a table. The table was big."

Since Berman's categories of Pronominal, Demonstrative and Comparative Reference, Nominal, Verbal and Clausal Substitution, and Nominal Verbal and Clausal Ellipsis all express the principle of substitution, the present author has condensed these categories into the category of substitution. The principal of substitution is: instead of repeating the subject, the speaker makes reference to the subject by using other words as substitutes. The example is: Jane went to school. Later she went to the gym.

The present author has maintained all of Berman's categories of conjunctions but has broken down the additive category into additive complex and additive simple. The principal of conjunctive ties is: connecting thoughts and ideas with conjunctive ties either by similarity, contrary to expectation, by causal relation or by a temporal sense. The example, using a causal conjunctive tie, is: The gym was closed. So she went to the library. The entire scale is presented in Appendix B.

Validity was established by two psychologists trained in the study of communication in psychoanalysis and psychotherapy. The scale was developed based on previous existing scales (see adaptation of scales) by the examiner

and collaborated by clinical judgement. The process was a belabored one with many discussions with the two senior clinicians who were establishing validity. Each part of the scale was developed separately and then presented to two senior clinicians who are authorities defining and evaluating symbolization of narrative and who have had experience evaluating 5 minute monologues and therapy sessions. After many revisions with many deletions and additions, the final scale was presented for review to the two senior clinicians. The final scale was independently judged, by these two clinicians, to measure higher and lower levels of the ability to symbolize narrative.

Reliability was established with trained psychology graduate students at the Masters level. Coders were trained on a subset of monologues till they reached criteria level of reliability. Then interrater reliability was established using the pre-treatment monologues. The Alpha reliability coefficients obtained are presented in table 1.

Table 1

<u>SONS Variables</u>	<u>Alpha Reliability Coefficients</u>
Repetition	.96
Substitution	.95
Additive Simple	.97
Additive Complex	.82
Adversative	.98
Causal	.99
Temporal ties	.86
Mode	.95
Desire	.99
Degree	.63
Temporal Perspective	.96
Predication	.86
Narrative Coherence	.77
Sentence Structure	.63

All of the 5 minute monologues for all three groups, pre and post were scored by 2 trained psychology graduate students at the Masters level. Coders were blind as to the patient identity and the pre and post status of the transcripts. The scale was scored by counting up the number of instances of Linking Structures and Specifications within each monologue, scoring all

sentences, sentence fragments, and idea units. A summary statement of either good, fair or poor was given for Narrative Coherence and Sentence Structure. Good received a score of 3, fair received a score of 2 and poor received a score of 1. A higher score reflected a more developed and cohesive narrative. A lower score reflected a less developed and cohesive narrative.

3) Symbolization of Affect - the Gottschalk and Gleser Hostility Scale.

The Gottschalk and Gleser Hostility Scale is one of numerous scales developed for the assessment of psychological states. It has been used extensively in psychological research (Gottschalk, 1969). The scale consists of 4 subscales: Overt Hostility Outward, Covert Hostility Outward, Hostility Inward, and Ambivalent Hostility.

The hostility directed outward scale represents a continuum that varies from a denial of hostility, through references to anger without an object, to hostility toward a situation or inhuman objects, and finally to varying degrees of hostility toward human beings. There is a range of expression from mild dislike or criticism of an individual to stronger expressions of verbal aggression and physical violence. Overt hostility directed outward is when the speaker is the one who is represented having or verbalizing hostile feelings. A category is "Self killing,

fighting, injuring other individuals or threatening to do so" (p. 64). An example is: I used to fight with her.

Covert hostility directed outward is when others are represented as the hostile agents or passive recipients while there is denial of hostile feelings in speaker. A category is "Others (human) killing, fighting, injuring other individuals or threatening to do so" (p. 64). An example is: She just pushed him away.

Hostility directed inward is when the speaker makes statements that are self-critical, self destructive, or self punishing. An example is: I want to hurt myself.

Ambivalent Hostility is when others are described as being destructive, injurious, or critical (including situations and objects) of self. There can be some overlap with ambivalent hostility and overt hostility. An example is: She is threatening to fire me.

Construct validation studies have been done on Hostility Inward and Hostility Outward and have revealed significant correlations with other clinical, psychometric and biological measures of hostility (Gottschalk, 1976). Hostility Outward has been positively correlated with hostility items on the Wittenborn Rating Scales for psychiatric inpatients (1955), the assault subscale of the Buss Inventory (1957), and the Oken (1960) hostility rating scales for psychiatric outpatients. It is negatively correlated with the Beck Depression Inventory (1961). Hostility Inward has been positively correlated with items

related to depression on the Wittenborn rating scale (1955) and with the Beck Depression Inventory (1961). Ambivalent hostility of psychiatric inpatients has been positively correlated with scores for aggression on the Wittenborn Rating Scales and with scores for hostility, negativism, and suspicion on the Buss Hostility Scales (1957).

A psychology graduate student who had prior experience using the Gottschalk Scale (Murphy, 1993) scored the 5 minute monologues using the 1969 training manual. Four separate hostility scores were obtained using the formula suggested by Gottschalk and Gleser for weighting intensity of hostility, which was calculated by computer using the following formula:

$$100 (f_1W_1 + f_2W_2 + f_3W_3 + \dots + f_nW_n + 0.5) / N$$

with F_n = frequency per unit of time of any thematic reference, with W_n = weight for each statement, and with N = number of words per unit of time. $100/N$ is the correction factor. The 0.5 factor is added to avoid discontinuity when there are no scoreable items in a given subscale. The final score is obtained by taking the square root of the number obtained with the formula above.

4) The Level of Associative Organization (LAO)

The LAO is an instrument developed by Berzofsky and Freedman (1988) which has four components: A) the capacity

to represent self and object, B) the capacity for symbolic representation, C) the capacity to tolerate ambivalent affective experiences, and D) the capacity to articulate self-experience. It has been shown in previous studies (Berzofsky and Freedman, 1990) that the B and C scales of the LAO (B - the capacity for symbolic representation and, C - the capacity to tolerate ambivalent affective experience) give an estimate of the patient's symbolizing ability. (See appendix for LAO coding criteria).

The LAO has not been validated, however, it reveals high correlations with other language measures including cognitive referential activity and narrativization in language (Berzofsky and Freedman, 1990), and with depression subscale measures of the Gottschalk Content Analysis Depression Scales (Murphy, 1993).

Procedures

Procedures for the collection, organizing and rating of the monologues.

All monologues for the first part of the study were collected between 1980 and 1987. A few days after patients agreed to be in the study, they were given an audio recorded clinical interview by an experimenter which focused on their adjustment to the hospital. At the end of the interview, which usually lasted 15 minutes, the patient was instructed as follows:

Now that we have talked together for a while, I'd like you to speak for about five minutes about anything you

want to talk about. You can talk about what brought you to the hospital, or just talk about anything that is important to you. I'll be sitting here listening to you but I won't interrupt. This is your time to talk about what is on your mind, what is important to you.

The experimenter remained quiet and would only offer encouragement to continue if the patient stopped talking.

Prior to discharge, the clinical interview and monologue were given again using the same procedure. The audiotapes were then transcribed by an experimenter using a common sense rendering of punctuation and grammar.

Repetitions, pauses, and false starts were included.

The five minute monologues were scored by trained psychology students and psychology fellows using the Level of Associative Organization (LAO). Coders were blind as to the patient identity and the pre and post status of the transcripts. A gamma co-efficient obtained for interrater reliability was .86 (Berzofsky and Freedman, 1990).

In the first part of the present study, a sub-sample was selected from the larger sample of available cases that completed treatment, $N=27$, on the basis of two criteria determined from the LAO scoring: 1) whether the patients are symbolizers or non-symbolizers at the beginning of their treatment, and 2) in the group of non-symbolizers whether the patients are changers or non-changers at the end of their treatment. Clinical experience has actually indicated that there may be two kinds of patients who show failure to symbolize at the beginning of treatment, those who are truly resistive to change and those who may show an

increase in symbolization in the course of treatment. As a good estimate of this potential, the overall change on the LAO measure was used to discriminate low LAO patients, non-symbolizers, who did and did not change over the course of treatment. Two groups were distinguished which were termed non-symbolizers non-changers and those who were identified as non-symbolizer changers.

The N=27 was selected from an N=48 that was used in Berzofsky and Freedman's 1988 study. Of the N=48 there were no discernible demographic or diagnostic differences among the patients when accounting for age, marital status, sex, precipitating factors, outpatient treatment status, number of previous hospitalizations, and DSM III diagnosis. The symbolizers and non-symbolizers were determined by their scores on the LAO at the beginning of their treatment. The symbolizers were patients who obtained an average score equal to or greater than 2.5 on the LAO. The non-symbolizers are patients who obtained a score less than 2.5 on the LAO.

The non-symbolizers non-changers and the non-symbolizer changers were determined by their scores on the LAO at the end of their treatment. The non-symbolizer changers were that group defined by an overall increase of change equal to, or greater than, 5.5 points distributed among the LAO scales. The non-symbolizers non-changers were defined by a magnitude of change equal to zero distributed among the scales. The 14 subjects selected for

the present study were those who met these criteria. Thirteen patients of the N = 27 did not meet criteria and were not used. It was demonstrated in a previous study (Freedman et al 1988) that the symbolizers and the non-symbolizers had similar Brief Psychiatric Rating Scale scores at admission, illustrating that severity of illness is not the issue; both the symbolizers and non-symbolizers had similar amounts of pathology.

Overall there were three groups (A) symbolizers, = 4 patients, (three female and one male), (B) non-symbolizer changers = 6 patients (five females and one male) and (C) non-symbolizers = 4 patients (four females). There were 14 subjects total. The symbolizing variables were independent of DSM III-R diagnosis. (See chart of patient statistics in the Appendix D).

Application of scales to data

One of the coders, a female psychology fellow, who obtained reliability on the SORS, scored all of the pre and post 5 minute monologues for all three groups:

1) symbolizers, 2) non-symbolizers non-changers and 3) non-symbolizer changers using the Symbolization of Object Relations Scale. The scale consists of 13 items which can receive either a score of 1 or 0. The highest score that can be obtained is 13. A higher score reflects a more developed capacity for symbolization of object relations. The coder was blind as to the patient identity, the pre and

post status of the transcripts, and blind to the topic and hypothesis of the study. See appendix A for the scale.

One of the coders who obtained reliability on the SONS, a female graduate student at the masters level, scored all of the pre and post 5 minute monologues for all three groups. The coder was blind as to the patient identity, the pre and post status of the transcripts and was blind to the topic and hypothesis of the study. The scale was scored by counting up the number of instances of Linking Structures and Specifications within each monologue, scoring all sentences, sentence fragments, and idea units. A summary statement of either good, fair or poor was given for Narrative Coherence and Sentence Structure. A higher score reflects a more developed and cohesive narrative.

Part II From Non-symbolization to Resymbolization during Short-term Psychotherapy: The Therapy Session Study.

Procedures for the collection, organizing, and rating of the sessions.

The first part of this study was to establish patterns of change over the course of short-term inpatient psychotherapy based on an associative monologue given at the beginning and at the end of treatment. One of the most challenging questions raised by the first part of the study

is whether a patient identified as a non-symbolizer will show resymbolization, and furthermore, to investigate such psychic change in the course of psychotherapeutic treatment. The purpose of the second part of the study was to validate the observations of the first part of the study by relying on actual psychotherapy transcripts.

The sessions were conducted by psychology fellows who received ongoing weekly supervision by supervising psychologists. The type of therapy that was conducted was psychodynamic treatment. All therapy sessions were audiotaped.

This method focuses on the detailed analysis of the treatment course of 2 inpatients who have completed treatment. Each of these patients were identified on the basis of clinical ratings by the therapist at the time of intake to show the attributes of non-symbolization: lack of narrative, lack of object representation, low on representation of affect. The patients selected were rated on the basis of clinical observations that show that the patients have made significant changes, by the therapist in collaboration with her supervisor, over the course of treatment. The selection process was governed by the fact that the patients were chosen because they made changes, rather than change being a finding. What is different in this method is the ability to pinpoint change in the session itself rather than using the monologue to predict

when the change occurred. To accomplish the objectives of this study various steps were undertaken.

The Scan of the Treatment Process

The first step was dictating the post session commentary. Each of the therapists were trained by one of the supervising psychologists to give post session commentaries after each session. The therapist's commentaries evaluate the session and include the following:

- a) the quality of affect - the ability of patient to articulate his feelings. Is the affect all good, all bad or is the patient able to represent ambivalence.
- b) the quality of narrative coherence - how clearly can the patient articulate, does the narrative hang together or is it fragmented and disjointed.
- c) quality of object relations - how well can the patient speak about the people in their lives, in detail involving significant relationships, or are the relationships vague and undefined.
- d) quality of the relationship to the therapist - does the patient speak of the therapist at all and are there any transference themes articulated.
- e) The reactions of the therapist towards the patient -any countertransference themes.
- f) Any major interventions tried - did the therapist try to understand, make an interpretation, a clarification, and what is the patient's reaction.

g) Things the therapist thought of doing but did not.

h) Any major change from the previous session.

After each of the therapists reached consensus with the supervisor psychologist on the variables listed above, they were instructed to dictate their post session commentaries into the tape recorder, after each therapy session, onto the audiotape that recorded the therapy session. After the treatment was completed, all of the post session commentaries dictations, from each therapy session, were then combined on a single tape, in chronological order, starting with the first commentary and ending with the last one. This made it possible to listen to all of the post session commentaries at once, in a time span of an hour or so, and to glean the highlights of the treatment process.

Three research clinicians then listened to the post session commentaries. They evaluated the course of treatment by rating the post session commentaries and charting out the course of change within the treatment. They then selected the marker sessions by reaching consensus. The marker sessions were those sessions whose post session commentaries demonstrated that either change had taken place along the variables a - h listed above (resymbolization) or that no change has taken place (non-symbolization). After the criterion sessions reflecting non-symbolization and resymbolization were selected they were transcribed. The transcript of each session selected

was arranged into 5 minute windows yielding between 5-7 windows per session. Each window was scored using the LAO. Only the third and fourth 5 minute windows were scored using the Symbolization of Object Relations Scale and the Symbolization of Narrative Scale. This method enabled a determination of not only the pattern of change but when in the session the change occurs.

The therapy study was concerned with replicating the results found in the monologue study.

RESULTS

A total of 14 subjects were used in the monologue study. There were 4 subjects in the symbolizer group, 4 subjects in the non-symbolizer non-changer group, and 6 subjects in the non-symbolizer changer group. The paradigm study will be referred to as the monologue study. The monologue data consists of 28, 5 minute samples, consisting of 2 monologues from each of 14 patients; one monologue collected at intake and one monologue collected at discharge.

A total of 2 subjects, who are both defined as non-symbolizer changers, were used in the "in vivo" study which will be referred to as the therapy transcript study. In the therapy transcript study 2 therapy sessions from each patient were used. For both patients, a therapy session was collected at the beginning of treatment and a therapy session was collected during treatment, at a time when it had been determined the patient has made a significant change (the "peak session"). Each of the 30 minute sessions were then broken down into 6 segments consisting of 5 minutes each and resulted in a total of 24, 5 minute samples. The Level of Associative Organization (LAO) was used to score all 24 segments. The third and fourth 5 minute segments, of the initial and peak therapy sessions, were scored using the Symbolization of Object Relations Scale (SORS) and the Symbolization of Narrative Scale

(SONS). The therapy transcript data consists of a total of 8 five minute windows, 4 from each non-symbolizer changer, that were scored using the SORS and the SONS. These scores were then compared to the results obtained from the monologue study.

Hypothesis #1.

It was hypothesized in the paradigm study that: At the beginning of treatment, patients identified as symbolizers, non-symbolizers and non-symbolizer changers can be distinguished along specific lines of symbolizing activity:

1.1 It was predicted that at the beginning of treatment, symbolizers will demonstrate higher levels of symbolization of object relations than both groups of non-symbolizers.

A One-way Analysis of Variance was used to compute significance between the three groups on the Symbolization of Object Relations Scale at pre-treatment. Results revealed that at pre-treatment there was a significant difference between groups, [$F(2,11) = 13.53, p < 0.001$]. The symbolizers were significantly different from both groups of non-symbolizers. Means and standard deviations for each of the three groups are presented in table 2.

Table 2

Means and Standard Deviations for Symbolizers, Non-symbolizers, and Non-symbolizer Changers on the Symbolization of Object Relations Scale at pre-treatment, [n = $F(2,11) = 13.53, p < 0.001$]

	X	SD
Symbolizers	9.25**	3.09
Non-symbolizers	2.00	1.41
Non-symbolizer changers	3.66	1.63
** [$F(2,11) = 13.53, p < 0.001$].		

Thus, the symbolizers could be distinguished from non-symbolizer changers and non-symbolizer non-changers at the beginning of treatment on the dimension of symbolization of object relations. As predicted, at pre-treatment, the symbolizers demonstrated a higher level of symbolization of object relations than both groups of the non-symbolizers.

1.2 It was predicted that at the beginning of treatment, symbolizers will demonstrate higher levels of symbolization of narrative than both groups of non-symbolizers.

One-way Anovas were conducted to compare the three groups on fourteen variables of narrative to distinguish a difference between groups at pre-treatment. Results revealed that at pre-treatment there was a significant difference between groups on the variables of repetitional linking ties, [$F(2,11) = 7.06, p < 0.01$] and causal conjunctive linking ties, [$F(2,11) = 6.84, p < 0.01$]. The

symbolizers were significantly different from both groups of non-symbolizers in that they used more repetitional linking ties and more causal conjunctive ties at the beginning of treatment. Means and standard deviations for each of the three groups are presented in table 3.

Table 3

Means and Standard Deviations for Symbolizers, Non-symbolizers, and Non-symbolizers Changers on the Symbolization of Narrative Scale at pre-treatment. [F (2,11) = 7.06, p < 0.01] [F 2,11) = 6.84, p < 0.01]

	X	SD
<u>Repetitional Ties</u>		
Symbolizers	25.25**	8.34
Non-symbolizers	5.50	4.72
Non-symbolizer changers	8.17	9.70
**[F (2,11) = 7.06, p < 0.01]		
<u>Causal Conjunctive Ties</u>		
Symbolizers	13.00**	8.83
Non-symbolizers	1.25	1.50
Non-symbolizer changers	3.00	2.36
**[F (2,11) = 6.84, p < 0.01]		
<u>Substitutional Linking Ties</u>		
Symbolizers	30.50	3.96
Non-symbolizers	16.48	17.85
Non-symbolizer changers	14.33	11.53
<u>Additive Simple Ties</u>		
Symbolizers	23.00	5.88
Non-symbolizers	14.25	12.37
Non-symbolizer changers	16.50	10.03
<u>Additive Complex Ties</u>		
Symbolizers	1.00	1.41
Non-symbolizers	0.75	0.96
Non-symbolizer changers	0.33	0.51
<u>Adversative Ties</u>		
Symbolizers	7.25	4.19
Non-symbolizers	4.50	5.07
Non-symbolizer changers	6.83	8.63

Table 3 (cont.)

	X	SD
<u>Temporal Ties</u>		
Symbolizers	6.00	4.08
Non-symbolizers	1.00	0.82
Non-symbolizer changers	2.17	2.04
<u>Mode</u>		
Symbolizers	4.50	2.08
Non-symbolizers	5.00	5.72
Non-symbolizer changers	4.33	2.73
<u>Desire</u>		
Symbolizers	4.00	4.76
Non-symbolizers	3.50	3.10
Non-symbolizer changers	4.50	4.18
<u>Degree</u>		
Symbolizers	2.75	2.63
Non-symbolizers	3.00	2.58
Non-symbolizer changers	1.33	1.50
<u>Temperal Perspective</u>		
Symbolizers	8.50	11.79
Non-symbolizers	0.75	1.50
Non-symbolizer changers	0.33	0.82
<u>Predications</u>		
Symbolizers	12.25	3.59
Non-symbolizers	4.25	4.03
Non-symbolizer changers	6.83	5.56
<u>Narrative Coherence</u>		
Symbolizers	2.00	0.00
Non-symbolizers	2.75	0.50
Non-symbolizer changers	2.50	0.55
<u>Sentence Structure</u>		
Symbolizers	2.25	0.50
Non-symbolizers	2.50	0.58
Non-symbolizer changers	2.83	0.41

Thus, as predicted, the symbolizers could be distinguished from non-symbolizer changers and non-symbolizer non-changers at the beginning of treatment on

the dimension of symbolization of narrative on the variables of repetitional linking ties and causal conjunctive ties. At pre-treatment, the symbolizers used more repetitional linking ties and causal conjunctive ties than did both groups of non-symbolizers.

The symbolizers seemed to demonstrate higher means on seven other variables of narrative, yet the f values were not significant. The symbolizers had higher means than both groups of non-symbolizers on the variables of substitutional linking ties, additive simple ties, additive complex ties, adversative ties, temporal ties, temporal perspective, and predications; however, the f values were not significant. Only for the variables of substitutional linking ties, additive simple ties, temporal ties and temporal perspective was the mean value of the symbolizers substantially greater than both groups of non-symbolizers.

1.3 It was predicted that at the beginning of treatment, symbolizers will demonstrate higher levels of symbolization of affect than both groups of non-symbolizers.

One-way Anovas were conducted to compare the three groups on four variables of affect to distinguish a difference between groups at pre-treatment. No two groups are significantly different at the 0.05 level. Means and standard deviations for each of the three groups are presented in table 4.

Table 4

Means and Standard Deviations for Symbolizers, Non-symbolizers, and Non-symbolizers Changers on the Gottschalk and Gleser Hostility Scale at pre-treatment.

	X	SD
<u>Hostility Inward</u>		
Symbolizers	176.50	56.55
Non-symbolizers	153.25	62.97
Non-symbolizer changers	227.67	127.16
F (2,11) = 0.7846, n.s.]		
<u>Ambivalent Hostility</u>		
Symbolizers	189.50	64.91
Non-Symbolizers	134.50	83.77
Non-symbolizer changers	187.00	23.33
F (2,11) = 1.24, n.s.]		
<u>Overt Hostility Outward</u>		
Symbolizers	211.50	48.31
Non-Symbolizers	186.75	97.12
Non-symbolizer changers	174.00	56.29
F (2,11) = 0.36, n.s.]		
<u>Covert Hostility Outward</u>		
Symbolizers	169.00	45.74
Non-Symbolizers	134.25	70.20
Non-symbolizer changers	203.00	45.31
F (2,11) = 2.01, n.s.]		

Hypothesis #2

In the paradigm study, it was predicted that patients will show changes in the level of symbolization independent of initial trait characteristics:

2.1 It was predicted that at the end of treatment, the non-symbolizer changers will improve in their capacity to symbolize object relations.

T-tests for paired samples were done to compare the ability to symbolize object relations at post treatment,

independent of initial trait characteristics. There was a significant main effect at post treatment, $t(2,11) = 2.65$, $p < 0.045$]. The non-symbolizer changers resembled the symbolizers and these two groups were significantly different from the non-symbolizers non-changers. Means and standard deviations for each of the three groups are presented in table 5.

Table 5

Means and Standard Deviations for Symbolizers, Non-symbolizers, and Non-symbolizers Changers on the SORS at post treatment [$n = T(2,11) = 2.65$, $p < 0.045$]

	X	SD
Symbolizers	9.25	2.75
Non-symbolizers	3.25	1.50
Non-symbolizer changers	7.33*	3.56
* $T(2,11) = 2.65$, $p < 0.045$]		

2.2 It was predicted that at the end of treatment, the non-symbolizer changers will improve in their capacity to symbolize narrative.

One-way Anovas were conducted to compare the three groups on fourteen variables of narrative to distinguish a difference at post treatment, independent of initial trait characteristics. At post treatment there was a significant main effect on the variable of Narrative Coherence, [$F(2,11) = 9.21$, $p < 0.005$] and on the variable of Temporal Conjunctive Ties, [$F(2,11) = 5.65$, $p < 0.023$]. The

symbolizers and non-symbolizer changers had significantly higher levels of narrative coherence and used more temporal conjunctive ties than the non-symbolizer non-changers.

When the variable of substitutional linking ties was combined with the variable of repetitional linking ties (SRLT) there was a significant main effect, [$F(2,11) = 4.55, p < 0.04$]. The symbolizers and non-symbolizers changers used repetitional and substitutional linking ties (linking structures) significantly more than the non-symbolizers non-changers.

When the variables repetitional linking ties, substitutional linking ties and mode (specification of intent) were combined (RSM) there was a significant main effect, [$F(2,11) = 4.44, p < 0.042$], meaning that the symbolizers and non-symbolizers changers used repetitional and substitutional linking ties and mode significantly more than the non-symbolizers non-changers.

The symbolizers and the non-symbolizer changers had substantially higher means than the non-symbolizers non-changers on ten of the narrative variables such as: repetitional ties, causal conjunctive ties, substitutional linking ties, additive simple ties, additive complex ties, adversative ties, mode, temporal perspective, predications, and sentence structure; however, the f values were not significant. The Means and standard deviations for each of the three groups are presented in table 6.

Table 6

Means and Standard Deviations for Symbolizers, Non-symbolizers, and Non-symbolizers Changers on the Symbolization of Narrative Scale at post treatment.
 [F (2,11) = 5.65, p < 0.023] [F (2,11) = 9.21, p < .005]

	X	SD
<u>Repetitional Ties</u>		
Symbolizers	30.25	9.50
Non-symbolizers	12.00	1.41
Non-symbolizer changers	27.00	9.17
<u>Causal Conjunctive Ties</u>		
Symbolizers	10.75	2.50
Non-symbolizers	3.00	3.16
Non-symbolizer changers	10.00	5.44
<u>Substitutional Linking Ties</u>		
Symbolizers	47.25	24.07
Non-symbolizers	15.75	10.34
Non-symbolizer changers	56.17	28.46
<u>Additive Simple Ties</u>		
Symbolizers	37.50	34.38
Non-symbolizers	16.50	9.29
Non-symbolizer changers	26.67	12.82
<u>Additive Complex Ties</u>		
Symbolizers	2.00	1.83
Non-symbolizers	1.59	1.73
Non-symbolizer changers	2.50	2.43
<u>Adversative Ties</u>		
Symbolizers	12.75	5.31
Non-symbolizers	4.75	6.29
Non-symbolizer changers	9.33	3.20
<u>Temporal Ties</u>		
Symbolizers	10.25	5.74
Non-symbolizers	1.50	2.38
Non-symbolizer changers	6.50*	3.33
* [F (2,11) = 5.65, p < .023]		
<u>Mode</u>		
Symbolizers	8.75	5.91
Non-symbolizers	1.50	1.29
Non-symbolizer changers	7.16	3.71

Table 6 (cont.)

	X	SD
<u>Desire</u>		
Symbolizers	8.25	4.79
Non-symbolizers	4.50	3.32
Non-symbolizer changers	6.33	3.72
<u>Degree</u>		
Symbolizers	2.25	1.71
Non-symbolizers	2.25	2.22
Non-symbolizer changers	5.17	5.50
<u>Temperal Perspective</u>		
Symbolizers	3.75	1.71
Non-symbolizers	1.50	1.00
Non-symbolizer changers	3.83	3.19
<u>Predications</u>		
Symbolizers	23.00	16.06
Non-symbolizers	5.00	3.46
Non-symbolizer changers	22.50	7.48
<u>Narrative Coherence</u>		
Symbolizers	3.00	0.00
Non-symbolizers	1.75	0.50
Non-symbolizer changers	2.67**	0.52
** [F (2,11) = 9.21, p < .005]		
<u>Sentence Structure</u>		
Symbolizers	2.50	0.58
Non-symbolizers	2.00	0.82
Non-symbolizer changers	2.33	0.52
<u>SRLT = Substitution + Repetition</u>		
Symbolizers	77.50	33.04
Non-Symbolizers	27.75	10.47
Non-Symbolizer Changers	83.17*	33.74
* [F (2,11) = 4.55, p < 0.04]		
<u>RSM = Substitution, Repetition + Mode</u>		
Symbolizers	86.25	35.26
Non-Symbolizers	29.25	12.54
Non-Symbolizer Changers	90.33*	35.92
* [F (2,11) = 4.44, p < 0.04]		

The non-symbolizer changer group is more disparate.

Standard deviations are greater at post treatment which indicates greater variability and the possibility that

other factors are contributing to the change. The present author can only speculate about changes because of the smallness of the groups used.

2.3 It was predicted that at the end of treatment, the non-symbolizer changers will improve in their capacity to symbolize affect.

Multiple anovas were conducted to compare the three groups on four variables of affect to distinguish a difference at post treatment, independent of initial trait characteristics. At post testing no two groups were significantly different at the 0.05 level. There were no main effects. Means and standard deviations for each of the three groups are presented in table 7.

Table 7

Means and Standard Deviations for Symbolizers, Non-symbolizers, and Non-symbolizers Changers on the Gottschalk and Gleser Hostility Scale at post treatment.

	X	SD
<u>Hostility Inward</u>		
Symbolizers	182.75	98.21
Non-symbolizers	140.50	109.06
Non-symbolizer changers	89.67	63.14
<u>Ambivalent Hostility</u>		
Symbolizers	123.50	80.97
Non-Symbolizers	129.25	78.36
Non-symbolizer changers	89.00	64.31
<u>Overt Hostility Outward</u>		
Symbolizers	91.50	75.87
Non-Symbolizers	46.75	10.91
Non-symbolizer changers	116.67	56.49
<u>Covert Hostility Outward</u>		
Symbolizers	86.25	41.76
Non-Symbolizers	72.00	42.25
Non-symbolizer changers	94.83	43.01

Hypothesis #3.

In this study the two areas that demonstrated the greatest promise, symbolization of narrative and symbolization of object relations, will be applied to the therapy study. The Gottschalk and Gleser Hostility Scale was not used to score the therapy data because it failed to yield significant results in the monologue study.

The third hypothesis of the present study predicted that in the "in vivo" case study approach, patients who are non-symbolizer changers will show a reorganization of

symbolization in their capacity to symbolize and will demonstrate increased symbolization of object relations and symbolization of narrative within the therapeutic hour of an optimal treatment session.

Unfortunately, with such a small sample, it was not possible to do tests of significance. Instead, the scores from the therapy transcript data of the two cases of non-symbolizer changers were calculated into means and compared to the 95% confidence intervals of the non-symbolizer changers from the monologue study. Using confidence intervals is a way to establish comparability of patients in two different situations. If the initial scores from the therapy data are lower or within the 95% confidence intervals of the initial scores from the monologue study then the inference is that the two groups are considered comparable. If the peak scores from the therapy data are higher or within the 95% confidence levels of the post scores from the monologue data, then the inference is that the two groups are considered comparable, and that the change trends of the two patients in the two different situations are comparable. This method of analyzing results was used in the symbolization of object relations and symbolization of narrative sections below.

Symbolization of Object Relations: comparing the non-symbolizer changers from the therapy session study with the non-symbolizer changers in the monologue study.

On the measure of symbolization of object relations, the pre-treatment mean for non-symbolizer changers in the monologue study was 3.67, with a 95% confidence interval of 2.36 to 4.98. The pre-treatment mean for the non-symbolizer changers from the therapy session data on the measure of symbolization of object relations was 1.00. This value is well below the confidence intervals values which means that the non-symbolizer changers exhibited substantial non-symbolizing tendencies at the beginning of treatment; they displayed a primitive ability to symbolize object relations.

The post-treatment mean for the non-symbolizer changers in the monologue study was 7.33, with a 95% confidence interval of 4.47 to 10.19. The peak-treatment mean of the non-symbolizer changers from the therapy session data on the measure of symbolization of object relations was 9.75 which is close to the high end of the confidence interval. This demonstrates that at a peak treatment session the non-symbolizer changers demonstrated substantially high symbolizing tendencies. They demonstrated an even higher mean than the symbolizers' mean of 9.25 from the monologue study. Means and 95% confidence interval for each of the three groups are presented in table 8.

Table 8

Means and 95% confidence intervals of the monologue non-symbolizer changers and therapy non-symbolizer changers on the Symbolization of Object Relations Scale at pre, post, and peak treatment.

<u>Pre-treatment</u>	<u>X</u>	<u>95% Conf Int For Mean</u>
Monologue Changers	3.67	2.36 to 4.98
Therapy data Changers	1.00	
<hr/>		
<u>Post and Peak Treatment</u>	<u>X</u>	<u>95% Conf Int For Mean</u>
Monologue Changers	7.33	4.47 to 10.19
Therapy data Changers	9.75	
** Monologues symbolizrs	9.25	

Symbolization of Narrative: comparing the non-symbolizer changers from the therapy session data with the non-symbolizer changers in the monologue study. All the variables from the Symbolization of Narrative Scale were calculated separately.

On the measure of symbolization of narrative, the means of the symbolizer non-changers from the therapy session study were compared with the symbolizer non-changers from the monologue study. Only the variables from the monologue study that reached a level of significance were compared. The narrative variables from the monologue study that were significant at pre-treatment were repetitional linking ties and causal conjunctive ties.

The pre-treatment mean for non-symbolizer changers in the monologue study for the variable Repetitional ties was 8.17 with a 95% confidence interval of -2.02 to 18.35. The pre-treatment mean for the non-symbolizer changers from the therapy session data on the measure of Repetition was 11.50. This value is within the confidence interval and demonstrates that the non-symbolizer changers from the therapy study exhibited non-symbolizing tendencies at the beginning of treatment on the measure of repetition. This means that at the beginning of treatment, the "in vivo" non-symbolizing changers were more similar to the non-symbolizer changers from the monologue study who used repetitional linking ties significantly less than the symbolizers.

The pre-treatment mean for non-symbolizer changers in the monologue study for the variable Causal Conjunctive Ties was 3.00 with a 95% confidence interval of 0.52 to 5.48. The pre-treatment mean for the non-symbolizer changers from the therapy session data on the measure of Causal Conjunctive Ties was 4.00. This value is within the confidence interval and demonstrates that the "in vivo" non-symbolizer changers exhibited non-symbolizing tendencies at the beginning of treatment on the measure of causal conjunctive ties. This means that at the beginning of treatment the non-symbolizing therapy cases were more similar to the non-symbolizer changers from the monologue

study who used causal conjunctive ties linking ties significantly less than the symbolizers.

The narrative variables from the monologue study that were significant at post treatment were Temporal Conjunctive Ties, Narrative Coherence and SRLS Linking Structures (Substitutional and Repetitional linking ties combined). The post-treatment mean for non-symbolizer changers in the monologue study for the variable Temporal Conjunctive Ties was 10.00 with a 95% confidence interval of 3.00 to 10.00. The peak-treatment mean for the non-symbolizer changers from the therapy session data on the measure of Temporal Conjunctive Ties was 6.75. This value is within the confidence interval and demonstrates that the "in vivo" non-symbolizer changers exhibited symbolizing tendencies during the peak treatment session on the variable of Temporal Conjunctive Ties. This means that during the peak treatment session, the non-symbolizing "in vivo" cases were more similar to the non-symbolizer changers from the monologue study who were demonstrated to be significantly different from the non-symbolizer non-changers on the variable of Temporal Conjunctive Ties at post treatment.

The post-treatment mean for non-symbolizer changers in the monologue study for the variable Narrative Coherence was 2.67 with a 95% confidence interval of 2.12 to 3.21. The peak-treatment mean for the non-symbolizer changers from the therapy session data on the measure of Narrative

Coherence was 3.00. This value is within the confidence interval and demonstrates that the "in vivo" non-symbolizer changers exhibited symbolizing tendencies during the peek treatment session on the variable of Narrative Coherence. This means that during the peek treatment session, the "in vivo" non-symbolizer changers were more similar to the non-symbolizer changers from the monologue study who were demonstrated to be significantly different from the non-symbolizer non-changers on the variable of Narrative Coherence at post treatment.

The post-treatment mean for non-symbolizer changers in the monologue study for the variable SRLT Linking Structures (Substitutional and Repetitional linking ties combined) was 83.17 with a 95% confidence interval of 47.76 to 118.57. The peak-treatment mean for the non-symbolizer changers from the therapy session data on the measure of SRT Linking Structures was 47.00. This value just misses being within the confidence interval, and demonstrates that the "in vivo" non-symbolizer changers did not exhibit symbolizing tendencies during the peak treatment session on the variable of SRLT. This means that during the peak treatment session, the non-symbolizing "in vivo" cases were not similar to the non-symbolizer changers from the monologue study at post treatment. Means and 95% confidence intervals for each of the three groups are presented in table 9.

Table 9

Means and confidence intervals of the monologue non-symbolizer changers and therapy non-symbolizer changers on the Symbolization of Narrative Scale at pre, post and peak treatment.

<u>Pre-treatment</u>	<u>X</u>	<u>95% Conf Int For Mean</u>
<u>Repetitional Linking Ties</u>		
Monologue Changers	8.17	-2.02 to 18.35
Therapy data Changers	11.50	
<u>Causal Conjunctive Ties</u>		
Monologue Changers	3.00	0.52 to 5.48
Therapy data Changers	4.00	

<u>Post and Peak Treatment</u>	<u>X</u>	<u>95% Conf Int For Mean</u>
<u>Temporal Conjunctive Ties</u>		
Monologue Changers	10.00	3.00 to 10.00
Therapy data Changers	6.75	
<u>Narrative Coherence</u>		
Monologue Changers	2.67	2.12 to 3.21
Therapy data Changers	3.00	
<u>SRLT = Substitution + Repetition</u>		
Monologue Changers	83.17	47.76 to 118.57
Therapy data Changers	47.00	

Summary of Findings

From the monologue study it was demonstrated that there are two groups of symbolizers identified at the beginning of treatment: the symbolizers, and the non-symbolizers (changers and non-changers). The symbolizers were significantly different from both groups of non-symbolizers

and demonstrated higher levels of symbolization of object relations and narrative.

Furthermore, there was a significant main effect at post treatment. The non-symbolizer changers were distinguished to have a significantly higher level of symbolization of object relations and narrative than the non-symbolizer non-changers.

Finally, in the therapy study, a comparability of change was found. The non-symbolizer changers demonstrated a similar pathway of change to the non-symbolizer changers from the monologue study. In the therapy study, the non-symbolizer changers displayed the inability to symbolize at the beginning of treatment, but, at peak moments, they demonstrated the capacity to symbolize object relations and narrative, just as the non-symbolizer changers demonstrated in the monologue study at post treatment.

Below are some excerpts from the therapy transcripts to give a clinical illustration of some of the results described above. The female patient in the therapy study gives a description of her inner world at the beginning of her treatment. She states:

...uhm... because of the breakup and ramification to how this monarch was going to continue, this is the way I'm understanding it and uhm... that uhm... you know, that I was involved and coming up again, coming across, and or... or being exposed to and I don't believe it was always this, her voice, I don't believe it was always her. I believe it was her voice, sometimes Ivanna Trump's voice... challenging me or doing different things related to aah how you respond to it, a queen, a monarch....there were other people you know, that would uhm... say you know,

you know, make me think or you know, shape, were shaping my thoughts or attempting to shape my thoughts about how uhm...I was being considered to be one of Donald Trump, one to be considered to be a... you know or he was considering me as a possible uhm mate...

This segment demonstrates her inability to symbolize object relations and narrative. A segment of her therapy transcript during a peak therapy session reads as follows:

No I feel like the truth of the matter is I was unfairly treated and I don't feel that you stood up for me on that, and you KNOW me better than they do, you see, and that's why I feel like you disappoint me...with that I'm not a violent to handle person. I do go along with the norm. We work well together most of the time. So why didn't you say that to him to let him know..that if I wanted to leave I, I may have felt like it but I wasn't going to..I'm very very honest.

In this segment she is more able to symbolize object relations and narrative.

The male patient in the therapy study gives a description of his inner world at the beginning of his treatment. He states:

No. I have no wishes...I don't function...I'm depressed...I don't know what it is. I haven't done anything with my life since graduating college in 1984... I don't think anything can make me feel better, I've felt like this for a few weeks now... Use to be able to speak with more gusto...More verve... More sophistication... Now I must seem awfully stupid.

This segment demonstrates his inability to symbolize object relations and narrative. At his peak therapy session he states:

Well, I didn't want my sister buying anything for me. I don't want her, I didn't want her to spend money on me. She was always doing that, offering something. And some friends argue in her favor saying she's nice. But, she might also be making

herself poorer by being so generous... Well there was a time, well a month later see, uh her husband and I were seeing the same psychiatrist.. And we both had the same appointment at the same time. My sister had come with her husband and we were all there in the waiting room and my sister hadn't talked to me in about a month... And then we went into the dining room after we, uh.. decided to talk to one another again... We went into a diner and she, uh, offered to pay for what I was taking... And this time I let her do it... And I shouldn't have. I should have said, "Debbie you're starting again".. I, I don't like my sister always giving me money. Sometimes I take it because its uh, I get a little greedy or something like that.

In this segment he is more able to symbolize object relations and narrative. These results will be discussed further in the following discussion section.

Discussion

The major findings of this study are concerned with the patterns of change in symbolization over the course of short term psychotherapeutic treatment. The aim of the present study was to shed light on some specific dimensions of symbolization, to further define the components of symbolization and to propose that using measures of symbolization is a useful way of measuring change in psychotherapy. This study proposes that symbolization is a way to conceptualize change in a more sophisticated way than just describing the reduction of symptoms; and it is a less complicated way of describing change than adhering to discrete theoretical psychoanalytic models that make comparisons within psychoanalytic theory difficult, if not impossible, because of the overly restrictive language that is used. By developing a more general and useful way to describe change, through the use of symbolization measures, advocates for a way to catalogue change in a more common ground fashion.

Another aim of this study was to illustrate how patients with differing symbolizing abilities have different baseline propensities for becoming involved in treatment. Furthermore, it is the aim of this study to demonstrate that the different groups of symbolizers have different trajectories of change and therefore receive different benefits from psychotherapy. The change being

described in this study is change associated with the psychotherapy process, not change due to psychotherapy.

This study compared symbolizers with non-symbolizer non-changers and non-symbolizer changers to elucidate specific characteristics of both groups. There were significant similarities between the experimental groups in that all were so significantly disturbed that they required hospitalization. There were no systematic differences on major demographic variables such as race, ethnicity, socioeconomic class, education, religion, age, sex and language. Any differences that will be discussed reflect different response propensities not accounted by diagnostic or demographic variables.

This chapter will focus on a discussion of the hypotheses and results of the research. Theoretical and therapeutic implications will be discussed. The limitations of the present study and recommendations for future research will be explored.

Hypotheses

Hypothesis 1 was concerned with empirically identifying specific characteristics of symbolization to differentiate the symbolizers from the non-symbolizers at baseline. This hypothesis was confirmed in part. At pre-treatment the symbolizers were distinguished to have a higher level of symbolization of object relations than non-symbolizers. The symbolizers were more able to represent significant object relationships in their narrative. Since

a patient's internal object relations are a central constituent of any psychotherapeutic process, the symbolizer demonstrates an integral step in being engaged in the therapeutic process by being able to symbolize significant object relationships.

The symbolizers were also distinguished to have a higher level of symbolization of narrative on 2 specific variables: repetitional linking ties and causal conjunctive ties. The symbolizers were more able to use repetition as a way to link their ideas together which provides for continuity from one idea to another. Like the chorus of a song, the more something is repeated the more likely one is apt to get the meaning of, or to remember what the speaker is saying. Although repetition is seen as the most simple form of the linking devices and based on the symbolic function of imitation (Piaget, 1962), acquired in the first year of life (Bates, 1979), nevertheless, it is seen as an attempt to provide a form of cohesiveness in a rudimentary fashion. In contrast, causal conjunctive ties are seen as a much more complex way to link ideas together by using causality to provide more complex meanings to the text. Causal conjunctive ties join words, clauses and sentences together and allows the speaker to elaborate and deepen the meaning of his narrative by expressing a causal relation of result, reason or purpose. The ability to use a conjunctive tie indicates an even greater differentiation between self and object (Steingart & Freedman, 1972).

The fact that the symbolizers seemed to demonstrate higher means on 7 variables of narrative which did not show significant f values is interesting. That the symbolizers had higher means than both groups of non-symbolizers on the variables of substitutional linking ties, additive simple ties, additive complex ties, adversative ties, temporal ties, temporal perspective and predications, is very much in line with the author's predictions. This result suggests that at baseline, the symbolizers can be further distinguished from the non-symbolizers on other variables of narrative if a more elaborate research design was used. This will be further discussed in recommendations for future research.

The symbolizers could not be distinguished from the non-symbolizers on the symbolization of affect. There can be a number of possibilities to explain this result. Hostility might be more distinguishable in interaction with someone such as a therapist, rather than in an isolated 5 minute monologue. This is unlikely in light of Gottschalk's (1969) research and the massive evidence based on detecting affect in five minute monologues. Another possibility is that it might be that at baseline all patients are in such emotional, acute crises that affect is very much undifferentiated for both the symbolizers and the non-symbolizers. This would need to be explored in future research. Or, affect, specifically hostility, cannot be isolated by itself and needs to be connected to some other

variable such as object relations. This will be discussed in recommendations for future research.

That the symbolizers were significantly different from the non-symbolizers at baseline on measures of symbolization of object relations and narrative is an important finding. First of all, because it demonstrates that the symbolizers and the non-symbolizers are significantly different groups. The symbolizers demonstrate more of an ability to create meaning by being able to represent significant object relationships and by providing a narrative with more linkages between thoughts and ideas, through the use of repetitional linking and causal conjunctive ties.

These findings indicate that at baseline there are two distinguishable groups: the symbolizers and the non-symbolizers. The symbolizers are more able to create a richer narrative containing representations of significant object relations and a narrative that includes more links and connections between thoughts and ideas. In contrast, the non-symbolizers are not able to represent significant object relations and their narrative lacked significant linkage between thoughts and ideas resulting in a more fragmented and disjointed narrative.

Hypothesis #2 was concerned with empirically demonstrating that the non-symbolizer changers will improve in their capacity to symbolize object relations, narrative and affect, independent of initial trait characteristics.

This hypothesis was confirmed in part. There was a significant main effect at post treatment and the non-symbolizer changers were distinguished to have a significantly higher level of symbolization of object relations and a higher level of symbolization of narrative than the non-symbolizer non-changers.

At the end of treatment the non-symbolizer changers were significantly more able to represent object relationships in their narrative and closely resembled the symbolizers. Whereas at the beginning of treatment the non-symbolizer changers were unable to represent object relations in their narrative, something shifted during the course of treatment which allowed the non-symbolizer changers to transcend their original category of non-symbolizer, to become a changer. The non-symbolizer changers subsequently demonstrated a higher level of symbolization of object relations by being able to symbolize significant object relationships in their narrative.

The non-symbolizer changers also improved in their ability to symbolize narrative. At post treatment the non-symbolizer changers were distinguished to have a significantly higher level of symbolization of narrative than non-symbolizer non-changers on four variables: temporal ties, narrative coherence, substitutional and repetitional linking ties combined (SRLT) and substitutional and repetitional linking ties and mode

combined (SRM). At the end of treatment the non-symbolizer changers resembled the symbolizers and were significantly different from the non-symbolizer non-changers.

The finding that at the end of treatment the narrative of the non-symbolizer changers contained more temporal ties shows that they developed the ability to engage in a more complex form of symbolization of narrative. The temporal tie is a form of the conjunctive tie, the most complex of linking structures, and connects ideas and thoughts through a temporal sense. The temporal tie expresses a relationship through time by using words which indicate a time sequence such as, for example; just then, before that, and formerly. The ability to distinguish between time frames is one of the essential components of Freedman and Wilke's (1994) concept of spatialization, a form of symbolization in which there is a linkage between images occurring in different psychic spheres such as past and present.

The finding that at the end of treatment the narrative of the non-symbolizer changers demonstrated a higher level of narrative coherence is significant. A cohesive narrative contains a steady flow of ideas that are connected to each other; either the narrative contains few themes that are connected in meaning, or the narrative explores and expands upon one idea. The themes are elaborated with sentences that are linked together and are related to the main idea of the theme. Each sentence helps

to develop the theme. A cohesive narrative contains a richness of description and becomes a more meaningful narrative. A cohesive narrative is an essential component of symbolization because it is a vehicle to "establish or reestablish connections between items of experience." (Loewald, 1988 p. 58). A patient who is able to establish links between words, thoughts, and feelings is engaged in the process of creating meaning for himself and for another, the therapist.

At the end of treatment the non-symbolizer changers were able to use significantly more substitutional and repetitional linking ties combined (SRLT). Not only were the non-symbolizer changers more able to use a more advanced form of conjunctive tie, the temporal tie as discussed previously, they were also able to use the more basic forms of linking structures, repetitional and substitutional linking ties. As explained in the hypothesis one section, the repetitional link is the most simple form of the linking structures and based on the symbolic function of imitation, (Piaget, 1962). Repetition is a way to connect one sentence to another by repeating the subject.

A more complex form of linking is substitution, where instead of repeating the subject, a more abstract form such as a pronoun, demonstrative or comparative is used as a substitute for the subject. The ability to use this form of linking device implies some ability to abstract which is

only acquired after some form of identity is achieved. It is during the depressive position that the capacity for abstract thought develops (Segal, 1994).

As the non-symbolizer changer becomes more differentiated and develops more of an identity s/he begins to engage in what Freedman and Wilke (1994) call verbalization, the process by which a patient defines his/her subjective world to him/herself and to others, the therapist.

At the end of treatment the non-symbolizer changers were able to use more substitutional and repetitional linking ties and mode combined (SRM). The importance of both substitutional and repetitional linking ties have been explained above. Mode is a form of specification of intent that functions as helping to further define the relationship between a subject and event (object). Mode is identified when the idea of possibility is indicated with the use of auxiliary verbs such as might, must, could, would or should, which help to elaborate the relationship between a subject and object. Mode further specifies the meaning between subject and object. For example, she might go to the concert implies that the subject can go to the concert but there is an element of doubt.

To be able to engage in mode it is necessary for a person to have a sense of identity. For without a subjective sense of self, it is difficult to contemplate one's experience or to be able to perceive the possibility of acting. Ogden

(1990) states that the self only exists as an object in the paranoid-schizoid position, without the ability to perceive in the possibility of something other. A relatively stable sense of self, one with a degree of self constancy, is necessary for one to perceive oneself as existing over time, having a past and being able to project into the future (Mahler, 1986). Bach (1990) states that one of the most important capabilities for a person to develop is the capacity for reflexive self awareness, the ability to integrate both a subjective and objective sense of self. This makes it possible for one to "think about his thinking, to develop multiple perspectives upon himself" (Bach, 1990. p. 232).

Mode, therefore, is an example of a person thinking about his thinking and acting, in different time frames, and demonstrates a complex form of symbolization. The finding that the non-symbolizer changers had a significantly higher degree of substitutional and repetitional linking ties and mode combined (SRM) suggests that the non-symbolizer changers acquired the ability to develop a subjective self that could engage in abstract and symbolic thought in multiple time sequences, all of which aid in the service of creating meaning.

The non-symbolizer changers were not distinguished to have a higher level of symbolization of affect. Even at the end of treatment, affect is non distinguishable among the three groups. It might be that the concept of affect is a

much more complex process that might not show discriminations within such a small subject sample. It is possible that hostility can only be differentiated in more integrated patients, a less disturbed group of symbolizers, not inpatients who are in acute crises. Or, It could be, that hostility, in more disturbed patients, has a more non-verbal component that can only be distinguished in body movements, or lack of engagement in the task at hand, such as in paucity of speech. This will be discussed further in recommendations for future research.

To summarize, at post treatment the non-symbolizer changers were distinguished to have a significantly higher level of symbolization of object relationships and a significantly higher level of symbolization of narrative on four variables: Temporal ties, narrative coherence, substitutional and repetitional linking ties combined (SRLT) and substitutional and repetitional linking ties and mode combined (SRM). The non-symbolizer changers were not distinguished to have a higher level of symbolization of affect. These results demonstrate that at the end of treatment the non-symbolizer changers have acquired many symbolizing capacities.

This is a significant finding in many ways. First of all it demonstrates that the labels of symbolizer and non-symbolizer are not static entities impermeable to change. With all things being held constant in the hospital setting, there was something that enabled the non-

symbolizer changers to change, to become more like the symbolizers. Although the present author can not account for what causes the change, she can speculate that there might have been something in the psychotherapy that enabled the patient to engage in a more meaningful dialogue.

One can speculate that the non-symbolizer changers are those who have started to make the transition from the paranoid-schizoid position to the depression position where the patient begins to acquire the ability to develop a subjective self that can engage in abstract and symbolic thought. The non-symbolizer changer can be described to be on the road to self constancy and developing the ability to perceive him/her self in multiple perspectives having a past and being able to project into the future. The non-symbolizer changer can be described as developing the capacity for reflexive self awareness, the ability to integrate both a subjective and objective sense of self, all in the service of creating meaning of his/her inner and external worlds.

This result is also an important finding because it demonstrates that the Symbolization of Object Relation Scale (SORS) and the Symbolization of Narrative Scale (SONS) validate the Level of Associative Organization (LAO) scoring system. The assessments of the symbolizers and non-symbolizers obtained by using the SORS and the SONS corresponded to the assessments obtained by the (LAO) scoring system. The three groups of symbolizers were

originally selected based on their LAO scores. Those subjects with higher LAO scores at pre-treatment received higher scores on the SORS and on certain measures of the SONS. Those subjects with lower LAO scores at pre-treatment received lower scores on the SORS and on certain measures of the SONS. Those subjects with higher LAO scores at post treatment received higher scores on the SORS and on certain measures of the SONS. Those subjects with lower LAO scores at post treatment received lower scores on the SORS and on certain measures of the SONS. The SORS and SONS help to broaden the meaning of symbolization defined by the LAO by incorporating the important dimensions of object relations and narrative.

On the basis of these findings it can be concluded that different patterns of change occur over the course of short-term inpatient psychotherapy for symbolizers, non-symbolizer changers and non-symbolizer non-changers. These different trajectories of change were determined by applying the Symbolization of Narrative Scale and Symbolization of Object Relation Scale to associative monologues given at the beginning and at the end of treatment.

Hypothesis 3 was concerned with testing the prediction that the non-symbolizer changers from the therapy study were similar to the non-symbolizer changers from the monologue study. Not surprisingly, this prediction was supported. At pre-treatment the non-

symbolizer changers from the therapy study were unable to symbolize object relations. This finding demonstrates that at pre-treatment the non-symbolizer changers from both the therapy study and the monologue study were equally unable to symbolize object relations.

However, during the peak therapy session, it was demonstrated that the "in vivo" non-symbolizer changers were able to symbolize object relations. The "in vivo" non-symbolizer changers were able to acquire the capacity to symbolize object relations during the peak therapy session, just as the non-symbolizer changers from the monologue study were able to acquire the capacity to symbolize object relations at post treatment. Thus, the non-symbolizer changers were equally able to acquire the capacity to symbolize object relations, as demonstrated in the peak therapy session and in the monologue study at post treatment.

At pre-treatment the non-symbolizer changers from the therapy study were unable to symbolize narrative on the variables of repetitional linking ties and causal conjunctive ties, as was demonstrated by the non-symbolizer changers in the monologue study. At pre-treatment the non-symbolizer changers from both the therapy study and the monologue study were equally unable to symbolize narrative.

However, during the peak therapy session, it was demonstrated that the "in vivo" non-symbolizer changers were able to symbolize narrative on the variables of

temporal conjunctive ties and narrative coherence, as were the non-symbolizer changers from the monologue study at post treatment. The "in vivo" non-symbolizer changers were not able to symbolize narrative on the variable of SRLT linking structures (substitutional and repetitional linking structures combined), even though they came extremely close, as were the non-symbolizer changers from the monologue study at post treatment. Thus, the non-symbolizer changers were able to acquire the capacity to symbolize narrative as demonstrated by the "in vivo" non symbolizer changers during the peak therapy session and by the non-symbolizer changers from the monologue study at post treatment on the variables of temporal conjunctive ties and narrative coherence.

On the basis of these findings it can be concluded that the observations in the "in vivo" therapy study clinically validate the observations of the monologue study. This is an important finding because it has implications on the process of being able to pinpoint change from the therapy session itself in contrast to using a secondary method such as the 5 minute monologue. This enables the therapist to glean changes while they occur by paying attention to the symbolization of object relations and symbolization of narrative. The symbolization of Object Relations Scale and the Symbolization of Narrative Scale offer the therapist very concrete earmarks of change, change in symbolization of object relations and narrative, to provide a structure

for observing change in the psychotherapy session. The symbolization scales provide any therapist, no matter what theoretical orientation they adhere to, a common ground way to access change. For any therapist can understand the language of object relations and narrative. These two components of symbolization are vital to any psychotherapeutic process.

The non-symbolizer changers are a most interesting group not only because they show the greatest degree of change, but precisely because they started out as those patients who initially do not show the capacity to engage in the psychotherapeutic process, and then they subsequently acquire the ability for resymbolization. This finding allows us to have psychotherapeutic optimism and to view psychotherapy as being a process that can promote symbolization. This finding supports the idea that symbolization is not a cognitive attribute of style, rather, it is something that can alter and develop through treatment.

The significance of this study was that it attempted to arrive at a better understanding of the process of symbolization as it applies to the psychotherapy process; to harness a more concrete definition of what symbolization is, and to apply this definition of symbolization. This study was able to elaborate the meaning of symbolization defined by the LAO to include the components of object

relations and narrative to assess change in a more descriptive way, regardless of psychoanalytic orientation.

Theoretical Implications

The symbolization process has been approached in a theory neutral fashion; however, to gain a better understanding of the process it is necessary to return to a discussion of theory. The symbolizing process can be understood from a number of theoretical perspectives such as the contemporary Kleinian (1975); Ogden (1990); Mahler, Pine and Bergman (1975) with their emphasis on the separation-individuation process; Stern's (1985) recent work on the development of the emergent, core, and subjective self; and Brenner's (1982) conflict theory. However, the present author finds it is most useful to use Ogden's (1990) theoretical conceptions of the depressive and paranoid-schizoid position, and Bach's (1985) theory of reflective self awareness, to illuminate the symbolizing process, simply because they talk more explicitly about symbolization and the development of the subjective and objective self.

It can be suggested that the non-symbolizers are in the paranoid-schizoid position where the capacity to symbolize is limited. During the paranoid-schizoid position there is no subjective self, there is no sense of a continuous self, rather, the self exists primarily as an object. The self as object cannot think, feel or create meaning, instead it can only make "attacks on linking."

It is only in the depressive position that the patient begins to acquire the ability to develop a subjective self that can engage in abstract and symbolic thought. In the depressive position the subjective self can have thoughts and feelings and make connections between them to create a personal history with personal meanings. The subjective self begins to develop a reflective self awareness that exists over time. There is a fluidity and cohesiveness that is created by the subjective self's ability to make linkages between items of experiences, all to serve in the process of meaning making.

It can be suggested that after treatment the non-symbolizer changers are those who have started to make the transition from the paranoid-schizoid position to the depression position. They seem to develop the capacity for abstract thought, to link items together to create a more cohesive narrative, can make linkages between different temporal senses, can symbolize an identity of themselves in relation to others and can reflect upon possibilities for acting in the future. But most importantly, these are all examples that the non-symbolizer changer has become engaged in the process of defining their subjective worlds to themselves and to others, the therapist. They can be described as developing the capacity for "reflexive self awareness," the ability to integrate both a subjective and objective sense of self, all in the service of creating a

more comprehensive meaning of their psychic selves in relation to the external world.

Sheldon Bach (1990) states:

In working through of archaic transferences, the patient, through a laborious process of differentiation and reintegration, gradually becomes able to form and hold more abstract conceptualizations not only of self and object but of time, place, person, and causality. He moves from concrete imagery to abstract conception by analogy in the way in which Piaget has described the development of "concrete" and "formal" operations in latency and adolescence (p. 191).

As one makes the transition from the paranoid-schizoid position to the depressive position, s/he is in the process of becoming more differentiated, moving from the concrete to the more abstract. The non-symbolizer changers were able to demonstrate this during the course of treatment illustrated by the symbolization of narrative results. The non-symbolizer changers displayed a range of symbolization from the most concrete form of linking, repetitional linking ties, to a more complex form of linking which involves the ability to abstract, substitution, to the most advanced form of linking, involving the ability to place themselves within a time sequence using temporal conjunctive ties.

This study has attempted to offer a more descriptive rendering of symbolization by using the dimensions of object relations and narrative. It has also attempted to demonstrate that symbolization can aid many different psychoanalytic theories, in a more common ground fashion, in exploring the process of change. And it has attempted

to flesh out a more psychoanalytic understanding of symbolization by linking symbolization to established psychoanalytic theories such as those proposed by Klein (1930), Ogden (1990), Freedman and Berzofsky (1995), Segal (1964), Bach (1985), Loewald (1988), Jones (1948), Bion (1959), and Werner and Kaplan (1963).

A question to be asked is: do the non-symbolizer changers have the capacity to symbolize initially and temporarily lose the capacity during their acute crises and will they lose the ability again when another crisis sets in? It is well known that the depressive position and the paranoid-schizoid positions are not stages or phases but are positions that both persist throughout life with regression to the paranoid-schizoid position a possibility (Segal, 1964). What implications does this theoretical tenet have on the symbolizing process? Do symbolizers proper have the capacity to regress into non-symbolization? These are interesting questions and which need to be addressed with future, probably longitudinal, research.

Finally, it will be useful to once more revisit the whole notion of the utility of symbolization as a dynamic descriptive concept as opposed to other notions such as representation. Whereas representation refers to something that is represented such as an image or an object, symbolization refers to a process whereby the patient begins to communicate his/herself and to another, the therapist. The present author has shown through the

components of narrative and object relations, that there is a process of constructing meaning within the treatment setting that is best described by the term symbolization. Symbolization, not symbolism, is the best way to describe a shared symbolic code generated within an object relationship and the best way to describe the meaning making process that occurs in psychotherapy treatment.

Treatment Implications

The findings of this study provide a clear demonstration of the value of a symbolization approach to understanding patients differing psychic organization. Just as this approach identified differences in the symbolization of object relations and narrative in symbolizers, non-symbolizer changers and non-symbolizing non-changers, it also holds important implications for treatment.

Although a discussion of treatment strategies was not central to this work, the differences in technique arising out of differing levels of symbolization classification were noted.

First of all, since symbolization has been seen to be a process that can be altered with treatment it leads to therapeutic optimism: initial non-symbolizers can change and acquire symbolizing tendencies.

Secondly, by establishing where a patient is initially at the beginning of treatment, can guide the therapist's approach. The therapy process should have different aims

for patients in different states of the symbolization process. Those who are unable to symbolize initially might benefit more from containment, soothing, pacification, clarification and ego building mechanisms which help them to establish a more stable sense of self. Since the non-symbolizers are unable to link items of experience it would be useless, and possibly damaging, to make interpretations, making connections between their experience within different situations. Only when the self becomes more contained and cohesive, can further exploration, confrontation and interpretation be useful. Helping a patient to gain constancy of self will be of primary importance as the therapist acts as a transitional object.

It will also be useful when treating non-symbolizers to pay attention to non-verbal signs since they do not have the capacity to express symbolized material verbally.

As Freedman and Wilke (1994) outlined the continuum of symbolization with the 3 major dimensions: verbalization, spatialization, and interpretation; these dimensions can be seen to have their correlates in the treatment process. Of first order is to help patients to verbalize conscious and preconscious thoughts helping them to define their subjective worlds to promote the process of verbalization. Secondly, the therapist can help the patient link images of themselves occurring in different psychic spheres, different times, different spaces, different relationships and different realms of consciousness to promote the

process of spatialization. And lastly, the therapist can act as the interpreting ego to help expose the patient's unconscious wishes that lead to conflicts to promote the process of interpretation.

If one could harness, at the beginning of treatment, the differences between the non-symbolizers who will eventually change (the changers) versus those who will not change, (the non-changers), one could then predict which patients could best benefit from particular treatment approaches and, therefore, provide for more cost effective ways of providing treatment. This could have major implications on treatment in the new managed care climate.

Limitations Of The Study

The first limitation of the research was the sample size. This was an indepth examination of psychotherapeutic process, case material not easily accessed. Hence, there were small numbers of subjects in each group. Because there was inconsistent variability one should be cautious about interpreting the means and standard deviations. Greater standard deviations may indicate there could be other factors beyond simple differences in determining the ability to symbolize. Since there were only two subjects in the therapy study, tests of significance could not be done. A larger sample size would improve the power of the design.

In the monologue study the non-symbolizer changers and the symbolizers were significantly different from the non-symbolizer non-changers on only 2 of the narrative

variables but showed trends in the predicted direction on 11 other variables which failed to reach significance. A larger sample size would increase the power of these measures.

The symbolization of object relations and narrative scales were newly developed and need further use and validation. Using other scales of symbolization would be useful.

This study was conducted with time limited, short-term therapy and did not address the issue of future regressions or transformation cycles (Freedman, 1985) as treatment continues. A more long term study would be useful in this regard.

It would also be quite useful to be able to further clarify the role medication played in the treatment. For example do psychotropic medications relieve anxiety or bind psychotic process thinking to the degree of enabling symbolization to emerge differentially for some individuals (non-symbolizer changers) and not for others (non-symbolizer non-changers)? Such a research design, however, would not be approved for ethical reasons.

Recommendations For Future Research.

In this section recommendations for future research will be explored. The most compelling idea for future research would be to further investigate the two groups of non-symbolizers at the beginning of treatment. By getting a better idea of how these two groups are different, as well

as similar, would allow one to better distinguish the non-symbolizer changers from the non-symbolizer non-changers at the beginning of treatment. This would have major implications on the treatment process. If the non-symbolizer changers can be distinguished from the non-changers at the beginning of treatment, one could then predict which patients could benefit from psychotherapy treatment. This would allow for more efficient ways of providing psychotherapy.

Another area for future research would be to further investigate the specific nature of the changes that take place during the psychotherapeutic process. For example, how do the therapists' responses prompt and elicit, patients' responses. Do particular kinds of interventions produce different results? How does the patient respond to the therapist? Another way to study the causes of change would be to further explore the post session commentaries to get a better sense of the therapist's countertransference and how this contributes to the therapy process.

Affect and its role in the process of symbolization needs further investigation. There is currently quite convincing evidence, (Schoore, 1994) that what changes, especially in briefer forms of psychotherapeutic encounters, is, indeed, affect. Moreover, it is difficult to imagine that changes in the quality of narrative which are demonstrated, or changes in the quality of object

relationships, can occur without some reorganization in the patient's affect.

The Gottschalk scale that was selected has achieved a great deal of validity in a variety of psychopathological groups, however, it is primarily regarded as a measure of arousal. It is not particularly geared to describing affect in the context of narrative, or in the context of object relations. Future research will need to differentiate more clearly between affect naming and affect embedded in object relations and narrative, to assess more explicitly the changing nature of affect as part of the psychotherapeutic experience.

Summary

This study has examined the process of symbolization within the psychotherapeutic context. Symbolization can be defined as the ability to construct meaning and the process by which the inner subjective self of a patient is translated into a shared communicated speech. In this study the emphasis was on the ability to symbolize object relations and a cohesive narrative structure.

The capacity to symbolize object relations is demonstrated by the degree to which a patient can represent significant relationships in his/her narrative. The SORS was designed to measure the degree of detail, significance and interaction that a patient uses to describe his/her relationships.

The capacity to symbolize narrative is demonstrated by a patient's ability to tell a coherent story. The SONS was designed to evaluate a patient's capacity to shape his/her experience into a coherent form using specification and connective ties to link words, sentences and themes.

In the monologue study, three different groups, determined by their scores on the LAO were compared: symbolizers, non-symbolizer changers, and non-symbolizer non-changers. A total of 14 subjects were used; all were inpatients from a psychiatric unit of an urban medical center who received psychodynamic treatment. All subjects had the diagnosis of schizophrenia, except for one patient who had the diagnosis of bipolar disorder. The Gottschalk and Gleser Hostility Scale, the SORS and the SONS were applied to five minute monologues, before and after treatment. In the therapy study there was an indepth examination of two additional non-symbolizer changers, both with the diagnosis of schizophrenia. The SORS and SONS were applied to five minute segments of initial and change sessions.

As predicted, at pre-treatment, the symbolizers were significantly different from both groups of non-symbolizers and demonstrated higher levels of symbolization of object relations and narrative. The symbolizers were able to describe their relationships in greater detail and were able to create a narrative with more linkages between words and sentences using repetition and causal conjunctive ties.

It is assumed that those who are more able to deal with their significant personal relationships and represent a more cohesive narrative will be more able to gain from the therapeutic encounter.

As predicted, there was a significant main effect at post treatment. The non-symbolizer changers who were initially unable to symbolize were distinguished to have a significantly higher level of symbolization of object relations and narrative at post treatment. The non-symbolizer changers were subsequently able to describe their relationships in greater detail and were able to create a narrative with more linkages between thoughts using temporal ties, repetition, substitution and mode. The non-symbolizer non-changers were unable to demonstrate this capacity, even after they received treatment. It is assumed that those who do not develop the capacity to symbolize are less able to gain from the therapeutic experience.

Finally, as predicted, a comparability of change was found in the therapy study. The non-symbolizer changers displayed the inability to symbolize at the beginning of treatment, but, at moments of change, they demonstrated the capacity to symbolize object relations and narrative.

Conclusion

Based on the results of the study and including its limitations the following conclusions are warranted:

- 1) Different patterns of change occur over the course of

short-term inpatient psychotherapy for symbolizers, non-symbolizers and non-symbolizer changers on the dimensions of symbolization of object relations and narrative.

2) The labels of symbolizer and non-symbolizer are not static entities impermeable to change. Symbolization is the process of constructing meaning and it is a process that can develop in psychotherapy, through the use of narrative in the context of an object relationship.

3) Finally, that it is possible to objectively determine change within the therapeutic encounter by applying the SORS and SONS to actual psychotherapy transcripts, rather than relying on a secondary method such as a five minute monologue.

This study has been able to further elaborate the LAO measure which is a global measure of symbolization and has offered a more clinically descriptive and useful way to access change using the dimensions of object relations and narrative. Accordingly, any clinician, no matter his or her theoretical orientation, can apply the SORS and SONS to glean changes during the course of psychotherapy directly from patients' speech. The scales can aid in a more "common ground" approach in exploring the process of change. This approach allows for clinicians of different orientations to discuss therapeutic outcomes with a common foundation. It is the symbolizer who seeks to create meaning that fuels the clinical encounter making it a vehicle for change.

APPENDIX A

Symbolization of Object Relations Scale (SORS)

- | | |
|--|-----------------|
| 1) Does representation of the other exist;
does the patient mention another person? | yes) 1
no) 0 |
| 2) Is the other a significant person, either a family
member, loved one, or close friend? | yes) 1
no) 0 |
| 3) Is there specificity in description of other
in terms of attributes, feelings towards,
experiences with, or role in relation to self? | yes) 1
no) 0 |
| 4) Is the patient (self) described as being active
toward the object? | yes) 1
no) 0 |
| 5) Is there an interaction between self and other?
(the two are mutually interacting)
* Delusional interaction does not count. | yes) 1
no) 0 |
| 6) Is the interaction with a significant other,
defined as family member, loved one, or close
friend? | yes) 1
no) 0 |
| 7) Is the interaction described with specificity
in terms of attributes, feelings towards,
experiences with, or type of relationship? | yes) 1
no) 0 |
| 8) Is there an interaction between two others
described by self? (the patient is the observer
of the interaction). | yes) 1
no) 0 |
| 9) Is the interaction between two others defined
as involving a family member, loved one, or close
friend? | yes) 1
no) 0 |
| 10) Is the interaction described with specificity
in terms of attributes, feelings towards,
experiences with, type of relationship? | yes) 1
no) 0 |
| 11) Does the patient represent past and present
experiences of a relationship or is there a
linking of past relationships with present
relationships? | yes) 1
no) 0 |
| 12) Does the patient articulate conflict defined
as 2 antagonistic, or contradictory wishes that
can not be reconciled toward the other? | yes) 1
no) 0 |

no - all good (idealized) or
all bad (antagonistic)

- 4) Is the patient (self) described as being active toward the object?

To get a score of one the patient must describe him/herself as being active towards the object.

An example of a score of one is:

I told my mother that she can not come to visit tonight.

An example of a score of zero is:

I do not want my mother to visit but she keeps coming by.

- 5) Is there an interaction between self and other? (the two are mutually interacting).
* Delusional interaction does not count.

To get a score of one the patient must mention an interaction with another person. The interaction can be a dialogue or action performed together, or description of experiences or feelings between the two people.

An example of a score of one is:

My roommate and I went out on a walk.

An example of a score of zero is:

My roommate came into the kitchen while I was there.

- 6) Is the interaction with a significant other, defined as family member, loved one, or close friend?

To get a score of one it must be clear that the person mentioned in the interaction is more than just an acquaintance. There should be some reference to a relationship that has existed over time. The relationship might be elaborated at different points in the text. If the relationship is unclear, give it a zero.

An example of a score of one is:

Over the weekend my sister and I went shopping.

An example of a score of zero is:

This morning Kim and I had coffee.

- 7) Is the interaction described with specificity in terms of attributes, feelings towards, experiences with, or type of relationship?

To get a score of one there must be an adequate description of the person mentioned in the interaction so that the rater can get a sense of the relationship.

An example of a score of one is:

Over the weekend my sister took me shopping. She has such a good sense of style. She always helps me decide what to buy because I can never decide. She takes good care of me.

An example of a score of zero is:

My sister took me shopping and it rained.

- 8) Is there an interaction between two others described by self? (the patient is the observer of the interaction).

To get a score of one the patient must describe an interaction between two other people. The interaction can be a dialogue or action performed by the others, or a description of the behavior or feelings of the two or more people being discussed.

An example of a score of one is:

I saw Jane and Mark talking in the kitchen.

An example of a score of zero is:

Jane came into the kitchen while Mark was eating his breakfast.

- 9) Is the interaction between two others defined as involving a family member, loved one, or close friend?

To get a score of one it must be clear that the person mentioned in the interaction is more than just an acquaintance. There should be some reference to a relationship that has existed over time. The relationship might be elaborated at different points in the text. If the relationship is unclear, give it a zero.

An example of a score of one is:

My sister and mother were arguing about who was going to take care of my children.

An example of a score of zero is:

Jane and Mark were arguing in the kitchen.

- 10) Is the interaction described with specificity in terms of attributes, feelings towards, experiences with, type of relationship?

To get a score of one there must be an adequate description of at least one of the people mentioned in the interaction so that the rater can get a sense of the relationship being described. There can be a relationship between the patient and the people described in the interaction, or the patient can describe an interaction in great detail without specifying his/her relationship to the people involved.

An example of a score of one is:

My sister was trying to explain to my mother that I need a lot of support right now. She understands how difficult it is for me to take care of my children. My mother just does not understand and feels that I am being lazy.

An example of a score of zero is:

Jane and Mark were arguing in the kitchen. He seemed very nervous. She looked sad.

- 11) Does the patient represent past and present experiences of a relationship or is there a linking of past relationships with present relationships?

To get a score of one the patient must make reference to past and present aspects of a relationship.

An example of a score of one is:

My sister has always taken good care of me. When I was little she always helped me with my homework. I missed her when she went away. Lately we have spent more time together.

An example of a score of zero is:

Over the weekend my sister took me shopping. She has such a good sense of style. She helps me decide what to buy because I can never decide.

- 12) Does the patient articulate conflict defined as 2 antagonistic, or contradictory wishes that can not be reconciled toward the other? (no = all good (idealized) or all bad (antagonistic)).

To get a score of one the patient must describe both positive and negative aspects of a relationship

An example of a score of one is:

My sister has been so nice to me since I have been in the hospital. She is always so good. But I do not understand why she went away for so long and did not keep in touch. I am still angry at her for not helping me more.

An example of a score of zero is:

My sister is so good. She always knows the right thing to do.

or

I hate my sister. She never helps me.

- 13) Is there reference to doctor, therapist, or therapeutic relationship?

To get a score of one the patient must make reference to a doctor, therapist or the therapeutic relationship.

An example of a score of one is:

My therapist says that I need to tell my sister how I feel when she leaves.

An example of a score of zero is:

I am so glad that I get to leave the hospital tomorrow.

APPENDIX B

SYMBOLIZATION OF NARRATIVE SCALE (SONS)

In general we consider a symbolizing narrative structure to include four specific components: 1) Linking Structures, 2) Specification, 3) Narrative Coherence, and 4) Sentence Structure.

1) LINKING STRUCTURES

Linking Structures are defined as those elements which connect idea units together. Linking structures are divided into three groups: A) Repetitional Linking Ties, B) Substitutional Linking Ties, and C) Conjunctive Linking Ties.

A) Repetitional Linking Ties

Repetitional linking ties connect through repetition by using the same word, a synonym, or a near synonym.

Example - I bought a table. The table was big.
I bought a painting. It was a portrait.

**Repetitive phrases - when the entire phrase is repeated.

Example - Dan went home. Dan went home.

B) Substitutional Linking Ties

Substitutional linking ties connect by making reference to the subject by using other words as substitutes such as 1) pronouns and possessive adjectives, 2) demonstratives, 3) references to identity, or 4) implied substitutions.

1) Pronouns and possessive adjectives such as his, her, she, he, its, which, they, us, are used to substitute for a person's name.

Example - John went down the block. Later he returned home.

2) Demonstratives such as this, these, that, those, here and there are used to refer to objects and locations.

Example - Maybe I'll go to the gym later. You'll see me there.

3) Reference to identity is used to refer to subject without naming it by using words such as same, equal, identical(ly), similar(ly), other, different, else, otherwise, as well, one, ones, or the same.

Example - I bought new wine glasses last year. I bought the same ones today.

4) Implied substitution is when the noun is omitted altogether but the reference is clear.

Example - I just bought two books, I want to buy two more. (books)

C) Conjunctive Linking Ties

Conjunctive linking ties connect thoughts and sentences by similarity, contrary to expectation, causal relation or temporal sense. Conjunctive linking ties can be Additive ties, (connection through similarity), Adversative ties, (connection through contrary to expectation), Causal ties, (connection through causal relation), or Temporal ties, (connection through a temporal sense).

Additive Simple Ties connect sentences by similarity using the word and.

Example - She went to the store. And she bought some grapes.

Additive Complex Ties connect by similarity using the words also, nor, else, furthermore, add to that, alternately, by the way, as far as,

Example - She does not like him. Nor does she like his family.

Adversative Ties connect through the relation of "contrary to expectation" expressed by words: yet, though, only but, however, even so, all the same, in fact, actually, conversely, instead, on the contrary, rather, at least, I mean, or, rather, in any case, any how, somehow, unless, other than that, except that, although.

Example - It was a nice car. The price, however, was too high.

Causal Ties express a causal relation of result, reason or purpose expressed by words: so, therefore, consequently, on account of this, in consequence, for, because, it follows, to this end, in that case, otherwise, under the circumstances, in this respect.

Example - The library was closed. So she went to the movies.

Temporal Ties - express a relation through time by using words then, next, just then, before that, in the end, at first, formerly, now.

Example - First we went to the museum. Then we went out for coffee.

2) SPECIFICATION

Specification involves two components, A) Specification of intent and B) Specification of predication.

A) Specification of intent requires the presence of a grammatical subject, an event and some linguistic link either an adverb, auxiliary verb or a prepositional phrase that specifies the relation between the subject and event by making reference to the mode, desire, degree, or temporal sense. It is usually adverbs, auxiliary verbs, or prepositional phrases that elaborate the relation between subject and object.

Mode. The event is contingent on the idea of possibility and recognized by the auxiliary verbs might, must, could, would, or should.

The examples are: She might go away. She should go away.

Desire. The event is presented as the subject's intention, will or desire recognized by the verbs want, hope, plan, try.

The examples are: She hoped to go away. She tried to go away.

Degree. The subject's degree of participation is specified by adverbs and adjectives such as really and kind of.

The examples are: She really wanted to go away. She kind of wanted to go away.

Temporal perspective. The event is described in a temporal sense by specifying the action as beginning, finished or happening in the present.

The examples are: She started to go. She finished her travels. She is traveling.

** A temporal perspective not measured by clocks or calendar is demonstrated by the use of adverbs such as never, occasionally.

The examples are: He never went away. He occasionally went away.

B) Specification of Predication involves the addition of a verb phrase so that there is always more than one grammatical subject. These are more complex statements that contain the agent of the event being talked about and the subject of the added verb phrase whose subjectivity is being commented upon. In these more complex statements,

there is a greater interplay between events, actors and the actors' subjective experience or point of view. It is a way to comment on or to relate the actions or experiences of one person to him/herself or to someone else. A subject relates the actions of him/herself or of another person to him/herself or to another person by using a direct quote, or speculating on his/her performance in the present, past or future. A subject is usually reflecting or commenting on the actions or experiences of him/herself or another person and considering what kind of effect it has had on him/herself or on someone else.

The category of 'inner reflections of self and others' is used to contain the principle that all predications represent some form of inner dialogue of the speaker, or state of reflection, where the speaker is, or is becoming, aware of him/herself (inner reflections of self) or another person (inner reflections of others) and communicates this information. For example consider the statement "I realized that she wanted to go away". The addition of the new verb phrase "I realized that" to the basic event "she wanted to go away" indicates that the speaker gained an awareness of the "going away" event. This statement emphasizes the speaker's acquisition of awareness of the event, rather than the simple fact that it took place. It is an inner reflection about another person. The following list contains examples of predication subtypes of the category "inner reflections of self and others'.

Inner reflections of self and others

- a) There can be distinctions between being and seeming.

Examples are: I pretended to love him. She pretended to love him.

- b) The subject learns, does cognitive work to acquire knowledge or awareness of some other event.

Examples are: She learned that he never loved her. His frown showed her how sad he was.

- c) The subject transmits knowledge of an event to him/herself or to another subject.

Example are: She said to herself 'I do not really love him'. She told him she did not love him.

- d) The subject has an awareness of knowledge of a perspective towards event located in the future.

Examples are: She thinks she will love him. She thinks he will love her.

- e) The subject has an opinion about an event that is happening in the present.

Examples are: She thinks she loves him. She thinks he loves her.

- f) A perspective towards an event is formulated and the content of that perspective is the result of the event. (enjoyed, disliked).

Examples are: I was confused when he left me. She was confused when he left her.

- g) A subject expresses an intention, wish, desire that is linked to the action of some other subject.

Example is: I want you to come over.

3) NARRATIVE COHERENCE

Narrative coherence is described by a summary statement that reflects the quality of the thematic cohesion within the narrative.

1) Poor - The narrative has a tangential quality; many different ideas presented without much connection or development. Or a single theme is presented without any development. The narrative has a barren quality to it.

2) Fair - Many themes are presented and are not that developed. They are loosely connected to each other.

3) Good - Few themes are presented which are developed adequately. There is a richness of description.

4) SENTENCE STRUCTURE

Sentence structure is described by a summary statement that reflects the quality of the sentence structure within the narrative.

1) Poor - Sentences are run on, fragmented with poor grammar. The narrative contains mostly simple sentences.

2) Fair - There is a mixture of grammatically correct sentences with sentence fragments and run on sentences. There is a mixture of simple and complex sentences.

3) Good - Most sentences are grammatical correct. The narrative contains mostly complex sentences.

Scoring Sheet

1) Linking Structures

A) Repetition _____ B) Substitution _____

C) Conjunctive ties

Additive Simple _____ Additive Complex _____

Adversative _____ Causal _____ Temporal _____

Total Ties _____

2) Specification

A) Specification of intent

Mode _____ Intention _____ Degree _____

Temporal Perspective _____

Total _____

B) Specification of Predication

Inner reflections of self and others _____

Total _____

3) Narrative Coherence

1) poor - _____

2) fair - _____

3) good - _____

4) Sentence Structure

1) poor - _____

2) fair - _____

3) good - _____

APPENDIX C

The Four Scales For Rating LAO

A. LEVELS OF SELF AND OBJECT REPRESENTATION (MANIFEST IN PRONOUN USE)

- 6 - Self as agent interacting with objects (mutuality, "we").
- 5 - Representation of self acting on the object (I---> he or she).
- 4 - Representation of object acting on the self (he, she --> me).
- 3 - Oscillation between "me" and "not me" (I/it).
- 2 - Frequent use of impersonal pronouns (Emphasis on "it", "I" and "You" rarely used.
- 1 - Blocking: no definable pronoun use.

B. LEVELS OF SYMBOLIC REPRESENTATION

- 6 - Integration of interrelated personal experiences: self reflectiveness.
- 5 - Connections between interrelated personal experiences.
- 4 - Preoccupation with concrete, personally relevant experiences.
- 3 - Affirmation or negation of personal meanings.
- 2 - Incapacity to represent symbolically; i.e., repetition, stereotypy; delusional projection.
- 1 - Blocking: i.e., no content.

C. LEVELS OF TOLERANCE FOR AMBIVALENCE

- 6 - Integration of affective experiences in relation to conflicting goals and values.
- 5 - Representation of ambivalence; contradictory affects can be simultaneously held in consciousness.
- 4 - Stubborn adherence to one set of experiences with alternatives excluded.
- 3 - Oscillation between positive and negative affective experiences (splitting of objects).
- 2 - Rapid alternation of fragmentary affective experiences (schizophrenic ambivalence).
- 1 - Blocking, flat affect, affect unavailable to consciousness.

D. LEVELS OF SELF-EXPERIENCE

- 6 - Capacity to attain one's goals and values in the external world.
- 5 - Conflict over wishes concerning self-satisfaction independent of object satisfaction (stable self can experience conflict).

- 4 - Over-emphasis on self experience. The object is experienced only peripherally. Illusions of self-sufficiency; narcissistic coldness.
- 3 - Oscillations with self-experience; the self is dependent on the external object.
- 2 - Fusions and confusions between the self and the object world.
- 1 - The self is undifferentiated from the external world; blocking and discharge.

TRACING THE ASSOCIATIVE PROCESS Berzofsky and Freedman

Raters are alerted to both the content of the narrative productions as well as the manner in which the content is manifest. With respect to the first two dimension (i.e., the capacity to represent self and object, and the capacity for symbolic representation), the scales tap the relatively formal aspects of mental organization as revealed in the patient's manner of structuring his language product. With regard to the last two dimensions (i.e., the capacity to tolerate ambivalent affective experiences, and the capacity to articulate self experience), the scales tap the qualities of experience that may be inferred from the content of the patient's narrative.

THE FOUR DIMENSIONS OF ASSOCIATIVE ORGANIZATION

A. The capacity to represent self and object. The capacity to represent self-experience and object-experience in relatively discrete terms is an important developmental achievement. Out of an initially undifferentiated matrix, there occurs a gradual emergence of both the self and the object as relatively independent entities in interaction with one another. Since language itself is an important factor in this developmental achievement, we look to the language product for manifestations of the degree to which the self and object are represented discretely. The evaluation of this capacity is assessed, here, through the patient's use of pronouns. Thus, the optimum level of representing self and object is reflected in the patient's capacity to establish relations between a clearly distinguishable "I" and "you." In assessing this dimension, the rater should also be attuned to the state of agency of the self (i.e., whether it appears in the active or passive position) with respect to object relevant experience.

At the highest level of self and object experience, representations appear in the form of "I", "me," "I-you"

"me-you" linkages. At intermediate levels, there is an oscillation between the "me/not me" relation; that is, between the "I" and the "it." At the lowest levels, there is no reference at all to an "I" or a "me." Rather, object relevant experiences are, at best, given by the impersonal pronoun "it."

This method for evaluating self and object experience from verbal text has proven useful in previous studies (Freedman, 1980) comparing language samples of different psychopathological groups (e.g., schizophrenic, borderline, depressed, and "normal" volunteer subjects).

B. The capacity for symbolic representation. The individual's capacity to symbolize, that is, to transform inner experience into a shared code, is another developmental achievement. By meaningful symbolization we refer to that use of language which reveals a capacity for self-conscious awareness and a sense of the broader context within which concrete personal experience can be embedded. At the highest level of symbolization, the patient uses words not only as signs of the formal categories of experience, but is aware of the diverse and derivative categories of meaning and affect which are associated with such concrete experience. In scoring this dimension, raters should be attuned to the specificity, or explicitness of content; to the use of affect-related adjectives or references to affect; to changes in thematic structure; and to reflectiveness in the patient's narration.

While self-reflectiveness and the establishment of connections between experiences represent the highest levels of meaningful symbolic representation, at intermediate levels, this capacity is seen in the preoccupation with concrete personally relevant experience and oscillations between affirmation and negation of meanings. At the lowest levels, repetition and stereotypy prevail, or an apparent absence of the capacity to symbolize appears.

The empirical basis for our conception of the capacity for meaningful symbolic representation comes from a series of studies at our center focusing upon the referential activity of subjects drawn from various psychopathological and normal populations and engaged in monologue and dialogue/speech (Freedman, in press; Bucci & Freedman, 1981).

C. The capacity to tolerate ambivalent affective experiences. The capacity to tolerate ambivalence, that is, to hold conflicting and contradictory experiences in consciousness, is another major developmental achievement. At the highest level of affective functioning, the patient

reveals the capacity for a realistic relation to whole objects in his world. Objects are neither totally good nor totally bad, but contain aspects of both which are tolerated and which contribute to a more complex affective experience. For this dimension, raters are required to make inferences from the content of the narrative rather than point to instances of formal language structure appearing in the text. The rater is asked to infer from the content, the form of the affective experience (i.e., is it integrated or contradictory), and the extent to which the affect can be maintained in consciousness.

At the highest levels, the patient is able to integrate divergent and often antagonistic feelings in relation to goals and values vis-a-vis the object world, or at least is able to hold such divergent affects in consciousness while he tries to resolve dilemmas. At intermediate levels, there is a stubborn adherence to one set of experiences or an oscillation between positive and negative affects vis-a-vis the object. At the lowest levels, there is either a fragmentation of affect, often occurring in a dissociative form, such that one could infer that neither positive nor negative affects are being experienced, or total blocking of any affective experience occurs.

The clinical thinking underlying this dimension finds its power in the earlier writings of Winnicott (1954) and the more recent writings of Steingart (1983).

D. The capacity to articulate self-experience. The evolving of a cohesive self is yet another dimension representing a major developmental achievement. The emergence of a clearly defined boundary between self and object and a subjective sense of continuity in the attainment of one's goals and values in the object world is the hallmark of the highest level of functioning on this dimension. Again, as for dimension C, the capacity to articulate a cohesive self-experience derives from the content of the patient's narrative and not from formal properties of language. As such, it focuses on the patient's narrative and not from formal properties of language. As such, it focuses on the patient's experience of self, rather than upon pronoun usage, as in dimension A.

At the highest level of this dimension, the focus is upon attainments and satisfaction in the object world as they relate to self-experience. At intermediate levels, there is either an excessive emphasis on self-experience (a kind of rigidity excluding the object world) or an extreme oscillation between self and object experiences resulting in the defense of splitting. Finally, at the lowest levels, there occur fusions with the object or a totally selfless and objectless world (i.e., autism).

A large clinical literature has emerged over the past 30 years which provides the theoretical source for this dimension. Notable in this regard are the writings of Mahler (1968), Jacobson (1964), and Winnicott (1965).

Note: We are aware of the contribution made by Gendlin's "Experiencing Scale" depicting an individual's relative capacity to integrate the flow of inner promptings and to include these in the communication about Self. While there is a recognized similarity between the seven anchoring points of the Gendlin scale and in the six anchoring points of the LAO scales, it was the intention of the investigators to adhere to a levels notion which closely parallels our conception of levels of integrative failure.

APPENDIX D

Patient Characteristics

Patients Sex DOB Race Educ Diag

Monologue StudySymbolizers

B.A.	F	1961	W	HS	ChronSchiz
M.B.	F	1947	B	Col	ParaSchiz
T.C.	F	1955	B	Col	ParaSchiz
S.D.	M	1957	W	HS	Schizophreniform

Average DOB = 1955

Non-symbolizer non-changers

N.H.	F	1954	B	HS	Schizophrenia
R.I.	F	1955	B	HS	ParaSchiz
B.J.	F	1956	B	Col	ParaSchiz
G.K.	F	1956	W	Col	ChronParSchiz

Average DOB = 1955

Non-symbolizer changers

R.T.	F	1960	B	HS	ParaSchiz
A.U.	F	1958	B	HS	ChronParaSchiz
J.V.	F	1955	B	HS	Schizo affect
M.W.	F	1946	W	HS	ChronParaSchiz
L.X.	F	1925	W	HS	Bipolar
W.Y.	M	1962	B	HS	Schizophrenia

Average DOB = 1951

Therapy StudyDesymbolizer changers

J.J.	F	1955	B	Col	ParaSchiz
J.M.	M	1951	W	Col	ChronParaSchiz

Average DOB = 1953

Col = college
HS = high school



DEPARTMENT OF PSYCHIATRY

APPENDIX E

Obtaining Consent:
Instructions to Patients
(Oral)

As you know, this is a teaching hospital and research is conducted here on a regular basis to help us learn how to better help people like yourself. I would like to request that you participate in a study of how people talk about their problems. This will involve taking several tests and being interviewed by one of the other psychology staff members (on tape) in addition to permitting your regular therapy sessions with me to be audiotaped. The tapes and test data will be kept strictly confidential. You will be given an identifying number so that your name will not appear on the data. The data will be seen only by myself and designated staff members of the Psychology Department, working under the auspices of Dr. Norbert Freedman and Dr. Ken Feiner. Again, this is strictly for research and teaching purposes, but may benefit you in your present treatment as well as helping us to better help patients who follow after you. The results of this study will be accessible to you when the study is completed, if you are interested. You should also be aware that you may refuse to participate, with no negative consequences for yourself or your treatment. You may also drop out of the study at any time you choose. If, however, you agree to participate, you must sign a form acknowledging your consent. If, after you read the form, you have any questions, please let me know, so I can answer them for you.

REFERENCES

- Ainsworth, M.D.S. (1979). Attachment as related to mother-infant interaction. In J.B. Rosenblatt, R. H. Hinde, C. Beer, and M. Bushell (Eds), Advances in the study of behavior (pp. 1-51). New York: Academic Press.
- Bach, S. (1985). Narcissistic states and the therapeutic process. New York: Jason Aronson, Inc.
- Barrett, B. (1990). Reawakening the revolution of psychoanalytic method: Notes on the human subject, semiosis and desire. Psychoanalysis and Contemporary Thought 13, (1) 139-163.
- Beck, A.T., Ward, C.H. Mendelson, M., and Erbaugh, J. (1961) An inventory for measuring depression. A.M.A. Arch. Gen. Psychiat., 4:561-571.
- Berman, L. (1985). A comparison of discourse maintenance in learning disabled and non-learning disabled children's conversations. Unpublished doctoral dissertation. The New School for Social Research.
- Berzofsky, M. & Freedman, N. (1988, February). Tracing the associative process. Paper presented at the meeting of American Psychological Association, Division 39, San Francisco, CA.
- Berzofsky, M., Freedman, N. & Passik, S.D. (1988) Alterations in associative organization during brief hospitalization. Unpublished manuscript.
- Bion, W.R. (1967). Second Thoughts. New York: Jason Aronson, 1967.
- Bion, W.R. (1962a). Learning from Experience. New York: Basic Books.
- Bion, W.R. (1959). Attacks on linking. International Journal of Psycho-Analysis 40: 308-315.
- Blatt, S. L., Brenneis, B., Schimek, J. G., & Glick, M. (1976). Normal development and psychopathological impairment of the concept of the object on the Rorschach. Journal of Abnormal Psychology, 85, 364-373.
- Blatt, S. J., & Lerner, H. (1983). Investigations in the psychoanalytic theory of object relations and object representations. In J. Masling (Ed.), Empirical studies of psychoanalytic theories (Vol.I, pp. 189-249). Hillsdale, NJ: Lawrence Erlbaum.

Blatt, S. L., Ritzler, B. A. (1974). Thought disorder and boundary disturbances in psychosis. Journal of Consulting Clinical Psychology, 42, 370-381.

Blatt, S. J. Schimek, J.G., & Brenneis, C. B. (1980). The nature of the psychotic experience and its implications for the therapeutic process. In J. Strauss et al., eds., The Psychotherapy of Schizophrenia. New York: Plenum.

Blatt, S. J., Wein, S., Chevron, E. S., & Quinlan, D. M. (1979). Parental representations and depression in normal young adults. Journal of Abnormal Psychology, 78, 388-397.

Bowlby, J. (1980). Attachment and loss: Vol. 3. Loss: Sadness and depression. New York: Basic Books.

Bransford, J.D. (1979) Human cognition: Learning, understanding, and remembering. Belmont, CA: Wadsworth Publishing Company.

Brenner, C. (1982). The Mind in Conflict. New York: International Universities Press.

Bruner, J. S. (1986). Actual Minds, Possible Worlds. Cambridge, MA: Harvard University Press.

Bucci, W. (1985). Dual coding: A cognitive model for psychoanalytic research. Journal of the American Psychoanalytic Association, 33, 571-607.

Buss, A. H. (1961). The Psychology of Aggression. New York: John Wiley.

Buss, A., and Durkee, A. (1957). An inventory for assessing different kinds of hostility. J. Consulting Psychology, 21, 343-349.

Cassirer, E. (1957). The Philosophy of Symbolic forms, Vol., III: The Phenomenology of Knowledge. New Haven: Yale University Press.

Dahl, H. (1991). The key to understanding change: Emotions as appetitive wishes and beliefs about their fulfillment. In J. Safran & L. Greenberg (Eds.) Emotion, Psychotherapy & Change. New York: Guilford Press.

Endicott, J. Spitzer, R.L., Fleiss, J. L., & Cohen, J. (1976). The Global Assessment Scale: A Procedure for measuring overall severity of psychiatric disturbance. Archives of General Psychiatry, 33, 766-771/

Essig, T. (1989). Self-disclosing discourse features in an investigation of therapeutic change during short-term inpatient psychiatric treatment. Unpublished doctoral dissertation, The Graduate Faculty of the New School for Social Research, Department of Psychology, New York.

Fishler, P. H., Sperling, M. B., Carr, A. C. (1990). Assessment of Adult Relatedness: A review of empirical findings from object relations and attachment theories. Journal of Personality Assessment, 55 (3&4), 499-520.

Freedman, N. (1985). The concept of transformation in psychoanalysis. Psychoanalytic Psychology, 2 (4), 317-339.

Freedman, N. (1986) On depression: The paralysis, annihilation, and reconstruction of meaning. In J. Masling (Ed.) Empirical Studies of Psychoanalytic Theories, Volume II. Hillsdale, New Jersey, The Analytic Press.

Freedman, N., & Berzofsky, M. (1990, June). Change in associative organization during brief treatment. Paper presented at the Society for Psychotherapy Research, Wintergreen, Virginia.

Freedman, N., & Berzofsky, M. (1992, May). The Shape of the Communicated Transference in Difficult and Not-So-Difficult Patients. Paper presented at The New York Academy of Medicine, New York, New York.

Freedman, N., & Berzofsky, M. (1995). Shape of the communicated transference in difficult and not-so-difficult patients: symbolized and desymbolized transference. Psychoanalytic Psychology, 12(3), 363-374.

Freedman, N., O'Hanlon, J., Oltman, P., & Witkin, H.A. (1972). The imprint of psychological differentiation on kinesthetic behavior in varying communicative contexts. Journal of Abnormal Psychology, 79, 239-258.

Freedman, N., & Wilke, S. (1994) Toward a descriptive language of clinical discourse - symbolization and de-symbolization in the course of psychoanalytic therapy. Provisional manuscript, from the research Unit for the Study of Communication in Psychoanalysis and Psychotherapy, Department of Psychiatry, SUNY Health Science Center at Brooklyn.

Freud, S. (1917). Mourning and Melancholia. In General Psychological Theory. New York: Macmillan Publishing Co., 1963.

Freud, S. (1921). A differentiating Grade in the Ego. In Group Psychology and the Analysis of the Ego. (trans. & ed. J. Strachey). New York: W.W. Norton & Company, Inc., 1959.

Freud, S. (1923). The Ego and the Id. (trans. J. Riviere, & ed. J. Strachey). New York: W.W. Norton & Company, Inc., 1960.

Gill, M., & Hoffman, I. (1982) A method for studying the analysis of aspects of the patient's experience of the relationship in psychoanalysis and psychotherapy. Journal of the American Psychoanalytic Association, 30. 137-167.

Gottschalk, L.A., Gleser, G. C. (1969a). The measurement of psychological states through the content analysis of verbal behavior. Irvine: University of California Press.

Gottschalk, L. A., Gleser, G. C., & Winget, C. N. (1969). Manual of instructions for using the Gottschalk-Gleser content analysis scales: Anxiety, hostility, and social alienation-personal disorganization. Berkeley and Los Angeles: University of California Press.

Gottschalk, L. A., Hoigaard, J. C., Birch, H., & Rickels, K. (1976). The measurement of psychological states: Relationships between Gottschalk-Gleser content analysis scores and Hamilton Anxiety Rating Scale scores, Physician Questionnaire Rating Scales scores, and Hopkins Symptom Checklist scores. In L. A. Gottschalk & S. Merlis (Eds.), Pharmacokinetics of psychoactive drugs: Blood levels and clinical response (pp. 61-113). New York: Spectrum.

Gottschalk, L. A., Winget, C. M., Gleser, G. C., and Springer, K. J., (1966). The measurement of emotional changes during a psychiatric interview: A working model towards quantifying the psychoanalytic concept of affect. In Gottschalk, L. A., and Auerbach, A. H. (Eds.), Methods of Research In Psychotherapy. New York, Appleton-Century-Crofts.

Giliani, Z. H., Bucci, W. & Freedman, N. (1985) The structure and language of a silence. Semiotica, 56, 99-113.

Green, A. (1986). On Private Madness. Connecticut: International Universities Press.

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

Halliday, M., & Hasan, R. (1976). Cohesion in English. London: Longman.

Hartmann, H. 1953. Ego psychology and the problem of adaptation. New York: International Universities Press.

- Hartman, H., Kris, E., & Lowenstein, R. M. (1949) Notes on the theory of aggression. Psychoanalytic Study of the Child, 3/4:9-36.
- Jakobsen, R. (1960). Closing statement : Linguistic and poetics. In T. Sebeok (Ed.). Style in language. Cambridge: MIT Press.
- Jones, E. (1948). The theory of symbolism. In: Papers on psychoanalysis, (5th ed., pp. 87-144). Baltimore: Williams and Wilkins.
- Klein, M. (1930). The importance of symbol-formation in the development of the ego. In M. Klein. Love, guilt, reparation and and other works, (p.219-232). New York: The Free Press.
- Klein, M. (1975). Love, guilt, reparation and and other works 1921-1945. New York: The Free Press.
- Klein, M. (1975). Envy and Gratitude and other works 1946-1963. New York: The Free Press.
- Kohut, H. (1978). The search for the self, vols. 1 and 2. Ed. P. Ornstein. New York: International Universities Press.
- Kris, E. (1956). On some vicissitudes of insight in psychoanalysis. International Journal of Psych-Analysis, 37,445-455.
- Krohn, A., & Mayman, M. (1974). Object representations in dreams and projective tests. Bulletin of the Menninger Clinic, 38, 445-466.
- Langer, S. K. (1967). An introduction to Symbolic Logic. New York: Dover Publications.
- Langer, S. K. (1942). Philosophy In a New Key : Cambridge: Harvard University Prehss.
- Langs, R. D. (1978-1979). Some communicative properties of the bipersonal field. International J. Psychoanal. Psychotherapy. 7:87-135.
- Langs, R., Bucci, W., Udoff, A. L., Cramer, G., & Thomson, L. (1993). Two methods of assessing unconscious communication in psychotherapy. Psychoanalytic Psychology. 10 (1), 1-16.
- Leigh, J., Westen, D., Barends, A., Mendel, M.J., & Byers, S. (1992). The Assessment of complexity of representations of people using TAT and Interview Data. Journal of Personality 60:4, 810-837.

Loewald, H.W. (1983, March) Comments on the psychoanalytic concept of symbolism. Hartmann Award lecture, New York Psychoanalytic Institute/Society, New York, NY.

Loewald, H.W. (1988). Sublimation: inquiries into theoretical psychoanalysis. New Haven: Yale University Press.

Luborsky, L. (1993). How to maximize the curative factors in dynamic psychotherapy. In N. E. Miller, L. Luborsky, J. P. Barber, & J.P. Docherty. Psychodynamic treatment research: A handbook for clinical practice. New York: Basic Books. 519-535.

Luborsky, L. (1977). Measuring a pervasive psychic structure in psychotherapy: The core conflictual relationship theme. In N. Freedman and S. Grand (Eds.), Communicative structures and psychic structures (pp. 367-395). New York: Plenum Press.

Luborsky, L., Docherty, J.P., Miller, N. E., & Barber, J.P. What's here and what's ahead in dynamic therapy research and practice. (1993) In N. E. Miller, L. Luborsky, J. P. Barber, & J.P. Docherty. Psychodynamic treatment research: A handbook for clinical practice. New York: Basic Books. 536-553.

Mahl, G.F. (1987) Everyday disturbances of speech. In R.L. Russell (Ed.). Language in psychotherapy: Strategies of discovery (pp. 213-272), New York: Plenum Press.

Mahler, M., Pine, F. & Bergman, A. (1975). The psychological birth of the human infant: Symbiosis and individuation. New York: Jason Aronson.

Malinowski, B. (1938). The problem of meaning in primitive languages. In C.K. Ogden & I.A. Richards (Eds.). The meaning of meaning. New York: Harcourt, Brace & Co.

Malinowski, B. (1948). Magic, science, and religion. Garden City: Doubleday.

Mayman, M. (1967). Object representations and object relations in Rorschach responses. Journal of Projective Techniques and Personality Assessment, 31, 17-24.

Murphy, L. (1993). Associative organization and depression in language between admission and discharge of hospitalized male and female schizophrenics. Unpublished manuscript.

Ogden, T.H. (1990). The Matrix of the Mind. London: Jason Aronson Inc.

Oken, D. (1960). An experimental study of suppressed anger and blood pressure. A.M.A. Arch, Gen. Psychiat., 2: 441-456.

Overall, J.E. & Gorham, D.R. (1962). The brief psychiatric rating scale, Psychological Reports, 10, 799-812.

Piaget, J. (1962). Play, dreams and imitation in childhood. New York: Norton.

Porcerelli, J. H., Dietrich, D.R. (1994) Dietrich Object Relations and Object Representations Scale: Convergent and Discriminant Validity and Factor Structure. Psychoanalytic Psychology, 11 (1), 101-113.

Ragin, A. & Oltmanns, T. (1986). Lexical cohesion and formal thought disorder during and after psychotic episodes. Journal of Abnormal Psychology, 95(2), 181-183.

Rochester, S., & Martin, J.R. (1979). Crazy talk: A study of the discourse of schizophrenic speakers. New York: Plenum Press.

Rosen V. (1969). Sign phenomena and their relationship to unconscious meaning. International Journal of Psychoanalysis, 50, 197-207

Rosen, V. (1977). Style, character and language. New York: Jason Aronson.

Russell, R. (1987b). Processive outcomes in psychotherapy: Toward a theory of narrative pluralism and change. In W. Huber (Ed.), Progress in psychotherapy research. Journal of Consulting and Clinical Psychology, 54, 16-21.

Russell, R., Van Den Broek, P. (1992) Changing narrative schemas in psychotherapy. Psychotherapy, 29 (3) 344-354.

Schafer, R. (1958). How Was The Story Told? Journal of Projective Techniques, 22 181-210.

Schafer, R. (1992). Retelling a life: Narration and dialogue in psychoanalysis. New York: Basic Books.

Schore, A.N. (1994). Affect regulation and the origin of the self: The neurobiology of emotional development. Hillsdale, NJ: Lawrence Erlbaum.

Segal, H. (1981). The work of Hanna Segal: A Kleinian approach to clinical practice. New York: Aronson.

Segal, H. (1964). Introduction to the work of Melanie Klein. New York: Basic Books, Inc.

Shapiro, T., (1992) Words and feelings in the psychoanalytic dialogue. In T. Shapiro and R. N. Emde (Eds.), Affect: Psychoanalytic Perspectives. Connecticut: International Universities Press, Inc.

Singer, M. T., & Wynne, L. C., (1965). Thought disorder and family relations of schizophrenics. IV. Results and implications. Archives of General Psychiatry, 12. 201-212.

Smith, M.L. & Glass, G. (1977). Meta-analysis of psychotherapy outcome studies. American Psychologist 32, (9) 752-760.

Smith, M.L., Glass, G., & Miller, T. (1980). The Benefits of Psychotherapy. Baltimore: John Hopkins University Press.

Spence, D. (1982). Narrative truth and historical truth: Meaning and interpretation in psychoanalysis. New York: W. W. Norton.

Stern, D. (1985) The Interpersonal World of the Infant. New York: Basic Books.

Steingart, I. & Freedman, N. (1972). A language construction approach for the examination of self/object representation in varying clinical states. Psychoanalysis and Contemporary Science, 1, 132-178.

Teller, V., & Dahl, H. (in press). The characteristics, identifications, and applicability of frames. In L. Luborsky, C. Popp, J. Barber, D. Shapiro, & N. Miller (Eds.), Seven transference-related measures: Each applied to the Ms. Smithfeild interview. Psychotherapy Research (Special Issue).

Todorov, T. (1977). The poetics of prose (R. Howard, Trans.). Ithaca: Cornell University Press. (Original work published 1971).

Tuber, S.B. (1989). Children's Rorschach object representations: Findings for a nonclinical sample. Psychological Assessment: A Journal of Consulting and Clinical Psychology, 2, 219-230.

Urist, J. (1977). The Rorschach test and the assessment of object relations. Journal of Personality Assessment, 41, 3-9.

Wallerstein, R.S. (1992). One psychoanalysis or many? In: Wallerstein, R.S. (Ed.), The Common Ground of Psychoanalysis, Northvale, New Jersey, Jason Aronson, Inc.

Werner, H. & Kaplan, B. (1963). Symbol Formation. New York: John Wiley & Sons.

Weston, D., Lohr, N., Silk, K. R., Gold, L., & Kerber, K. (1990). Object relations and social cognition in borderlines, major depressives, and normals: A TAT analysis. Psychological Assessment: A Journal of Consulting and Clinical Psychology, 2, 355-364.

Wicks, L. (1987). Speech production of severely disturbed psychiatric patients: A description of language patterns across the time of hospitalization within therapeutic sessions. Unpublished doctoral dissertation, New School for Social Research.

Winnicott, D.W. (1965). The Maturational Processes and the facilitating Environment. New York: International University Press, Inc.

Witkin, H.A., Lewis, H. B., & Weil, E. (1968). Affective reactions and patient-therapist interactions among more differentiated and less differentiated patients early in therapy. Journal of Nervous and mental Disease, 146, 193-208.

Wittenborn, J.R. (1955). Wittenborn psychiatric rating scales. New York: The Psychological Corporation.