# Therapeutic Communications and the Process of Change in a Psychoanalytic Treatment

**By**

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**Abstract**

**Therapeutic Communications and the Process of Change in a Psychoanalytic Treatment**

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This study looked at the interplay of the analyst verbal speech acts and the process of change in a psychoanalytic treatment. Using a single case design on the session transcripts of the well studied case of Mrs. C., following Halfon and Weinstein's (2013) methodology the study tracked linguistic patterns as represented by the interaction of fixed/exact repetitions and representational language, assessed through the patient's use of Referential Activity (Bucci, 1997). These linguistic structures organize the psychodynamic content and meaning of the exchange that is taking place between the analyst and his patient.

The representation of the different speech patterns in conjunction with the analyst's interventions allowed the creation of a map of the process inside the sessions at different points of the treatment. Results indicate that these speech patterns do not happen in a random way, 38% of the units evidenced a baseline speech pattern, 23% a symbolizing mode, 11% an overexcited mode, 8% a disengaged pattern and 3% of the units the patient was in a conflict mode.

One important finding was the addition of the baseline pattern as a distinct mode of psychic functioning. By analyzing the baseline segments a picture emerged that was characterized by the patient's usual defensive style. In these instances the patient is adhering to the fundamental rule, the alliance is in place, and the potential for symbolization and discovery is within reach. 52% of the time the analyst intervened this

is the type of speech pattern that preceded his interventions, 48% of the time after the analyst spoke the patient would go towards a baseline mode of functioning; both of these frequencies are significantly higher than those observed for any of the other reported patterns.

It was hypothesized that interventions with exploratory functions would evidence a greater disorganizing potential, which would be reflected by increased repetitions. Additionally interventions with linking qualities were predicted to have greater organizing potential to be evidenced in speech with greater symbolizing qualities and more integration. Quantitative analysis showed no significant findings for either of these hypotheses. Qualitative analysis, however, indicated that the way the analyst intervenes has an effect on the response that can be observed in the patient's speech, it was therefore suggested that the measures employed failed to capture this effect.

In terms of the evolution of the treatment it was predicted that the analyst would increase his level of activity as the treatment progressed and that he would use more interpretive comments in the later phases of treatment, additionally faster fluctuations in terms of the speech patterns would be observed as the treatment progressed. The data trended in this direction but statistical evidence did not corroborate these hypotheses. Qualitative observations note that interpretations become more detailed and transference based and explorations are aimed to unconscious fantasies in the later stages of treatment.

Finally integrating qualitative and quantitative results, questions of analytic technique and process are revisited using the concepts of Vigotsky's zone of proximal development (ZPD), thirdness and symbolization following Norbert Freedman's contributions.

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# Therapeutic Communications and the Process of Change in a Psychoanalytic Treatment

## Introduction

The effort to understand which aspect of the psychoanalytic method delivers its mutative power remains critical in an era of multiple models of therapeutic change. Questions about what constitutes psychoanalytic action and of how the analyst is able to facilitate change are not yet settled. How much emphasis is placed on the qualities of the relationship between the analyst and his patient or on the insight generated between them as the principal mutative agent of the patient's internal structure, is a matter that continues to be debated between the different schools of psychoanalytic thought. Although the clinical literature on questions of technique is very rich and continues to expand, the corresponding empirical research literature is relatively limited. As Westen and Gabbard (2003) point out, in psychoanalysis there is a long tradition of debating the subject of therapeutic action as if the question of how to best help our patients is one that can be settled by logical argument, when in fact it is an empirical question.

Mental life and human relationships have qualities that can be understood in terms of process, and qualities that can be understood in terms of structure (Bass, 2001). Typically in the clinical setting, structure refers to relatively fixed, stable and repetitive patterns of behavior that have been internalized by the patient, which generate a set of expectations that regulate his modes of interaction. The notion of process, on the other hand, is concerned with dynamic factors that contribute to the formation and modification of these very structures, namely the relationship between the analyst and his patient.

Models of therapeutic action are generally anchored to the relationship between process and structure. Questions of technique relate to uncovering qualities or events in the relationship that facilitate the most transformation in terms of the patient's internal structure. In other words, for the clinician the challenge is to find ways to effectively interact with the patient in a manner that allows their internal structure to change or expand; thereby creating new possibilities for relating, being and experiencing by transcending the limitations imposed by those very structures.

Since its foundation psychoanalysis has intended to have a dual aim, aspiring to be a theory of mental functioning, but also a theory of a technique to treat certain mental disorders. In Freud's words: "Psychoanalysis is the name (1) of a procedure for the investigation of mental processes which are almost inaccessible in any other way, (2) of a method (based upon that investigation) for the treatment of neurotic disorders and (3) of a collection of psychological information obtained along those lines, which is being accumulated into a new scientific discipline." (1923a (1922), p.235) Traditionally psychoanalysis has developed its insights on the processes and structures of the human mind and the psychic reality of individuals by engaging in a process –the analytic process-, considered by its proponents scientific and therapeutic at the same time. Much of the critiques and reproaches directed at the psychoanalytic method are linked to the unique methodological setting that is part of the psychoanalytic situation. Criticism is particularly accentuated when attempting the scientific study of the phenomena of psychoanalysis. A key methodological question is that of data collection and its subsequent utilization for the development of theoretical constructs and/or therapeutic applications. Much controversy exists as to what can be taken as evidence and therefore

as an empirical database for research in the field of psychoanalysis. Questions about permissible data as well as about permissible methods of data collection and evaluation are always methodological questions, and methodological questions in their turn frequently touch on questions of the scientific status of a given discipline (Dreher, 2000), giving footing for those who deny psychoanalysis any standing in the social or natural sciences.

Customarily the therapeutic encounter between the analyst and his patient is an intimately private one. An important focus of the therapeutic process devolves around the intricacies of this particular relationship, its various iterations and its different elaborations. In this way, the analyst is both a participant in the process and also the observer of the various transactions that occur between himself and the patient. Although the psychoanalytic situation can be thought of as an "experimental" laboratory, providing a relatively standardized observational framework, with an observer trained to minimally disrupt the flow of emerging material (Fonagy and Moran, 2006); there are intrinsic problems to the claims made by reporting psychoanalysts, when the data from which conclusions are being drawn, is generated by the analyst who is also an active participant of the process. Notwithstanding the intrinsic complications of this method, it is in this tradition that analysts have claimed responsibility for therapeutic change in their patients, as well as for the data on which analytic theory and its codes of practice have evolved – and continue to do so-. Questions persist and a shadow of inscrutability looms over the psychoanalytic tradition. On one hand, working clinicians would concur that many reports of psychoanalytic sessions are inadequate to convey the subtlety of the unique experience of human individuality as it becomes manifest within the analytic session; on

the other hand, these accounts are dismissed by critics as flawed because they are too subjective to "prove" any of the claims supported by the treating analysts (Tuckett, 2008).

In addition to the criticism and skepticism that has surrounded psychoanalysis and its practice from without, it is also important to take into account the many fragmentations and mutations that have occurred through the later half of the twentieth century in the body of psychoanalytic theory from within (Sandler et al, 2005). The many schools of thought and the wide variety of practices that place themselves under the umbrella of "psychoanalysis" are not only diverse but also, at times, in opposition to each other. This ever-widening array of practices has in ways created, what is recognized by psychoanalysts themselves as: "the crisis of psychoanalysis" (Green, 2005). This "crisis" being no other than the fragmentation of psychoanalytic discourse as a unified and coherent body of knowledge, its dispersion, and the utter lack of consensus among psychoanalysts of different persuasions over essential questions of theory and clinical practice. This has made psychoanalytic data difficult to communicate among clinicians (Tuckett, 2008); as Denis (2008) comments: "misunderstandings between psychoanalysts from different schools and countries are not common –they are the norm" (p. 38). Although it could be argued that the tension generated by the dialectical battles between the different camps has generated a rich and complex body of ideas that is both sophisticated and fertile, it nonetheless creates a foggy and confusing landscape for the interested researcher who is in the business of operationalizing concepts and testing them with real data.

The lack of consensual agreement regarding essential theoretical and clinical questions has repeatedly failed to be resolved by dialogue. Over time these divisions have become territorial and as such the subject of political trade. Wallerstein (2002) comments: "We are without warrant… to claim the greater heuristic usefulness of validity of any one of our general theories over the others, other than by the indoctrination and allegiances built into us by the happenstance of our individual trainings, our differing personal dispositions and the explanatory predilections then carried over into our consulting rooms." (p. 1251) Psychoanalysis as a discipline and as a practice is pressed like never before to shift strategy and incorporate empirical research as a way to settle the score.

If we accept these criticisms as valid -and perhaps we should-, a fundamental epistemological problem arises for the psychoanalytic enterprise, namely the question of what constitutes psychoanalytic data. As Teller and Dahl (1986) point out, "commitments to narratives and case histories are misguided; they confuse hypothesis about the data with the data itself" (p. 765). As a solution Teller and Dahl suggest the use of recorded and transcribed sessions as the primary source of data, so that we can examine and study the actual words of the analytic exchange and infer from them structures and process patterns which in turn can inform and refine the tenets of clinical theory. For the interested researcher the difficult task is that of "re-presenting" these words –the actual words- to reveal the structures embodied in them, to then identify their relation to the key ideas of contemporary psychoanalytic thinking, submitting them to examination, while trying at the same time not to short change their complexity.

Although in the past two decades there have been renewed efforts in trying to assess the effectiveness of psychoanalytic and psychodynamic treatments, many of the measures utilized in outcome and effectiveness studies are problematic at best and misleading at worst. Typically, outcome and effectiveness studies use behavioral descriptors, self-report index of symptoms and depression scales in order to assess change. While these can be perfectly valid and reliable measures which can indicate desirable change, they nevertheless fail to capture the complexity of the analytic process and more specifically the kind of change that psychoanalytic treatment is after. In other words, effectiveness studies are useful ways to ascertain whether a certain kind of technique is working or not, but it sheds little or no light as to *how* the kind of change that is recorded is actually effected. Clinicians, who deal intimately with the intricacies of the human mind, will invariably have an impression of reductionism when they see the complexity of an individual's struggle with his internal and external experience reduced to a single-hundred point scale (Fonagy, 2004). Outcome and effectiveness studies tend to create a theoretical over-simplification as an inevitable consequence of the methodological operationalization of variables and the limit on the number of concurrent observations that can be entered into a single study. Some may say this type of research has little if no bearing on helping us understand the complexity of the psychoanalytic situation and its process (Green, 2003).

One of the most difficult challenges for psychotherapy research has been to demonstrate convincingly the -undoubtedly complex, and not necessarily linear- link between what occurs in the treatment hour and patient change. Furthermore, although inherent in most theories of psychotherapy is the assumption that the psychotherapist's

attitudes (e.g.: empathic listening, relative benevolence, neutrality etc.) and technical interventions (e.g.: interpretations) play a critical part in facilitating (and potentially sometimes impeding) the patient's therapeutic progress, it is even more complicated to establish the links between the therapist's activity and the patient's change. Despite many attempts, surprisingly small progress has been attained in demonstrating how the therapist affects the process and ultimately contributes to the success or failure of psychotherapeutic treatment. Some reviewers have suggested that this lack of progress is due to: a) an inadequate conceptualization of how therapists interventions affect particular patients (Fiske, 1977; Greenberg & Pinsof, 1986), b) the methods employed to evaluate the therapists actions that are too global, imprecise or clinically irrelevant and (Jones et al, 1988; Persons, 1991), c) lack of agreement about what constitutes an appropriate action (Greenberg & Pinsof, 1986,;Stiles et al, 1986; Strupp, 1986).

Regardless of the many questions and critiques that threaten to unseat psychoanalysis as an effective therapeutic method and as a useful model of the workings of the human mind, it still remains an inevitable reference for clinicians that work with the suffering patient who struggles with their ability to love and work. In essence, the heart of the question of psychoanalytic technique has to do with managing and understanding the specificity of the engagement between the analyst and his patient. The particular ways in which each patient elicits something in his analyst and the analyst in turn elicits something in his patient has furnished the literature with invaluable vignettes and technical recommendations of great clinical utility. However, the challenge to find a broader and more comprehensive understanding of the ways in which the therapeutic process is modulated by the interaction between the analyst and his patient is still to be

met; anchoring this understanding in clinical data that is linked to the immediate exchange between the analyst and his patient is an important part of this challenge.

The purpose of this investigation is to examine in a single case study the manner in which the analyst's participation contributes to the analytic process as it is reflected in the patient's speech patterns, in the way they can be represented when measuring the interactions between exact verb repetitions and Referential Activity (RA). A patient's capacity to change in the context of a psychoanalytic treatment has come to be understood as a non-linear process that builds over time and can be tracked by studying the patients' utterances as they occur during the course of treatment. Since in principle and practice such change can be bi-directional, the research will attempt to differentiate between the forms of therapeutic activity that promote or interfere with therapeutic progress. Specifically, this investigation will examine the impact of the different types of intervention made by the analyst on the therapeutic process during the course of a 6-year psychoanalytic treatment that was recorded and transcribed in its entirety.

In order to frame the present study, a revision of the basic premises and debates around the theory of psychoanalytic process and therapeutic action is presented. This revision leads the way to a detailed description of the most important aspects that inform clinical practice, namely the treatment framework, the analytic stance, the therapeutic alliance and the transference and countertrasference matrix.

Following the description of the essential aspects of clinical technique that guide therapeutic action, the concept of thirdness is introduced as a model to describe the analyst's process of listening. The role of language and the importance of representation are explored to approach the meaning of the analyst's communications. Vigotsky's

(1978) concept of the Zone of Proximal Development is used to revisit the question of therapeutic action and the role of the analyst during treatment.

In the current study, the above-mentioned conceptualization of psychoanalytic process and representation will be applied to a research design that reflects the final generation of psychoanalytic process research on a long-term psychoanalysis making use of multiple perspectives that involve quantitative ratings of the clinical material, computerized linguistic measures as well as a qualitative analysis based on clinical impressions (Bucci, 2007; Dahl, Kächele and Thomä, 1988). In the final section, the psychoanalytic case to be used in this study will be discussed and the empirical studies applied to this case will be reviewed. Finally, the methods and key aims of the current study will be explicated.

## Chapter I

### Psychoanalytic Process and Therapeutic Action.

For decades there has been a long-standing debate among psychoanalytic clinicians regarding the nature of therapeutic action. The arguments have evolved around two main hypothesized sources of therapeutic change: 1) Interpretation and psychological knowledge and 2) the interpersonal aspects of the therapeutic relationship. While neither point of view excludes the other, they do place different emphasis on the importance of different factors as mutative agents of the therapeutic process. Those who emphasize the importance of interpretation view as decisive the patient's self knowledge, understanding and insight. On the other hand, those who emphasize interpersonal and relationship factors, consider as crucial the therapeutic alliance, feelings of safety, the containing aspects of the relationship and the analyst's capacity to empathize with his patient (Jones, 2000). Although these positions differ in the emphasis placed on the here-and-now transferential environment versus the more traditional goal of excavating the there-and-then with the aim of reconstructing the patient's history (Weinstein, 1997), in reality neither approach negates the other.

These issues parallel the debate concerning the usefulness of a "one-person" as opposed to a "two-person" psychology for conceptualizing the nature of therapeutic action. The main question is whether psychological processes can be conceptualized as occurring primarily within the mind of an individual, or whether the primary factor lies in the quality of the patient's interactions with the therapist. "One-person" models presume that the therapist's actions promote patient change, so that influence is presumed to flow principally in one direction, from the therapist to the patient. The assumption that the

patient lives in a self-contained intrapsychic world, a world the analyst can enter only through an act of self-assertion, is problematic because it gives a one-sided picture of the therapeutic interaction. Nevertheless, it underlines the fact that the patient can take the analyst's words in a variety of ways, including leaving them if he chooses.

The interactional perspective supported by the "two-person" model recognizes more explicitly the influence of the patient's characteristics and behavior on the therapist, on the therapeutic relationship, and on the evolution of the therapeutic process (Jones, 2000). Two-person models depict the therapeutic process in a bidirectional fashion, where patient and therapist are under each other's influence and the process is co-constructed by both members of the dyad. However, it is not implausible that the one and two person position may each privilege a perspective set of functions that are simultaneously operating in every analytic situation.

In this past decade there has been an increased recognition of the role played by the analyst's subjectivity -countertransference reactions- in the course of analytic treatment. In this sense, there has been a shift in the conception of the analyst as a purely objective instrument, to the recognition and the inevitable inclusion of his subjectivity. While positions vary in terms of how problematic, unavoidable, useful, and even necessary they consider the analyst's subjectivity to be during the analytic process, it is generally acknowledged that it is an undeniable piece of the analytic puzzle.

The intricacies of the arguments that surround this long-standing debate cannot be addressed in full here, however it is worth mentioning that it is in the area of clinical technique where the biggest divisions exist, particularly in what concerns the boundaries between the analyst as an "object of transference" versus the analyst as "a real object" to

the patient, and the corresponding degrees of neutrality and abstinence recommended or endorsed by the different positions. When the analyst aims to stand as a "prop" for the patient to "transfer" his internalized relational patterns, the rule of thumb is to offer a "neutral" field for the patient's 'projections". On the other hand, if the aim is to provide a corrective "new" experience by becoming a benign presence in the patient's life, the emphasis on neutrality and abstinence is much less determinant and the benevolent qualities of the interaction become the cornerstone of the process. In reality a more nuanced understanding can include both aspects without having to create an either/or scenario. Accepting "transference" as a basic phenomena of psychic life does not negate the possibility of new experience, in fact allowing the transference to develop and seeking to illuminate its dynamics implies that a "new experience" is taking place. Ideally, the analyst's "neutral" stance is a form of respect that implicitly communicates acceptance to the patient, and in this way through the alliance becomes a new experience and model of relating.

Another important aspect of this debate relates to issues of power and the asymmetry of the analytic relationship. When the analyst who stood as an "objective observer" *of* the process is replaced as a "subjective participant" *in* the process, epistemological questions come to the fore and with them the value and meaning of interpretations and psychological insight as instruments of change are also recast, and one may also say, unseated as the cornerstone of analytic work.

As the theory becomes politicized these positions are often caricaturized where an emphasis on subjectivity is thought to offer free reign to the analyst as participant, while underlying objectivity is played to restrict the analyst's position while imbuing him/her

with a degree of power that is counterproductive to the process and difficult to defend. From the analyst's perspective a view that attempts to integrate both positions as intrinsic parts of the analytic work presents a duality that emerges within the analyst, where he is both a *participant*, immersed in the analytic encounter with the patient, capable of identifying and empathizing with him, and a *witness* of the process, actively thinking and conducting the treatment. Addressing this issue Smith (2003) comments: "We hear ourselves characterized as positivist and perspectivists. But is this polarization accurate? Do positivism and objectivity truly distinguish one school of analysis and perspectivism and intersubjectivity another, or are these not fundamental aspects of mind that are unavoidable in the clinical encounter? Might it not be said that we are all objectivists at one moment and perspectivists at another?" (p.137)

This discussion has important bearing in the field of psychotherapy research as well. As Jones (2002) points out, these issues have implications when deciding whether to look at "specific factors", such as intentional actions on the part of the therapist, like interpretations or linking past experiences to present ones; versus the alternative of attempting to measure "non-specific factors" like the qualities that characterize the relationship between the patient and his analyst that are presumed to support the internalization of more benign and better integrated representations of self and other, which in turn are thought to be conducive in generating new adaptive patterns of behavior.

Inherent in this form of debate is a presumptively false dichotomy that has drawn clinicians and theorists to take a position of either /or in order to characterize a process that is incredibly complex. In effect, for the psychoanalytic process to develop it requires

both external input and the presumption of an endogenous process, a setting that stimulates a progressive transformation of interactional patterns and the assumption that many of the interactional dimensions that will be manifest in the treatment will echo difficulties that arose in the context of the psycho-social development of the individual. It seems artificial to separate interpretive aspects from relational features in order to create a theory of therapeutic action. As Gabbard and Westen (2003) point out, these mechanisms can be thought of as operating "synergistically" in most cases, with various degrees of prevalence at different points of the treatment and even varying emphasis from one patient to the next.

For the purpose of this investigation the focus will be placed on therapeutic process as observed through interactional patterns between the analyst and his patient, without attempting to validate a particular theoretical perspective. Here I will be looking at interactional patterns and how they correlate with the patient's generativity (e.g.: patients capacity to make new connections and relate them in a vivid way), openness to experience and ability to symbolize these experiences. The purpose is not to ignore internal processes, but rather presumes that as interactional patterns develop and change over time they presumably become correlated to a modification of the patient's internal structures. These internal structures can ultimately be inferred through observable behavior; specifically as revealed by the patient's speech patterns. The basic assumption is that the interactional context of the analytic relationship is what supports the intrapsychic by giving it meaning and form, therefore the distinction between the intrapsychic and the interpersonal exists only in theory not in nature. As Wilson and Weinstein (1996) point out: "In actuality they (intrapsychic and interpersonal factors) are

mutuality potentiating, necessary for each other's continued evolution, and rely upon the other for their shape and function" (p.182).

Assuming the complexity of the analytic process, it is challenging to determine its effects on both analyst and patient due to the multiple and highly variable factors that intervene upon it. Because of the highly personal nature of the material, each psychoanalytic treatment is unique, at best a unique manifestation of a discernable set of fundamental principles. As Dewald (1990) points out, "no two patients or analysts would respond identically to the psychoanalytic procedure. Not only are there differences in personal experience, past events, current realities, mental organization, and individual tastes and idiosyncracies, but there are also issues of behavioral styles, theoretical orientation, and technical understanding and skills. In that sense one must think in pluralistic terms of a variety of psychoanalytic processes." (p. 696) Despite the many sources of variability, however, there are also a number of similarities, and generally agreed upon, common factors that apply to the effective practice of psychoanalysis. It is some of these generalizations that I will attempt to formulate, understanding that the way in which they come to exist in any given treatment, are subject to endless variation.

Psychoanalytic practitioners, such as Dewald, that emphasize the analysis of transference as the focal point of the analysis, describe a process that develops over time in which "the patient develops a variety of transference-inspired expectations, and projects them onto the analyst as part of the transference neurosis." (Dewald, 1978. p. 324) By virtue of the analyst's "abstinence", (i.e.: not satisfying the patient's longings) (Loewald, 1980; Dewald, 1978) and "benevolent neutrality" (Green, 2002) the patient has the opportunity to re-experience infantile and early childhood core psychic conflicts in

the context of a new and optimal relationship (Pine, 1985). This particular application of psychoanalysis depends upon specific actions on the part of the analyst that is thought to promote a series of regressive processes on the patient in the context of the treatment. This particular perspective will be explained in detail here as it describes the perspective adopted in the treatment of the case study.

Tracking the intricacies of the transference, with its iterations and elaborations over time, does not necessarily have to imply an underrating of the therapeutic effect of the analyst as a real person and as a new object for the patient. In many cases, looking back over their analyses, patients have reported that the most important contribution the analyst made was not their interpretations but their unfailing presence, their consistency, and their quiet strength throughout the stormy journey of the analytic process (Roughton, 1994). It is interesting however to note that these aspects of the relationship are rarely discussed or interpreted within the hour, but rather are taken to be part of a corrective emotional experience that is a by-product of the benign qualities that the analyst brings into the room.

**Treatment Framework**

The Treatment Framework refers to the overall conditions required for the practice of psychoanalysis and the development of its process. These conditions are a set of specific parameters. They include the material arrangements that regulate the interactions between the analyst and his patient (payment of fees and missed sessions, length of sessions, coordination of vacations, etc.). Customarily, these arrangements are part of the initial therapeutic agreement and constitute a convention between the two

partners that sets up a frame for the process. It is generally understood that these parameters create a set of conditions that promote a sense of constancy and predictability which not only serve to protect the treatment, but also in time contribute to cement a sense of reliability and benevolence on the figure of the analyst.

A constituent part of the setting is the analyst's enunciation of the "fundamental rule" for the treatment, which stands as the only requirement laid down by the analyst concerning the analysand's work. This "fundamental rule" was initially described by Freud in *The interpretation of Dreams* (1900) and later prescribed and further elaborated on his technique papers to practicing clinicians (1912, 1915), a deceptively simple injunction to the patient, asking him to say everything that comes to mind, including what seems to him the most absurd or shameful. As Green (2005) points out, "it will be accepted by the patient, even if it proves impossible to respect in practice. But the rule plays yet another role, namely of inscribing itself as a third, as a law above the two parties." (p.33). As a corollary to "the fundamental rule" for the patient, Freud (1912) suggested that the analyst should match the patient's free associations with a corresponding attitude characterized by "evenly suspended" floating attention and listening. The main idea is that the analyst is to avoid directing his notice to anything in particular in order to avoid "selecting" the material to follow his "expectations or inclinations". By virtue of these principles, both analyst and patient establish a particular dialogue that roots the analytic activity in the unconscious process that is to ensue and sets the analytic stage for the unfolding and development of the transference-countertransference matrix.

The 'fundamental rule' invites the patient to embark on a particular journey that enlists a certain kind of thought process; it is a journey partly down the road of remembering; a thought that is chasing a trace. Thinking is expeditionary and the destination is familiar: it has been visited before and the work of thought is to find it again, to attain once more the place that has been made by an experience or the memory of that experience. This idea raises an important question about the relationship of memory, thought and speech, which is essential to the treatment and the psychoanalytic cure as it was originally conceived. As we try to find ways to illuminate this journey we come to understand the importance of describing in relatively simple ways the speech patterns we usually encounter in the course of analytic treatment.

Rizzuto (2002) likens the invitation to free associate to early caretaking relationships; the analyst like the mother insists that the patient use words to make him/herself understood enough so that the analyst/mother can make sense of the message and the wish imbedded in it. The analyst raises the ante to further, deeper understanding of meanings and feelings by inviting the patient to a freer mode of self-expression. "The analyst's demand is not only a mild superego injunction to keep the fundamental rule but also an affective invitation to the patient to be present as him/herself. The analyst, following similar steps to those of the childhood mother, progressively expects that the analysand would assume responsibility for his/her communications and learn to free associate to the point of being able to carry out self-analysis" (p. 1337)

It is generally understood that initially on a conscious level the patient is willing to accept the contractual and structural elements of the setting. At the outset the patient has little understanding of the implications of these rules and usually as the treatment

unfolds will develop a series of conflictive and ambivalent reactions to them that will serve an important function for the analysis. As Dewald (1972) points out, this initial dynamic that sets the parameters of the treatment is anchored in the asymmetrical qualities of the analytic relationship; by virtue of his emotional pain the patient is willing to accept these rules, placing himself under the care of the analyst who chiefly assumes the position of a skilled and qualified expert on the services needed to help the patient.

**The analytic stance**

On a behavioral level, it is generally accepted by most "classical" analytic traditions (e.g, transference analysis, or defense analysis) that the analyst should attempt to maintain a relatively constant attitude toward his patient, as well as relative personal anonymity. For practitioners that adhere to a more "classical" approach a low range of variation on the analyst's behavior and a close adherence to the setting regulations are useful devices that help optimize the analytic situation by attempting to insure that the analyst's behavior itself is not a source of "uncontrolled variation". As Dewald (1972) points out, variations in the analyst's response (in the quality of his reactions and/or the maintenance of the setting) to the patient's material make noise in the treatment and can be perceived by the patient as ways of punishing or rewarding him. In contrast, the more the analyst can maintain a "neutral" and constant way of responding, the more the patient's reactions can be understood as a reflection of his internal struggles and not as a consequence of the variations introduced by the analyst.

The term "neutrality" has often been used to describe the attitude that the analyst is supposed to adopt throughout the psychoanalytic treatment. Freud (1915) did not use

this term to describe the therapist's stance; instead he used the term "abstinence", which was used to refer to the boundary that prevented the analyst from using the activity of the treatment to satisfy his own personal needs. Abstinence has also been understood, by proponents of the analytic model that centers its work on the analysis of the transference neurosis (Dewald, 1972), as linked to the construct of optimal frustration that describes the lack of gratification and fulfillment of the analysand's wishes and desires from the part of the analyst. The main rationale supporting this posture is that by not satisfying the patient's projections (i.e. the patient's need for approval, or conversely his fear of rejection) the analyst increases the intensity of his wishes, or fears and fosters the development of the patient's transference neurosis. The aim of frustration is thus to create the optimal conditions for the re-evocation of past patterns of behavior in the transference, thereby promoting a certain intensity and pressure that deepens the emotional experience of the analysis and increases the power of the insights that are generated within the treatment. As Green (2002) has suggested, ideally the analyst becomes available to the transference but does not respond to the demands for satisfaction that are expressed in it. Specifically he does not respond with action, but responds by hearing the request and, in due time, interpreting it, thereby indicating that it has been 'heard'. Abstinence hinders the gratification of a wish, so that the wish might be put into words and analyzed, rather than simply disappearing by the way of action.

According to Mijolla (2004), the term neutrality first appeared in the psychoanalytic literature after Strachey used it to translate the word *indiferrenze* in Freud's observations on transference love. The use of the term, however, has been problematic and often criticized (Mitchell, (1998); Renik, 1996; Wachtel, 1982). Critics

point to the obvious difference between the neutrality of the healer and that of a researcher. Ideally the researcher should attempt to maintain an indifferent stance vis-à-vis the outcome of a given process whereas the healer/analyst cannot. Simply put, indifference to deleterious treatment outcomes would not be ideal.

According to Loewald (1960) the analyst's neutrality is required for two main purposes, 1) to keep the space of observation from being "contaminated" by the analyst's affective intrusions and 2) to safeguard a kind of blank slate for the patient's transferences. The latter reason is closely linked to the function of the analyst as a "mirror" that deliberately reflects back to the patient his conscious and particularly his unconscious processes through verbal communications. In an interesting way, Loewald relates the need for objectivity on the part of the analyst to the possibility of existing as a "new object" for the patient. As Loewald explains, being a new object for the patient implies that the analyst is able to receive the patient's transference distortions and objectively reflect them back to him in the form of interpretations.

Lasky (1993) points out that in the Freudian model neutrality is meant to signal the analyst's ability to abstain from taking sides in any of the patient's conflict, whether it be conflict between the psychic structures or within each psychic structure and between the patient's needs. The analyst is expected to stay "neutral" and not be caught up in one side of the struggle against the other. Interestingly Lasky relates this understanding of neutrality to Freud's indication to the analyst to sustain an "evenly hovering attention" in regards to the patient's productions, that is, without taking more interest in any particular aspect of the patient's associations, which could indirectly signal to the patient that the analyst is taking side with a particular side of the conflict.

If looked at from the patient's perspective, the analyst's abstinence and neutrality should signal to the patient a sense of safety and containment, a sense that the analyst is comfortable in dealing with the material at hand. The analyst's observing stance and "benevolent neutrality" (Green, 2002) is a way of marking the difference for the patient between thought and action. The analyst allows the patient to feel safely contained by indicating that he will remain comfortable with the material that emerges (Dewald, 1990).

This particular view of the analyst has emphasized the "objective" qualities that the analyst can bring into the analytic situation. However many have questioned these assumptions suggesting that whatever the analyst does or doesn't do in the context of the treatment becomes a variable of the treatment; so that –for example-, even by choosing to respond (and indeed selecting) to certain elements of the patient's discourse the analyst is already signaling something to the patient. For practitioners who have questioned these assumptions (Renik, 1996; Wachtel, 1982, Mitchel, 1990 among many others), neutrality is never tenable, nor does it make much sense since, as they argue, there is no such thing as purely internal psychic phenomena. The argument is indisputable if we conceive of neutrality as an all or nothing quality. However if neutrality is thought of as a quality that exists within a gradient then there is reason to also consider its effect on the patient's intrapsychic phenomena.

Meissner (2007) makes the case that neutrality and abstinence are inherent qualities of the therapeutic alliance. In Meissner's view neutrality in the context of the alliance is not just a behavioral norm, but a mental perspective from which the analyst can assess the therapeutic interaction with as much objectivity as is possible to determine at any given point what course of intervention is reasonable and appropriate to facilitate

the analytic work and the patient's progress. The image that begins to emerge is that of a way of knowing that comes from an internal space where the analyst can observe the process and think about what is taking place despite the pressures that are placed upon him by the feelings aroused in him by the patient. We arrive here at a nodal point in terms of the internal process of the analyst who must navigate the tension that arises between the necessity for thought counteracted by the propensity to act.

**The analytic relationship**

Meissner (1992, 1996, 2006) formulates a particularly useful conceptualization of the therapeutic relationship, breaking out its components into three fundamental constituents, the transference-countertransference, the real relationship and the therapeutic alliance. Meissner notes that these three elements overlap and mingle at any given moment of the treatment. In his view the therapeutic alliance is a central aspect of the treatment and great attention should be devoted to its development and maintenance throughout the treatment. The therapeutic alliance is vital for establishing and maintaining a meaningful context of effective therapeutic work, it concerns "the qualities and negotiated arrangements for structuring and facilitating the analytic work that pertain to the analyzing function of the analyst and the contributory role of the patient in advancing the analytic process" (Meissner, 2007 p.233). As constituent aspects of the alliance Meissner proposes: "the therapeutic framework, the analyst's authority, responsibility, empathy, trust, autonomy, initiative, freedom, neutrality and abstinence, and certain ethical considerations." (p.655). Following Meissner's conceptualization we come to understand the importance of a particular way of listening, as well as a particular

way of enlisting the patient in a process that invites him to join the analyst in observing the phenomena of his own mind. This relates clearly to the necessity of a triangular space where symbolization can exist. Meissner's conceptualization of the therapeutic alliance calls attention to the aspects of the therapeutic relationship that are corrective and may foster further change.

In a plea for a mindful therapist who understands the impact of his demeanor and verbal expressions on the patient, Wachtel (2011) makes the case for all the aspects of the therapeutic relationship that strengthen a sense of collaboration and mutual respect. In this spirit he calls exploration, "the art of gentle inquiry" pointing out that effective inquiry: "increases the likelihood that the patient will experience the therapist comments as an invitation to explore rather than take them as a challenge to be warded off or as a signal to hide".

Palombo (1997) points out that the therapeutic alliance is the structure of mutual trust that allows the analytic work to proceed. Palombo suggests that as the treatment progresses and the structure of trust is cemented, the level of cooperation between analyst and analysand increases (cooperation being understood as being able to say what comes to their mind on the part of the patient and staying open to what the patient says without preconceptions on the part of the analyst). This increased level of cooperation is reached as both analyst and analysand develop strategies to recognize reliable patterns in the sequence of interactions between each other.

**Transference/Countertransference Matrix**

From a psychoanalytic perspective transference is a basic interactional phenomena of psychic life. Transference neurosis, however, refers to a specific set of phenomena that determines the experiences of the patient in regards to the analyst through the course of analytic treatment. Psychoanalysts that focus analytic work on this particular phenomena base their rationale on the premise that intellectual insight is not enough to generate change (Loewald, 1980; Dewald, 1990, Lasky, 1993). It is suggested that fruitful and effective self understanding cannot be attained unless the significant experiences and inner conflicts that brought the patient to the treatment become alive again in the context of the analysis and regain a measure of affective immediacy and urgency in the context of the analytic relationship. In other words, as the figure of the analyst becomes an important object in the patient's life the emotional push that this generates allows the analyst's interventions to gain traction in the internal world of the patient. Transference neurosis is thus an operational concept, which denotes the possibility of actualizing old and conflicted relational patterns so that they can be observed and re-signified in the context of the analytic relationship.

Although the analytic process is a bidirectional one, the analytic relationship has been also described as asymmetrical; in this sense both analyst and patient are acutely sensitive and responsive to the reactions of the other, however the focus of the analysis is on the mental life of the patient. Although the analyst and the patient are not invested in the same way or equally reactive to the influence of the other when considering the analytic situation, both analyst and analysand must operate as open systems that influence

each other so that the psychoanalytic investigation can proceed; as Loewald (1980) points out, "each must renounce a degree of autonomy for the sake of the investigation" (p.278). Indeed the investigative attitude is demonstrated by the analyst but soon adopted by the patient as well, as he identifies with the analyst and develops the capacity to observe his thoughts and reflect upon his mental processes (Dewald 1972, Loewald, 1980, Lasky, 1993). Nevertheless, the analytic process is also an intense emotional experience that deepens its reach as the patient, by virtue of the safety provided by the analyst and the setting, allows the regressive process of the transference to take place.

As the treatment unfolds and the transference develops, the analyst should be capable of tolerating certain levels of anxiety and ambivalence in regards to the patient's dynamics without outward discomfort or the need for premature closure (Dewald, 1972). By maintaining the analytic attitude the analyst makes room for the patient to explore his unconscious fantasies and wishes, while at the same time preserving the therapeutic alliance.

When the transference neurosis is the centerpiece of the analytic investigation, a paradox needs to be set in place so that, by virtue of the safety provided by the treatment and the therapeutic alliance, the patient can allow his defenses to come down in order to permit the regressive experience of the transference to unfold. On many occasions this regression involves experiences of terror and vulnerability, that are tolerated because of the containing qualities of the therapeutic alliance. As Dewald (1990) points out, the issue of safety is key, for as the analytic process is set in motion, changes begin to occur, that signal "a progressive mobilization of previously unconscious levels of intrapsychic conflict. These reactivated conflicts are experienced in a current version with the analyst.

For this to occur there must also be a decrease in the patient's defenses and resistances, and an increased capacity to tolerate the unpleasure and anxiety related to the conflicts being activated" (p.699) As the transference experience deepens, pre-existing conflicts are reenacted in the patient's expectations of the analyst; these expectations are amplified by the patient's ubiquitous unconscious wish to repeat old patterns of interaction and his/her attempts to provoke in the analyst a complementary response that confirms the patient's internalized pattern of interaction. However, by responding in a different way, it is at these critical moments when the analyst's observing and empathic stance begins to activate the possibility of change. Thus it could be said that analytic work is about the discovery of the transference both by the analyst and by the patient. Analysis, is the invitation -and also the requirement- to both participants to explore the development and vicissitudes of this unique phenomena. The understanding of transference as a repetition of unconscious patterns that are shaped by the patient's past history of relationships is questioned by others (Gill, 1982, 1983; Wachtel, 2011; Hoffman, 1998, 2006) who view transference reactions as also idiosyncratic, but significantly shaped by the actuality of the situation, even as they give a particularized meaning to that actuality.

Freud (1910) introduced the concept of countertrasference to note that the patient's influence can elicit unconscious feelings in the analyst that can interfere with the treatment. Since then, the understanding of countertransference phenomena has evolved to include the idea of its utility. Westen et al (2005) conducted a study in which they were able to correlate the clinician's reactions toward their patients with the patient's diagnosis, finding that these reactions are systematically related to the patient's personality pathology. Freedman et al. (2009) suggest that a distinction should be drawn

between ordinary countertransference "a transitory disruption residing within the analyst's consciousness" and the extraordinary countertransference, characterized as an "impasse intolerable to the analyst to such an extent that it remains outside of his awareness". (p. 1)

**Thirdness: a model for Analytic Listening**

Britton (1998), Green (2002) Benjamin (2004) and Freedman et al. (2009) suggest that the analyst's listening ideally takes place in a triangular space where symbolization can optimally occur. For some of these authors triangulation, be it the ability to accept the oedipal situation (Britton, 1998), to look at one's self through a subjective as well as an objective lens and to confront contradictory states of consciousness (Benjamin, 2004), is a prerequisite for evolving symbolization and reflective functioning.

Schematically the idea of a triangular space distinguishes two different poles from which the analyst operates and relates to the patient and his productions during the treatment. As suggested by Freedman et al (2007) on one hand, there is the '*view from within',* where the analyst is an active participant in the encounter with the patient, empathizing and identifying with both the patient and his inner objects; and on the other hand there is the '*view from without'* in which the analyst acts as witness and observer. The gap between these two poles as they relate to the patient as the third pole of the analytic situation creates the space where new meaning can be generated and symbolization can take place. As Freedman et al (2009) point out, in this model triangulation: "embraces an ideal wherein a dual consciousness by the analyst can be maintained in the service of the patient's symbolizing work." (p. 5) If one of these poles

ceases to exist in the analyst's relation to the patient, triangulation breaks down leading to the disruption of the analytic work. In a study of the transcripts of a series on continual sessions of a long term analytic treatment, Freedman et al (2007) point out that the threshold to track the appearance of these moments in the treatment can be observed when there is a gross discrepancy between what the analyst is able to recall about what happened in the session and the session's actual material; thereby signaling the presence of a countertransference reaction on the part of the analyst that is interfering with his ability to accurately recall and think about what actually transpired during the analytic hour.

This model of triangulation in which the analyst's way of listening to the patient's material is optimally sustained between alternative perspectives, '*the view from within'* and '*the view from without'*, could be thought of as a reframe of Freud's (1912) well-known technical rule for the analyst regarding the need to sustain an "evenly hovering attention". Correspondingly, in this instance, the analyst is attempting to balance between the pull to unconsciously identify with the patient and his internal objects and the push to distance himself by holding the position of an observer of the process, thinking about the patient's material and the interactional transactions from an exclusively conceptual angle. Emphasizing the same point, but using a different metaphor, Bion (1962) and later Meltzer (1978) advanced the idea of the analyst as *participant observer* in which the analyst is able to use a *binocular* viewpoint in order to simultaneously contain, digest and interpret the patient's projections.

As we continue to define the qualities and capacities that the therapist is expected to cultivate in order to sustain and advance the treatment, it seems only natural to pause

and establish this set of guiding principles as defining an ideal stance that does not represent what actually takes place in most treatments. In other words, the assumption that the analyst will always be receptive, appropriately containing, and capable of understanding and interpreting the emotions in the relationship is likely to become disproven. If instead we accept that a certain degree of fluctuation (in terms of the degree of containment, receptivity and understanding) is a more accurate depiction of what really takes place, then the interesting question is to try to describe and understand the times when the analyst seems to be able to meet this challenge as well as the specific circumstances in which the lack of containment or understanding can lead to disruptions in the treatment, or even a traumatic situation in which the treatment takes a halt.

Thus the dynamics of interaction that allow this kind of trajectory to develop over time are relevant to the understanding of the psychoanalytic process. Considering that the analytic dyad operates as a system that fluctuates, but develops a level of complexity and coordination as the experiences of the dyad begin to establish patterns that are recognizable and significant in their own right, underlines the importance of memory processes and the development of a shared meaningful narrative over time (Palombo, 1997).

**The role of language**

Language is the primary medium of symbolic exchange between the members of the psychoanalytic dyad. Ideally, through the use of language, a version of the thoughts and feelings of the patient and the analyst can exist outside their bodies and internal experience in a common space to which both participants have access (Palombo, 1999).

The plotting from thought to spoken language is not one to one. Representations include non-linguistic modes of communication. Structures of meaning can be translated into different spoken sentences, which contain both linguistic and non-linguistic information, that provide different emphasis or nuance. The relationship between language and meaning is thus not fixed or ever finished. In some ways the development of language is an ongoing process, this one of the main qualities that make language a rich medium for the creation of new connections in the context of an interpersonal relations. As Palombo (1999) notes, the analyst's use of language, via explorations and interpretations, is ideally designed to increase the connectedness of the patient's mental contents. In the context of the safety provided by the frame and the analytic alliance, explorations are meant to expand the patient's understanding and acceptance of his internal world; interpretations on the other hand can provide grounds for greater integration and connectedness.

Soviet psychologist Lev Vigotsky studied the ontogenesis of thought and speech. In his work we discover a refined and sophisticated description of these functions which can serve to illuminate the role of language in the analytic process. Vigotsky saw these functions as separate yet closely related, for him thought and speech intermingle but don't overlap, "thought is restructured as it is transformed in speech, it is not expressed but completed in the word" (1988, p. 250). Freud established that language is one way by which we can allow thoughts to become conscious. Thought and speech are mutually defined, as thought presses onto speech for expression, speech in turn gives shape to thoughts and thinking. As Wilson and Weinstein (1990) point out, for Vigotsky the relationship between thought and speech is always a process "Before a thought can reach its fully formulated state a person must go back and forth between thought and word

searching for the proper articulation. This process is not necessarily a consciously directed process, but goes on outside of awareness." (p.26). Through the act of articulation thought becomes more and more differentiated, in Vigotsky's scheme meaning is created by the unification of thought and word, which implies that meaning is not a given but has to be actualized by the individual.

Vigotsky's theory derives from an epigenetic study of the structure of the mind. As he studied the development of thought and language he proposed a number of fundamental tenets: a) A child can only transcend the immediacy of sensory experience with the aid of language, b) language is a fundamental psychological tool that allows us to regulate experience be it internally or externally determined and c) Language is one of the foundations of memory and planning. For Vigotsky language supersedes yet encompasses affect, cognition and volition.

The analytic situation provides the conditions for the patient, in the company of the analyst, to explore his thoughts through the process of free association. Language provides structure to the mind and serves a dual function, on one hand it serves to communicate with others and on the other it is a vehicle to discover and reveal the internal world of experience; in the analytic situation these functions are equally relevant. "Word meaning is a phenomenon of thinking only to the extent that thought is connected with the word and embodied in it" Word meaning is initially forged in the context of the dynamic interplay between a child and its caretaker; through a similar process meaning is forged in the context of the analytic situation. One of the driving forces in any given treatment is that of creating new and meaningful narratives through a historizing process that partially involves revisiting the past in order to link current and past experiences in

significant ways. Vigotsky talks about "living speech" to signify the ever-evolving quality of language as an instrument that designates sense and meaning to experience in an ongoing way; so that the connotative space of words has a more fluid quality than we usually recognize. As we continue to experience life, our referents continue to expand by incorporating new meanings and larger networks of associations. In a sense words expand as we move forward but also as we move inward, so that "previously unarticulated experience can be put into words by the jurisdiction of speech" (Wilson and Weinstein, 1990 p.) as is generally intended in the analytic process through the use of free association and interpretation.

Meaning is central to the analytic situation. However meaning, as Green (2002) suggests, is not the exclusive domain of language. "Extra-verbal" factors (such as conscious and unconscious thing presentations, bodily states, actions and the representations of acts) are paths of meaning that are combined with language and that, in turn denote "different registers, that are charged, to a greater and lesser extent, with conflictual tensions." (p. 306) One of Freud's main discoveries is that conflict has a disorganizing effect on the psyche, bearing pressure on the expression of meaning and inducing it to seek alternative routes of expression. In this way, affect, bodily states and actions can be linked to representations and substitute for language. Emphasizing the centrality of language in the analytic encounter, Green suggests: "Psychoanalysis transforms the psychic apparatus into a language apparatus" furthermore, he elaborates: "Clinical thinking is the result of a mutual work of observation and self-observation of the mental processes using the channel of speech. " (Green, 2002, p. 26) Additionally as

Wilson and Weinstein (1990) note, speech also serves as an aid to the self-regulation of internal states.

Drawing on developments in the cognitive neurosciences Westen and Gabbard (2003) have sketched a model of therapeutic action that is centered on the idea of changing unconscious associational networks. Related to the idea of implicit memory they underscore the importance of "*associative memory*, a subtype of implicit memory that refers to unconscious links between cognitive, affective and other psychological processes that have become associated through experience." (p.827). Much of implicit memory is based on "procedural memory" or learned action based memory. Westen and Gabbard (2003) note that these networks are largely unconscious whether or not they are conflictual or defended against, and although we are not aware of their relative activation at any given moment they guide most of our thoughts, feelings and behavior. In this model associative change implies weakening links between mental processes that have become linked by association, "structural change" involves the creation of new associative linkages, or the strengthening of links that were previously weak. Free association is thus a technique that allows the therapist and his patient to explore implicit networks of association, and interpretation is seen as a way of intervening at the level of the links between the implicit networks (i.e., thoughts and feelings). Broadly speaking the analytic work could be described as a cyclical process that moves back and forth between the general to the particular and from the particular to the general and back again, creating continual interfacing of explorations, that leads to new forms of integrations, which in turn opens up new possibilities of inquiry. To support the patient in the process of free association the analyst has to be able to contain and gently explore. To forge new

connections and support new levels of integration the analyst has to be able to establish links and formulate empathic interpretations.

Green (2003) points out that: "to explore the internal world of the individual, we have no direct tools, only indirect devices such as speech expressing thoughts, dreams that are reported via language, fantasies that can be guessed, plays that can be understood or shared." (p. 43) In this way what takes place during the analytic hour occurs largely on the domain of symbolic exchange between the patient and his analyst. Because the material is symbolic the tools to explore these must possess symbolic qualities as well (Green, 2003).

Interpretation is one of the unique things a therapist can offer. From the vantage point of the analyst the naming and clarification of the patient's inner experience helps him bring these experiences out of the shadows, allowing him to draw upon his cognitive powers to access a new level of integration and self-understanding regarding his emotional experiences (Pine, 1985). Loewald (1968) likens the analyst's act of interpretation to the creative activity of poets, where "language is found for phenomena, contexts, connections, experiences not previously known and speakable. New phenomena and new experience are made available as a result of the reorganization of material according to hitherto unknown principles, contexts and connections" (p. 242) Discussing the role of speech during the analytic encounter, Lowenstein (1956) points out the following: "When the analyst's believes, on the basis of preparatory work, that the time has come, that the patient is ready for it, he lends him the words, so to speak, which will meet the patient's thoughts and emotions half way…" adding that the analyst's interpretations: "might be compared to a kind of scaffolding which the patient thought

can gradually fill" (p.465). Emphasizing the important role of interpretations is not to say that at times the content of interpretive comments may be less important than unconscious and relational meanings transmitted in the course of the interpretation (Gabbard and Westes, 2003) or that further insights into the aspects of the therapeutic relationship that are corrective are also contributing agents that give the treatment its mutative power.

As Palombo (1999) points out, transference interpretations are commonly thought of as the culminating mutative events of an analysis. It is commonly understood that these events take place during pivotal phases of the treatment, operating at a high level of symbolization and integration that ties together neurotic elements of the past and present in a particularly vivid way. Much preparation often takes place before the analyst ventures such statements. Preliminary and preparatory types of interventions, that include maintaining the frame, generally occur to increase the level of connectedness between the patient's mental contents and promote a kind of permeability that allows for such type of transference interpretations to take place. An interpretation that is appropriate as well as timely should be able to verify a connection as well as clarify a piece of material for both analyst and analysand, furthermore it should be able to re-establish connections in the patient's internal world (Loewald, 1980) in ways that then become evident in the patient's verbalizations and behavior.

It is possible to assume that these "pivotal moments" of the treatment could not exist without such preliminary types of interventions, some of which presumably escape both the analyst and the patient's awareness. Thus, the complexity of the therapeutic process is partly due to its multi-determined nature, occurring on multiple levels of

complexity, some of which escape the verbal realm. These issues present important questions for the curious researcher, in terms of the possibility of assessing and measuring the cumulative effect of such elements and events.

The non-specific supportive aspects of the relationship are inherent in the therapist's presence, attentive listening, and empathic concern. However, when the patient is in distress and the moment is ripe the therapist is in the unique position to offer what no one else ordinarily can: a new level of understanding about the nature of the patient's conflicts and internal world. "A correct interpretation means to the patient that the analyst is capable of understanding and of empathic awareness of the patient's experience. It also signals to the patient that the analyst is comfortable in working with whatever the subject of the intervention is, even if it was previously considered unspeakable by the analysand. In this way the analyst is also relieving some of the patient's sense of isolation." (Dewald, 1990; p. 699-670).

**On the meaning and impact of the analyst's communications**.

When trying to study the impact of the therapist's communications a question that arises is what are the factors that aid the therapist in deciding when to speak, and what to say? It is only logical to say that the specific answer to this question in any given instance would be determined by the analyst's empathic understanding of the patient's dynamics, but also by his/her theory of technique, and that by virtue of the degree of validity of these constructs interventions will

have a lesser or greater reach. Proponents of the common factors theory[1] suggest, however, that the specificity of the therapist's actions is not the decisive factor that determines the success of a treatment. What is crucial according to some studies (Hatcher and Barrends, 2006; Horvath and Bedi, 2002) is the coherence and consistency by which the therapist is able to apply his working model, the therapist's capacity to empathize and his ability to enlist the patient's trust and collaboration in the process. A paradox is set in place where the theory itself is not as important as it being internalized by the clinician in such a way that he can convince the patient of its healing power, where it provides grounds for a coherent way of understanding and working with the patient and, guides his actions in a consistent manner throughout time.

Wachtel (2011) raises an important point about the therapeutic process and technique when he says: "the meaning of the therapist's comments is ultimately the meaning as experienced by the patient; and on the other hand, that experience is significantly determined by the actual shape and tone of the analyst's remarks". (p. 162)

In some ways the challenge of any therapeutic intervention lies at the crossroad of, on one hand, raising further resistance or increased defensiveness in

[1] In 1936 Rosenzwieg observed that no form of treatment is without cures to its credit, concluding that success is not a reliable guide to the validity of a theory, suggesting that some implicit potent common factors were perhaps more important than the methods purposely used. Following Rosenzweig , Frank (1973) identifies four features that characterize all successful therapies: 1) An emotionally charged, confiding relationship with a helping person; 2) a healing setting; 3) a conceptual scheme or "myth" that offers a plausible explanation for the patient's symptoms and prescribes a "ritual" or procedure to address them; and 4) a ritual or procedure that requires the active participation of the therapist and his patient and that is believed by both to be the means to resolve the patient's suffering.

the patient and, on the other hand opening up the space for curiosity, potentially freeing the patient to explore his/her internal representations and evoke unconscious associations. To this effect, at any given moment, there are multiple variables that enter into this equation, notably the quality of the therapeutic alliance as well as the actual tone and shape of the analyst's way of intervening (i.e. degree of empathy and sensibility), but also the patient's internal representations and transferential needs as they are being activated at the specific time of the exchange. In this sense any intervention has the potential to scare and threaten the patient or alternatively to open up the possibility for discovery and internal reorganization. As Wachtel (2011) points out: "the basic thrust of the patient's communication or mode of expression cannot be understood adequately in cross section alone. Whatever mixture of productive self-exploration and fearful evasion is evident at any moment, it must be understood as part of a continually changing series of mental states in which the degree of defensiveness or expressiveness will vary depending on a host of influences. Effective clinical response to what the patient is saying requires that the direction of change be taken into account, that the complex product of competing inclinations evident at any moment be understood in relation to what has come before and to whether it represents an increase or a decrease in the patient's tendency to give voice to conflicted feelings and wishes." (p.189)

Arlow (1979) illuminates an important distinctions in terms of the functions of interpretive comments when he points out: "An interpretation directed toward the

defensive maneuvers of the ego has the effect of saying to the patient: "Don't be so vigilant, don't be so wakeful, let yourself sleep and dream and produce derivatives of unconscious wishes" On the other hand, an interpretation directed toward revealing an id impulse is tantamount to saying to the patient, "Wake up. Observe the implications of what you have just been thinking or dreaming." (p. 194,195)

In a similar vein, emphasizing the relational and communicational aspects of the analytic encounter, Rizzuto (2002) points out that the analyst's task is diverse and wide ranging, helping the patient: 1) to find a voice for his/her experiences and the freedom to communicate them, and 2) to believe that the analyst has the intention to listen and maintain a level of emotional connection that allows him to understand what he/she is saying. Having cemented the basic structure of trust during the initial phases of treatment, Rizzuto notes that, "Changes in the manner of participating in the speech event frequently become noticeable in the middle phase of analysis and obtain full fruition, when things have gone well, during the termination phase, when analyst and patient share a rich private style of speaking to each other, from idiosyncratic vocabulary to prosodic melodies and tone of voice.' (p.1336)

Similarly, Spence, Dahl and Jones (1993) report increased associative freedom, measured as the co-occurrence of unlikely pairs of nouns in the patient's speech, over the course of treatment on the psychoanalytic case of Mrs. C. This increased freedom was significantly related to the number and type of analyst intervention per hour. Spence, Dahl and Jones also noted that as the treatment progressed this relationship tended to become stronger, so that in the latter stages of treatment the patient's ability to use the analyst's interventions as an "opening" of sorts became stronger. Conversely at the

beginning of treatment they identified that the analyst's interventions appeared to decrease the patient's associative freedom. In addition, they noted in the latter stages of treatment the presence of a "carryover effect", so that certain types of intervention would influence up to three of the sessions that followed. Specifically, Spence, Dahl and Jones identified that when the analyst made interpretations directed towards the patient's defensive style, identified a recurrent theme in the material or discussed the patient's dreams or fantasies the patient would show at some point during that same hour an increase in his freedom to associate. Interestingly they also noted that these same type of interventions had the opposite effect during the first cluster of hours (1-30), hypothesizing that these type of interventions are ineffectual without the modulating influence of a strong therapeutic alliance.

**Categorizing the analyst's speech acts.**

Having looked at the different components of the analytic process, key questions in trying to understand how the analyst's actions affect the process are: what are the best ways to characterize the analyst's actions? What is the best way to categorize the analyst's contribution to the process, and the totality of his possible interventions, including actions that have therapeutic effect and contribute to the development of the process, as well as actions that may impact the process in a negative way?

As reported by Tuckett et al. (2008) in the year 2000 the International Psychoanalytical Association (IPA) began an initiative to gather together analyst's coming from a wide variety of psychoanalytic traditions, forming a series of "working groups" in an effort to define the different working assumptions behind the various

theoretical orientations of practitioners and their corresponding models of therapeutic action. As a result of the successive meetings (which incidentally are still ongoing) of these "working groups", these groups have generated a set of categories that help describe what the analysts tend to do regardless of their particular orientation. Using some of the guidelines generated by the IPA working groups but also incorporating observations generated by three different recorded analytic treatments, a set of descriptive categories (see methods section for detailed description) were generated. By noting the utterances generated by these three different analysts these categories were progressively refined in an effort to inform the coding of all possible speech acts performed by the analyst in the current case study.

As a guideline to generate this set of categories for the analyst's communications these are some dimensions that were taken into consideration in order to discriminate and define the different kinds of actions and aims that the analyst can perform at any given moment.

1. Is the analyst directing the attention towards the patient's conscious or unconscious processes?

   Unconscious----------Conscious

2. Is the analyst statement referring to a more general experience (long held patterns of behavior) or to something that is occurring in the here and now?

   General patterns----------Here and now

3. Is the analyst aiming to explore (seeking further elaboration), to respond empathically or is he establishing links between different aspects of the patient's material?

Exploration----------Mirroring/ empathic resp. ----------Linking

4. Is the analyst referring to a specific feeling-state or ideational contents (conscious or unconscious) or is he attempting to define a phantasy?

   Feeling-state/ ideation----------Core unconscious phantasy

5. What is the object that is being addressed by the analyst?

   Narcissistic----------Other relationships----------Transference

   Self-experiences, feelings  figures, or objects  Analyst related

**The Zone of Proximal Development (ZPD) – a model for therapeutic action –**

In an effort to address the relationship between learning and development, Russian psychologist Vigotzky (1978) proposed the concept of the zone of proximal development (ZPD). "It is the distance between the actual developmental level as determined by independent problem-solving and the level of potential development as determined through problem solving under adult guidance or in collaboration with more capable peers" (p.86). Vigotsky further elaborates, "The zone of proximal development defines those functions that have not yet matured but are in the process of maturation, functions that will mature tomorrow but are currently in an embryonic state." Vigotsky was interested in understanding how regulations, rules and structures, which are originally compelled from the outside, come to be internalized as mental processes. The ZPD provides an interactional model for understanding the prospective development of a given function, attempting to explain how internalization transforms all the structures and functions of mental process on the way from outside to inside. The concept of the ZPD underscores three important elements: the interactive nature of development, the fact that

its dynamic force rests on its prospective potential and the differential gap that sustains the structure of the relationship between the subjects.

In a similar vein, Loewald (1960) by likening the analytic process to the developmental process that takes place between the infant and its caretaker comments: "As the mediating environment conveys structure and direction to the unfolding psychophysical entity, the environment begins to gain structure and direction in the experience of that entity; the environment begins to take shape in the experience of the infant. It is now that identification and introjection as well as projection emerge as more defined processes of organization of the psychic apparatus and of environment."(p.36) Furthermore, Loewald underscores the essential aspect of the gap between the different levels of organization between the structures, "The higher organizational stage of the environment is indispensable for the development of the psychic apparatus and, in early stages, has to be brought to it actively. Without such a differential between organism and environment no development takes place." (p.37) The idea of this gap also relates to the notion of "thirdness", or the analytic third, because in this model it is implied that the differential between the environment and the psychic apparatus has to be mediated by an active relationship that is co-created between the two sides. Linking the attainment of insight with the developmental model of the treatment Pine (1985), points out that what allows the patient to take in the therapist as a "new object" and make use of this "new object" to foster better functioning and/or growth is only possible when the therapist has been able to help simmer some of the patient's anxieties by containing and promoting self-understanding, and thus being a "good-object" in actuality.

Translating the construct of the ZPD to the analytic situation, Loewald's model of treatment provides us with a useful bridge. Loewald suggests that the patient who comes for help and is seeking increased self-understanding is led to this self-understanding by the understanding he finds in the analyst. Loewald points out that through the interpretive act the analyst organizes and provides the patient distance from himself in a way that enables him to: "…understand, to see, to put into words, and to "handle" what was previously not visible, understandable, speakable, tangible. A higher state of organization of both himself and his environment, is thus reached, by way of the organizing understanding that the analyst provides. The analyst functions as a representative of a higher state of organization and mediates this to the patient, insofar as the analyst's understanding is attuned to what is, and the way in which it is in need of organization." (p. 38) What is essential in Loewald's view of the analyst as it applies to the ZPD is that he functions as a mediator into a higher organizational level. Correspondingly in a further elaboration, Lowenstein (1956) suggests that the gap which exists between the analyst's understanding and the patient's experience is to be breached by a kind of scaffolding that is provided by the preparatory work leading to the interpretive moment, in which the analyst meets the patient's thoughts and emotions at an intermediate place.

Wilson and Weinstein (1996) propose the following modified definition of the ZPD, as specifically tailored to describe the clinical situation, "*The processes that beget the differences between an analysand's ability to advantageously make use of the dyadic nature of the clinical situation as contrasted with solitary introspection and self-analysis, in order to acquire insight and capacities that promote self-knowledge and ultimately self-regulation*" (p.171) Emphasizing the importance of the dyadic nature of the analytic

work, they note: “in the analytic situation, a pair creates capabilities beyond the limits of one alone.” (p. 169) This notion of the ZPD as applied to the clinical situation will encompass aspects that are typified by constructs like the therapeutic alliance and the holding environment.

Underscoring the link between the structuring aspect of the therapeutic work through the use of language Palombo (1999) suggests, that change in the patient’s internal world occurs as his structures are transformed by the new connections that are revealed and/or reconstructed in the verbal space shared by the patient and his analyst. “Ancient words from deep in the linguistic past form the basis for the commonality, but the language is brand-new nevertheless, since it develops out of their work together, which has no exact precedent. The language of the analytic discourse is shared only by the two of them, but it is a language that describes aspects of the patient’s experience that have never been put into words before.” (p. 96) When confused mental spaces are differentiated by the creation of meaning and significant linguistic links, new psychic structure is built. Refining this notion even further, Wilson and Weinstein (1996), underline the connection between the role of speech and the different levels of transference, suggesting that this awareness can serve to guide the interpretive work by considering the interactive analytic context as it develops in the form of a shared vocabulary. The analytic dyad is separated by a gap, supported by the therapeutic alliance, the use of language and the different levels of transference they embark on the journey of analytic work; the analyst, the patient and the analytic work, create the three points that support the triangular space in which symbolization can take place.

Treatment that fosters the development of the transference neurosis as a central mutative factor is particularly compatible with this model of change (Wilson and Weinstein, 1996). The development of the transference is a process that develops over time and involves in part an enactment of previously internalized phenomena that is at the heart of the patient's neurosis. Over time the analyst plays the part in the patient's mind of an internalized function or object relation. Proponents of this model (i.e. Dewald, 1970) would suggest that at the moment when the transference neurosis comes to the fore the time is ripe for transformative change to occur. By reviving what was previously warded of and making it current in the analysand's emotional life, the neurosis becomes accessible and subject to the influence of the analytic work; internalized phenomena becomes susceptible to transformation as it is reedited and relived through the current relation with the analyst.

This model recasts and expands the role of the analyst by underlining his active role in the scaffolding (holding functions and through maintaining the setting in place) and interpretive functions, so that the analyst is no longer solely the focus of transference distortions to be deciphered. In this view the analyst lends the patient subtle mental attributes indispensable for emotional transformation; the analyst not only interprets transference distortions but also subtly, yet evocatively, conveys a new and less deceiving reality which the analysand comes to internalize. "In the act of articulation, the analyst's words that serve as the vehicle for an interpretation also create a dialogic condition whereby canonical meaning negotiations will occur, further personalizing the interpretation, fleshing it out with the analysand's own thoughts and associations" (Wilson and Weinstein, 1996. P.176) Hence, the analytic dyad when immersed in the

analytic process creates capabilities that each participant alone does not possess and that are an intrinsic aspect of the relational process that is taking place.

## Chapter II

### Empirical Research in Psychoanalysis / Interesting Findings

When attempting the study of psychoanalytic phenomena a crucial question was posed by Bucci (1997), "How do we develop a science whose subject matter consists of mental and emotional representations, which are private and sometimes inaccessible, when the sine qua non of science is that events be jointly observed?" (p. 156)

Psychoanalysis, as a practice and a way of thinking about the human mind, challenges researchers by the particular nature of the treatment and the way it conceptualizes its goals. Usually, it is understood that the patient enters treatment with a set of internalized structures that shape his emotional life and worldview. The analyst brings her own emotional meanings and views. The mental and emotional representations of each participant are internal, private, known directly at the level of their personal experiences and sometimes known only partially even to them. The change that is desired is in the patient's internal world of representations.

The challenge for researchers is to find observable events in the form of observable patterns, –preferably recurrent patterns-, from which to infer these non-observable entities and functions that serve as hypothetical constructs for the theory of psychoanalysis. Ideally each hypothetical construct could generate a rule that links them to observable phenomena in a systematically defined way. As Jones and Windholz (1990), have pointed out: "data derived from the psychoanalytic case are difficult to study in ways that are simultaneously clinically and scientifically relevant. The difficulty lies in preserving the depth and complexity of clinical material without putting it beyond the objective and quantifiable realization" (p. 988). When using case studies to inform

research in the field of psychoanalysis Jones and Windholz (1990) also stress the importance of managing and translating the wealth of observations that characterize case studies to objective and quantifiable dimensions while capturing the uniqueness of the individual case and allowing comparisons among observers and between cases.

Comprehensive reviews of outcome research on psychotherapy have come to one basic conclusion. Psychotherapy in general has been shown to be effective (Blatt, S. et al, 2006; Shea, M. T. et al, 1992). Reviews of empirical studies comparing a wide-range of psychotherapies have found no significant difference between different types of psychotherapies in terms of their effectiveness (Westen, D. et al, 2004). The prevailing understanding in terms of the equivalence of outcome for highly diverse types of treatments is the existence of "common" or "non-specific" factors that are present in all forms of therapy and lead to positive change. Frequently cited as "common" factors, are the therapist's empathy, warmth and acceptance, the patient's ability to experience trust and feel understood, a coherent and consistent adherence to an internal working model on the part of the therapist, and the therapeutic alliance.

Perron (2003) makes an interesting distinction between "research *in* psychoanalysis" and "research *on* psychoanalysis". While the former attempts to understand better what happens during the treatment, that is the therapeutic process itself; the latter is an approach from the outside, aiming to assess treatment indications, outcome, and so on.

For the over the past two decades The Psychoanalytic Research Consortium (PRC)[2] has developed methods for the assessment of analytic process. They have assessed multiple audio-taped treatments through the development and use of the analytic process scales (APS) (Waldron et al, 2004). The APS facilitates the assessment of tape-recorded sessions, enabling the evaluation of the nature and quality of the contributions of analyst and patient to the psychoanalytic process and to study their interactions. Looking at three analytic cases the authors reported significant correlations between core analytic activities, (e.g., interpretation of defenses, transference and conflicts) and patient productivity immediately following the intervention. Differences were found in terms of the quality of the intervention, defined as the clinical raters judgment of the aptness of the analyst's intervention, the potential usefulness of its content, and the skill and tactfulness of its presentation. (Waldron, et. al, 2004).

A decade ago, research began to show that particular patterns of patient-therapist interactions can have either a deleterious (e.g. Strupp, 1998) or positive (e.g. Messer and Holland, 1998) influence on therapeutic progress. Indications suggest that the former is marked by increases in highly repetitive patterns of thought and behavior, as well as a reduction in the capacity to symbolically represent and thus (re)consider one's conduct or thought representations. Whereas the latter may be associated with, among other things, increased fluidity of thought, an increased capacity to symbolize those thoughts and a related capacity to discern possible connections between heretofore apparently disparate ideas and feelings (see for example Palombo, 1999; Freedman, Lasky &Ward, 2009).

[2] The Psychoanalytic Consortium is a non-profit organization dedicated to the purpose of collecting, safeguarding and distributing recorded psychoanalyses and psychotherapies for research and teaching purposes.

As reported by Messer (2001) and Crits-Cristoph (1999), there is evidence that the outcome of psychodynamic therapy is related to psychotherapeutic techniques and, not surprisingly, the therapist's skillfulness. In studies that have looked at psychodynamic psychotherapies, length of treatment and quality of object relations appear as important modulating variables in regards to the effect of transference interpretations. Connoly, et. al. (1999), Hoglend (1995), Ogroniczuk, et al. (1999) studied the quality of the therapeutic alliance and treatment benefits in short-term psychodynamic psychotherapy of patients who rated low on quality of object relations, reporting that frequency of transference interpretations is associated with both poor outcome and a shaky therapeutic alliance. On the other hand, Connoly, et al. (1999) and Piper et al. (1991a, 1991b) suggest that although patients with a high quality of object relations (i.e. ability to maintain long term relationships, and to deal with ambivalent feelings or emotions) may benefit from low to moderate levels of transference interpretations, they do not benefit from high levels of transference interpretations. Research that has studied the therapeutic alliance suggests that the alliance is a modest predictor of treatment outcome (Crits-Cristopher, 1999; Barber, et al, 2000; Horbath, 2005). Crits-Christopher, et al. (1993) looked into the accuracy of interpretations and found that it correlated significantly with the therapeutic alliance in treatments of moderate length. These results are consistent with the idea that transference interpretations are more conducive to the treatment in the context of a good therapeutic alliance, and that even in the case of patient's with good object-relations it takes some time for the alliance to take hold. It would seem that analytic treatment, which is generally conducted with a high frequency of sessions and a prolonged length of time

would allow for transference interpretations to operate with greater efficiency, particularly as the treatment progresses.

An experimental study conducted by Hϕglend et al. (2007) looked at the moderators of the effects of transference interpretations in brief dynamic psychotherapy (i.e. once a week for one year), specifically interpersonal functioning and symptom severity, finding that patients with greater interpersonal problems, more severe symptoms and poorer quality of life tended to respond better to therapy with transference interpretations than to therapy without such interpretations. On the other hand patient's that were found to be more resourceful and less disturbed tended to have a negative response to transference interpretations. As the authors point out these results are at odds with mainstream clinical thinking, however because the framework in this study differs significantly from the usual analytic setting in terms of the frequency and length of treatment it would be interesting to replicate this design with higher frequency and longer duration of treatment to determine if these variables may create a different outcome.

Comparing a cognitive behavioral therapy and a matched short-term dynamic therapy by using the analytic process scale (APS) Waldron & Winarick (2004) reported marked differences between the two cases in "core analytic activities" (i.e., clarifying, interpreting, addressing inner conflict and transference manifestations). Although these differences appeared in the direction expected, the cognitive behavioral treatment was still found to show a substantial level of these types of activities. As in previous findings reported by Waldron et. al (2004) the quality of the intervention (e.g., type of intervention, usefulness of its content, tact, timing and language appeal) evidenced a

pivotal role in the patient's subsequent communications both for the behavioral treatment and the psychodynamic approach.

Green (2003) asserts that statements about psychotherapy that are derived from group data or outcome research typically have little direct relevance for the clinical problems that are presented to the psychoanalytic therapist. In his view, to a large extent much of the therapy research enterprise has remained peripheral to the clinical practice of psychoanalysis and to its major theoretical and intellectual currents; because it focuses mainly on results that are measured through symptom checklists and self-questionnaires which generally address questions of behavior and degrees of satisfaction but do nothing to elucidate questions of process or internalized object relations. Whether one agrees or not with Green's grim view of the current efforts to evaluate psychoanalytic treatment by comparing it through outcome group studies, it is fair to say that pre and post measures commonly employed in outcome studies shed little light over the question of process. In addition the group data blurs the identity of the individual subject obscuring the particularities of the individual case-study that have been the bedrock of the psychoanalytic way of thinking.

**Single-case research.**

Even if the study of individual cases has long been a fundamental source of data for psychoanalysis, there are many recognized difficulties in using such data for hypothesis testing of for the verification of clinical constructs. As Jones (1998) has pointed out the main problems are: the difficulty of assessing the reliability of the case study data, e.g.: the way in which observations are selected and/or recorded; the dilemma

of choosing between alternative interpretations of the same observations; comparing a single-case study to another; determining the sources of uncontrolled variation; and the challenges of replication (Hilliard, 1993); limitations attributable for the most part to not having access to the original data set.

As a method of investigation, single-case research has been consigned conventionally to the role of discovery or hypothesis generating. For the past two decades, however, new developments in the methodology of single-case designs have extended its applicability to the testing of clinical theoretical constructs and hypothesis, and in some cases even the identification of causal relations. As Jones (1993), points out single-case designs are more closely linked to traditional means of clinical inquiry, teaching and learning, than are large sample studies, and they are likely to have more immediate relevance for how treatment is conducted.

The multitude of data points available in the analysis of a long-term psychoanalysis –all generated by the same individual- give researchers the advantage of both the law of large numbers and the relative absence of statistical noise (Spence et al. 1993), particularly when the sampling is generated throughut the course of treatment allowing to study the process as it unfolds. Single-case analysis provides researchers with the opportunity to systematically study the course of change, within an individual, over time, and anticipating the possible set of antecedents of such changes.

On the importance of using taped recorded sessions, Bucci (2001) has remarked: that precisely because of the nature of subjectivity, because perception and memory are active and constructive processes rather than passive and reproductive ones, that it is preferable to access a verbatim record of reference. It is desirable for the researcher to

have a more dilated space where his or her own subjectivity -as well as research methods- can apply. In addition, to the extent that we are interested in the "music" of the clinical encounter, its rhythmic patterns, such data –including pauses, rhythm, tone and modulation- are better preserved in the form of recordings than in notes (p. 62). Using recorded analysis offers a clear advantage over clinical reports, the latter are subject to the analyst's retrospective reconstruction and are limited to his or her conscious awareness of what has transpired in the treatment, in addition the data is generally selected and contextualized by the analyst's theoretical tilt (Freedman et al, 2009).

The recent generation of psychoanalytic process research includes multiple perspectives on the analytic data that involves impressions of the treating analyst, quantitative ratings of clinical judges (such as APS, CCRT or PERT) as well as computerized linguistic measures (such as Referential Process). Such a design allows a comparative process and outcome study integrating multiple lenses (Bucci, 2007). This framework will also be adopted in the current study.

An intensive single case study of an ongoing treatment, now being carried out by the Research Group of the Institute for Psychoanalytic Training and Research (IPTAR), is one of the few examples of this approach (Freedman, Lasky and Hurvich, 2003). Freedman and his group (1985, 2002, 2003, 2009) systematically study the varying levels of symbolization in an analytic session and try to empirically predict significant moments of change in psychoanalysis, which lead to a transformation in the patient's functioning.

According to Hill (1990) research on therapist techniques has historically developed through at least two different approaches: one that operationalizes therapist interventions as verbal response modes that constitute nominal categories refering to the

grammatical structure of the therapist intervention, independent of the topic or the content of the speech; and the other that focuses on measures that involve facilitating conditions (e.g., empathy). Hill also points out that the first approach is favored by some for possessing better psychometric conditions.

In a series of studies that examined the differential effects of therapist response modes on in session immediate outcome, Hill et al. (1983) and O'Farrell, Hill and Patton (1986) found that therapist interpretation was associated with decreased client description of the problem and increased experiencing and insight. Barkham and Shapiro (1986) found that patients rated therapists as being more empathic when they used more exploration than other type of supportive/type comments.

Freedman and colleagues (Freedman and Lavender, 2002; Freedman and Russell, 2003) identified three phases that make up their incremental symbolization scale: A "pre-representational phase" predominantly characterized by action and discharge; a "symbol generating" phase by which actions are transformed into symbolized thought and a "symbol-deployment" phase where images are transformed to symbolized thought giving rise to more elaborate and higher order associations. Afterwards, they created a rating scale to characterize these shifts in the patient's mental functioning taking into account processes of integration, developmental progression, relatively stable exploration and reflective function as well as qualities associated with non-integration, regression and destabilization (Freedman, Lasky, Hurvich, 2003, pg.208). Using measures of referential process and this rating scale, Freedman et al. (2003) found a statistically significant difference between sessions that were high in symbolizing activity which involved much reflection and a wide affective range and sessions low in symbolizing activity which were

found to be not only low in terms of reflection and affective range but also revealed higher "speech disfluencies" (pausing, fragmentation and repetition) and prevalence of negative affect.

Freedman's work on incremental symbolization and Bucci's referential process model, each using different lenses, look at transformation of emotional information from presymbolic forms of expression towards symbolic forms. Halfon (2010) reports that by combining a measure of repetition and RA, a series of speech patterns can also be used as a lens to identify different levels of mental organization/representation and significant moments of change in the treatment. Even though repetition and RA serve different functions, each are attempts to master and pattern stimulation. Halfon (2010) reported the following groups of patterns to describe the patient's speech, these patterns commonly fluctuate within each session. 1) The low repetition & high RA patterns, these are markers of symbolizing activity given that the patient is able to freely use vivid differentiated memories and fantasies that are clearly linked to her internal states and the transference. 2) The high repetition & low RA segments, which point to a representational impasse as the patient fails to integrate conflictual representations and in effect is thrown into psychic confusion and concreteness. 3) Low repetition & low RA patterns, where the conflictual psychic state is completely disavowed as the patient attacks all activity associated with thinking and meaning making. At these moments the patient withdraws investment from anything associated with the external world (i.e. analyst, analytic task or demands of reality principle) and in contrast, preserves an archaic fantasy that substitutes reality. And finally, 3) the high RA & high repetition segments, in which the patient is overly involved and immersed in a traumatic narrative

governed by the principles of primary process that disrupts the continuity of his identity, in time and in space. These measures will be used as part of this study, in the interest of assessing the effect of the analyst's interventions on the fluctuations marked by these speech patterns.

**The case of Mrs. C**

Mrs. C's case was a six-year, five times a week, classical analytic treatment of a young woman in her twenties that was recorded in its entirety, providing a total of 1,114 sessions. Mrs. C, a married social worker, sought treatment because of lack of sexual responsiveness, difficulty in experiencing feelings of pleasure, and low self-esteem. This case is perhaps one of the most widely studied cases in the psychoanalytic literature (Weiss and Sampson, 1986; Dahl, Kachele and Thoma, 1988; Jones and Windholz, 1990; Jones, 1993, 1997; Ablon & Jones, 2005; Spence 1993, 1995, 2003; Caston and Martin, 1993; Vaugh & Roose, 1995). While the majority of these studies view the treatment as a success, there are exceptions to this view. In a study performed by Luborsky et al (2001), seventeen complete tape-recorded treatments were evaluated by independent clinical judges, using quantitative outcome measures (i.e Health-Sickness Rating Scale, HSRS; Global Assessment of Functioning, GAF; Combination of Success Satisfaction and Improvement, SSI). These measures were applied to the contents of three early sessions and three late sessions from each treatment. As opposed to the "moderate", "equivocal", and "failed" outcomes of most of these cases, the treatment of Mrs. C was described as having achieved "very good" improvement.

Jones and Windholz (1990) conducted a systematic study of the therapeutic process of the analysis of Mrs. C, using a Q-technique method. Q- sort is a methodology that requires judges to sort items relative to one another along a specific dimension to apply Q-methodological statistics. In this study consecutive sessions were selected from each year of the treatment at regular intervals, forming 6 blocks of 9 sessions for analysis (approximately one block per year) spanning the duration of the treatment. Clinical judges applied the Q-sort technique to the selected transcripts in order to provide a standard language to classify and describe the process in a longitudinal framework. Each year-block description attained high levels of reliability among the judges. Reliabilities calculated for the pool of transcripts attained .88 (Pearson R), with a range of .58 to .95 (Spearman-Brown corrected).

Results showed the following descriptions in terms of dominant themes, the first year (hours 91-100) was dominated by conflicts around sexuality (fears of being raped, finding sex dirty, aggressive wishes). On his part, the analyst interpreted Mrs. C's resistances and drew connections between her feelings of fearfulness, powerlessness, and difficulty in talking in social encounters, to long-standing reactions toward her father. In the second year (hours 258-267), Mrs. C's narratives extend to wishes of being reassured by her husband and concerns around her sexual identity, her womanhood and becoming pregnant. During this period, the analyst frequently interpreted the patient's feelings of guilt. His communications are described as tactless and patronizing. The third year (hours 429-438) coincides with the time preceding and following Mrs. C delivery of her first child, during this time she presents with feelings of disappointment and powerful aggressive fantasies (i.e. harming

her child). During this time the analyst is much more forthcoming with transference interpretations that link her current reactions to her early history and outside experiences. The fourth year (hours 596-605) is filled with long and frequent silent periods, where Mrs. C oscillates between feeling defiant and angry, wishing to avoid her analyst and husband, and on the other hand feeling guilty, deserving of punishment. The analyst increasingly made the treatment relationship and the transference the focus of his interpretive work. Mrs. C. struggled with and resisted feelings about the analyst. The analyst interpreted the transference and drew parallels between the analysis and other relationships. The patient resisted knowing this, but also, and even more than earlier in the analysis, accepted his interpretations. The fifth year (hours 765-774) is mostly about her continued conflicts about her aggressive feelings and her feelings of remorse towards her clients and her husband. The analyst repeatedly interprets Mrs. C.'s avoidance and denial, connecting to this her earlier report of her father's angry reactions, and her feelings regarding the parental couple. Finally the sixth year (hours 936-945) is characterized by a focus of Mrs. C's feelings toward her analyst and her husband, she gains greater contact with her sexual feelings and is capable of speaking more directly about her wishes and fantasies. During this period the analyst's interpretations are judged as clear and evocative revolving primarily around Mrs. C.'s resistances and transference wishes.

Jones and Windholz also reliably identified meaningful shifts in the treatment between three major phases of the analysis: from the first to second year (early phase) Mrs. C was perceived as generally freer; less shy, more trusting and confident. The middle phase (shift from third to fourth year) was characterized by a shift toward greater

resistance in the form of increased silences, difficulty starting the hour, pronounced struggles to control and ward off painful feelings, diffuse dialogue, absence of material from early history, and increased ambivalence. The late phase (shift from fifth to sixth year) was characterized by a marked shift toward greater access to her own fantasies, more frequent and direct expression of sexual and romantic feelings and longings, greater independence, and increased open expression of positive feelings toward her analyst. Using summary estimates of the course analysis, Jones and Windholz characterize the treatment as a success. Mrs. C was noted to have moved from intellectualization, resistance, and hostility to increased trust, self confidence, openness and a more natural discourse, less dominated by rationalization, with the expression of a deeper and wider range of emotion.

The Q-sort was also applied to describe the process as a whole, the items that emerged portray the analyst's stance as neutral, accepting, self-assured and non-defensive, while not supportive, reassuring, or advisory. The patient's posture as anxious and tense, active in initiating dialogue, yet neither controlling nor demanding. The analyst was judged to perceive the analytic process accurately (i.e., effectively understand the patient's experience of the analytic relationship, her emotional state, and the nature of the interaction between them). Countertransference was judged to be largely absent, or at least not apparent in a way that could be identified by the raters. The analyst's basic orientation was not intended to avoid upsetting the patient's emotional balance, nor did he intervene to help the patient avoid or suppress disturbing feelings or ideas. On the contrary, the

analyst characteristically emphasized the patient's feelings in order to promote a deeper experience of them, and interpreted her behavior during the hour in ways that allowed the patient to experience herself differently.

Jones and Windholz detailed description of the case provides the image of an evolving narrative, and also clearly denotes the elements of a specific way of working with the patient's material. The analyst stance is described as neutral, accepting, and self-assured, yet not offering the patient support or reassurance. It is also noteworthy that interpretations move from connecting present with past experiences early in the treatment, to mostly transference based by the end of the treatment.

In contrast to Jones and Windholz, Bucci (1997b), using the same 70 sessions, reached a different set of conclusions. In her study Bucci set out to observe shifts in the quality of the patient's language in the course of the treatment using computerized versions of the referential process. The referential process includes three major phases, arousal, symbolizing, and reorganizing, which repeat within sessions and also across treatments (Bucci and Maskit, 2007). Using the earlier versions of the computerized referential activity dictionary, the CRA (Mergenthaler and Bucci, 1993), showed that paradoxically the patient's referential activity (RA, a measure of vivid, imagistic and detailed language that is associated with the patient's capacity to link non-verbal and bodily modes to words) declined over time while the analyst's increased. Bucci's linguistic analysis indicated that Mrs. C evidenced a general decline in expression of

emotional experience across the six years of her analysis and that in effect her language style became more intellectual and abstract.

Weiss and Sampson (1986) studied the first and last hundred hours of this case using a set of process research methods based on assessment of the patient's unconscious pathogenic beliefs, goals, and plans. They report that the patient's plan, as inferred from the beginning set of sessions, was still guiding her behavior during the last set of sessions. "Throughout her analysis, Mrs. C. was unconsciously worried about the analyst, for whom she felt omnipotently responsible. During the first 100 sessions she tested her belief in her responsibility for the analyst by attempting to demonstrate to herself that she could not push him around. During the last 100 sessions she tested the same belief by attempting to demonstrate to herself that she would not hurt the analyst if she made clear to him her "wish to terminate" (p. 25). These findings also led the researchers to question the effectiveness of the treatment in addressing her pathogenic beliefs.

In a separate study Bucci (1997b) set out to analyze the progression of the analytic process within single sessions. Bucci chose two sessions from the earlier and later phases of the treatment that had contrasting scores in terms of levels of engagement in the referential process. Session 38, for example, was chosen for having the highest combined scores on Referential Activity and two other measures; "emotional tone" which tracks the patient's capacity to select words that reflect his/her emotional state at the time and "abstraction" which consists of patient's access to complex and abstract words that are taken as signs of logical reflection and evaluation. This session was expected to demonstrate the referential process in relatively clear form. By contrast, session 726 was singled out for its low level of engagement in the referential process.

In her examination, Bucci carried out a microanalysis of the chosen sessions, attending to material that preceded and followed analyst interpretation and corresponded with various relational themes. Drawing parallels between the linguistic patterning of session 38 and Kris' (1956) model for the "good hour", which is basically characterized by a progression in the patient's narrative[3] that evidences a series of openings and connections to the material presented, allowing a clear path for interpretation and collaboration from the analyst. Following this premise, Bucci noted the way in which the patient began the session in a phase of disfluent, emotional activated arousal, followed by a flourishing narrative, filled with imagery, dreams and vivid associations, followed by the analyst's interpretation which spurred the patient into a more abstract, reflective period.

In contrast, the microanalysis of session 726 depicted a different picture from that of session 38. Unusually high abstraction, low Referential Activity, and low emotional tone distinguished this session as intellectualized and affectively dead, what Bucci referred to as a "stalemate" in the process. Here, Bucci detailed the way the patient's content (manifestly confirming the analyst's interpretation of hostility) diverged from her language style. In both cases, the consonance between the global linguistic analysis and the in-depth, qualitative microanalysis provided validation for the use of linguistic productive and struggling hours. This approach also provides a window into the process that presents the patient's verbal activity as linked to the analyst's communications. This

[3] In Kris's 1956 paper the progression of a good hour is described as beginning from an ordinary story for the initial minutes, then a memory, first a recent one then one from the remote past and finally a dream. Multiple scenarios are played out sometimes sequentially, sometimes concurrently. As the session progresses things move and potentially begin to fit together resulting in a recapitulation in the transference.

way of working with the patient's linguistic patterns and connecting the analyst's communications with the process will be elaborated in this study.

In a collaborative study conducted by Luborsky, Dahl, Gill, and Bucci (1988), the researchers performed microanalysis of a single session (session 5) that takes place early in the treatment, each applying their own measures independently. In this study the application of CCRT (Core Conflictual Relationship Theme- a measure which is designed to assess the patient's "relationship episodes" that involve a wish, a response from the self and a response from the other, as they are told to the therapist during the treatment hour-) to session 5 revealed a relationship episode between the patient and her husband, which evidenced her desire to seek approval and her fury when her request was rejected. At this point the analyst's interpretation was: "What strikes me is you went home after you left here and talked to your husband about it wanting reassurance, but not here". The congruence of the therapist's response with the CCRT wish was marked "moderately good" and this congruence was also found to be moderately good throughout the interventions in this sessions and other sessions as well. This kind of congruence was expected to be associated with the benefits the patient received from the treatment. Dhal's FRAMEs (Fundamental Repetitive and Maladaptive Emotion Structures) measure is a tool that provides a detailed description of each patient's recurrent maladaptive structures, allowing the researcher to identify the nature of the therapist's and the patient's contribution to the therapeutic process. When FRAMEs was applied in this same session, it identified that the patient had work related conflicts and wanted support; but expects not to get support, and indeed does not get support because she delays talking to those

who might help, which leads her in turn to express hostility. In this sense FRAMEs revealed a uniquely maladaptive pattern.

Gill and Hoffman's PERT schemata explores the patient's experience of the relationship with the therapist pointing to implicit and explicit references to transference in the patient's verbalizations. When applied to the specimen hour in the treatment of Mrs. C., PERT revealed a series of relationship episodes including hostility and jealousy in relation to an aggressive rival teacher, obsessional tendencies when it comes to decisions, especially with regards to potentially pleasurable experiences with her husband; inhibition and anxiety in her relationship with her father; and feeling she was tactless and impulsive in stating the faults of one of her students to the child's mother. According to PERT, all these relationship issues were deeply connected with the transference and the analyst offered transference related interventions. In the first, as also identified by CCRT, the analyst points out to the patient that she is seeking reassurance from her husband but omits reporting her experience to the analyst as if she were avoiding leaning on him as she has claimed she intended to do. In his second intervention, the analyst suggests to the patient that she may be inhibiting some critical thoughts about him. These interventions were found to be fruitful in that they opened the door for disclosure and further associations by the patient of several previously suppressed ideas regarding her relationship to the analyst.

Bucci also applied her linguistic measures to this specimen hour in the analysis of Mrs. C, finding that the passages marked as containing emotional FRAME structures mentioned before (the patient's desire to seek reassurance and react with hostility in absence of it) were significantly higher in Referential Activity level than those not so

marked, indicating a greater access to nonverbal experience in the associative process of the patient at those points. This study provided a strong demonstration of converging evidence for emotional structures in the process of free association of an analytic patient. The assessment of emotional structures and the evaluation of linguistic qualities were carried out by applying distinct concepts and following independent procedures, showing striking correspondence and congruence of findings.

This study provides an interesting window into the microanalysis of a single analytic hour, and even though it is limited in terms of what it can say about the treatment as a whole it offers an interesting research approach by overlapping different methodologies into the same data. All three measures (FRAMES, PERT and CCRT) are methods of evaluating repetitive relationship patterns and the derived transference experiences. They can all be used to define relational repetitive patterns and track their change over the course of psychodynamic treatment. However, they have serious limitations. One problem with regards to the conceptualization of these repetitive patterns is the overemphasis on behavioral patterns that bypass different functions of repetition that are not necessarily behavioral such as the role of repetition in language as it appears in the patient's speech acts (Fonagy et al., 2002).

Another major problem in the case of CCRT and FRAMES is their emphasis on manifest content. The fundamental problem with using these measures is associated with inferring the relationship between conscious and presumed unconscious mental representations and processes (Dahl & Teller, 1994). Even though PERT relies less on manifest content, a major problem that it brings is the identification and selection of

patient material for use based on predefined categories instead of the narrative of free association itself (Dahl, Kächele and Thomä, 1988).

in a separate study, Dove and Bucci (1997) identified patterns in Mrs. C's silences, noting that they tended to occur around the end of flourishing narrative phases. Baerson (1998) elaborated by finding that when silence followed these narrative periods, the developmental level of Mrs. C defenses (using Perry's Defense Mechanism Rating Scale) was higher, more mature, than when the analyst spoke. They also found that Mrs. C tended to pause less after narrative phases as the treatment progressed (speculating that the patient had learned the implicit "rules" of her analyst).

In a more recent study, Graham (2008) set out to study the clinical meaning of silence and affective valence in the referential process of the cases of Mrs. C and Mrs. Y (another well studied case). In the case of Mrs. C, the individual factor of negative affect was consistently and powerfully associated with productivity. Greater amounts of negative affect were related to higher scores on all four linguistic measures. In addition, the individual factor of the proportion of overall silence amount occurring in the first third of sessions was highly related to productivity: higher proportions of total silence in the first third of sessions were strongly associated with higher productivity on two of four linguistic measures. In addition the study indicated no effect on the productivity indicators in relationship to the length of silence on the second half of the session; more frequent occurrences of protracted silences were not found to be either particularly harmful or helpful.

In the treatment of Mrs. C silences are a prominent part of the exchange (sometimes adding up to half of the sessions time), however it would appear as if neither

of these studies is able to capture the communicational meaning of these instances in terms of the therapeutic relationship. By correlating silences with measures of productivity and maturity of defense the relational aspect is by-passed.

Udoff (1995) and Meisels (1998) examined the period of Mrs. C's pregnancy during her analysis. Udoff found a greater expression of maternal fantasy (via words captured in her maternalism dictionary) during the pregnancy period than before, a significant correlation between maternalism and Referential Activity (measured by CRA), a significant correlation between aggression and maternalism, and an overall decline in Referential Activity from the beginning to the end of the analysis. Through this study, Udoff challenged the analyst's case formulation by positing that the patient primarily focused on themes of repair, affiliative trends, aggressive maternal protectiveness, not penis envy, as suggested by the patient's analyst. Contrary to Udoff, Meisles found that aggression actually decreased during the pregnancy to post-pregnancy period. She understood these differing results in terms of the somewhat different focus of her aggression dictionary that looked primarily at the destructive aspect of aggression contrasting to Udoff's measure which included notions of competition and control. Similar to Udoff, she too found that the patient's level of Referential Activity declined over time. In addition, she found that emotional contents measured by Merghenthaler's Emotion Tone dictionaries (Merghenthaler, 1992; Merghenthaler & Bucci, 1993) declined during the first trimester of the patient's pregnancy, and that the patient and analyst's aggressive language tended to cluster together. Meisels explained the results in terms of the patient's compliance; she argued that as the analyst became more engaged in

his own interpretations about penis envy, the patient became increasingly disengaged, while dutifully joining the analyst in his interpretations of penis envy and aggression.

Both of these studies reach similar conclusions to Bucci (1997), perhaps partially due to the fact that they are using the same measure, -RA-, in order to describe the patient's process. The decline over time in RA is understood as an indication of the patient's overt compliance with the analyst which masked an underlying affective disengagement from the treatment.

## Chapter III

### Statement of the Problem and Exploratory Hypotheses

This work focuses on exploring the intersection between the technical aspects of psychoanalytic treatment and its process. Psychoanalysis takes the analyst and his patient through a journey of transformation that is signified, among other things, by the verbal exchange that takes place between them. During treatment the analyst and his patient are engaged in a mutually affecting process. Studying transcribed audio taped sessions offers a window into this process. It has been hypothesized that change in this context is not a linear progression but rather an oscillating function involving different speech patterns that fluctuate in terms of the level of organization and the degree of symbolizing activity. These fluctuations are hypothesized to be a normative aspect of this process.

Following Halfon and Weinstein's (2013) methodology this study attempts to track linguistic patterns as represented by the interaction of fixed/exact repetitions and representational language, which will be assessed through the patient's use of Referential Activity (Bucci, 1997). Referential Activity (RA) is a measure of vivid, imagistic and detailed language that is associated with the patient's capacity to link non-verbal and bodily modes to words. Halfon and Weinstein (2013) propose that the RA measure combined with a measure of repetition offers the opportunity to describe what we believe to be essential linguistic patterns of the analytic process. Exploring and describing the way in which the analyst speech affects this process is the overarching goal of this study.

Psychoanalysis can be, in part, described as a process of exploration that seeks to represent and symbolize experience, leading in turn, to the reorganization and reintegration of internalized relational patterns (Loewald, 1980 ; Bass, 2006). These

relational patterns can be inferred through the patient's verbal accounts of present and past experiences as well as through the experiences recreated inside the treatment room with the analyst. It has been hypothesized that the analyst acts as a transference object, whose psyche can be used to help decode, metabolize and transform original traumatic experiences towards new representational structures. Although in this study the focus will be placed on the analyst's verbal acts, it is understood that multiple variables account for the transformative potential of the analytic process. (i.e. the containing aspects of the frame and setting, the analyst's demeanor, the continuity and unwavering availability of the analyst are understood to be other essential aspects of the treatment that cannot be accounted for in this study).

Furthermore this study attempts to look at the analytic process as a bidirectional process, meaning that just as the analyst is meant to influence the patient's speech, the patient influences the analyst as well. For this reason a specific goal of this study is to describe the types of speech patterns that usually follow the analyst's interventions as well as to describe what types of speech patterns usually precede the analyst's intervention. In order to describe the effect of the analyst's communication, this study will discriminate between interventions that are "exploratory" from those that link or interpret speech acts that the patient has produced. It is hypothesized that interventions that have exploratory functions will have the potential to open up more unconscious process and therefore will have a greater disorganizing potential. On the other hand, interventions that have linking qualities will have greater organizing potential and will tend to provide a calming effect on the patient, which will reflect in speech that is better symbolized and more integrated.

A final aim of this study is to describe the interactional patterns of the analytic dyad as they evolve over time. For this purpose the frequency and type of interventions will be plotted over time. Based on Jones and Windholz's (1990) description of the case, it is hypothesized that the analyst will tend to use more exploratory types of interventions in the beginning phase, and will likely place greater emphasis on interpretations and linking communications in the middle and later phases of the treatment. It is also hypothesized that because analyst and patient are thought to develop greater mutual understanding over time, faster fluctuations in terms of the speech patterns will be observed as the treatment progresses.

This work then describes the interaction between the analyst interventions and the analytic process as it can be described when combining measures of linguistic repetitions and Referential Activity (RA). The transcripts of audio taped psychoanalytic sessions, which provide the spoken words of both analyst and patient were used in order to provide a direct window into the psychoanalytic process.

## Methods

Data:

The data was derived from fully transcribed sessions from the archival psychotherapy of Mrs. C, a fully recorded psychoanalysis of a young woman during six years of treatment, conducted five days a week, for a total of 1,114 sessions. This case was selected for several reasons. It is one of a handful of long-term psychotherapies that was audio-recorded in its entirety, more than one third of which has been transcribed

verbatim. In addition, this case has also been studied using a number of different methods, which sets the stage for comparative studies.

Sampling of Sessions:

Specimen sessions were selected to represent the analytic process during early, middle and late phases of the treatment. Sessions were also selected based on those already studied in depth by other researchers; especially those who had studied process by employing linguistic measures (Jones and Windholdz, 1990; Weiss and Sampson, 1986; Bucci, 1993; Siegel; 2010; and Halfon, 2010). Session blocks at relatively regular junctures were used: Session 91 and 92 from the first year, session 259, 260 from the second year, sessions 431 and 432 from the third year, session 628 and 629 from the fourth year and session 1000 and 1001 from the sixth and final year of treatment. As is evident each block consisted of two consecutive sessions.

**Measures**

In order to do the coding, all sessions were segmented into idea units, following the procedure developed by Waldron et al. (2004). This procedure was chosen because it allowed to create units that take into consideration the turns of speech between the analyst and his patient, which is of particular importance for this study given that the focus is on trying to observe the effect of the analyst's communications on the process. Specifically, idea units consist of clinically meaningful segments of communication that aggregate around a given theme. In addition these units are also consistent with the idea that there are certain discernable speech patterns that oscillate throughout the process.

Analyst Communications:

Every one of the analyst's communications were coded using the categories described below. This set of categories was validated by three independent judges, reporting a reliability score of 87% level of agreement. Each communication was coded and due to the low frequency of events in some categories, interventions were grouped into larger clusters that allow more significant comparisons. To describe and compare the data, interventions were grouped into two major categories: exploratory interventions and linking/interpretive interventions.

1) **Actions that contribute to maintain the basic setting.** These are interventions aimed at the patient's conscious experience; they are directed at preserving the concrete aspects of the frame as well as reinforcing the therapeutic alliance –encouraging the patient to participate and to associate-. These interventions aim to create a predictable environment and to ensure the minimal conditions for the analytic work.

   1.a) Basic housekeeping, including maintaining the basic analytic structure i.e.: the time frame, payments, vacation schedules, etc. E.g.: "We'll stop here for today".

   1.b) Comments that acknowledge specific affects or predicaments and that, therefore, signal the analyst's empathic understanding of the patient's affective experience. E.g.: "You are feeling sad and frightened", "this feels to you like an impossible situation", "you don't sound too sure"; may include questions aiming to clarify feeling states or ideational content that has been already laid out by the patient.

1.c) Seeking associations or further elaborations: these include comments that ask the patient for additional elaboration on specific conscious experiences. E.g.: “What’s the detail of the feeling of fright?” “What’s going through your mind?” (Some of the A’s comments on this category can overlap with categories 3 and 5, 1c can also overlap with category 2)

2) **Actions that aim to create space for unconscious exploration and room for free association.** Comments here include ambiguous and brief statements that seek to facilitate the space for the elaboration of unconscious representational process (e.g.: “walls?”, “a mouth with teeth…”), as well as direct questions (e.g: “what was the detail of the fright itself?”, “What comes to your mind about…”).These interventions enable the patient to explore fantasies, wishes and the nature of his internal representations. These comments are addressed at unconscious rather than conscious precepts and aim to draw attention to unconscious connections as well as to facilitate linguistic elaboration and linking.

3) **Questions, clarifications and reformulations, aimed at making matters conscious.**

3a) Comments that point out certain patterns of behavior and emotional expectations, these could include statements that establish connections between past and present experiences (e. g.: “do you think there is a pattern in the way you are here and how you are with your wife?”)

3b) Comments that signal defensive maneuvers, these comments will most likely describe behavior outside the session that relates to figures other than

the analyst (e.g.: “Perhaps you have been keeping yourself occupied as a way to avoid thinking about the things that you have lost and not feel the sadness that accompanies this realization”)

3c) Comments that signal resistances against the deepening of the transference. These interventions will most likely link behavior or feelings that are taking place in the here and now directly relating to the figure of the analyst. (e. g.: “you seem to be holding back some of your feelings and thoughts”, “by doing that you are able to turn away from the thoughts of loving me”).

4) **Interpretations (historical and/or transference related)**. Designating here and now emotional and fantasy meaning of the situation with the analyst. Constructions directed at providing elaborated meaning and establishing links between past and present, conscious and unconscious experience, as well as experiences inside and outside of the consulting room.

4.a) establishing links between past and present experience. E.g.: “So we can see that the feeling that you are having here with me now is in a sense a partial repetition of the feelings and problems you felt about controlling things as a little girl.”

4.b) Analyst states the terms of a given conflict as well as its links with the past and the here and now, e.g.: “I think you are afraid of your own hostility, and you think that I’m an idiot not to be afraid of it too. But the fact that I am not showing any fear means that you are tempted to rely on me, but at the same time that temptation causes you to be afraid.”

4.c) Specifying a core organizing unconscious phantasy. In this instance the A's draws together a number of observations about what has been learned about the emotional and phantasy experience with the analyst and presents it as a way of defining a deeper organizing structure. E.g.: "When you are being friendly to me I think you feel like a 'good girl' who is performing me a service, but at the same time false. – I think you only feel real when you are hating me."

5) **Interventions (or lack of) that indicate the break down the analytic stance**. These include glaring reactions not easily recognized as the analyst's usual way of interacting or intervening. These instances usually signal interference that is generated by the A's countertransference reactions, and denote a temporary collapse of the triangular space that is required for symbolization to take place. Reactions include the analyst failure to respond -including feeling paralyzed, attacked or other-; as well as the analyst's disavowal of what transpired in the session as evidenced by the analyst's report in the recorded scan that follows the session. The loss of neutrality may become apparent by comments that establish intellectual distancing from the emotional content being evidenced in the session, or conversely by a kind of symmetry between analyst and patient, where the latter gets pulled into a role responsiveness by virtue or overidentifying with the patient's emotional dynamic.

5a) Analyst's loss of "neutral" stance by overidentifying with patient's emotional dynamic. This category includes: analyst feeling threatened or

overwhelmed by emotional tenor in the room as evidenced by analyst losing the capacity to think and participate, i.e.: analyst adopting punitive attitudes such as showing irritation towards the patient as well as unconsciously reinforcing patient's attitudes like valuing certain kind of behaviors over others and signaling to the patient being pleased by her compliance or other types of attitudes ('view from within').

5b) Analyst losing the capacity to empathize and emotionally connect with the patient ('view from without'). This category includes interventions that evidence the analyst distancing himself from the patient by over-intellectualizing as evidenced by the use of jargon or of certain formulations that are generated from a theoretical standpoint as opposed to using the patient's material and referred experience. This kind of distancing can also be evidenced by interventions that could be theoretically sound but that are poorly timed and as such cannot be utilized by the patient; in fact, on the contrary, these interventions may generate further resistances in the patient.

Repetition

Following Halfon's (2010) methodology, Each transcript was coded for the exact repetition of verbs. Verbs were chosen by Halfon as a unit of analysis because verb forms are part of "action language" and "action is human behavior that has a point; it is thus considered meaningful human activity; it is intentional or goal-directed performances by people; it is doing things for reasons" (Schafer, 1976). The language of verbs is expected to capture repetitions that are used with intention.

In order to do the coding, all the verbs within the transcript were extracted in the order that they were articulated by the patient. Afterwards, the first uttered verb was compared to the next three verbs. If this verb was repeated in the next three consecutive verbs, then it was assigned a score of 1. If there was no repetition in the next three verbs, then it received a score of 0. For example, if the patient used the verb "go", and if this verb was found in any syntactic form (went, will go, have gone etc.) in the next three verbs, it received a score of 1. This procedure was used to code every verb in the session and was completed by hand due to the inexistence of a linguistic computer program that could perform these functions.

Weighted Referential Activity Dictionary (WRAD)

Referential Activity (RA) is a psychological construct that "concerns the degree to which speakers (or writers) are able to access nonverbal, including emotional experience, in their own minds and to express this verbally in a form that is likely to evoke corresponding experience in the listener" (Bucci and Maskit, 2007, p. 1366). Initially, referential activity was scored by judges along four scales that reflected components of the concept (concreteness, specificity, clarity, and imagery described above). Computerized measures modeled after the judge scoring (and empirically validated) were constructed. First, the measure of CRA was developed by Mergenthaler and Bucci (1999). This comprised two dictionaries that included 181 word types. One set of types was considered characteristic of high RA speech, and the other, low. This first generation computerized measure has been used successfully in many research studies (Bucci, 2002).

A second generation computer dictionary, the Weighted Referential Activity Dictionary (WRAD), was developed to more closely reflect judges' scoring by differentially weighting items in the dictionary. A complete description of the building of the WRAD is explicated in Bucci and Maskit's: *A Weighted Referential Activity Dictionary* (2005). What distinguishes the WRAD dictionary from other computer dictionaries, is the way it captures language style rather than content. Rather than developing this dictionary from conceptual categories, words were selected for the WRAD empirically based on their correlation to texts rated by judges to be high or low along the dimensions of referential activity. To develop the WRAD, these judges scored a set of sample texts using the four RA scales (concreteness, clarity, specificity, and imagery). The sample texts included monologues, early memories, Thematic Apperception Test (TAT) responses, and portions of analytic sessions. The judges achieved inter-rater reliability of at least 0.80 as measured by Cronbach's alpha. RA ratings for both clinical and non-clinical populations were used to develop the WRAD. WRAD contains 696 items that account for 85% of spoken language found in texts used by the measure. The WRAD assigns weights to the words contained in the dictionary that are proportionate to the RA level of each word. The assignment of weights allows for greater coverage of sample texts and yields a closer correlation to judges' ratings of RA. The WRAD has weights lying between -1 (for words most common in Low RA speech), and +1 (for words most common in high RA speech) (Bucci and Maskit, 2005). This dictionary has been normalized so that an average WRAD weight of zero corresponds to the neutral RA score of 0.50.

**Procedures**

In order to assess the analyst's communications, a sample of ten sessions was studied, these sessions were drawn at systematic intervals throughout the course of the treatment. Each of the analyst's intervention was coded using the set of categories previously described. Charts were created combining the types of interventions with the scores generated by the interaction of the repetition and the RA scores. The broadest approach is the description of speech patterns that precede the analyst's communications as well as the speech patterns that ensue once the analyst has spoken.

In order to assess the patient's overall use of repetition, session means for repetition were calculated by dividing the number of repeated verbs with the total number of verbs uttered. Moreover, in order to micro-analyze the psychoanalytic process within the sessions and to analyze the fluctuations in the use of repetition during the sessions, each session was divided into idea units following Waldron et al's (2004) procedure and repetition means were computed for each block and then these means were converted to standard scores.

Afterwards, all transcribed sessions were coded according to Maskit and Bucci's Discourse Attributes Analysis Program (DAAP) transcription rules (version 21, 2007) to facilitate computerized operations. DAAP is able to apply all computerized measures of linguistic process and content to the text of the sessions. In effect, DAAP calculated mean RA, reflection scores for each of the ten sessions. In addition, DAAP computed means of each measure for each idea unit and these means were also converted to standard scores.

In the next step, all these scores were graphed in order to create a visual linguistic profile of each session. These graphs allow the identification of segments in the session in which the measures peak or decline and thus were used to direct one to significant therapeutic moments in the sessions. Moreover, it is possible to analyze the extent to which these measures tend to move together or move in opposite directions within a session. Thus it is possible to see the effect of one measure on another throughout the session.

Based on these graphs, segments of sessions were selected for a qualitative clinical analysis. The criteria for selecting these segments is based on parameters specified by Halfon and Weinstein"s (2013) reported speech patterns. These patterns are considered to be clinically meaningful as well as essential components of the analytic process.

## Chapter IV

## Results

The general descriptive statistics of the ten sessions analyzed will be presented, specifically the details of the analyst communications, including the type and number of interventions as well as the number of words employed by him. General descriptors of the process measures (Repetition and RA) will follow, including mean and standard deviation per session. Following these general statistical descriptions, tables combining the process measures and the analyst's interventions codes will be presented. Additionally nonparametric statistics comparing the different measures before and after the analyst intervenes are presented.

A qualitative analysis of two separate sessions will be presented in order to provide a more dynamic view of the analytic process of the case studied: penetrating the sessions by zooming in to follow the linguistic patterns as they unfold and fluctuate in the context of the therapeutic relationship and the analyst's communications. This exploration aims to further nuance the understanding of the findings from the quantitative section, fleshing out the data in order to generate future hypothesis.

To finalize the qualitative analysis the speech patterns specified by the process measures will be described in detail in combination with a general overview of the analyst's communications. Excerpts from different segments of the treatment will be presented in order to exemplify the interaction between the different type of speech patterns and the analyst's communications.

**Quantitative Analysis**

**I. Analyst Communications – General descriptors-**

Out of the 10 sessions analyzed in the present study, a total number of 83 interventions were coded using the categories described above. At least one instance of each code was generated. Of the 83 communications coded, only 73 were used in combination with the process measures applied in this study. The remaining 10 interventions, although noted and coded, were not taken into account for the process analysis because they marked the end of the session and could not be directly connected to the linguistic processes observed before and/or after the analyst's speech acts performed within the hour. Although it could be argued that the way the analyst ends any given session may influence what takes place in following sessions, measuring this type of impact is beyond the scope of the present study.

The mean number of interventions per session is 8.1, ranging from 5 to 13 interventions. The mean number of words per session is 208.8 ranging from 84 to 576 words per session. The overall mean number of words per intervention is 24.825, ranging from 10.2 to 44.2 mean number of words per session (see table 1). On the first half of the sample the analyst performed 31 interventions, 17 exploratory and 14 linking/interpretive communications; on the second half of the sample the analyst performed 42 interventions, 16 exploratory and 26 linking/interpretive communications (see table 1.1, and table 2).

In order to statistically evaluate whether there was a significant difference in terms of the number of interventions between the two halves of the treatment data and the type of interventions within each section, Fisher exact tests were performed comparing

the data (see tables 1.1.a, 1.1.b and 1.1.c). Statistical comparisons indicate no significant difference between these results.

Table 1. Analyst's Communications –General Descriptors-

| Session # | # of Interventions | # of words | X# of words/int. | # of Cycles | range |
|---|---|---|---|---|---|
| 91 | 6 | 105 | 17.5 | 10 | (3-48) |
| 92 | 5 | 84 | 16.8 | 7 | (2-42) |
| 259 | 10 | 102 | 10.2 | 7 | (4-25) |
| 260 | 8 | 279 | 34.6 | 6 | (4-58) |
| 431 | 5 | 101 | 20.2 | 13 | (1-37) |
| 432 | 12 | 267 | 22.25 | 13 | (5-76) |
| 627 | 6 | 215 | 35.8 | 10 | (4-123) |
| 628 | 7 | 218 | 31.1 | 11 | (4-100) |
| 1000 | 9 | 141 | 15.6 | 9 | (3-74) |
| 1001 | 13 | 576 | 44.2 | 16 | (4-266) |
| ΣX | 8.1 | 208.8 | 24.825 | | (1-266) |

Although the difference in terms of the number of interventions or the type of interventions in the two halves of the treatment data are not statistically significant a general trend was noted in terms of the analyst's level of participation as the treatment progresses, with a propensity to intervene more frequently and use more words in his communications as the treatment progressed (see tables 1.1.a,; 1.1.b & 1.1.c). This is probably associated to the fact that the analyst showed a greater tendency to formulate linking and interpretive comments in the later phases of treatment, as opposed to the more exploratory type of interventions that were noted during the initial phases. (See table 2).

In order to assess the frequency of fluctuations in terms of psychic modes of functioning during the sessions, cycles of distinguishable speech patterns (each cycle was defined as change from a distinguishable speech pattern to another) were counted in each

session. A Fisher's exact test (see table 1.2.a) was applied and no statistical significance was found in terms of the differences between the first and second halves of treatment. However, the data does indicate a tendency towards an increased number of cycles as the treatment progresses.

Table 1.1 Data comparing the treatment in two parts in terms of the types of communications.

| Session Numbers | Total N | Type of intervention | Total N |
|---|---|---|---|
| 91, 92, 259, 260, 431 | 31 | Exploration | 17 |
| | | Linking/interpretation | 14 |
| 432,627, 628, 1000, 1001 | 42 | Exploration | 16 |
| | | Linking/interpretation | 26 |

Table 1.1.a. Fisher exact Test comparing two halves of data on numbers of interventions.

| | Total N | Expected | Total |
|---|---|---|---|
| Sessions 91-431 | 31 | 37 | 68 |
| Sessions 432-1001 | 42 | 36 | 78 |
| Total | 73 | 73 | 146 |

The two-tailed P value equals 0.406. The difference is considered to be not statistically significant.

Table 1.1.b. Fisher's Exact Test comparing explorations vs. linking interventions for the first half

| | Total N | Expected | Total |
|---|---|---|---|
| Explorations | 17 | 15 | 32 |
| Linking/interpretation | 14 | 16 | 30 |
| Total | 31 | 31 | 62 |

The two-tailed P value equals 0.7997. The difference is considered to be not statistically significant.

Table 1.1.c. Fisher's exact Test comparing explorations vs. linking interventions for the second half.

| | Total N | Expected | Total |
|---|---|---|---|
| Explorations | 16 | 21 | 37 |
| Linking/interpretation | 26 | 21 | 47 |
| Total | 42 | 42 | 84 |

The two-tailed P value equals 0.3795. The difference is considered to be not statistically significant.

Table 1.2. Data comparing the treatment in two parts in terms of the number of cycles.

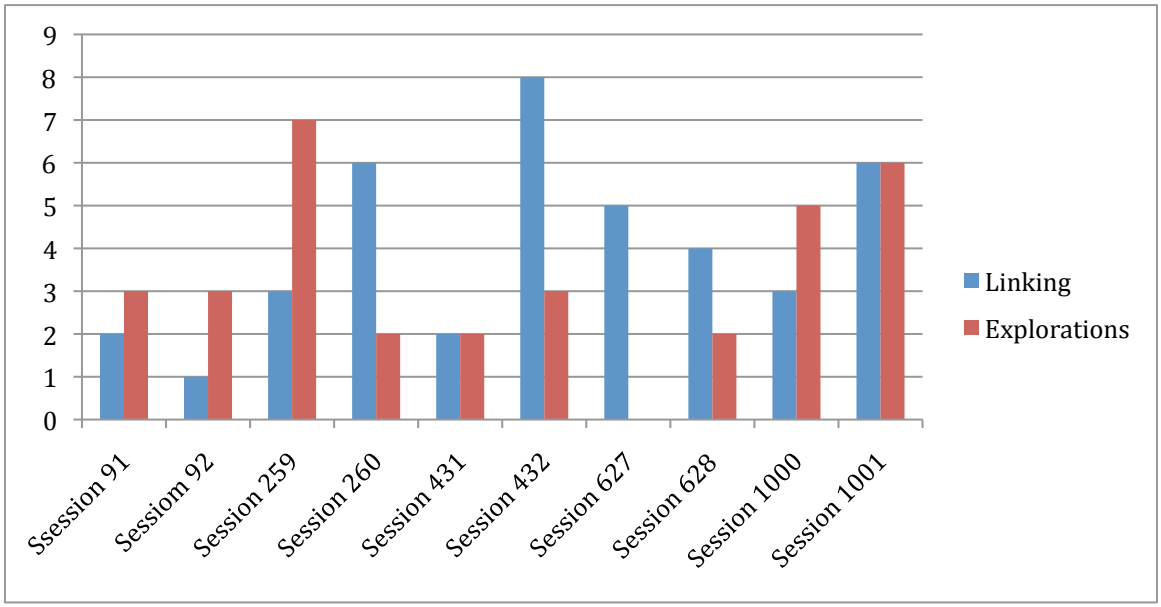
| Session # | Number of Cycles | X |
|---|---|---|
| 91,92, 259, 260, 431 | 43 | 8.6 |
| 432, 627, 628, 1000, 1001 | 59 | 11.8 |

Table 1.2.a. Fisher's exact test comparing number of cycles between two halves of treatment

| Session numbers | Total N | Expected | Total |
|---|---|---|---|
| 91,92,259,260,431 | 43 | 51 | 94 |
| 432,627, 628, 1000, 1001 | 59 | 51 | 110 |
| Total | 102 | 102 | 204 |

The two-tailed P value equals 0.3255. The difference is considered to be not statistically significant.

Table 2. Frequency by Type of Communication Chart



**II. Overall use of Repetition and RA across sessions (Table 3)**

The application of the repetition measure to patient's speech revealed considerable fluctuation in her use of repetition. The mean of repetition (sum of repetition mean for each session divided by number of sessions) across the sessions was 0.33 (sd = 0.04) with the session means (the number of repeated verbs divided by with the total number of verbs uttered in a session) ranging from 0.29 to 0.40.

The mean Referential Activity (RA) score for the ten sessions was 0.44 (sd = 0.034) with the session means ranging from 0.36 to 0.48.

Table 3. Session means for Repetition and RA scores

| Session Number | Mean Repetition | Mean RA |
|---|---|---|
| 91 | 0.40 | 0.48 |
| 92 | 0.38 | 0.46 |
| 259 | 0.33 | 0.39 |
| 260 | 0.29 | 0.46 |
| 431 | 0.39 | 0.44 |
| 432 | 0.29 | 0.43 |
| 627 | 0.33 | 0.45 |
| 628 | 0.34 | 0.38 |
| 1000 | 0.33 | 0.48 |
| 1001 | 0.31 | 0.37 |
| Overall means | 0.33 | 0.44 |

There are no established normative RA scores published for psychoanalytic sessions therefore comparisons between established normative scores and the scores of the present sample could not be calculated. However, 288 sessions from the case of Mrs. C have been used in the establishment of relative norms for the RA measure yielding a mean of 0. 37 (sd = 0.12) (Bucci and Maskit, 2005). The mean RA score of Mrs. C in the

selected ten sessions is close to her mean RA in these 288 sessions suggesting that the selected sample for the current study is representative of the patient's RA use.

Even though the reported overall means of these linguistic measures give a sense of the patient's use of these measures across ten sessions, this study focuses directly on the process within sessions, rather than providing measures for sessions as a whole. Bucci (1999) also differentiated her RA measure as a process measure rather than a global outcome measure and stated that "the computer assisted procedures point to *where* in the session particular aspects of the process are occurring; content measures are then applied to tell us *what* is happening (Bucci, 1999, pg. 263)". The same can be said for the repetition measure used in this study. Moreover, the sessions chosen come from different points in treatment and do not reflect a continuous process that would make it meaningful to compare these overall means. Therefore, in the qualitative section, the analyst interventions along with the fluctuations of the linguistic measures within sessions will be closely examined.

**III. Application of the linguistic measures and analyst's communications categories to session transcripts**

Following Halfon's (2010) and Bucci's methodology, the application of repetition and RA measures to individual sessions enabled the identification of discourse patterns in the treatment process. A graphic representation of each session was created representing the flow of linguistic measures within the sessions (see figures 1 thru 10 in the appendix). For each figure, the transcript of a session was divided into idea segments following Waldron et al. (2004) methodology. This methodology breaks the segments

following the speech turns between analyst and patient, which allows to locate the analyst's communications within the speech flow of each session. Mean scores were computed for each measure in each segment and then converted to standard scores (see appendix tables 1 thru 10) for unit means of repetition and RA for each session). The scores are fluctuating around their mean (shown as z = 0) with units of their standard deviation from the mean. The y axis represents the standard deviations from the mean and the x axis represents the unit number that the standard mean scores refer to within the session (See figures 1-10). This procedure enabled breaking the sessions into units to compare the fluctuation of the measures and the patient's psychic states throughout each session. It also located each intervention within the flow of the session.

**IV. Combined process scores (repetition and RA) with analyst communications categories.**

Analyst's communications were grouped into two large categories to facilitate meaningful comparisons. Interventions that were exploratory in nature were grouped together into one category (by combining categories 1 and 2) and interventions that provided a linking or interpretive function formed the second category (by combining categories 3 and 4). The analyst's interventions were located within the session and the speech patterns that preceded and followed were noted for each one. Speech patterns were initially coded into 9 separate categories (HighRA/HighRep; HighRA/XRep; HighRA/lowRep; XRA/XRep; LowRA/LowRep; LowRA/XRep; LowRA/HighRep; XRA/LowRep; XRA/HighRep) depending on the mean scores for any given unit. Mean scores for RA and Rep measures were assigned when a score fell between +/- .5 of the mean standard score.

Table 4. Frequency of combined process measures for totality of sample units

| | | Repetition (Rep) | | |
|---|---|---|---|---|
| RA | | high | mean | low |
| | high | 17 | 21 | 13 |
| | mean | 6 | 38 | 18 |
| | low | 6 | 18 | 12 |

Table 4.1 Speech patterns for totality of sample units

| Speech Pattern | Symbolizing High RA/Low Rep, High RA/Xrep | Disengaged Low RA/ LowRep | Conflict High Rep/ Low RA | Overstimulation High RA/ High Rep | Baseline XRA/XRep XRA/ Low Rep | Other |
|---|---|---|---|---|---|---|
| Total | 34 | 12 | 6 | 17 | 56 | 23 |
| % | 23% | 8% | 4% | 11% | 38% | 16% |

Table 4.2 Frequency of combined process measures for units analyzed

| | | Repetition (Rep) | | |
|---|---|---|---|---|
| RA | | high | mean | low |
| | high | 2 | 11 | 7 |
| | mean | 2 | 21 | 9 |
| | low | 5 | 8 | 8 |

Two main tables were derived, a table comparing process scores that preceded each intervention and a table that compared process scores following each intervention. (see tables 5 & 6). The resulting 9 categories measuring speech patterns in this chart were aggregated to form 5 separate categories that have clinical significance following Halfon's (2010) reported speech patterns. Halfon and Weinstein (2013) found that the repetition and RA measures pointed to four different kinds of functioning. In the low repetition & high RA segments, patient is able to think clearly, there are no disruptive affects and this is the space for optimal work. The high repetition & low RA segments point to a difficulty in integrating conflictual self representations

which creates an anxiety ridden dialectic. In the high RA & high repetition segments, the patient is overly involved and immersed in an emotional narrative that is quite disorganizing for her thought processes. In the low repetition & low RA segments the patient is very concrete and emotionally removed. Process scores were thus condensed into four separate clusters, Productive/Simbolyzing (HighRA/LowRep + highRA/Xrep); Overtimulated (HighRA/HighRep); Conflict/Stuck (HighRep/LowRA) and finally; Disengaged (LowRA/LowRep) (see tables 4 and 5). Moreover, in this study the patient's baseline scores, meaning when both RA and repetition are at their mean, was taken into consideration as a fifth category: Baseline (XRA/XRep + XRA/LowRep). At the baseline we observed the patient's habitual way of functioning and her usual defensive style, connections remain on a preconscious level.

For the sample that was used, process scores that precede the analyst interventions show that 52% of the time the analyst intervenes when the patient is at her baseline (XRA/XRep + XRA/LowRep), 25% of the time the analyst speaks when the patient is being productive and actively symbolizing (HighRA/LowRep+HighRA/Xrep); 8% when the patient is hyperstimulated or connecting to a traumatic memory (HighRep/HighRA); 11% when the patient is disengaged from the analytic process, attacking links and his own thought process (LowRA/LowRep) and finally 5% of the time the analyst intervenes when the patient is stuck in a state of conflict (HighRep/LowRA).

Table 5. Scores preceding the analyst's interventions.

| | Symbolizing (HighRA/low rep+ High RA/Xrep) | Baseline (Xrep/XRA+ XRA/lowrep) | Overexcited (Highrep/ HighRA) | Disengaged (Low RA/LowRe) | Conflict (HighRep/lo wRA) |
|---|---|---|---|---|---|
| Exploration | 7 | 15 | 2 | 4 | 0 |
| Linking | 9 | 18 | 3 | 3 | 3 |
| Σ | 16 | 33 | 5 | 7 | 3 |
| %exp | 44% | 45% | 40% | 57% | |
| %link | 56% | 55% | 60% | 43% | 100% |
| %total | 25% | 52% | 8% | 11% | 5% |

Table 5.1 Bar Chart for process scores preceding the analyst's interventions

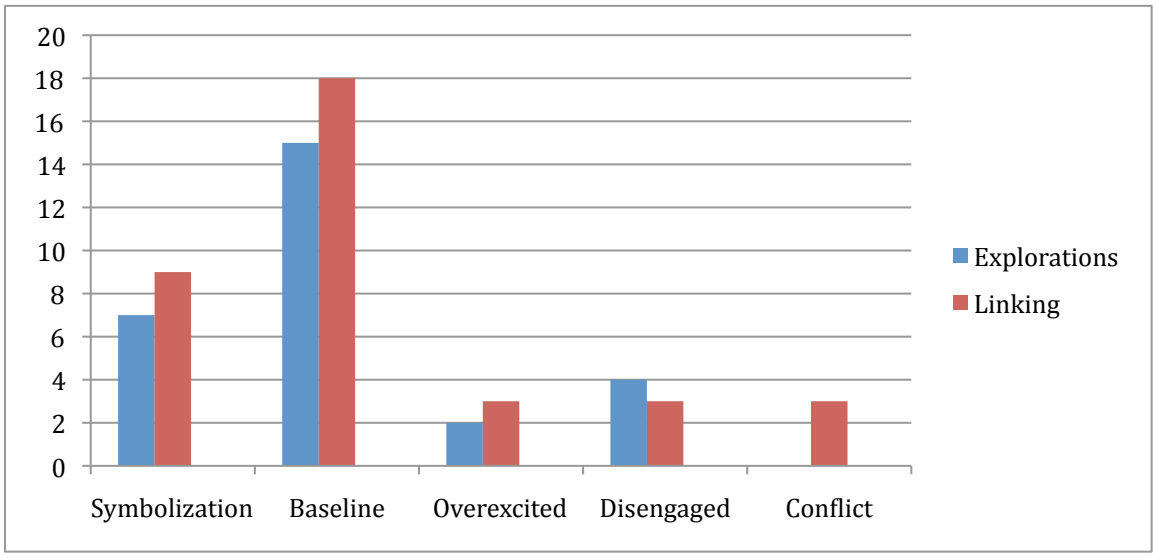
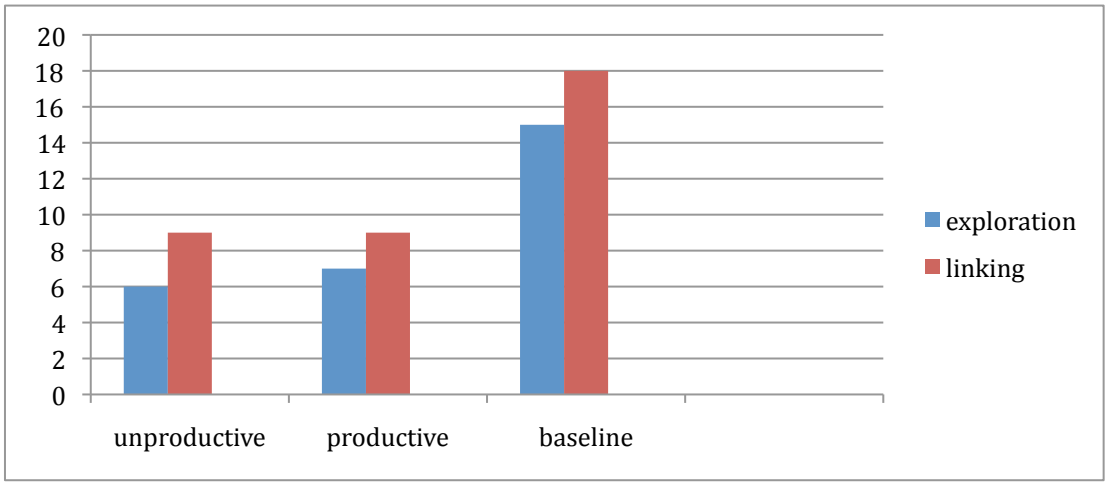



Table 5.1.a Scores preceding analyst's interventions -condensed table-

| | Symbolizing (HighRA/low rep+ High RA/Xrep) | Baseline (Xrep/XRA+ XRA/lowrep) | Unproductive |
|---|---|---|---|
| Exploration | 7 | 15 | 6 |
| Linking | 9 | 18 | 9 |
| Σ | 16 | 33 | 15 |
| %exp | 44% | 45% | 40% |
| %link | 56% | 55% | 60% |
| %total | 25% | 52% | 24% |

Table 5.2 Bar-chart of condensed scores preceding the analyst's interventions




Process scores that followed the analyst's communications show that 48% of the time after the analyst intervenes the patient is likely to go towards her baseline (XRA/XRep + XRA/lowRep), at the baseline we observe the patient's habitual way of functioning and her usual defensive style, connections remain on a preconscious level (further discussion pertaining this category will follow). 29% of the time after the analyst's has intervened the patient is capable of entering into a productive symbolizing phase (HighRA/LowRep + HIghRA/XRep). 3% of the time the patient enters into a speech pattern that indicates overstimulation and the reliving of traumatic experiences (HighRA/HighRep), 12% of the time after the analyst's speaks the patient disengages from the process, or enters into a phase in which he attacks her own thoughts (LowRA/LowRep); and finally, 8% of the time the patient enters into a conflictive state (HighRep/LowRA).

Table 6. Scores following the analyst's interventions.

| | Symbolizing | Baseline | Overexcited | Disengaged | Conflict |
|---|---|---|---|---|---|
| Exploration | 6 | 13 | 1 | 4 | 4 |
| Linking | 12 | 17 | 1 | 4 | 1 |
| Σ | 18 | 30 | 2 | 8 | 5 |
| %exp | 33% | 43% | 50% | 50% | 80% |
| %link | 66% | 57% | 50% | 50% | 20% |
| %total | 29% | 48% | 3% | 12% | 8% |

Table 6.1 Bar-Chart of scores following the Analyst's interventions

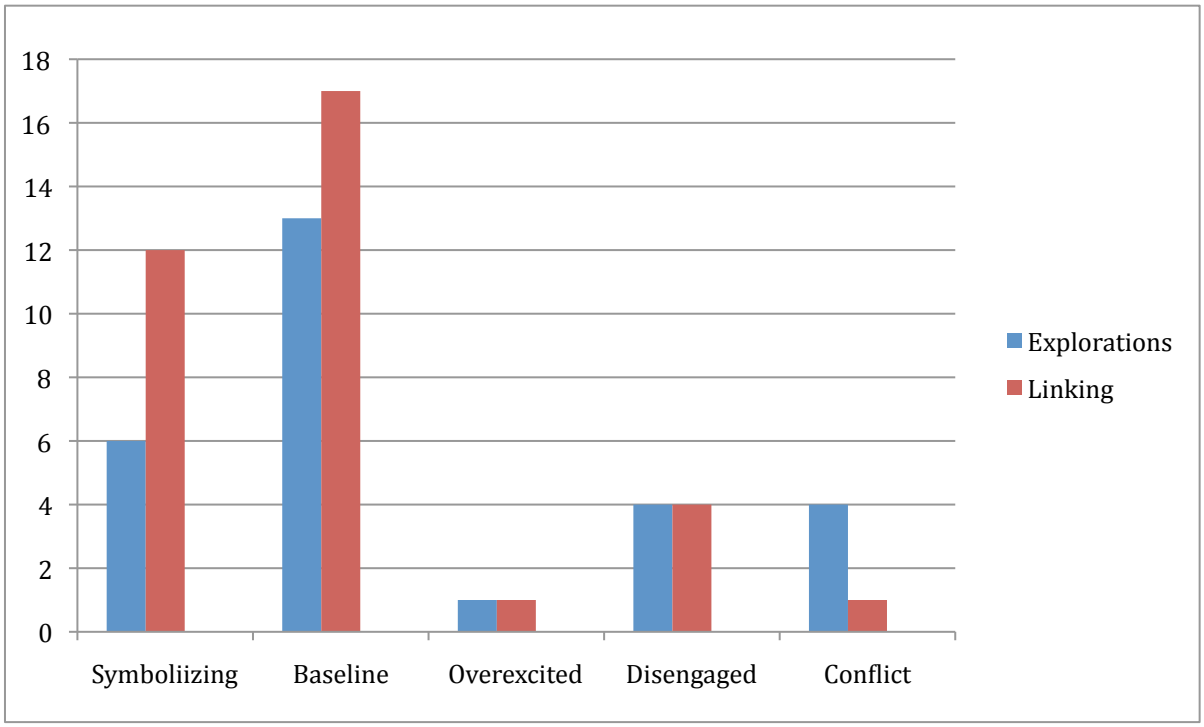
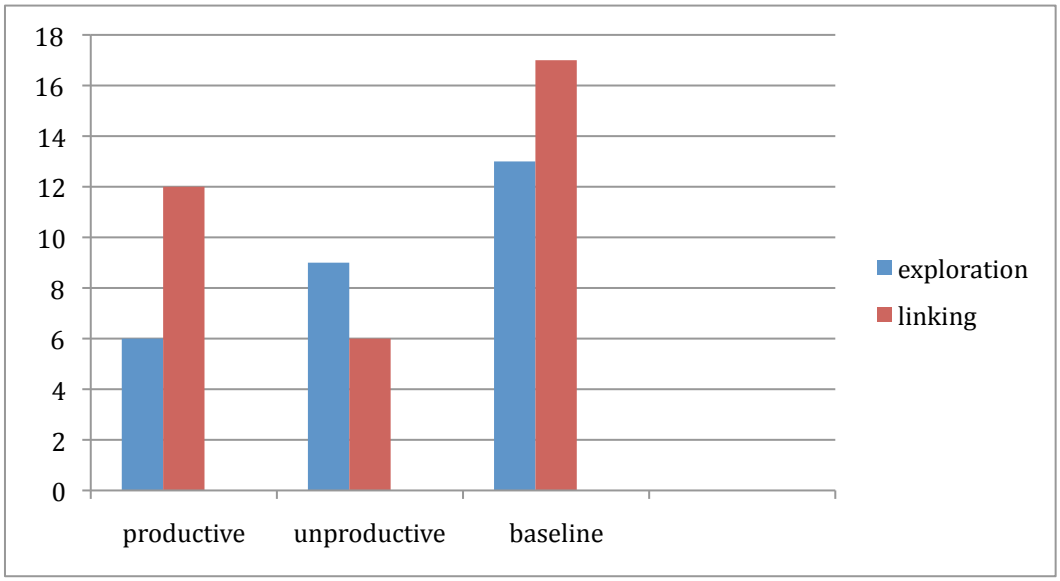



Table 6.1.a Scores following the analyst's interventions -condensed table-

.

| | Symbolizing | Baseline | Unproductive |
|---|---|---|---|
| Exploration | 6 | 13 | 9 |
| Linking | 12 | 17 | 6 |
| Σ | 18 | 30 | 15 |
| %exp | 33% | 43% | 60% |
| %link | 66% | 57% | 40% |
| %total | 29% | 48% | 23% |

Table 6.2 Bar chart of condensed scores following the analyst's interventions




In order to statistically evaluate whether there is a significant difference between the number of interventions that fall into each category these measures were tested using Fisher's Exact test (see table 7). Baseline scores were found to be statistically significantly different from the conflict, overexcited and disengaged categories. No significance was found between Baseline and Symbolizing scores. On the other hand Symbolizing scores were not significantly different from the overexcited and disengaged scores, but were significantly different from the conflict scores. Overall these results indicate that the analyst is more likely to intervene when the patient is at the baseline mode of functioning.

A second layer of tests were performed to analyze the data and evaluate the level of significance for these modes of functioning. Process data was once again combined to form three different categories: Symbolizing, Baseline and Nonproductive States (which combines the data from the Overexcited, Disengaged and Conflict categories). For the process scores that preceded the analyst's interventions, a one-sample chi-square test (see

table 7.1) was conducted to assess whether the analyst is more likely to intervene when the patient is symbolizing, when she is at her baseline or when she is "non-productive". The results of the test were significant, $\chi^2$ (2, 64) = 9.60, p= 0.01). The proportion of interventions that follow patient's base-line scores (45 %) was much greater than the hypothesized proportion of 0.33, while the proportion of interventions following productive (25%) and the proportion following unproductive (24 %) were approximately the same value and less than the hypothesized proportion of .33. A follow-up Fisher's exact test (see table 7.2) indicated that the proportion of interventions following productive states did not differ significantly from the proportion of interventions following unproductive states (the two-tailed P value equals 1.000). Overall, these results suggest that the analyst is more likely to make interventions when the patient is at her baseline. In Sum, by conventional criteria, this difference is considered to be very statistically significant, implying that the analyst is more likely to make interventions when the patient is at her baseline.

Table 7. Fisher Exact comparisons between process scores preceding the analyst's interventions

| Patterns being compared | P value | Level of significance |
|---|---|---|
| Symbolizing vs. Baseline | 0.2126 | Not Significant |
| Symbolizing vs. Overexcited | 0.0796 | Not Significant |
| Symbolizing vs. Disengaged | 0.2450 | Not significant |
| Symbolizing vs. Conflict | 0.0273 | Significant |
| Baseline vs. Overexcited | 0.0019 | Very Significant |
| Baseline vs. Disengaged | 0.0068 | Very Significant |
| Baseline vs. Conflict | 0.0003 | Very Significant |

Table 7.1 Chi square values for scores preceding the analyst's interventions

| Row # | Category | Observed | Expected # | Expected |
|---|---|---|---|---|
| 1 | Baseline (mean RA/rep, mean Ra/low rep) | 33 | 21.3312 | 33.330% |
| 2 | Productive (high RA/low rep, high RA/mean rep) | 16 | 21.3312 | 33.330% |
| 3 | Unproductive (high/high, low/low;high rep/low RA) | 15 | 21.3376 | 33.340% |

Table 7.1.a Fisher's Exact test follow-up for scores preceding the analyst's interventions.

| Row # | Category | Observed | Expected # | total |
|---|---|---|---|---|
| 1 | productive | 16 | 15 | 31 |
| 2 | unproductive | 15 | 16 | 31 |
| | Total | 31 | 31 | 62 |

The two-tailed P value equals 1.0000. The association between the types of interventions and the type of preceding score is considered to be not statistically significant.

For the process scores that follow the analyst's interventions Fisher's Exact test was performed (see table 8) in order to evaluate whether the patient was more likely to follow the analyst's interventions with a particular mode of functioning. Results show statistical significance between symbolizing and overexcited scores and between baseline and overexcited, conflict and disengaged patterns. No significant difference was found between baseline and symbolizing scores, or between symbolizing and conflict and disengaged patterns. These results indicate that the patient is more likely to follow interventions with her baseline pattern than other modes of functioning. They also show that symbolizing pattern is more likely to occur than the overexcited mode of functioning.

A second layer of analysis was applied using a one-sample chi-square test (see table 8.1) to assess whether the patient is more likely to end up in a productive state, in an unproductive state or return to her base-line functioning after the analyst's interventions. The results of the test were significant, $\chi^2$ (2, 63) = 6.004, p= 0.049). The proportion of

base-line scores that follow the analyst's interventions (48 %) was much greater than the hypothesized proportion of 0.33, while the proportion of interventions following productive (29%) and the proportion following unproductive (23 %) were very close and less than the hypothesized proportion of .33. A follow-up Fisher's exact test (see table 8.2) indicated that the proportion of productive scores after the interventions did not differ significantly from the proportion of unproductive scores (The two tailed P value equals 0.8057). Overall, these results suggest that the patient is more likely to return to her baseline functioning after the analyst's interventions. By conventional criteria, this difference is considered to be statistically significant. The analyst interventions are significantly more likely to return the patient to her baseline speech pattern.

Table 8. Fisher Exact comparisons for process scores following the analyst's interventions.

| Patterns being compared | P value | Level of significance |
|---|---|---|
| Symbolizing vs. Baseline | 0.3319 | Not Significant |
| Symbolizing vs. Overexcited | 0.0049 | Very Significant |
| Symbolizing vs. Disengaged | 0.2581 | Not significant |
| Symbolizing vs. Conflict | 0.0736 | Not Significant |
| Baseline vs. Overexcited | 0.0002 | Very Significant |
| Baseline vs. Disengaged | 0.0288 | Very Significant |
| Baseline vs. Conflict | 0.0019 | Very Significant |

Table 8.1 Chi-Square values for scores following the analyst's interventions

| Row # | Category | Observed | Expected # | Expected |
|---|---|---|---|---|
| 1 | Baseline | 30 | 20.9979 | 33.330% |
| 2 | Productive | 18 | 20.9979 | 33.330% |
| 3 | Unproductive | 15 | 21.0042 | 33.340% |

Table 8.2 Fisher's exact test follow-up for scores following the analyst's interventions

| Row # | Category | Observed | Expected # | total |
|---|---|---|---|---|
| 1 | productive | 18 | 16 | 34 |
| 2 | unproductive | 15 | 17 | 32 |
| | Total | 33 | 33 | 66 |

The two-tailed P value equals 0.8057. The association between the types of intervention and the type of outcome is considered to be not statistically significant.

**V. Type of change in linguistic measures after the analyst's interventions**

In order to assess the type of change that took place after the analyst intervened, pre and post measures were contrasted in order to note the movement that occurred in the measures after each of the analyst's communications (see table 9). Out of the sample studied there are no instances in which the analyst's interventions lead to no change in either of the measures. 20% of the instances studied led to increase in both measures, indicating a tendency towards overstimulation; 30% of interventions led to increased repetitions and decreased RA, indicating a tendency towards increased internal conflict; 20 % of the time the sample showed increase in RA and decrease in repetition, indicating a movement towards symbolization. 25% of the time the patient responded by decreasing in both measures indicating a tendency towards disengagement. 7 % of the time there was no change in repetition and decrease in RA and finally 3% of the instances observed showed increase in rep and no change in RA.

Table 9. Type of discourse change after the analyst intervenes

| | Increase in RA and increase in rep | Decrease in RA and increase in rep | Increase in RA and decrease in rep | Decrease in both measures | No change in rep and decrease in RA | Increase in rep and no change in RA |
|---|---|---|---|---|---|---|
| Explorations | 8 | 10 | 7 | 8 | 3 | |
| Interpretations | 6 | 13 | 7 | 10 | 2 | 2 |
| Total # of interventions | 14 | 21 | 14 | 18 | 5 | 2 |
| % exp | 57 | 42 | 50 | 44 | 60 | |
| % interp | 43 | 58 | 50 | 56 | 40 | 100 |
| % of total | 20 | 30 | 20 | 25 | 7 | 3 |

**VI. Comparisons between exploratory and linking interventions for the three condensed categories of process measures.**

In order to statistically evaluate whether there is a significant difference between the proportions of the two major types of interventions (explorations and interpretations/linking), Fisher exact tests were performed for the three types of condensed process measures (symbolizing, baseline and unproductive) before and after the interventions were made. Overall results indicate no statistically significant difference in any of the six instances evaluated. However because of the small number of observations found in this sample these are statistical tests with very low power. The overall number of interventions compared is 73 but as they are parsed into the different groups for comparison the number becomes much smaller in all of the following tables.

1. Comparison between exploratory and linking interventions for process scores preceding the analyst interventions

For the process scores that precede the analyst's interventions three Fisher's Exact tests (see table 10) were conducted in order to assess whether the analyst is more likely to

use explorations or linking interventions during the time that the patient is symbolizing, at her baseline or while she is an unproductive state.

When comparing the two different types of interventions for the instances in which the patient is symbolizing, at her baseline, and in an unproductive state (table 10.) results show no statistical significance. These results indicate that the analyst is just as likely to intervene with either type of intervention when the patient is presenting any of the different speech patterns.

Table 10. Comparison by type of intervention with process scores preceding the analyst's interventions

| Process scores preceding A's interventions | P Value | Level of significance |
|---|---|---|
| Symbolizing: Explorations vs. Linking | 1.0000 | Not Significant |
| Baseline: Exploration vs. linking | 0.8057 | Not Significant |
| Unproductive: Explorations vs. Linking | 0.7152 | Not Significant |

2. Comparison of the process following the analyst's interventions.

For the process scores that follow the analyst's interventions three one sample Fisher's Exact tests (see table 11) were performed in order to assess whether after the analyst intervenes the patient is more likely to: enter into a symbolizing phase, go back to her baseline or fall into an unproductive state.

When comparing instances in which the patient enters a symbolizing state, goes back to her baseline, or goes into an unproductive pattern (table 11) after the analyst has intervened, results show no statistical significance for either type of intervention. This indicates that the patient is just as likely to enter into any of the abovementioned speech patterns after either type of intervention is made.

Table 11 Comparison by type of intervention of process scores following the analyst's interventions

| Process scores preceding A's interventions | P Value | Level of significance |
|---|---|---|
| Symbolizing: Explorations vs. Linking | 0.4998 | Not Significant |
| Baseline: Exploration vs. linking | 0.7961 | Not Significant |
| Unproductive: Explorations vs. Linking | 0.7152 | Not Significant |

**Qualitative Analysis**

We will now descend from the global summary measures into the session material itself in order to flesh out broad conclusions, nuance these understandings, and potentially raise new hypotheses for further study. Two exemplary sessions were chosen for such exploratory work. Graphic depictions (see figure 3 for session 259 and figure 7 for session 627 in appendix) of the linguistic measures, RA and repetition scores provide a virtual image (Bucci and Maskit, 2007) of the entire session, giving us a visual map from which to derive a route of clinical investigation.

The results of the quantitative analysis helped enable the selection of two sessions from the second and fifth year of treatment with contrasting process patterns and intervention strategies from the analyst. Out of the sample studied session 259 is the session with the highest number of exploratory interventions, while session 627 is an hour in which the analyst only intervenes using linking communications. A clinical sequence analysis of these two sessions was conducted using the linguistic measures combined with the clinical material identified as salient by these measures.

**Session 259:** (see figure 3 in appendix)

Session 259, from the second year of treatment is a session that shows a relatively contained range of variation in terms of RA and repetition measures. During the session there are two important peaks that evidence the shifts in her process as she worked through specific issues regarding feelings of competency and adequacy. The first peak is noted in unit three where, after the analyst intervenes, the patient enters a phase that is marked by the highest use of repetition coupled with an RA score measuring within the average range. This peak may signify the emergence of conflicted material that is pushing to be signified. The second peak is during the second half of the session in unit 9, where RA is elevated and Repetition scores are within the average range, marking the beginning of a more reflective and productive phase where she finally appears able to uncover an unconscious fantasy that relates to the emergent anxiety that dominated the hour. Aside from these peaks the patient spends most of the session at her baseline (XRA and XRepetition scores) displaying her usual defensive patterns. The session was also remarkable for having the highest number of exploratory interventions being used in the whole sample.

The patient begins the session (units 1 & 2) after an initial silence (which is customary in her process) talking about feeling blocked and inhibited regarding work related responsibilities that require her to produce evaluation reports of the children that she works with. She reports feeling impaired and incapable in anticipation of having to perform this task; even though intellectually she knows that she can and will eventually have do it. These feelings are also connected to difficulties accessing her resources – *"knowing"*- when she is required to relate and connect to others. *"And I don't quite know*

*why I feel so much that I can't do them. Because if I'm just sort of offhandedly talking about the different boys, I do know them. But yet, now I have this feeling I don't know them at all and I just couldn't possibly write a report on any of them."* This issue is a common struggle that she usually brings to therapy and she frequently feels insecure about her resources. This is consistent with her linguistic scores which are both at their mean, meaning the patient is at her baseline which is associated with the patient's habitual way of functioning and her usual defensive style. During these segments the patient is overtly emotional and cries.

After exposing this issue the patient begins to display the use of her habitual defensive strategies to cope with the anxiety that is mounting internally. Specifically, seeking distance by going into action and using somatization in order to avoid connecting with the uncomfortable feelings of inadequacy, *"And then I was thinking of how last night when I went home, I had this great urge to eat something, like potato chips or that type of thing."* She is then critical of herself '*it just seemed like such a silly way to go about doing it"* which brings her back to feeling deficient and out of sorts. At this point she tries to seek distance yet again, this time through the use of intellectualization, "*And then I just began to wonder, just now, if the way I feel after the Christmas vacation has anything to do with the fact that (Clears throat) the reports are due shortly afterwards."*

After this, the analyst intervenes for the first time asking: "*What goes into the reports?"* This intervention marks the beginning of unit 3 in which the patient shifts her speech pattern by spiking up her use of repetition. At this point the patient becomes disorganized and gets stuck because she is conflicted over material that is pressing to be symbolized, but she cannot find a way to break through the anxiety. The analyst's

intervention is an interesting choice because it is an exploration that is on the surface level, only asking for content elaboration. This intervention is not really effective because although it brings back the focus to the material that the patient was trying to defend against it is too open and general and does not give her enough anchor to effectively explore.

In effect, as the patient explains what she is expected to do for these reports she connects once again with feelings of inadequacy and incompetence that relate to difficulties establishing a sense of connection to these children. At this point she has no inroad to explore further so she begins to attack herself by reporting her struggles to relate to the children connecting this to the high demands that she places on herself ("*I just generally feel like, I have some vague idea of what ideal teaching would be and I'm not measuring up"*) as well as on them ("*I don't know, almost being critical of practically every child, as if I had some perfect state that I thought these children should be in socially, and none measured up to it or very few did"*). As a result of this dynamic her feelings of inadequacy are projected outward and she ends up with the pervading sense that they are all deficient*, "this year I, they just all seem, each one has a problem of some sort or other, but I don't know what person doesn't".* Throughout this segment the patient expresses repeatedly feeling stuck, as if "paralyzed", and uncertain of her own thoughts. This is reflected in the linguistic measures as her repetition increases significantly and RA starts to drop.

There is a long pause that follows and when she resumes the repetition begins to subside and RA starts to increase as she describes her current experiences at school in regards to the feelings of incompetence and inadequacy. As she elaborates, she describes

a need to isolate and a conflict over exerting power and having to be the person in charge. "*But it was just somehow the aspects of being the teacher in charge that made me not like having to handle the children".* Although she is not able to make many new connections during these segments (units 4&5), she is calm enough to be able to expand her awareness and elaborate on the way she currently feels about her job. She is also capable of expressing a wish to feel freer, less constrained. By the end of this segment she starts to feel inadequate again and blames herself for the way the children are behaving in the classroom*, "I keep thinking well, they weren't that way before. And it really bothers me to see them being that way. And yet, then I -- this is 1 of the things that has been bothering me the last 2 days, because I can't think of anything -- well, I feel as if I'm not thinking of anything to do about it. Almost as if that somehow, they're fighting as a result of my attitude toward them."* This is also reflected in the linguistic measures that move towards their mean, i.e. her baseline affective and defensive style.

At this point the analyst intervenes again and asks if she feels responsible, and then says: "*Now, what are you afraid your attitude is?",* to which she responds*: "That I don't care about them."* Silence ensues and she resumes by attempting to explore her feelings toward the children and the way they fluctuated over time; at this point she connects the timing of the fluctuations to a pelvic surgery that she had undergone at the beginning of the year. The analyst pursues this and asks: *"how do you understand it? I mean, how do you explain to yourself the change in your feelings, so that you feel you don't care?"* This intervention is not particularly helpful, as it may have felt distant and possibly accusatory leading the patient to seek distance by disengaging from the analytic task. At this point RA begins to drop reaching its lowest points in the session, as the

patient enters a desymbolizing phase where she is trying to think about the question but can only come up with intellectualized explanations, "*I've sort of thought well, if I'm thinking more about myself then I'm going to think less about them. And then at one point, I know, I used to think -- and perhaps it's still something I'm wondering about -- I used to think that when I cared about them, before the, before I went into the hospital, it was almost like an escape from not thinking about other things and -- but I don't know, I don't know, it does -- when I say that now, it doesn't seem that would be true"* and then later : "*eating is a substitute for feeling interest in other things and, I don't know, feeling involved, anyway. And I think people have something to do with that. So maybe now I just am feeling more lack of confidence, but I don't know why I would now"*. As she reached in this direction she realizes at every turn that these explanations are dead ends that reinstate the feeling that she can't trust her own perceptions.

During this part of the session the patient feels lost in her perceptions and doubtful of her own thoughts, but then suddenly the process shifts as she is able to vividly recover and relate (marking the peak of RA in the session, coupled with mean scores of repetition) the memory of a recent event in which she was in the classroom with the children doing an activity with puppets when they were suddenly interrupted by the headmaster of the school. Once again she connects with feelings of inadequacy and the analyst intervenes by asking: *"You were afraid of what the headmaster would think?....He would disapprove of the fact that you were letting the kids be noisy?"* The patient hesitates at his suggestion but considers it and tries to elaborate making a few connections along the way and coming back to the idea that in the past she felt freer, more confident and less constrained in her ability to work. Also remembering that during

this time she was able to feel more connected to the children and enjoy her work a lot more, realizing that part of the difficulties that she was experiencing were linked to an increased sense of vulnerability related to her self image, and a growing concern about other people's perception of her. *"And I think what I start judging things on is how I'm going to appear as a teacher. Because I, then I started thinking back to that time when I was the happiest teaching. And I don't recall having that be part of my thinking or my reaction at all. It was more, just simply I felt, I knew, I had some idea of what the children would respond to and what they'd enjoy and get something out of, and what I believed would be worthwhile to do. Now it seems to be all what will make me look good as a teacher almost. And then, what do I have to do as a teacher, too*." After she is able to make this distinction the analyst's asks: *"So what's happened this year that has changed your feeling*?", to which the patient replies in an effort to deflect the question*:" I don't know that I understand that. Because it's something I've had off and on".* But the analyst persists: *"That's true, but then you did feel differently in the fall."* And it is at this point that the patient is able to uncover an important unconscious fantasy that had allowed her to regulate feelings of inadequacy and questions of competency in the past. *"Until the operation. (Pause) And I've never gotten back to that feeling that I had before I went into the hospital. And I remember, before I went in, I don't know, it was almost as if I knew what I was going to do to myself. Because in 1 way I didn't want to go in, I suppose because I was afraid of it and all, unconnected with school. But then, I kept also thinking that everything's going so nicely at school and I'll lose it when I go in. (Pause) But when I say it that way it makes me think, it's almost as if I thought I had a penis then*

*and I was afraid of losing it. And that sort of makes me wonder about how I felt then." (Sniff, Silence)*

After this connection is made the patient begins an upward slope of RA, and a sense of clarity sets in which allows her to observe herself with greater awareness, just before the session ends the patient declared: "*I started thinking about the reports again, and this time I was thinking about them a little bit more specifically. But I, but still, I don't know, it was almost as if now I know I can do it, but it will be horrible to go through."*

As a whole this session evidences a relatively successful process in as much as a fundamental unconscious fantasy was able to emerge into the patient's consciousness and become part of the therapeutic exchange. For the majority of the session the patient was at her baseline, trying to contain her anxiety through her habitual ways, evidencing her typical defensive strategies. The analyst's interventions were for the most part exploratory in nature. As we examine them closely we see a gentle progression in which he moves from the exploration of general content, to the exploration of feelings, gaining greater specificity in his approach at every turn. In two specific instances it appears as if the analyst's input was not helpful to the patient, both of these interventions were too distant from the patient's experience ("the view from without") and did not offer her enough ground for support to deepen the exploration. The more successful interventions have greater specificity taking into account the patient's affective experience and offering at the same time organizing elements that become inroads for the exploration.

The analyst's questions by the end of the hour introduce elements of time and underscore a connection between significant events and feeling states, helping the patient

organize her experience into a temporal narrative that is coherently grounded in specific events, making room for the unconscious fantasy to emerge. As Freedman (2003) specifies, the representation of time where there is a "historization" of one's narrative through focusing on the past, present or the future as well as a shift from one temporal mode to another is an essential dimension in the process of symbolization. Another dimension is the presence of a fantasy space where the patient can start to imagine and remember. Although most of the analyst's communications are closely connected in content to the material the patient was presenting we see the difference between the interventions that did not present anything new in contrast with the ones that introduced elements of time providing an organizing function for the patient's disorganized ego. The analyst tone, as it can be inferred through the text, is neither supportive nor judging.

**Session 627:** (see figure 7 in appendix)

Session 627 from the fifth year of treatment is a session in which the patient fluctuates between states of confusion and overexcitement (as evidenced by elevated pairs of RA and Repetition scores that peak twice throughout the hour), and attempts to disengage from the process in order to deal with her feelings of anxiety (evidenced by dipping scores in both RA and repetition). During this hour the patient is dominated by anxieties that relate to long-held feelings of powerlessness and subjugation connected to the relationship with her father and her feelings of inadequacy in connection to being a woman. The analyst intervenes attempting to link different aspects of the patient's material but fails to provide enough ground for the patient to feel safe and bind her anxiety. This is the only session of the sample studied in which the analyst only made

linking interventions. This hour is also remarkable for having the longest total amount of silence (over 27 minutes) out of the 10 sessions studied.

The session begins after a silence of over three minutes, the first two units of the hour are marked by high levels of RA and low repetition scores. During these segments the patient reports quite vividly the events of the previous night in which she struggled with her feelings of ambivalence around having sexual intercourse with her husband and having to deal with her daughter who was sick. She expressed guilt over her reaction to feeling ambivalent about making love to her husband, and *"taxing him"* by not being able to take care of their daughter on her own.

Later, the patient comments that these events seemed less overwhelming as she was relating them to the analyst than the way she had experienced them originally. At this point the analyst speaks for the first time and says: *"But you don't say what happened then between you and MSCZ."* To this comment the patient responds in a way that is interesting in two ways, on one hand she begins to disengage from the process as evidenced by the drop in RA and repetition scores, and on the other hand her response foreshadows her transferential feelings for the rest of the hour. Her response is dispassionate, she relates her feelings answering the analyst's question and as she does this she seeks to detach by continually denying ownership of her thoughts "*I don't know why I didn't, I was thinking well first I was just sort of assuming when I said it was a repeat of the night before, but, I mean it seemed to be in every way. We had intercourse but I can't call it making love because I didn't really, I was just being sort of well, I don't know, I me- I don't know, remember now how I was the first night, but last night the way I was feeling was being sort of an obedient wife and if he wanted to make love, well, then*

*I'd be there and not resist, but, MM. And it was as if I didn't expect anything for myself and I didn't want to have any reaction either".* In effect, the feelings of submission that she is relating about the previous night also apply to describe the way she is responding to the analyst's question and the way she is experiencing him in that moment. The analyst's intervention, which aimed to show her defense and refocus her thoughts, was experienced as distant and imposing, perhaps even an admonishment. The analyst's comment is not anchored within the patient's perspective (the view from without), which is why the patient cannot make use of it effectively.

In the following unit the patient attempts to reverse the situation, resisting the analyst by gently questioning something he had said on the previous session, *"And then what comes to my mind is, MM, you're saying yesterday. I don't remember you're exact words, but that it's from what I was saying it sounded to you as if I were planning on a new husband or at least getting rid of the one I have. And how I, I remember then and now when I think of it I just don't know what to make of that".* In this way the patient regains some momentum as her RA scores rise (unit 5) and she is able to make a meaningful association to feelings of ambivalence in regards to her father, "*he (her father) started talking as if he assumes he'll be up there and, I don't know, I think I had mixed feelings about that because I, I think on the 1 hand I was feeling pleased that he would want to be there when I was there, but yet on the other, for the reality of the situation, it's better when he's not there."* At this point the analyst intervenes and says: *"Well, I wonder if you realize that you were just describing your father and MSCZ in almost exactly the same terms. You said you wanted MSCZ to want you, but you didn't really want him close to you. You want your father, you're pleased that he wants to be*

*with you in PTN, but, in fact, you don't really want him there when you're there."* In response to this comment the patient sighs, and goes back to her baseline, trying to intellectualize the connection that the analyst is pointing out through a series of explanations. Her inability to bind the underlying anxiety leads her to generalize her experience and polarize her position even more: "*it's almost as if I'm feeling I want no man to figure very importantly in my life. Except I do, but then again I don't. Because if I, if they do then somehow I, I don't know if it's I become dependent on them or, I don't know, I just, I seem to be less of a person. Or I'm afraid of that and I'm afraid the only way I can be, be me is by being completely independent of any, anybody I guess, but specially any man."*

After this the patient enters into a space of confusion, she becomes concrete falling into a space of psychic equivalence, *"I also think of MM, the thing I was thinking of at the end yesterday and it bothered me very much last night, too. And, there are times when it bothers me more than others and the last two nights it really has, of, MM, the feeling when MSCZ's inside that he's going to keep coming out and come in again. And he's not really. But, I just get so I can't stand it. And then, well, I guess yesterday when I was thinking about having things sort of in effect that I guess one was burned off me, but one cut out of me and, I don't know if, if that feeling when we're having intercourse has anything to do with my fearing over and over again I'm loosing a penis, but, MM."*

Then there is a pause (over 2 minutes long) after which the patient resumes and recovers briefly (unit: 8; RA rises once again and repetition stays low) by having a couple of meaningful associations: first, to trying to feed her daughter by force and second, she recalls an incident that involved conflict with her nanny over scheduling issues. This

association leads her back to the transference as she remembers a scheduling issue in regards to the treatment in which she had felt that the analyst had imposed a new time and ignored her preference for a different schedule, *"But I'm also wondering if it really is that I'm angry, but, MM because I was recalling something you pointed out earlier a few days ago about my feelings about the change in times and MM, and just my feeling today of, MM, well, now I think of it as almost as if I were just sitting there waiting until I came here and I could, and, and then it became a situation where I could barely cope with FSO because all I was really doing was sitting, waiting."* At this point the patient pauses for over 4 minutes and goes back to the subject of force-feeding her daughter; her use of repetition quickly rises (unit 9) indicating a level of overstimulation by the feelings that continued to be stirred up in her.

The analyst intervenes at this point by saying: *"You think it's just accidental that you think of FSO uh, refusing what you feel you're forcing on her and the time when you were telling me about how the last two nights you've felt MSCZ was in effect forcing his penis on you. You were constantly preoccupied with that idea that quite literally he would be doing it over and over. And you were kind of wondering if maybe you were mad at me for having forced this new time on you. Something you didn't want and you're telling me how you feel by explaining FSO. You acted obedient but you were obviously fighting MSCZ in your own way and I think you must feel like that to me."* After this intervention there is a long pause (over 3 minutes), the patient's speech patterns quickly change as RA continually drops reaching its lowest point by the end of the session and repetition scores peak to the highest point after an initial dip. The analyst intervention accurately points out a series of relationship patterns (including the therapeutic

relationship) that replicate a dynamic of dominance and submission, but once again he fails to empathize with the patient's perspective and contain her affective experience, as if unwittingly replicating the very dynamic that he is trying to describe.

Initially, after the pause, the patient responds with imposing distance by trying to intellectualize and describe in a rote way the sequence of her associations, seemingly agreeing with the analyst's interpretation. She describes the sequence of events that led to the disagreement with the analyst over the schedule indicating that she had felt that the analyst was not interested in taking her needs into account and that he was in fact ignoring her perspective on the issue, *"And I was thinking also, with you, MM, I don't remember being that upset about the change of time until I, I began to indicate a preference for the earlier time and you sort of said let's keep this time and, MM, so in effect then I wasn't getting my way."* Once again the analyst is unable to take into account the patient's affective experience and instead responds by challenging her, defending his position: *"Ah, but you forgot. You indicated your preference after I said that."* The patient responds presenting a regressive wish for merger and attunement, in which the analyst would somehow "know" her wants and needs coupled by the counter fear of total control by the analyst. *"Yeah. But, I mean my feeling had begun to develop like that, I guess. At first I didn't know what my preference was, but when you said that I knew I, I thought my preference was for the earlier time, even if I hadn't said it. Well, now I wonder if I were assuming you knew that was my preference. Well, then I'm remembering that, MM, I think I assumed you knew something and that you were somehow controlling me ha- wh- exerting control over me, sort of indicating you were the one to make the decision, not me or something like that."* The patient struggles to gain

some ground and defend her position but in fact gets progressively upset, losing her sense of boundaries as she becomes confused about her desire and her sense of self *"...I don't know which came first, but, but, I think I assumed you thought I was well, I don't know. I don't know what I felt and I don't know if playing games with you is exactly right or, MM, not being honest with you or, MM, exerting control myself or, or what exactly but that, MM, (sniffs, rumbles, sigh) I don't know, I just as thinking that some of this, I can't seem to clarify it exactly, but that, there's something in that that seems to be in my relationship with MSCZ and in my relationship with my father that maybe I see it in the end as not getting my way, but, MM (stomach noise), I don't, it's a way of behaving I want to be able to behave and that none of you will let me (sniff, stomach noise)".* The patient is struggling between her desire to get her wants recognized on the one hand and her fear of assertion on the other. The resolution of all these conflicts is achieved by aspiring to be nothing and to negate her desires so as to not choose between either position.

For the rest of the session the patient continues to struggle trying to assert her position, continually expressing how trapped and weak she feels in the face of this struggle *"...somehow in the end I get the feeling both of you are saying I want w- in your case it would be I want us now to keep this time and with MSCZ saying this I want to make love and my feeling in both cases I'm saying, but I don't want to. I want something else. And feeling that I'm the weaker one. And I, I think a feeling that my wants should be recognized but if, if both of you keep saying you want something else I can't, MM, well, maybe there are other things involved but I can't just feel that's not what I want and go my own way. I, the only way is f-, the only solution for me is for you both then to say all right, if that's what you want and give in on what you both want. Because otherwise, it*

*seems like I give in and, and (sigh) that seems to be part of (sigh) I mean I I feel as, as if I'm giving in. That's what it is and I feel as if somehow I've lost something of myself then*."

This session is an interesting example of an enactment being played out between the patient and the analyst. On the surface the communications of the analyst are accurate in content; they are precise and pointed, almost surgical, but at the same time distant in tone and affectively disconnected. The analyst does no explorations, positioning himself from his initial intervention in a position of "knowing". As the analyst continually points out the ways in which the pattern of domination and submission is present in the different relationships that the patient is relating, this very pattern begins to emerge in the dynamic between them in the room. The analyst's view is locked and seemingly faithful to the content presented by the patient; a sense of inevitability emerges as she is compelled to accept these connections but cannot really do much with the analyst's comments because her experience is one in which she is yet again being forced into something. The patient recognizes these connections and accepts them with a sense of resignation. As the session progresses one gets the impression that the analyst is unwilling to shift his perception to include in his communications other aspects of the patient's experience that would have potentially allowed her to contain her desire and the undercurrent of anxiety that dominates the session, thereby averting the enactment. The patient is left in a passive and helpless state struggling with a sense of loss relating to her identity and identifications. The external objects are turned into depriving figures who refuse to recognize her needs and this lack of recognition creates an impoverishment in her sense of self

It is conceivable that if the analyst had included in his communications a sense of the patient's wish for attunement or an empathic understanding of the pain connected to her feelings of inadequacy and powerlessness, the patient might have felt heard and understood in a way that included the full complexity of her experience, potentially allowing her to use his interpretation in a transformative way. By keeping himself fixated in a certain view, the analyst loses sight of the patient's experience and can no longer identify with her, thereby missing an important source of data that can only be obtained from "the view from within". By losing this connection the therapeutic alliance is temporarily broken, as patient and analyst get locked into a role responsive mode and can no longer reflect about the experience that is taking place between them. The experience of the transference becomes overwhelmingly "real", loosing the "as if" quality that normally allows the patient to both experience and reflect about what is taking place at the same time. The analytic task is suspended as the patient is submerged in the experience of powerlessness and subjugation and the analyst's perception is fixated on a single aspect of what the patient is presenting. In effect, throughout the session there is a tendency towards the concrete, an insistence on a single meaning and a wish not to know as the patient is unable to form a higher order representation that would house contradictory attitudes. As Freedman (2003) points out, another important dimension of the symbolizing process is the existence of an object relational space where the patient's investment in the analyst and the analysis is clearly present yet at the same time there is a boundary between the self and the other. In this case, the patient is only able to associate and remember as a way to amplify the experience that is taking place in the present

moment. On his part, the analyst is wrapped in a space of certainty that provides no new elements for discrimination or the possibility a new narrative to emerge.

**Speech Patterns and Analyst interventions, further considerations.**

Combining the measures of repetition and RA, Halfon & Weinstein (2013) reported four distinct speech patterns or "psychic zones", that represent differentiated ways of psychic functioning in the patient's speech. These modes of functioning are thought to co-exist with varying degrees of prevalence and emerge in different moments of the analytic process. As Halfon (2010) suggests, "they determine the very conditions of the patient's as well as the analyst's positions. In each case, the analyst's listening and interventions require a responsiveness that is unique to the demands and characteristics of these modes." (p. 87) In addition to these four modes, a fifth pattern (Baseline pattern) was found to be the most prevalent measure recorded as well as clinically relevant and is thus included for descriptive purposes in the current study. The following segment provides a detailed description of the different psychic zones that correspond with the conceptualization advanced in the cited studies (Halfon, (2010), Halfon & Weinstein, 2013) and looks at the analyst's participation from a more global perspective.

**1. Low Repetition & Low RA: Disengaged Pattern**

**"Attacks on Thinking and Difference"**

The low repetition and low RA linguistic pattern reveals a collapse in the psychic representational space of the patient. Thinking becomes concretized and continuous attacks on thinking and meaning making are observed in these units. There is a defensive

substitution of reality by fantasy and the resistance to interpretation. Halfon (2010) notes that: "this is not a developmental arrest, but an active attempt to destroy the "mental space" necessary for differentiation and representation in order to hold onto an archaic illusion". (p. 82) In the case of Mrs. C the avoidance of thinking and meaning making, were noted as an insistence of a single meaning (i.e: as described in session 627, see below) and the refusal to fully engage with the outside world/reality.

This mode of functioning presents an important challenge to the treatment, it is indeed a veritable attack on the work of analysis. When in this mode, the patient is disengaged from the analytic task, foreclosing the possibility of reflection and historization. There are thoughts, but there is no thinking (Bion, 1962). As Halfon (2010) points out: "The transferential impact of this kind of repetition is a resistance to the interpretative activity of the analyst which, by definition, works on the principle of difference as it introduces the possibility of multiple meanings. It closes the possibility to see repetition as repetition and to introduce historicity—the possibility of relation between past and present; here and then". (p. 80)

In the sample studied 11% of the analyst's interventions were preceded by this type of speech pattern. No significant differences were noted in terms of the types of interventions that were used by the analyst in these instances. 12% of the times the analyst intervened, the patient was noted to follow by turning into this psychic space. If we contextualize these percentages with the total number of units studied we realize that every time this speech pattern was coded it either followed the analyst's intervention or preceded it.

In session 260, a low repetition and low RA session, where the patient trends towards a disengaged pattern and is holding onto an organizing fantasy of having a penis in order to deal with her tension states, it is possible see how the analyst's interpretations that attempt to create a symbolic space lead to further concretization and collapse of meaning. In this session, in units 6 and 7, the analyst makes multiple interpretations that differentiate reality and the illusion that she has a penis: *"Well, you know, you say it again today and you said it yesterday, that you had the idea yesterday that you wondered if you had felt better about yourself and about the school before the operation, because you had fooled yourself into thinking you had a penis. And you allude to that again today. Then you say you're afraid you will lose what you have. You will lose the illusion, really is what you seem to be saying."* However, the interpretation does the opposite of what it intends because it loses an essential form of connection to the patient and thus only serves to confuse the patient as she gets concrete about what an illusion is and how it works: *"So that would mean unless I think I have a penis, I don't have any confidence. But then I, I don't understand how I got this illusion yesterday, so that by the time I got home I felt differently about the reports, anyway. I didn't even – today when I was going to school I was kind of afraid I'd still feel the same way I had yesterday at school. And then I didn't."* The analyst, possibly realizing the problem in the reception of the interpretation, restates more forcefully his original claim: *"Well, it's true you don't understand, but you also make it clear that you were afraid to find out. Because that would be equivalent to losing the illusion, what you're afraid is an illusion."* Both interpretations are fruitless attempts at trying to reenlist the patient into the analytic task. The patient remains in a state of psychic equivalence throughout the session because

these interventions assume a level of psychic differentiation between an illusion and the reality that is outside of the patient's reach -"beyond the Zone of proximal development"- . In addition theses interventions fail to consider the regulatory function that this illusion provides for the patient. When the analyst intervenes in this way he has lost the connection with the patient's perspective (the view from without) by prematurely attempting to force the patient to abandon a very powerful regulating fantasy.

**2. High Repetition & High RA: Overstimulation Pattern.**

**"The Language of Trauma"**

High repetition & high RA segments are associated with speech in which the patient is locked into memories/fantasies linked to bodily states with no psychological differentiation between fantasy and reality, memory and present time. This pattern was likened to the language of trauma because it is a kind of vertical speech, like a free fall, locked in the present moment and heightened in intensity by its emotional valence "where the memories reproduced are under the timeless power of primary process with rudimentary condensation and displacement" (Halfon, 2010, p. 83). This speech pattern can be likened to primary process thinking, the challenge for the analyst is to effectively maintain a dual perspective and hold his own in the presence of this highly disorganized and affectively charged state, that can be experienced as overwhelming.

Out of the sample studied 8% of the analyst's interventions were preceded by these speech patterns. No differences were recorded in terms of the type of interventions made. In terms of the speech patterns that followed the analyst's interventions only 3% of the time did the patient go into this mode of functioning after the analyst had intervened.

This pattern was noted 7 times as in relation to the analyst interventions, but it occurred a number of 18 times in the totality of the units studied. This is an interesting ratio, given that for most patterns the relationship for other types of speech patterns was closer to 1:2

The traumatic themes that Mrs. C is struggling with in the excerpts studied by the sample, namely her fear of bodily damage in the form of losing the fantasized penis and the effect of this fear on her feminine identity are evident in the transference material. As observed in session 627 (see qualitative analysis above), where patient and analyst are locked enacting a masochistic dynamic in which the patient feels like she has to subjugate to the Other's will in order to stay connected to them. In the session we hear the patient mention her fear of losing a fantasized penis, as a result of this forceful encounter, which in her mind is repeated in a series of relationships, present and past. All of the relationships that she relates feel exactly the same way as she is unable to discriminate between them.

An interesting example of this type of discourse can be found in units 11 and 14, of session 431, both high repetition and high RA units. In these segments the patient is talking about her labor and she enters a space where her ideas become disjointed and contents of bodily sensations inundate the material, evidencing a lack of psychological distance between fantasy and reality as she is immersed in a fragmented narrative that evocates the feeling of trauma: *"And uh, but then when he started sewing me up, and I had, I knew what I'd had and I don't know if I'd seen her yet, or not. But anyway, I wasn't going to s--, uh, I think they were doing th--, whatever they do to babies when they're born. So I couldn't see her right then. And I immediately I think, asked him something -- I can't remember my question exactly now -- but it was something to with would what he*

*was doing now, sewing me up, have any, be affected at all by my first operation, when I'd had to be sewed up. And I don't know, I gu--, maybe, or maybe I was wondering if he could tell where it was. Or anyway, the time when I'd fallen on the stick and had be to sewed up, came to my mind right then. And it's almost as if I, I, I think it's almost as if I were, just from the way I remember my question; I think of this as sort of a progressive thing, that whatever happened to my, in my vagina then, was just a little bit making it not right, or bad, or abnormal, or something. And then, this time it would be a little bit more. And -- (Pause)".* In response to this chaotic narrative that contains idiosyncratic impressions and sensations that are confusing and disorienting, the analyst is able to ask a question: *"Do you remember shortly before we interrupted, before you went into labor, you had among other things thought about an operation your mother had after your brother was born? For some reason that occurs to me now."* This intervention is very helpful to the patient, because it reintroduces her into a linear narrative by referencing two important elements: a past event and significant figures in her life. Symbolization occurs when a narrative can be anchored within the elements of time and where objects are sufficiently differentiated (Freedman, 2003). This intervention also exemplifies the analyst's dual perspective ("from without and from within"), showing his connection to the patient by holding her in mind and remembering something that she had once told him in the distant past, and at the same time displaying the ability to think and associate in a meaningful way to the material that she was presenting without getting overwhelmed by it. Lastly, in doing this the analyst effectively "lends" the patient the ability to organize her experience by introducing a temporal perspective where objects are differentiated and fantasy is distinguished from reality, the "lending" function recalls the

"scaffolding" principle established by the zone of proximal development (Wilson and Weinstein, 1998). In effect, the patient's ensuing narrative completely shifts as she is able to differentiate different moments in the past as well as separate out fantasy, memory and reality, which until then, had been fused. Moreover, the affective tone of the session remarkably changes from pain and horror towards the use of humor as she responds with a chuckle: *"Because that, that's kind of funny, actually. (Chuckle) Because my mother came down after my daughter was born, to uhm, help me in my first week home. And I'd been, I w--, that was on my mind then too, because I was wondering just what had happened. Why had she had a hysterectomy then, or something? And it turned out that that operation was a year after he was born. And that particular operation, which I was recalling, was an operation for hemorrhoids, not a hysterectomy. Although, and so then I was thinking my husband and I were laughing about it because, uhm, at first I was wondering, well did she ever have a hysterectomy. And then later on, uhm, she said something and, and, and said, "When I had my hyster--." Oh, I know, we were talking about appendix and appendicitis and she said, "Well, when I had my hysterectomy, they took my appendix out, too." So I--, now I don't even know when that was. But yet that's how I thought of it. and it was a year after my brother, not right after."* The analyst's intervention that aimed at containment and construction is crucial in creating bridges of cohesion for the patient's disjointed memories, fantasies and communications towards a more integrated narrative.

**3. High Repetition & Low RA: Conflict Pattern**

**"Confronting Inner Conflict"**

High repetition & low RA segments reflect intolerable ambivalence regarding issues of identity and identifications, which become a source of panic. The recurring repetitions and concreteness are fueled by this overwhelming fear. These patterns are associated with conflict that is already in the psychic space and has reached the level of words. However because of the conflictual nature of the representation, the patient fluctuates between concreteness and symbolization as she tries to integrate the conflict into her psyche.

Out of the sample studied only 5% of the time the analyst interventions are preceded by these types of patterns. In all of the instances noted in this sample the analyst intervened by making linking and interpretive comments. On the other hand 8% of the time after the analyst intervened the patient followed by displaying this mode of functioning. Out of the 4 instances studied 3 of these interventions were explorations.

For example, in session 432 (unit 8), a high repetition and low RA segment, the patient is torn between her desire to receive the analyst's approval and her fear of not getting it. This happens within the context of wanting to reschedule one of her sessions; however she finds herself unable to make a direct demand. The analyst makes an interpretation addressing the conflict: *"You know, it seems possible to me that one of the reasons you didn't want to ask, was because you're inhibiting exactly the opposite. As though you really would like to have me change the time as sort of a token of my appreciation and you have passed your test very well, and that I'm pleased by it, and all*

*that. It would indicate that I was giving you something in return to show my appreciation."* This intervention shows the patient her defensive maneuver but also reflects the analyst's ability to identify with the patient's struggle. The patient's response evidences an opening as she associates to an incident regarding her parents that in fact elaborates on the reasons underlying her conflict. Furthermore as she continues to elaborate, later on she is able to face the two contradictory sides of her conflict which had led to the inhibition regarding making a demand*: "Mm. Yeah, when you say that, first I think that's crazy. Why would I do that, if that's what I want. But then, it reminds me of when I was at my parents' house, and my father was giving us some money. And then I had that reaction to I don't know, not feeling good on one hand, but yet feeling awkward about showing any, any signs of affection, physically. And, and then, anyway it's, it's something about, I don't know, I'm so used to thinking I wish my parents had been more a--, openly affectionate with me. Because I wanted to be in return. And yet, it seems like I want to avoid anything that will then sort of make me feel obligated to, or I m--, it s--, it seems sort of awful to use the word that I'd be in debt, but I think that's how I feel, And then I'd owe something. And I don't know, maybe it's with you too, just as it's with my parents. There's something about if you don't do anything for me, then I can feel freer about feeling angry at you when I want to. If you do nice things for me, then I won't feel that I can be free and feel angry, or anyway, feelings that I don't like having. And, or maybe I shouldn't say don't like having so much as don't like showing, don't like admitting… And (Pause), and I, I don't know, it just, I was just thinking that it seems like I'm caught either way. Because by asking, I was just remembering there was a time when I was feeling very strongly this way. And I don't think it's just that time, I think it's always*

*true, that I feel a certain anger, or some negative feeling anyway, if I don't get what I want, which is to change the time. And so, I don't want to face, or set up the possibility that you'd say no. But on the other hand, it seems like I can't handle your saying yes, too."* In this case, the therapeutic exchange allows the patient and the analyst to work together within the context of shared meaning that is further elaborated into new meanings and associations.

**4. Mean Repetition & Mean RA/ Mean RA & Low Repetition: Baseline Pattern**.

This pattern was included as a separate entity because it was found to be clinically significant and very prevalent in the current sample. Segments that were classified by mean Repetition and mean RA scores were noted to represent the patient's usual mode of psychic functioning and defensive style. It is a space that is marked by the potential for transformation, the working alliance is in place and the patient is actively engaged in the process of association. Although affect is being warded off by the use of defenses, it is a state where contents and meanings are simmering and connections exist in the preconscious vicinity.

Specifically for Mrs. C these instances displayed her usual defensive patterns, which are mainly characterized by a tendency to intellectualize, rationalize, externalize and somatize her experiences. Her commitment to the treatment is evidenced in the form of a diligent compliance to the fundamental rule, as she methodically continues to enumerate and report her thoughts. This form of compliance was understood both as signifying the state of the therapeutic alliance as well as a form of transferential repetition.

In the sample studied, 52% of the analyst's interventions were preceded by this type of speech pattern. No statistically significant differences were found in terms of the types of interventions used, although a slight tilt towards linking communications was noted. In terms of the type of speech that followed the analyst's interventions 48% of the time after the analyst spoke the patient would go back to her baseline. No statistically significant differences were noted in terms of the type of intervention that preceded this type of speech.

In the sampled studied this was the most prevalent speech pattern presented, unlike the other patterns, at least two or more instances of Baseline units were recorded in each session. Many of the segments that were recorded with these scores evidence increased activity going back and forth from the analyst to the patient, particularly when they are clustered together as in sessions: 259 (units 11 to 13), 260 (units 7-10), 431 (units12-13). It appears as a space where the analyst feels freer to intervene and is generally holding a dual perspective. The patient in these segments seems open to the process of exploration but also guarded towards fully connecting with her affective experiences both inside the room and out. There is a looming awareness of the underlying tensions but a muted sense of experience that prevails. The challenge for the analyst is to find a way to conduct explorations to keep the patient engaged in her thought process and gently find a way to show the defensive maneuvers at play. In a way, it makes sense that at least some part of the sessions are spent in this mode, because it is also a kind of save haven from the intensity of the analytic experience.

A good example was observed in session 1000 where the prevailing anxiety throughout the session is linked with the issue of termination. In the following exchange we can see the patient struggling with her feelings in regards to this.

*Patient: "Well, the first thought I had when I was quiet, and I, I'm not sure why I didn't just say it, was, MM, I guess I was thinking, well, am I really feeling moody and depressed and negative right now because I was just thinking, well, why am I thinking about FDD and all these things. And, MM, I suppose it all with FDD comes down to -- you know, today anyway I was just, just thinking of again this -- some feeling of being asked to do something for her, by her that I can not do. And I suppose then I get back to thinking, well, mm, am, am I really indirectly thinking about, MM, my reaction here and what I want you to do (sigh). Well, I found again, because both times when I started being quiet I ended up, sort of, thinking about, well, the first time I was thinking about some things that I can do after we're taking a trip tomorrow to a police station and, MM, there are different projects that we can get into after that. And then, MM, just now I was thinking about something that I started to oversee that FDD used to and, MM, I did it partly because I've felt she felt trapped, always being in the same thing, but I also felt there were some other possibilities in children's approaching them, too, that weren't being explored and encouraged. And, MM, so I guess I was just wondering if she feels happy that I've relieved her because she once expressed a desire not to do it every day. And, it's the woodworking or whether she feels, you know, somehow I'm -- taking it away from her because I didn't like the way she was doing it or, I don't know. But, MM, I, I keep getting back to this feeling of well, I guess, mainly I was worried, you know, it's sort of like after that night when MSCZ and I'd had such a terrible time and I came in very*

*upset. MM, yesterday I was really upset with my back starting up again because I knew it had to do with tension I was feeling. And MM, I don't know, now my back's not so bad, I don't have a headache and I just somehow feel as if I've have withdrawn, or….*

*Analyst:" That's the way you sound."*

*Patient: " Of course then I think about what we were talking about at the very end which I'd not thought about since yesterday of, MM, everything getting back to our talking about, you know, really my finishing here. And. "*

*Analyst: "Well, it's not exactly the way I would put what we were saying here, what I was saying at the end, I was saying that you're reaction to finishing is as though I were kicking you out and not caring for you, which was the way you felt about you're father after MLWZ was born and you want to hold on to me the same way you wanted to hold on to your father. "*

*Patient: "And I guess first I was just thinking what I did think yesterday, MM, when you said that. That (sigh) I don't know whether it really makes any difference, but, MM, I don't think I was wrong in thinking my father didn't care, but then again, he can't really, he doesn't really care in some ways. I don't know…"*

**5. Low Repetition & High RA/ Mean Repetition & High RA: Symbolizing Pattern "Rewriting of the Past"**

Low repetition and high RA segments are the hallmark of symbolization as the patient is no longer locked in fixed repetitions or stuck in defensive states but is able to utilize multiple devices such as the narrator, context, characters and time in the internal "rewriting of her past". Ideally in the context of the analytic relationship, the patient is

able to reedit central organizing relational patterns from the past into the transference and open herself up to a new experience. Halfon (20120) notes: "As opposed to the paralyzed, fragmented or absent objects in the other segments, repetition in this case is bound up with alive objects who are loved, feared, hurt but more importantly preserved. The ambivalence felt against these objects is used towards building a complex awareness of others. This, in Green's words, is the hallmark of objectalization. In these segments, there is a clear symbolizing activity in the patient's use of vivid narrative that is evocative yet at the same time clearly differentiated in time and space. The higher order representations, in effect, as hypothesized, put out of use the exact repetitions." (p. 85)

Out of the sample studied, 25% of the analyst's interventions were preceded by symbolizing activity. No differences were noted in terms of the types of communications employed by the analyst. 28% of the time, after the analyst intervened the patient's speech entered into a symbolizing mode. Out of all the instances studied (n=18), 12 were noted to be linking or interpretive type of interventions while the remaining 6 were coded as explorations, although this difference is not statistically significant it makes sense to find a higher frequency of linking interventions in these segments, because linking and interpretive comments are intended to be organizing, pulling towards integration and symbolization.

For example, by the end of session 1001 (unit 19), the analyst offers a very complex interpretation in which he addresses a central organizing theme regarding her feminine identity, as well as relational anxieties connected to sibling rivalry that were repeated in the transference throughout the treatment and were resurfacing as the analysis approached its end. In response to the analyst's comment the patient is able to associate

and vividly narrate painful feelings of rejection and neglect that she connects to being a woman through a character in a book, as she simultaneously references her early history as well as her position in the transference relationship. Here is the exchange: *Analyst:"Yeah, well, you know, that would sort of shatter your -- as though you have it one moment and then the next it is gone. Yeah. (sigh). But I think the, uh, the main point is that, you see, again what, what, what you can see is how strongly, even now, you remember in this particular way, what a, what a traumatic experience that was when MLWZ was born for you and you felt he turned away. And now, at the time when we're talking about finishing it, you see it as my turning away from you and you have these things that you feel jealous of with me. So, again, I'm turning away to somebody else that's more important. And, I think in those circumstances you feel well you'll be damned if you admit then you want anything from me. Which is, of course, what you felt with him." Patient: "Yeah, I, I also think something that did occur to me yesterday, I think, at some point. MM, I mean I, it just sort of supports what you said, but I've been reading Dombey and Son by Dickens lately. And, when I started it, I found I could almost not read it because the first scene, or just about the first scene, is of a boy being born to the, you know, character Domby and it turns out his wife's dying, but anyway, he only sees the son. He almost doesn't even care about his wife. And he's completely unaware of his daughter. And then, you know, this just gets pointed out again and again how he just doesn't care at all for his daughter who's several years older. And then, of course, she loses her mother and, you know, there. I just, I just found that whole scene almost too painful to read (sniff)."*

## Chapter V

### Discussion:

This work sits at the interplay of the technical aspects of psychoanalytic treatment and the process of change it purports to induce. Psychoanalysis is a process of exploration that is signified, among other things, by the verbal exchange that takes place between the analyst and his patient. The psychoanalytic process has been described (Bass, 2006) as a process of exploration that seeks to represent and symbolize experience (Freedman, 2006), leading in turn, to the reorganization and reintegration of internalized relational mental patterns (Loewald, 1980). These mental patterns can be inferred through the patient's verbal accounts of present and past experiences as well as through the experiences recreated inside the treatment room with the analyst (Palombo, 1999).

Ever since Freud discovered the phenomena of transference (1910) it has been hypothesized that repetition in the transference becomes the means whereby the patient remembers forgotten, unconscious mental attitudes: "The part of the patient's emotional life which he can no longer recall to memory is re-experienced by him in his relation to the physician" (1910a [1909], p. 51). In turn, the analyst is thought to act as a transference object, whose psyche can be used to help decode, metabolize and transform original traumatic experiences towards new representational structures. As the treatment unfolds the analyst and his patient are engaged in a mutually affecting process of mental change. It has been hypothesized that this change is not a linear progression but an oscillating function reflected in different speech patterns that fluctuate in terms of the level of organization and the degree of symbolizing activity. Some authors (Freedman, 2007, Halfon and Weinstein, 2012) have suggested that these fluctuations are a normative

aspect of the analytic process. The central question undertaken by this work was how does the analyst's verbal communications affect this process?

Following Halfon and Weinstein's (2013) methodology this study tracked linguistic patterns as represented by the interaction of fixed/exact repetitions and representational language, assessed through the patient's use of Referential Activity (Bucci, 1997). This measure offers the opportunity to describe, what we believe to be, essential linguistic patterns of the analytic process. Describing the way in which the analyst's speech acts interface with these measures is the main exploratory tool used in this study.

Although this study focused on the analyst's verbal acts as an inroad for the study of technical questions, it is understood that this is only one of the various variables that account for the transformative potential of the analytic process. (i.e. the containing aspects of the treatment frame and setting, the analyst's demeanor, the continuity and unwavering availability of the analyst are understood to be other essential aspects of the treatment that cannot be accounted for in this study). The analyst's verbal acts are considered as an appropriate unit for research because they can be observed directly and classified with relative clarity. A more complicated matter is ascertaining how these communications are related to, and can serve as evidence to assess more abstract qualities that are also hypothesized as mutative agents of the therapeutic process. In this way, these verbal acts can be used as units of study if one were to attempt to understand countertransferential reactions from the analyst, the qualities of the therapeutic alliance and the holding aspects of the treatment, to name a few.

**I. Exploratory hypothesis:**

A general aim of this study was to find a way to describe the interactional patterns of the analytic dyad as a function that evolved over time. For this purpose sessions were sampled at different points in the treatment and the frequency and type of interventions were plotted across the sampled sessions. Based on Jones and Windholz's (1990) findings, it was hypothesized that the analyst would tend to use more exploratory type of interventions in the beginning phase, and would likely place greater emphasis on interpretations and linking communications in the middle and later phases of the treatment.

In the sampled data for this case study, statistical evidence was not found in order to corroborate the hypothesis proposing that the analyst would increase his level of activity as the treatment progressed or that he would tend to use more interpretive comments in the later phases of the treatment. Although a slight trend was noted indicating a higher frequency of interventions and the use of more linking communications in the second half of the sampled data, the difference in these measures for the two parts of the data was not statistically significant. Because of the type of treatment and the analyst's style, this treatment is characterized, relatively speaking, by the use of small number of interventions per session, which consequently rendered a reduced number of observations to be tested in this study. In this way, the limitations imposed by the small sample size would warrant further explorations in this direction with a larger number of sessions. Another important modification for future studies using a larger sample would be to divide the treatment into three different phases, beginning, middle and end, for a more sensible comparison.

From a qualitative standpoint however, observations point in the direction of differences in terms of the analyst's activity as the treatment moves ahead, interpretations become more detailed and transference based and explorations are more geared towards unconscious fantasies than at the level of elaborations on the content or feeling. For example, if we look at the differences between an interpretation made during the second year of treatment in session 260 :*"Well, I think from what you've said that the real clue to what you wish you have, had now, what you are afraid you don't have or will lose, at the moment lies in the way you felt when you woke up this morning from a disturbing dream. When you literally had morning sickness"*, and one made towards the end of the treatment in session 1001: "*yeah well that would sort of shatter your as though you have it one moment and then the next it's gone. Yeah…. But I think the main point is that you see again what what you can see is how strongly, even now, you remember in this particular way, what a, what a traumatic experience that was when MLWZ was born for you and you felt he turned away. And now, at the time when we are talking about finishing you see it as my turning away from you and you have these things that you feel jealous of with me. So again I'm turning away to somebody else that is more important. And I think in those circumstances you feel well you'll be dammed if you admit then you want anything from me. Which is of course what you felt with him.*" The differences are quite significant in terms of the level of complexity and the degree of integration; while the first interpretation attempts to begin to flesh out an important unconscious fantasy, the second interpretation pulls together historical elements, relational patterns from present and past, as well as fears and fantasies that are being re-experienced in the transference. Although qualitatively the differences in the analyst's interventions over time are

noticeable, these types of differences were not captured by the coding system used in the quantitative analysis applied to the data.

It was also hypothesized that because analyst and patient are thought to develop greater mutual understanding over time (Palombo, 1999; Dewald, 1990), faster fluctuations in terms of the speech patterns would be observed as the treatment progressed. Palombo (1999) suggests that as the treatment progresses and the structure of trust is cemented, the level of cooperation and mutual understanding (Dewald, 1990) between analyst and patient increases (cooperation being understood as being able to actively maintain the analytic task). This increased level of cooperation is reached as both analyst and patient develop strategies to recognize reliable patterns in the sequence of interactions between one and other, the anticipation of these patterns reduces the amount of time spent in spurious and sidetracked interactions. In a study on the use of silences based on the case of Mrs. C. Baerson (1998) also reported significant change over time on the subject of a growing mutuality and shared rhythm between Mrs. C and her analyst as the treatment progressed: "The analyst's discipline in adhering to technique *(in reference to the use of silence)* had a powerful effect on the patient's discourse expectations and behavior as the treatment progressed, she accommodated to the analyst's listening posture by pausing less often and for shorter durations." (p.100). In the sampled data for this case study, in terms of the number of fluctuations of the speech patterns observed within sessions as the treatment progressed, the statistical analysis of the data did not corroborate the hypothesized increase in the fluctuation of speech patterns. Once again it becomes important to note that the trend noted in the data did

point in this direction, and that further explorations with a larger sample of sessions may yield different results.

Furthermore this study looked at the analytic process as a bidirectional process, meaning that just as the analyst is thought to influence the patient's speech, the patient is believed to influence the analyst as well. For this reason another specific goal of this study was to explore and describe the types of speech patterns that usually followed the analyst's interventions as well as to describe the types of speech patterns that usually preceded the analyst's interventions. Two sets of categories were created to differentiate the type of action the analyst was performing, -explorations and linking/interpretive-, in order to assess whether a discriminating factor for the effect on the patient's speech patterns of the analyst's communications was the type of interventions being used. Authors (Palombo, 1990, Wachtel, 2003, Schafer, 1993) have suggested that explorations are meant to expand the patient's understanding and acceptance of his internal world, while interpretations on the other hand can provide grounds for greater integration and connectedness It was hypothesized that interventions that have exploratory functions would have the potential to open up more unconscious process and therefore evidence a greater disorganizing potential, which would be reflected in greater prevalence of speech patterns that showed increased repetitions. On the other hand, it was also suggested that interventions that have linking qualities would have greater organizing potential and would tend to provide a calming effect on the patient, which would reflect in a speech pattern that showed greater symbolizing qualities and more integration.

The representation of the different speech patterns in conjunction with the analyst's interventions allows us to create a map of the process inside the sessions and

throughout the treatment (see figures 1-10 in the appendix). The data gathered shows that the occurrence of these speech patterns does not happen in a random way, not all modes of functioning occur with equal frequency or in similar circumstances (refer to tables, 6.7, and 8). Results indicate that 38% of the totality of the units studied evidenced a Baseline speech pattern, in 23% of the units the patient was in a symbolizing mode, 11% of the time in an overexcited mode, 8% of the time in a disengaged pattern and 3% of the time the patient was in a conflict mode.

Analytic work takes place in the context of an interpersonal relationship, and as we are able to begin to appreciate through the qualitative analysis of the sessions there are specific dynamics between the analyst and his patient that shed light into what generates the different speech fluctuations within the session. The occurrence of the different types of speech patterns is not randomly determined but reflects specific interactional patterns as well as evolving cycles of the patient's process as a whole. These interactional patterns are determined by transference countertransference dynamics and the way the analyst and patient are able to maintain a working alliance (Meissner, 2006) throughout the process. Not enough data was recorded in order to group together specific interactional patterns and types of process cycles throughout the sessions, however the specific discourse distribution that was observed in terms of the overall frequencies of the different speech patterns is thought to represent a meaningful dynamic between this particular dyad. Further investigation through controlled comparisons of multiple cases will shed more light into the variations in terms of frequencies for process measures across treatments.

One important finding in this study was the addition of the Baseline pattern as a distinct mode of psychic functioning; this particular mode of functioning was defined by units with mean scores (+/- .5 sd) for RA and Repetition measures, and units with mean RA and low repetition scores. It is thought to represent a separate set of clinical phenomena that is also an important part of the analytic process. By analyzing the segments with these types of scores the picture emerged of a mode of communication that was characterized by the patient's usual defensive style, it was understood as a space in which the patient is working with the analyst and is adhering to the fundamental rule, the alliance is in place, and the potential for symbolization and discovery is within reach. The majority of the analyst's activity takes place around the units that were marked by these scores. 52% of the time the analyst intervened this is the type of speech pattern that preceded his interventions, 48% of the time after the analyst spoke the patient would go towards a baseline mode of functioning; both of these frequencies are significantly higher than any of the other reported patterns.

The Baseline pattern is thought to be representative of the patient's habitual way of functioning, and thus the significantly higher prevalence (38% of total units studied) recorded seems to make sense intuitively. Additionally the fact that there is significantly greater amount of interaction during the periods where the patient is in this mode of functioning also indicates that the analyst is able to perceive this as a more productive space and responds to the patient when she is in this psychic mode with greater freedom. It would be interesting to study the Baseline pattern qualitatively over time in the course of a single case in order to evaluate whether changes in the defensive patterns could be

noted, particularly to assess whether more adaptable defensive patterns can develop over time as a result of the therapeutic gains.

In terms of the overall differences between exploratory and linking/interpretive interventions, quantitative analysis showed no significant differences in terms of the type of interventions used by the analyst and the type of speech patterns that preceded or followed them. The qualitative analysis, however, showed a different story indicating that in fact the way the analyst intervenes does have an effect on the response that can be observed in the patient's speech. The differences noted were not directly related to the type of intervention being used per se, but rather to a series of specific of relational factors having to do with the quality of the therapeutic alliance, the dynamics of the transference/countertransference matrix, as well as the actual content, tone and shape of the analyst's way of intervening. Persuasive evidence was found in the qualitative analysis over the importance of the analyst being able to maintain a dual perspective (the "view from within", and the "view from without)" while listening to the patient.

A series of dynamic issues could be influencing the way the analyst intervenes, as well as the way the patient responds at any given moment. The patient's internal representations and transferential needs as they are being activated at the specific time of the exchange are also important variables to consider. In this sense any intervention has the potential to scare and threaten the patient or alternatively to open up the possibility for discovery and internal reorganization. As Wachtel (2011) points out: "the basic thrust of the patient's communication or mode of

expression cannot be understood adequately in cross section alone. Whatever mixture of productive self-exploration and fearful evasion is evident at any moment, it must be understood as part of a continually changing series of mental states in which the degree of defensiveness or expressiveness will vary depending on a host of influences. Effective clinical response to what the patient is saying requires that the direction of change be taken into account, that the complex product of competing inclinations evident at any moment be understood in relation to what has come before and to whether it represents an increase or a decrease in the patient's tendency to give voice to conflicted feelings and wishes." (p.189)

In some ways the challenge of any therapeutic intervention lies at the crossroad of, on one hand, raising further resistance or increased defensiveness in the patient and, on the other hand opening up the space for curiosity, potentially freeing the patient to explore his/her internal representations, eventually leading up to newer forms of integration of self and others.

The difference between the quantitative and qualitative analysis indicates that the categories of the analyst's interventions employed for the quantitative analysis by this study were not discriminating in a way that is relevant to the process being observed. Based on the observations derived from the qualitative analysis we suggest that a different way to qualify the analyst's speech acts might potentially be more discriminating and yield a better understanding of how it interfaces with these modes of functioning. In the following segment the lessons derived from the qualitative analysis of sessions will be presented, attempting to define criteria to qualify the analyst's activity in

ways that are more discerning and relevant to the underlying dynamics of the analytic process.

**II. Looking at interventions in order to assess significant factors.**

When attempting to describe the process of symbolization in the patient's discourse Freedman et al (2001, 2003), have suggested specific signifiers of "psychic space" as key elements of this process. These signifiers are: 1. A temporal dimension, 2. Access to fantasy and, 3. An object-relational world, where objects are differentiated and more or less integrated. What we discover through the qualitative analysis of the sessions is that these qualities have a corresponding counterpart in the analyst's communications, in the sense that the analyst role is to introduce these elements when appropriate to aide the patient's narrating process.

These dimensions become discriminating elements for the patient's narrative, helping to organize his experiences in a temporal dimension that establishes fluid connections between the past, present and future. They also facilitate the development of a theory of mind (Fonagy and Target, 1999) by understanding the differences and relationships between fantasy, imagination and reality and their influence on the experience of affective states. Finally, it provides the space to integrate conflictive representations of self and others, developing an internal landscape where objects are well differentiated and experience is fuller. "When we now speak of dynamic symbolization, we hope to show that the structure of the scene offers to both, the objective observer as well as the experiencing subject a means to fathom the depths of inner conflict. We say this so as to underscore the relevance of these distinct forms of

symbolization because they can be generative in the clinical interchange. Together they comprise the goal of the therapeutic enterprise, namely to help the patient access the spheres of affect, to contextualize more coherent self and object representations and then to appropriate inner conflict." (Freedman et al, 2003, p.62-63)

In order to fine grade the elements that discriminate the analyst's interventions, by recapitulating the observations of the qualitative analysis, we can track the process as it unfolds by looking at the progression of the analyst's interventions and attempt to isolate certain elements or dimensions that are particularly relevant for our understanding. The following is the full progression of the interventions made by the analyst in sessions 259 and 627 and a brief summary of the relevant dynamics uncovered by the qualitative analysis.

Session 259.

1. What goes into the reports? (exploration)
2. You mean, as though you're responsible for it? (exploration)
3. Now, what are you afraid your attitude is? (exploration)
4. How do you understand it? I mean, how do you explain to yourself the change in your feelings, so that you feel you don't care? (Linking/interpretation)
5. You were afraid of what the headmaster would think? (exploration)
6. He would disapprove of the fact that you were letting the kids be noisy? (exploration)
7. I mean that's what you were afraid of? (exploration)

8. So what's happened this year that has changed your feeling? (exploration)
9. That's true, but then you did feel differently in the fall. (linking/interpretation)
10. Well, our time's up

In session 259 the patient's narrative revolves around issues pertaining to feelings of inadequacy and competency. Looking at the communications of the analyst throughout this session, we find that most interventions were exploratory in nature. As we examine them closely we see a gentle progression in which the analyst moves from the exploration of general content, to the exploration of feelings, gaining greater specificity in his approach at every turn. In two specific instances (interventions 1 & 4) it appears as if the analyst's input was not helpful to the patient, both of these interventions were too distant from the patient's experience ("the view from without") and did not offer her enough ground for support to deepen the exploration. The more successful interventions have greater specificity taking into account the patient's affective experience and offering at the same time organizing elements that become inroads for the exploration. Intervention #8 introduces two of the dimensions proposed by Freedman et al (2003) as essential signifiers of symbolization; first, the element of time, which situates the patient's narrative in a space that is anchored in the linear dimension of past present and future, and secondly the notion that feelings have a fluctuating quality. As we saw through the qualitative analysis by introducing these two elements the patient is able to anchor herself and move past the concrete aspects of her experience as she had been reporting it until then, opening up to uncover a central organizing unconscious fantasy that would play an important role throughout the treatment.

What is important about this intervention is that the analyst lends the patient an organizing capacity that she is lacking in that moment, showing her and indeed giving her the ability to use it for her own benefit. Through this act we are reminded of the principle that rules the zone of proximal development (Wilson and Weinstein, 1996), where the analyst is able to move the patient ahead by introducing elements that ground her narrative and present a higher degree of organization in a way that is attainable to her in that moment.

Although this seems to have been the intervention that allowed the patient to make a qualitative shift in the session, the analyst's comment did not happen in a vacuum. In this sense, it is impossible to discount that there is an accumulated effect of everything that had occurred until that point (i.e. the sustained working alliance, and the analyst's ability to hold his own) which might have allowed the patient to be receptive to the analyst's input at that particular moment.

Session 627:

1. But you don't say what happened then between you and MSCZ. (linking/interpretation).
2. Well I wonder if you realize that you were just describing your father and MSCZ in almost exactly the same terms. You said you wanted MSCZ to want you, but you didn't really want him close to you. You want your father, you are pleased that he wants to be with you in PTN, but, in fact, you don't really want him there. (linking/interpretation)

3. You think that it's just accidental that you think of FSO uh, refusing what you feel you're forcing on her and the time when you were telling me about how the last two nights you've felt MSCZ was in effect forcing his penis on you. You were constantly preoccupied with that idea that quite literally he would be doing it over and over again. And you were kind of wondering if maybe you were mad at me for having forced this new time on you. Something you didn't want and you are telling me how you feel by explaining FSO. (pt interjects) You acted obedient but you were obviously fighting MSCZ in your own way and I think you must feel like that to me. (linking/interpretation)
4. But you feel strongly that you want to force something in to her… (linking/interpretation)
5. Ah but you forget you indicated your preference after I said that. (linking/interpretation)
6. Well, our time's up.

In session 627 the patient is dominated by anxieties that relate to long-held feelings of powerlessness and subjugation connected to the relationship with her father and her feelings of inadequacy in connection to being a woman. During the hour we observe a different kind of process taking place, if we look at the analyst's interventions from the start his stance is defined by the use of linking and interpretive comments, he uses no explorations throughout the hour, placing himself at every turn in a position of "knowing". The analyst's view is locked and seemingly faithful to the content presented by the patient; a sense of inevitability emerges as she is compelled to accept the

connections that he presents but cannot really do much with them because her experience is one in which she is yet again being forced into accepting something she does not want. The patient recognizes the analyst's observations as accurate and accepts them with a sense of resignation. By adopting exclusively an interpretive stance the analyst fixates himself in a kind of omniscient position and by insisting on a single meaning to qualify the patient's experience he becomes a depriving figures who refuses to recognize the patient's needs, thereby unwittingly echoing her concerns; in this way an enactment unfolds.

By keeping himself fixated in a certain view, the analyst looses sight of the patient's experience and can no longer identify with her, thereby missing an important source of data that can only be obtained from "the view from within". By losing this connection the therapeutic alliance is temporarily broken, as patient and analyst get locked into a role responsive mode and can no longer reflect about the experience that is taking place between them. For the patient, the experience of the transference becomes overwhelmingly "real", loosing the "as if" quality that normally allows the patient to both experience and reflect over what is taking place at the same time. The idea of a sustained dual perspective to inform the analyst's listening suggests that had the analyst included in his communications a sense of the patient's wish for attunement or an empathic understanding of the pain connected to her feelings of inadequacy and powerlessness, the patient might have felt heard and understood in a way that included the full complexity of her experience, potentially allowing her to use his interpretations in a transformative way. When in fact the analyst locks himself in "the view from without" relying on fact or perception to generate understanding, the creation of meaning is foreclosed. What is

desired for the reflective space to prevail is the mutual engagement in multiple meanings which creates a "dialectic symbolizing process". (Ogden, 1986)

In sum, what we learn through the qualitative analysis of these two sessions is that the elements in the analyst's communications that seem to generate the potential for a new organization and openness to emerge are the following:

1. Incorporating in the communication organizing elements that facilitate symbolizing activity, such as a temporal dimension that anchors the experiences in a linear perspective that includes past, present and future, a spatial dimension that provides the sense of boundaries between objects, and the possibility to engage the imagination in a way that facilitates the exploration of internal fantasies.
2. Maintaining a dual perspective that facilitates the integration of perspectives and multiple meanings. There is the '*view from within',* where the analyst is an active participant in the encounter with the patient, empathizing and identifying with both the patient and his inner objects; and on the other hand there is the '*view from without'* in which the analyst acts as witness and observer of the process.
3. Maintaining the therapeutic alliance. This includes the actions taken by the analyst and his patient to keep the analyzing task alive, it is a shared commitment to the work that sees the analytic dyad thru, regardless of the experience of intensified emotions. As was previously mentioned this stance can be best observed during the Baseline mode of functioning.

**III. Speech patterns –psychic zones- and analyst's interventions, some technical considerations.**

Following Halfon (2010), and Halfon & Weinstein's (2013) methodology this work studies the same 10 sessions on the case of Mrs. C introducing the analyst's interventions as a new variable of study. In terms of the coding of the sessions a different approach was used to create new units of study within each hour. Units of analysis within the sessions were created following Waldron's (2004) methodology of theme units. These units facilitated looking at the ways in which the analyst's interventions interfaced with the different speech patterns recorded by these measures. Theme units were judged to be more apt for the present study because silences and turns of speech are taken into account for their creation, facilitating the tracking of fluctuations that followed and preceded the analyst's speech acts as well as offering the opportunity to locate significant segments for analysis within each session.

In what follows we will revisit the different speech patterns that were classified in this study as "unproductive" in order to ascertain the clinical challenges that the disengaged, conflict and overexcited modes of functioning present to the analytic process. Although it has been stressed that all of the modes of functioning described by this group of patterns are an intrinsic part of any treatment, it is also understood that they represent moments of tension, disorganization and regressions from the task of symbolization. These regressive and organizing movements in the psyche are thought to be crucial in the process of structure building and psychic change, however if these patterns were to prevail, the benefit and possible gains of the analytic process might be seriously compromised.

The disengaged, conflict and overexcited patterns of psychic functioning, recall Freedman et al.'s (2003) concept of desymbolization. Freedman et al, qualify this process as "the presence of the absent". This notion describes a clinical picture in which the patient's narrative presents a tendency towards the concrete and expresses a wish not to know. The absence of the symbolic is thereby signifying that which the void attempts to deny. The wish not to know is in this way, actively delineating that which it wishes to dispose, just like symptoms expose in a displaced manner that which is intolerable to the mind. This is not to imply that the only form of attaining knowledge is through symbolic representations, but it is way of processing information that is favored in analytic treatment because it entails apprehending experiences in a way that simultaneously makes it ones' own and at the same time allows for a way to communicate them to an other.

Freedman (2003) proposes three forms of de-symbolization:

1. Concreteness, psychic equivalence. As if quality is lost. In the context of facts meanings are foreclosed, mental states are treated as facts, and the creation of meaning is foreclosed. There is no triangular space.

2. Affect is foreclosed, the patient in order to rid himself of internal tension avoids affective experience or a sense of connection with the content of his thoughts.

3. Disavowal, negation, reflective function is severely constricted.

The general challenge for the analyst is to stand in the negative space along with that which is being pushed out of consciousness, in order to hold on to it until the patient is ready to tolerate looking at it once again. The underlying notion is that when in a desymbolizing state the patient is dealing with elements of trauma that either remain in

some inchoate form, or are still too polarizing for the psyche to be able to coherently integrate without encountering excessive amounts of tension.

For the analyst to stay in a functional mode during these moments it is important to understand the specific challenges presented by these different modes of functioning, in a sense the "zone of proximal development" might be defined as the need for the analyst to offer containment and the ability to hold on to a vision of the patient in a more organized and functional mode (Loewald, 1980).

a. Disengaged pattern

Halfon (2010) refers to this type of speech as "unrepresentable repetitions", in these cases the analytic task is one of recognizing the patient's paralysis of symbolic functions, attacks on thinking and linking (Bion, 1959) as well as the fears of differentiating from powerful wish-fulfilling fantasies (Bass, 1997). The clinical challenge is one of hearing patient's endless repetitions and concreteness not only as an attack to the analytic task but also as a demand on the analyst to help the patient tolerate a degree of difference. The paradox is that, as long as the patient maintains this state, the introduction of new meaning by the other is generally foreclosed. In fact, Halfon (2010) points out, "it is not just new meaning that is barred but the mind of the analyst that can generate any difference may be disavowed" (p.87).

This can be experienced as a very primitive and regressive state in which thoughts are kidnapped of their meaning, thinking is geared at destroying links and the analytic work is thereby suspended. In this sense the analyst is confronted with a sense of helplessness that may leave him bereft of any valid identifications. An interesting option

for the analyst in order to maintain his symbolizing ability is to avoid content interpretations and allow a kind of reverie (Ogden, 2004) to emerge. When in this state it is not helpful to aim at the creation of meaning, because meaning is too threatening to the patient's psyche, instead the analyst's pursuit aught to be one of reinstating the alliance through the means of identification. If the alliance is regained a meaningful leap has taken place.

There is no clear example of an analyst intervention in this case study, which effectively helps the patient reroute his narrative. For this reason it is suggested that the quieter qualities of the analyst's work (his unwavering presence, the ability to maintain a sense of continuity through the frame and by keeping the patient's history in mind) also come to the fore as key ways to combat the inertia commanded by this state

b. Overexcited Pattern

Halfon (2010) points out that this type of pattern has the potential to become a form of "recreative" repetition, because the activity in the mind is driven by the repetition compulsion as an attempt to achieve mastery and control over a traumatic experience. The important challenge for the analytic work is to consider that trauma is merely being replicated in these states and it has not yet been represented. What is observed in this mode is that the patient is locked into overwhelming and disturbing sensations, raw perceptual impressions and disintegrated images.

Recalling session 431 in which the patient narrates her experience of going into labor by entering a kind of primary process in which the past and present appeared as fused and sensations had a disorganizing quality. The analyst, in response to this chaotic

narrative dominated by idiosyncratic impressions and confusing sensations the analyst is able to ask a question: *"Do you remember shortly before we interrupted, before you went into labor, you had among other things thought about an operation your mother had after your brother was born? For some reason that occurs to me now."* This intervention is very helpful to the patient, because it reintroduces her into a linear narrative by referencing two important elements: a past event and significant figures in her life. In effect, the patient's ensuing narrative completely shifts as she is able to differentiate moments in the past as well as separate out fantasy, memory and reality, which until then, had been fused. Moreover, the affective tone of the session remarkably changes from pain and horror towards the use of humor as she responds with a quiet laugh.

Halfon (2010) also suggests that the challenge is to be able to "connect bodily excitations with psychic representations" (Lecours and Bouchard, 1997, pg. 855, as cited by Halfon). This is a process of transformation in which the analyst needs to participate as a mediator following very closely these fragmented, disharmonious and non-rhythmical messages from the patient, contextualizing them in time and space and returning them back to the patient in a more metabolized form (Bion, 1962). With time, the traumatic force of these repetitions decreases as they get repeated over and over. Ultimately, the challenge for the analyst is to find derivatives of the traumatic experience in the transference, so that they can be re-experienced and digested in a new way and re-presented in a symbolized form.

c. Conflict Pattern

These segments reflect intolerable ambivalence regarding patient's identity and identifications, which becomes a source of unbearable tension. The patient's use of recurring repetitions and concreteness is a process borne out of this strain. This mode of functioning brings to bear the challenges that were first discovered and elaborated by Melanie Klein in her description of the depressive position. The main motivation in the face of this mode of functioning is to help the patient accept distinct conflictual strivings. This type of conflictual stance can also refer to incompatible affective states, in which the conflict is rooted at the level of the self-representations. The analyst job is to introduce degrees of difference in the search for integration. The patient can gradually move out of this state towards a narrative with greater coherence and expanded representations of self and others.

For example, if we recapitulate an example from session 432, in which the patient is torn between her desire to receive the analyst's approval and her fear of not getting it. This happens within the context of wanting to reschedule one of her sessions; however she finds herself unable to make a direct demand. The analyst makes an interpretation addressing the conflict: *"You know, it seems possible to me that one of the reasons you didn't want to ask, was because you're inhibiting exactly the opposite. As though you really would like to have me change the time as sort of a token of my appreciation and you have passed your test very well, and that I'm pleased by it, and all that. It would indicate that I was giving you something in return to show my appreciation."* This intervention shows the patient her defensive maneuver but also reflects the analyst's ability to identify with the patient's struggle. The patient's response evidences an opening

as she associates to an incidence regarding her parents that in fact elaborates on the reasons underlying her conflict. Furthermore as she continues to elaborate, and later on she is able to face the two contradictory sides of her conflict which had led to the inhibition regarding asking the analyst to change the session's time.

In a sense, this is a less regressed position than the previous patterns as such repetitions are associated with conflict that is already in the psychic space and has reached the level of words. However, because of the conflictual nature of the representation, the patient fluctuates between concreteness and symbolization as she tries to integrate the conflict into her psyche.

**IV. The Analytic Process, an integrated view.**

The idea of a scene, which in a general sense is created by the analyst, the patient and the analytic work, helps us think about a symbolizing space that is generated by the effect of the third. This triangular dimension has been identified by some to be the optimum space for analytic work to take place (Green, 1975; Ogden; 1986, 1994). In the case used for this study, the technical choice of the analyst was to re-engaged in a joint interpretative process with the patient in the context of the effort of symbolizing the transference.

As evidenced by the graphic representation of the sessions' process measures (see figures 1-10 in appendix section) it is important to note that the patient's possible shift from one psychic state to another in response to the analyst's interventions is not a linear phenomenon, as constituents of each mode were identified in multiple sessions across the course of treatment. These transitions and transformations involve cycles where

processes of integration, disorganization and reorganization move in oscillating spirals towards the attainment of a higher level of organization which is the essence of true change in psychoanalysis (Freedman et al., 2002).

Symbolization is an essential marker of the transformation that takes place in an analytic process. This process is marked by the resolution of conflict in which the passage of time is accounted for, where fantasy is integrated with the imagination, and objects have a definable existence and are reflected upon (Freedman et al 2003). The analyst's role is one that can be in part signified by the concept of Vigotsky's 'Zone of Proximal Development' (ZPD) in which one member of the dyad (the analyst) is in a position to scaffold the emerging material and promote the maturational process in the other (the analyzand) (Wilson &Weinstein, 1996). In this view the analyst lends the patient subtle mental attributes (i.e. ego functions) indispensable for keeping a sense of continuity, and fostering discrimination and the emotional transformation of internal representations.

In a series of empirical studies, Freedman and his colleagues (Freedman, Lasky and Ward, 2009) recognized that the analytic process involves a sequence of events from higher to lower levels of development (regression) and back again. At the core of this cycle is the notion of desymbolization, characterized by the tendency towards the same and a wish not to know. As treatment pushes forward the patient can gradually move out of this state towards a narrative with greater coherence and expanded representations of self and others. This is almost always a narrativization of the transference, which creates further psychic space for vivid representations of experience. Even in treatments where the analysis of the transference is not the main point of focus it is believed that the

experience of the alliance and the constancy of the analyst as a new libidinal object is thought to lead the patient to internalize new representations of self and others. What is striking is that the very attainment of a reflective space brings with it the danger of awareness and containment of the previous inner conflict and a potential encounter with the anxiety provoking situation. Such encounters have the potential to collapse the symbolizing space and threaten a return to concreteness and stuckness. This is why these cycles are ever present in the treatment. These regressive and organizing movements in the psyche are crucial in the process of structure building and psychic change.

Although the vision of process presented in this paper is akin to Freedman, Lasky, and Hurvitt's A and Z sessions, regresive and integrative cycles, this view introduces new refinement into the description of desymbolizing moments, by describing distinct modes of functioning that can be measured and observed through the analysis of written session transcripts, namely the disengaged, conflict and overexcited patterns. The most important finding of this study is the delineation of a fifth mode of functioning, the baseline pattern, which is where a significant amount of the interactions between the patient and her analyst as well as the narrative takes place.

What this study suggests is that for the analyst to stay in a productive space, in which he can simultaneously engage his thoughts (the view from without) and identify with the patient (the view from within), his way of listening and reacting to the patient's speech is contingent on the patient's psychic process as it fluctuates between the different states described. Each of these states present specific challenges to the analytic work and to the analyst, which deserve to be studied in further depth.

## V. Possibilities for Psychoanalytic Research

There is a growing awareness of the importance of more formal, empirical studies of psychoanalysis. There remains, however, some perhaps warranted skepticism about what such studies contribute beyond what can be learned through the traditional case study, already a powerful investigative tool but not one that can be replicated and systematically verified. This study of the case of Mrs. C. demonstrates that psychoanalytic case material can be studied in a formal, systematic manner. It illustrates that clinical impressions can be placed on a reliable, verifiable basis, and that clinical knowledge can be documented in a form that potentially allows replication.

In the current study, the analyst's communications were introduced as a variable of study in the context of the process described by the fluctuations of the patient's linguistic patterns. However, the empirical lens adopted in the study was able to differentiate distinct forms of mental organization and study their fluctuation without expecting linear behavioral progress and outcome which does not coincide with the way change comes about in psychoanalysis. In terms of the application of empirical research to psychoanalysis, it has generally been agreed upon that the most essential part of psychoanalysis is not its outcome but its process (Cooper, 1993; Wallerstein, 2001; Bucci, 2007). In psychoanalysis, the process is not a means to an end but a goal in itself. Therefore, fine grained studies of the treatment process that include multiple measures, such as the ones used in this study, applied to verbatim transcripts of psychoanalytic sessions enables the identification of specific features of treatment process that are essential for overall treatment effectiveness.

In the case of Mrs. C, this was achieved through systematic coding of the discourse

style of the patient and identifying different patterns of language which permit "reaching beneath the surface of the therapeutic interaction" (Bucci, 2007, pg. 21). Afterwards, it was possible to select parts of sessions found to be crucial for therapeutic process and outcome and apply a qualitative clinical analysis for an in depth understanding towards theoretical formulations. This is an ideal model for process-outcome methodology in psychoanalysis (Wallerstein, 2001, 2006). In an extensive review of methods employed in Social Sciences to study communicational patterns, Connor et al (2009) point out the limitations of only utilizing quantitative and statistical methods of analysis "No single statistical model can describe consultation processes realistically. Researchers therefore need to 'triangulate' on their hypothesis using different methods. Where satisfactory statistical methods are not available, qualitative methods have been advocated. While some quantitative researchers might consider these insufficiently rigorous, we have argued that the apparent precision of many quantitative methods is spurious" (p.176).

**VI. Limitations of this study.**

The results of this study point to a number of limitations and directions for future research. First, there is a basic limitation derived from the type of design used in this study, for practical reasons the methods used for the basis of the quantitative analysis process measures preceding and following the analyst's interventions were limited to the units that directly preceded and followed each intervention. As a consequence results appear as if speech at any point is a response to speech directly preceding it. Connor et al (2009) point out that this kind of analysis presents a conceptual limitation because the implicit assumption is hard to reconcile with the complexity of clinical communication,

in which a single utterance can carry multiple levels of information. In effect the constrains imposed by looking at adjacent speech also differs from the idea proposed that in fact analytic process is not a linear function but a series of oscillations that progressively evolve in terms of complexity and level of organization. Not only does change not occur in a linear way but the complexity of the interaction supersedes what can be captured in the fluctuations of the turn by turn exchange. One of the lessons that we learned from the qualitative analysis is that the totality of the session is more than the sum of its parts. As a consequence this study was not able to consider the impact of any given intervention over time, but instead was limited by a design that only took into account the patient's preceding state and immediate response in the ensuing idea unit to explore the effect of the analyst's speech acts. The limitations in the design did not follow the possibility of any rippling effect in the idea units that followed the analyst's speech acts for the rest of the session or over the same material in subsequent sessions. One way to deal with the limitations imposed when looking at adjacent units of communication is to explore a wider range of impact in communicational sequences as proposed by Connnor et al (2009) who suggest sequential analysis of units, as well as the selection of target responses to be tracked over time.

As suggested the search for change across interventions may be a more fruitful way to examine the symbolizing and referential cycles described with the process measures utilized in this study. It is also possible that additional measures of process to the ones used in this study may augment our understanding of the ways verbal interventions affect the patient's work, especially those that address content, an area largely untouched in this study.

One way of tracking the effects of a single intervention over time would require a shift to content and to time series analysis. Sharir (1991) developed a formula for the time series analysis of the effects of emotions on the patient's discourse. Sampling defenses in 2-minute units, she assessed the effects of identified emotions in subsequent time units and over ten minutes. She found effects in the subsequent two sampling units, but none thereafter. Her subjects were 26 inpatients diagnosed with Axis II disorders presenting with a wide range of problems who were assigned randomly to two variants of video taped short term dynamic psychotherapy, both of which confrontation to focus affect or cognition, very different techniques from classical analysis. This approach could be adapted using the process measures used in this study but including more refined criteria for the analyst interventions and a method that allowed tracking the salient elements of the interventions along time. Measures to evaluate theme changes after verbal interventions include Lang's Theme, Dahl's FRAMES, with emotion scoring and Luborsky's CCRT, among others.

Follow up studies should attempt to find ways to include greater discrimination on the quality of the analyst communications. Primarily including the constituent elements of symbolization as proposed by Freedman (2003). The interesting question is to assess whether interventions that introduce any or all of these dimensions have a differential effect on the patient's speech patterns. In addition to these important elements tracking the therapeutic alliance, and the analyst's stance as it can be captured through the interactions are important avenues for future inquiry.

The creation of theme units to compute RA and Repetition measures was introduced in this study for two reasons: firstly, it facilitated localizing the units where

the analyst intervened, and secondly because it was a more consistent approach with the stated purpose of exploring the patient-analyst interactions in comparison to the fixed word units employed by Halfon and Weinstein (2013) in their study. However, the impact that these units have on the fluctuations recorded by these measures within each session was not tested. It is conceivable that different units could create a difference in the graphic representation of the session and that these variations could yield different results in the comparison of the data. This is a question that should be taken into account for future studies, since at the present time there is no standard way to use these process-coding systems, and no norms exist on any of these measures.

In terms of addressing the question of how the relational patterns evolve over time between the analyst and his patient, an interesting avenue of study is to track the fluctuations of rhythm created by the different speech patterns in terms of the duration and frequency of cycles. An interesting variable to look at would be to study whether certain patterns are more prevalent at different times in the treatment, i.e. is the patient capable of entering a symbolizing space with greater frequency in the later phases of treatment? or alternatively: if there is a history of trauma is there evidence of greater use of the High RA/ High Repetition mode of functioning?, and if so, are there changes over time in how this presents itself?

Another important limitation in this study is that of the generalizability of the results. Even though longitudinal studies of single cases are ideal to study the psychoanalytic process in depth, there is an issue with generalizing from a single case. An improved methodology would be based on a repeated single case design, involving relatively large sample of treatments for adequate comparison.

The second area of concern with the data set is its small size. Ten sessions were appropriate for en exploratory study such as this one, but not sufficient to represent the patient's process and progression over time. In order to compare the different phases of the treatment a larger number of sessions from each period is needed, an N=2 from each particular time period presents great limitations. Most of the findings in this study concerning the evolution of the treatment could not be tested adequately. The real value of this study is the approach developed for assessing important and relevant questions about the communication of the analytic dyad and in the further refinements for coding suggested from the qualitative analysis. A larger sampling of sessions is also an important recommendation for future studies aiming to understand the variations of the process over time.

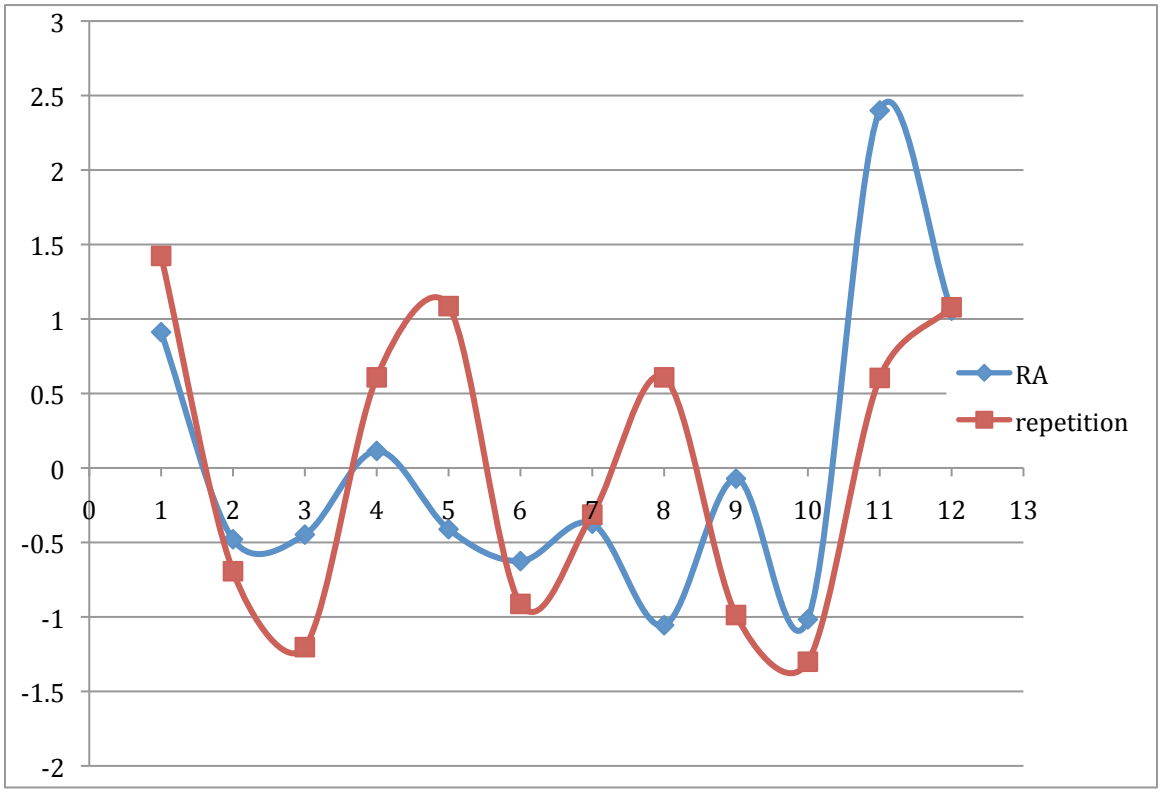
Given the small sample sizes, and the limited ability to generalize findings (both within these treatments and across to others), this study sought not to decisively settle the score in the ongoing debate over technical questions; rather, it was hoped that empirical tools could be used to deepen our understanding of salient forces within a small slice of the treatment, giving us clues about where to look more closely and raise new lines of inquiry. Examining the micro-processes within individual sessions offers the means by which to identify active processes of change, and propose new perspectives that may be applied to clinicians' own work.

Though unable to generalize the results, overall, to the treatment under study, or to other similar treatments, this empirical approach has provided pointed descriptions of the inner-workings of the analytic process. Of great value, have been the microanalyses from which these general descriptive observations were derived. This study has taken a

step in bringing an empirical eye to the mix of controversy around questions of technique in psychoanalysis. New technologies have enabled viewing the linguistic process with moment-to-moment specificity, observing the progression within sessions in a clinically meaningful and empirically supported way. We now have new insight into the way the process evolves in terms of the fluctuations in speech patterns, and the way the analyst's speech acts interface with this process in ways that are more or less helpful. Analysts now potentially have an objective resource to inform their clinical opinions about what sense to make of these sometimes perplexing moments and what to do (or not do) about them.

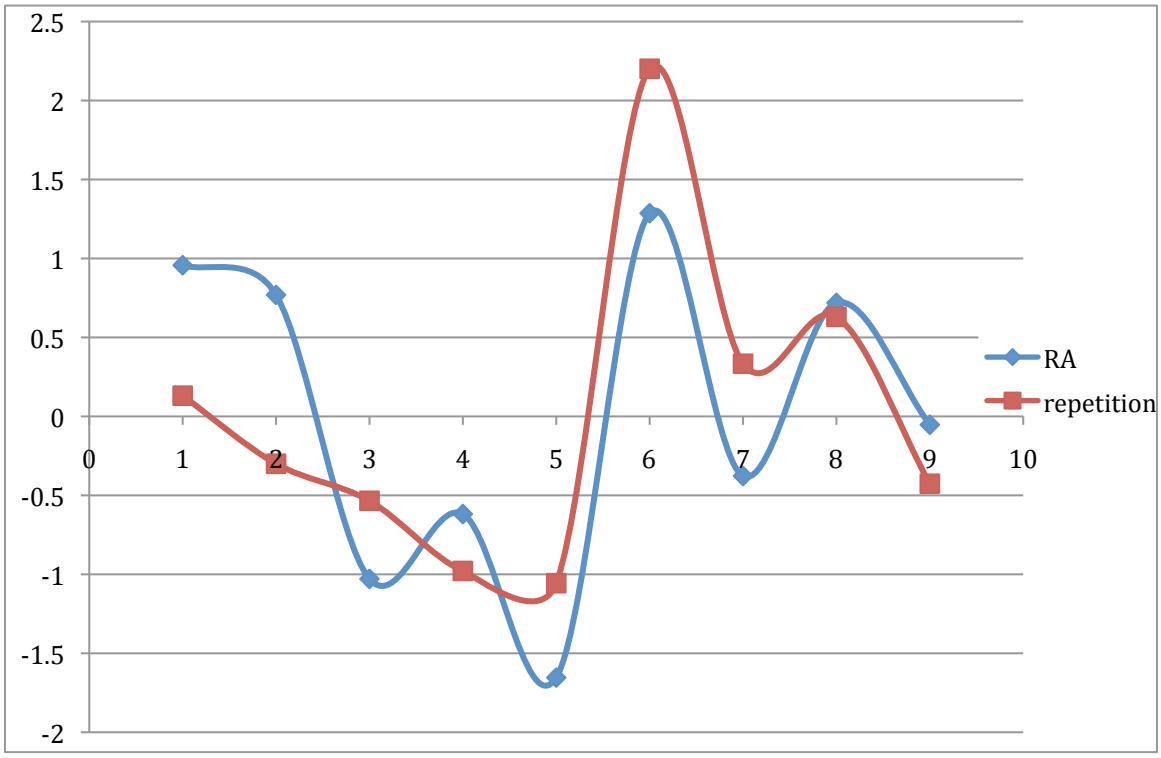
## Appendix

Figure A.1 Session 91 Graph



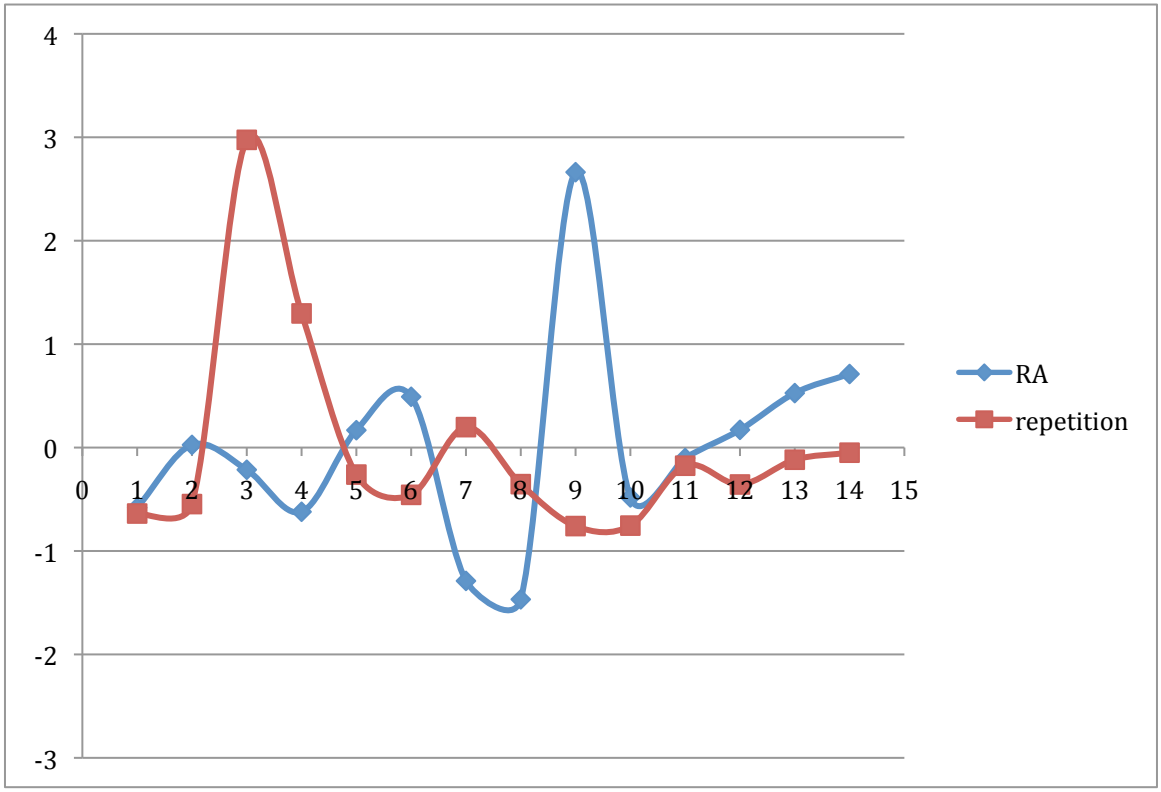

| UnitID | VerbCount | Repetitions | Weighted repetitions | Z-score (mean:0.8397 std:0.6089) | RA | zRA |
|---|---|---|---|---|---|---|
| 1 | 65 | 11 | 1.7064 | 1.4236 | 0.489475389 | 0.911740427 |
| 2 | 25 | 7 | 0.4177 | -0.6932 | 0.393158784 | 0.478812861 |
| 3 | 15 | 3 | 0.1074 | -1.2028 | 0.395331325 | 0.447447192 |
| 4 | 39 | 13 | 1.2100 | 0.6082 | 0.434253247 | 0.114480899 |
| 5 | 37 | 17 | 1.5012 | 1.0865 | 0.397829341 | 0.411382545 |
| 6 | 17 | 7 | 0.2840 | -0.9127 | 0.383027523 | 0.625081078 |
| 7 | 34 | 8 | 0.6492 | -0.3129 | 0.400378788 | 0.374575378 |
| 8 | 39 | 13 | 1.2100 | 0.6082 | 0.353197674 | 1.055744036 |
| 9 | 25 | 4 | 0.2387 | -0.9872 | 0.421348315 | 0.071831689 |
| 10 | 20 | 1 | 0.0477 | -1.3008 | 0.355902778 | 1.016689603 |
| 11 | 46 | 11 | 1.2076 | 0.6043 | 0.59252669 | 2.399524664 |
| 12 | 57 | 11 | 1.4964 | 1.0786 | 0.499454942 | 1.055818393 |

Figure A.2. Session 92 Graph



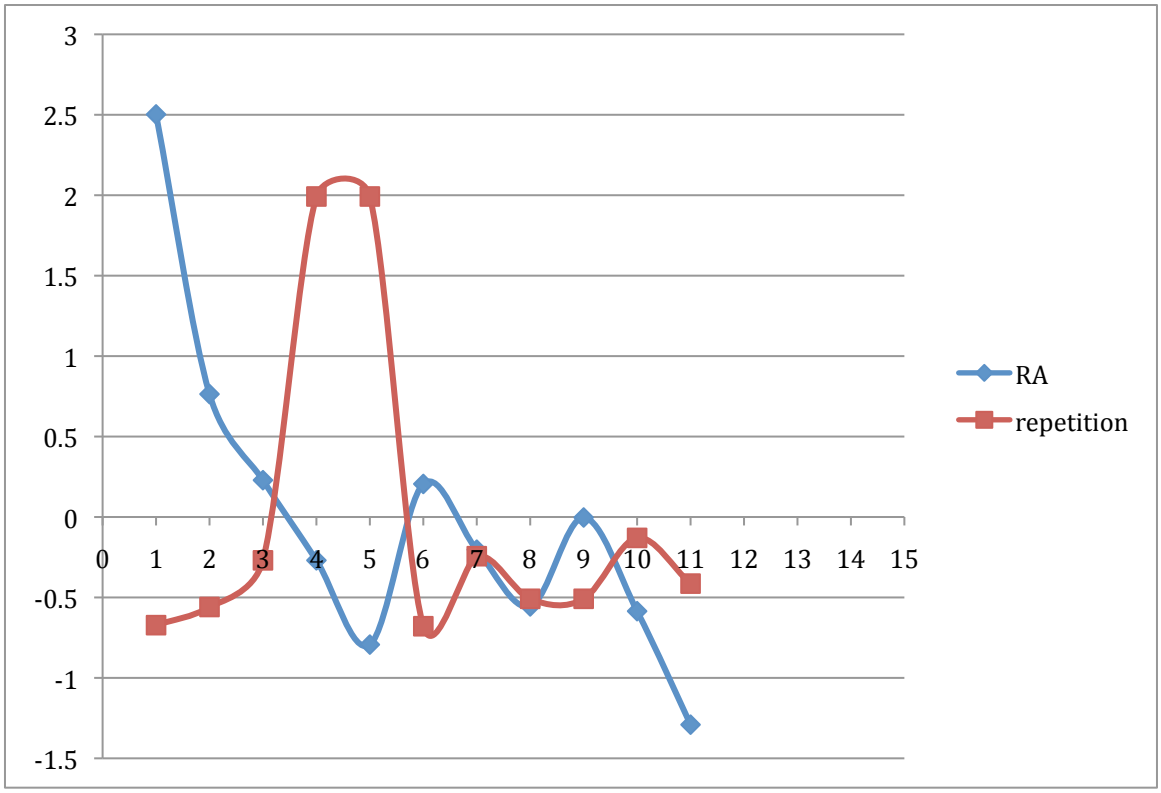

| UnitID | VerbCount | Repetitions | Weighted repetitions | Z-score (mean:1.5533 std:1.3634) | RA | zRA |
|---|---|---|---|---|---|---|
| 1 | 56 | 12 | 1.7320 | 0.1311 | 0.462628866 | 0.957129839 |
| 2 | 37 | 12 | 1.1443 | -0.2999 | 0.453417603 | 0.76917813 |
| 3 | 32 | 10 | 0.8247 | -0.5343 | 0.365295031 | 1.028923606 |
| 4 | 17 | 5 | 0.2191 | -0.9786 | 0.385416667 | 0.618350615 |
| 5 | 11 | 4 | 0.1134 | -1.0561 | 0.334677419 | 1.653662303 |
| 6 | 93 | 19 | 4.5541 | 2.2010 | 0.478763204 | 1.286343807 |
| 7 | 41 | 19 | 2.0077 | 0.3333 | 0.397212544 | 0.377661014 |
| 8 | 72 | 13 | 2.4124 | 0.6301 | 0.450943936 | 0.718704058 |
| 9 | 29 | 13 | 0.9716 | -0.4266 | 0.413135593 | 0.052758295 |

Figure A.3. Session 259 Graph



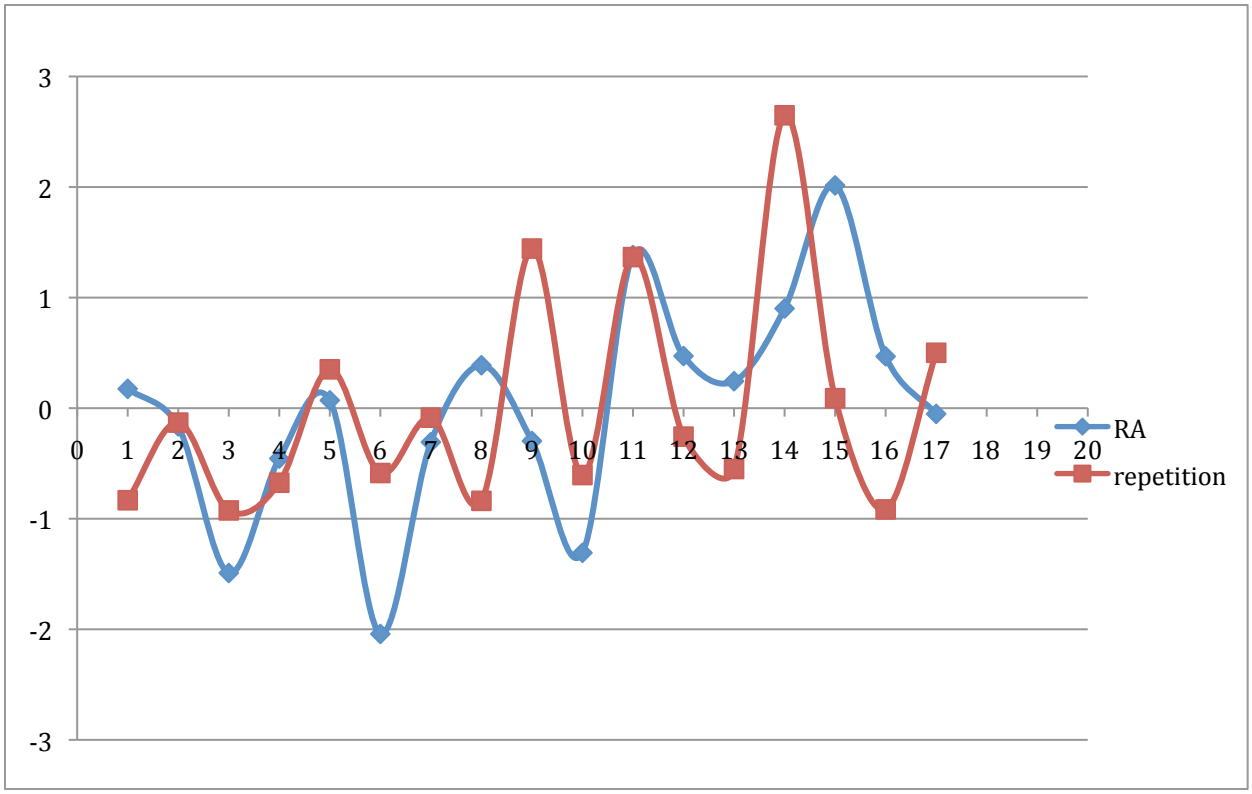

| UnitID | VerbCount | Repetitions | Weighted repetitions | Z-score (mean:1.1285 std:1.4321) | RA | zRA |
|---|---|---|---|---|---|---|
| 1 | 27 | 5 | 0.2153 | -0.6377 | 0.393072289 | 0.580972329 |
| 2 | 31 | 7 | 0.3461 | -0.5463 | 0.419811321 | 0.025958249 |
| 3 | 109 | 31 | 5.3892 | 2.9752 | 0.409221311 | 0.214416965 |
| 4 | 72 | 26 | 2.9856 | 1.2968 | 0.391319444 | 0.620758925 |
| 5 | 43 | 11 | 0.7544 | -0.2612 | 0.426067073 | 0.167953198 |
| 6 | 33 | 9 | 0.4737 | -0.4573 | 0.440304487 | 0.491118301 |
| 7 | 59 | 15 | 1.4115 | 0.1976 | 0.361865942 | 1.289303377 |
| 8 | 30 | 13 | 0.6220 | -0.3537 | 0.354014599 | 1.467515532 |
| 9 | 26 | 1 | 0.0415 | -0.7591 | 0.535971223 | 2.662590631 |
| 10 | 10 | 3 | 0.0478 | -0.7546 | 0.39740566 | 0.482612166 |
| 11 | 50 | 11 | 0.8772 | -0.1755 | 0.414202509 | 0.101352247 |
| 12 | 43 | 9 | 0.6172 | -0.3570 | 0.426219512 | 0.171413305 |
| 13 | 43 | 14 | 0.9601 | -0.1176 | 0.441872428 | 0.526707893 |
| 14 | 51 | 13 | 1.0574 | -0.0496 | 0.45 | 0.711189966 |

Figure A.4. Session 260 Graph



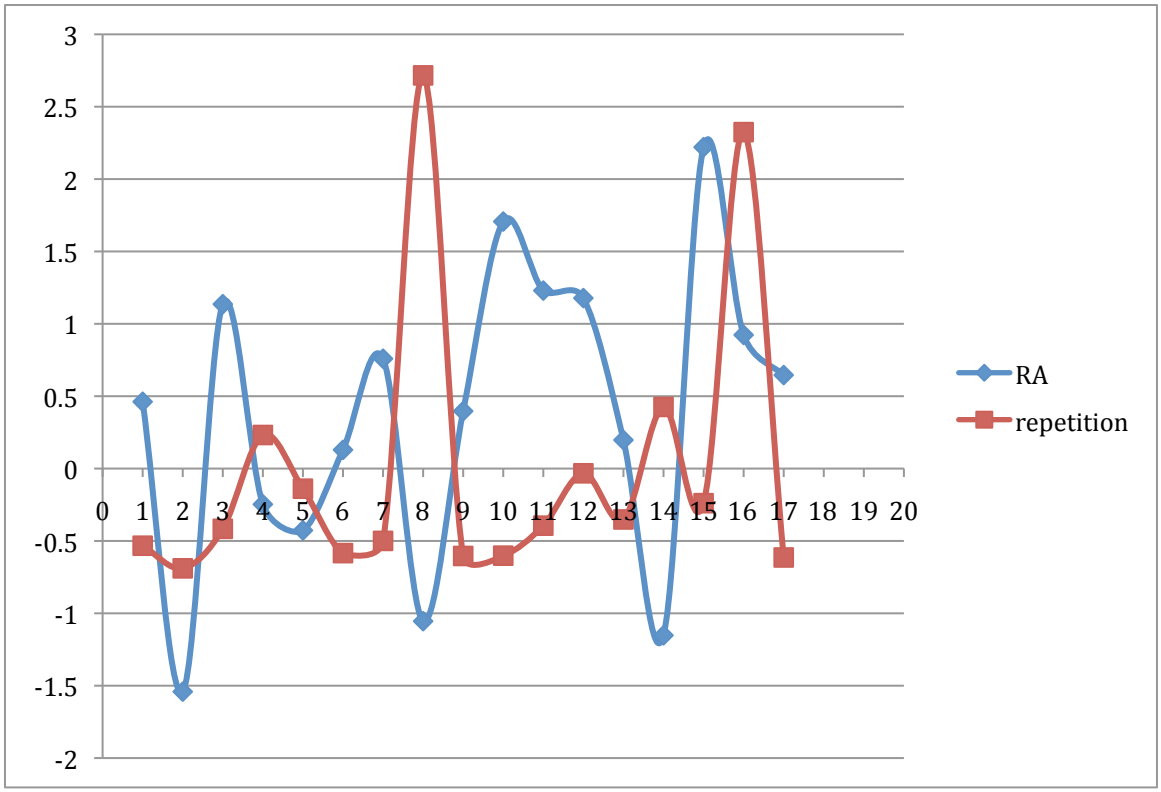

| UnitID | VerbCount | Repetitions | Weighted repetitions | Z-score (mean:1.5489 std:2.1685) | RA | zRA |
|---|---|---|---|---|---|---|
| 1 | 19 | 3 | 0.0912 | -0.6722 | 0.460553279 | 2.50232482 |
| 2 | 42 | 5 | 0.3360 | -0.5594 | 0.412176724 | 0.763901002 |
| 3 | 67 | 9 | 0.9648 | -0.2694 | 0.397285523 | 0.228781886 |
| 4 | 131 | 28 | 5.8688 | 1.9921 | 0.383421986 | 0.269407848 |
| 5 | 131 | 28 | 5.8688 | 1.9921 | 0.368850806 | 0.793026893 |
| 6 | 12 | 4 | 0.0768 | -0.6789 | 0.396634615 | 0.205391363 |
| 7 | 58 | 11 | 1.0208 | -0.2436 | 0.385270979 | 0.202963806 |
| 8 | 31 | 9 | 0.4464 | -0.5084 | 0.375452899 | -0.55577903 |
| 9 | 31 | 9 | 0.4464 | -0.5084 | 0.390833333 | 0.003079186 |
| 10 | 66 | 12 | 1.2672 | -0.1299 | 0.37462908 | 0.585383156 |
| 11 | 37 | 11 | 0.6512 | -0.4140 | 0.355 | 1.290759153 |

Figure A.5. Session 431 Graph



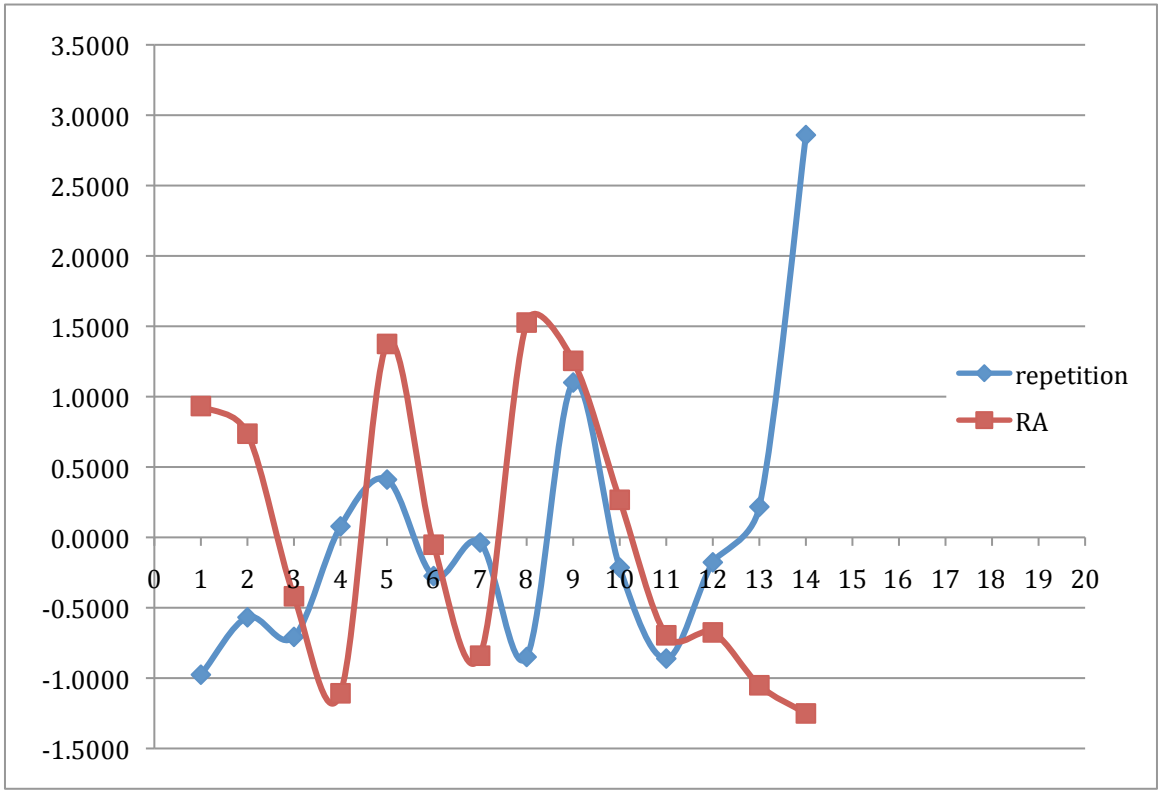

| UnitID | VerbCount | Repetitions | Weighted repetitions | Z-score (mean:1.3032 std:1.2755) | RA | zRA |
|---|---|---|---|---|---|---|
| 1 | 25 | 10 | 0.2408 | -0.8329 | 0.447674419 | 0.17467763 |
| 2 | 59 | 20 | 1.1368 | -0.1304 | 0.431469298 | 0.164886758 |
| 3 | 32 | 4 | 0.1233 | -0.9250 | 0.368189103 | 1.490868946 |
| 4 | 46 | 10 | 0.4432 | -0.6743 | 0.417594178 | 0.455627992 |
| 5 | 101 | 18 | 1.7514 | 0.3514 | 0.442717996 | 0.070820055 |
| 6 | 36 | 16 | 0.5549 | -0.5866 | 0.34187788 | 2.042198029 |
| 7 | 59 | 21 | 1.1936 | -0.0859 | 0.4246673 | 0.307416785 |
| 8 | 27 | 9 | 0.2341 | -0.8381 | 0.457859848 | 0.388104572 |
| 9 | 96 | 34 | 3.1445 | 1.4436 | 0.42517762 | 0.296723478 |
| 10 | 46 | 12 | 0.5318 | -0.6048 | 0.37691048 | -1.30811996 |
| 11 | 102 | 31 | 3.0462 | 1.3665 | 0.505412371 | 1.38452687 |
| 12 | 46 | 22 | 0.9750 | -0.2573 | 0.461838942 | 0.471483068 |
| 13 | 52 | 12 | 0.6012 | -0.5504 | 0.450969828 | 0.243730097 |
| 14 | 135 | 36 | 4.6821 | 2.6490 | 0.482344633 | 0.901162211 |
| 15 | 64 | 23 | 1.4181 | 0.0901 | 0.535488959 | 2.014755954 |
| 16 | 28 | 5 | 0.1349 | -0.9159 | 0.461693548 | 0.468436463 |
| 17 | 84 | 24 | 1.9422 | 0.5010 | 0.436863544 | 0.051854972 |

Figure A.6. Session 432 Graph



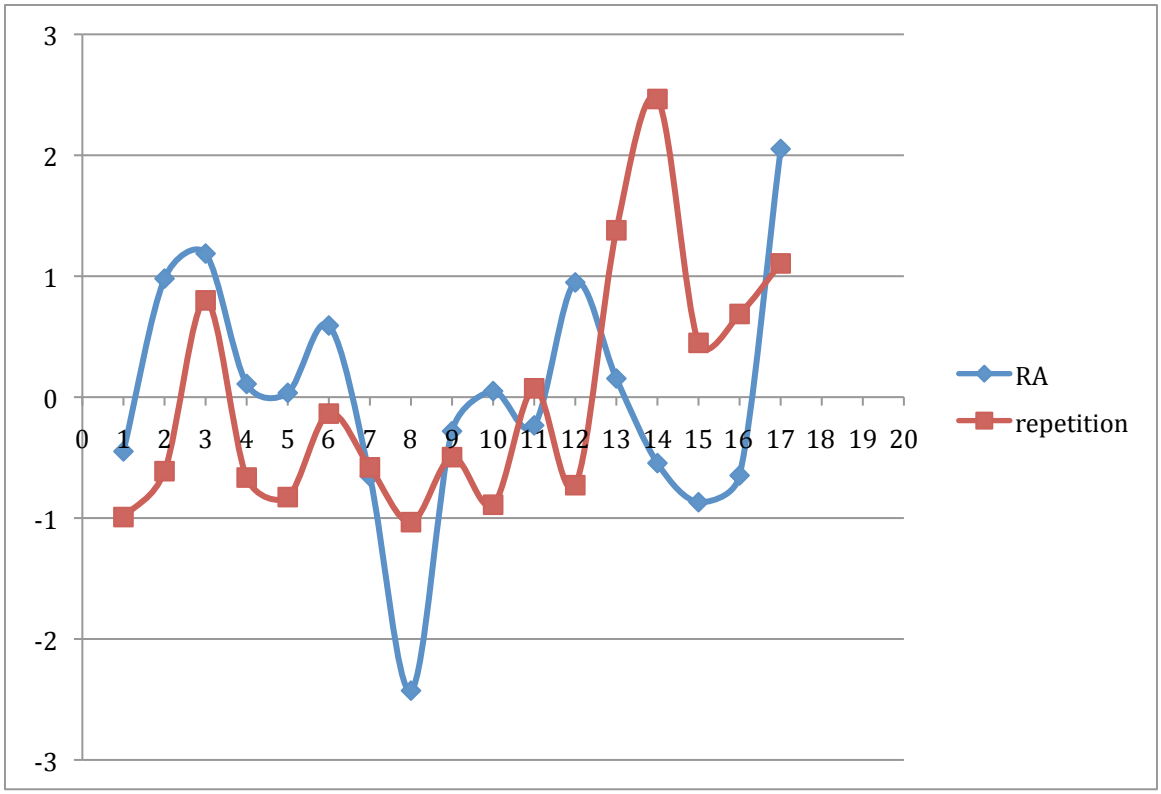

| UnitID | VerbCount | Repetitions | Weighted repetitions | Z-score (mean:0.8589 std:1.2132) | RA | zRA |
|---|---|---|---|---|---|---|
| 1 | 28 | 6 | 0.2124 | -0.5329 | 0.426209677 | 0.461810595 |
| 2 | 9 | 2 | 0.0228 | -0.6892 | 0.349184783 | 1.541188498 |
| 3 | 35 | 8 | 0.3540 | -0.4162 | 0.434065934 | 1.135790654 |
| 4 | 82 | 11 | 1.1403 | 0.2320 | 0.390222482 | 0.246942779 |
| 5 | 39 | 14 | 0.6903 | -0.1390 | 0.38451087 | 0.427075451 |
| 6 | 17 | 7 | 0.1504 | -0.5840 | 0.402151639 | 0.129278605 |
| 7 | 40 | 5 | 0.2528 | -0.4996 | 0.422121451 | 0.759085917 |
| 8 | 106 | 31 | 4.1542 | 2.7163 | 0.364620536 | -1.05437619 |
| 9 | 25 | 4 | 0.1264 | -0.6038 | 0.410640496 | 0.396999902 |
| 10 | 17 | 6 | 0.1290 | -0.6017 | 0.452168367 | 1.70670464 |
| 11 | 43 | 7 | 0.3805 | -0.3943 | 0.437045455 | 1.229758679 |
| 12 | 72 | 9 | 0.8192 | -0.0327 | 0.43539916 | 1.177837882 |
| 13 | 38 | 9 | 0.4324 | -0.3516 | 0.40430622 | 0.197229707 |
| 14 | 68 | 16 | 1.3755 | 0.4258 | 0.361519608 | 1.152173158 |
| 15 | 45 | 10 | 0.5689 | -0.2391 | 0.468455189 | 2.220357912 |
| 16 | 97 | 30 | 3.6789 | 2.3245 | 0.427325581 | 0.923213618 |
| 17 | 30 | 3 | 0.1138 | -0.6142 | 0.418534483 | 0.645960219 |

Figure A.7. Session 627 Graph



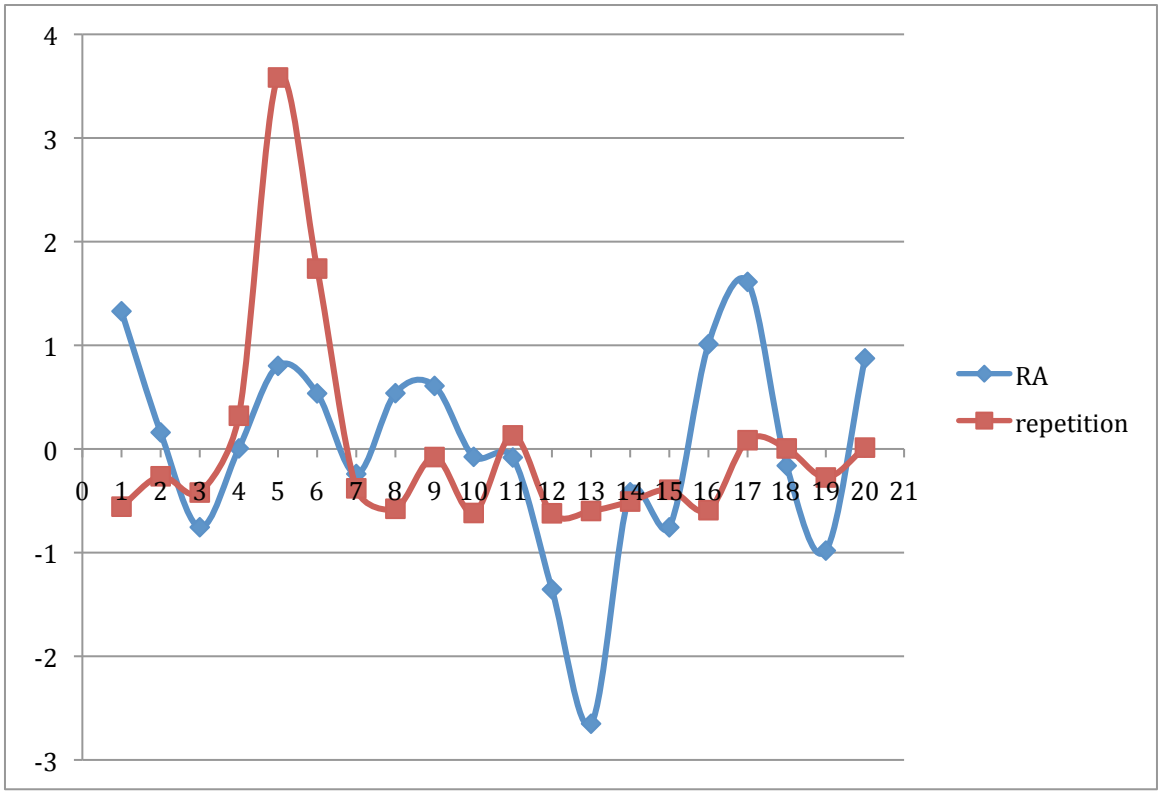

| UnitID | VerbCount | Repetitions | Weighted repetitions | Z-score (mean:0.9629 std:0.8342) | RA | ZRA |
|---|---|---|---|---|---|---|
| 1 | 19 | 5 | 0.1489 | -0.9758 | 0.454826733 | 0.933221796 |
| 2 | 39 | 8 | 0.4890 | -0.5681 | 0.447062842 | 0.736730728 |
| 3 | 34 | 7 | 0.3730 | -0.7071 | 0.40141369 | 0.418572752 |
| 4 | 41 | 16 | 1.0282 | 0.0782 | 0.374177632 | -1.10787174 |
| 5 | 49 | 17 | 1.3056 | 0.4108 | 0.472263314 | 1.374512426 |
| 6 | 36 | 13 | 0.7335 | -0.2750 | 0.415890957 | 0.052177397 |
| 7 | 35 | 17 | 0.9326 | -0.0364 | 0.384735202 | 0.840677321 |
| 8 | 27 | 6 | 0.2539 | -0.8499 | 0.478268194 | 1.526485883 |
| 9 | 80 | 15 | 1.8809 | 1.1003 | 0.467519685 | 1.25445914 |
| 10 | 50 | 10 | 0.7837 | -0.2149 | 0.428503788 | 0.267032195 |
| 11 | 26 | 6 | 0.2445 | -0.8612 | 0.390460526 | 0.695778973 |
| 12 | 40 | 13 | 0.8150 | -0.1773 | 0.391267123 | 0.675365356 |
| 13 | 73 | 10 | 1.1442 | 0.2173 | 0.376428571 | 1.050904226 |
| 14 | 89 | 24 | 3.3480 | 2.8590 | 0.368518519 | 1.251094404 |

Figure A.8. Session 628 Graph



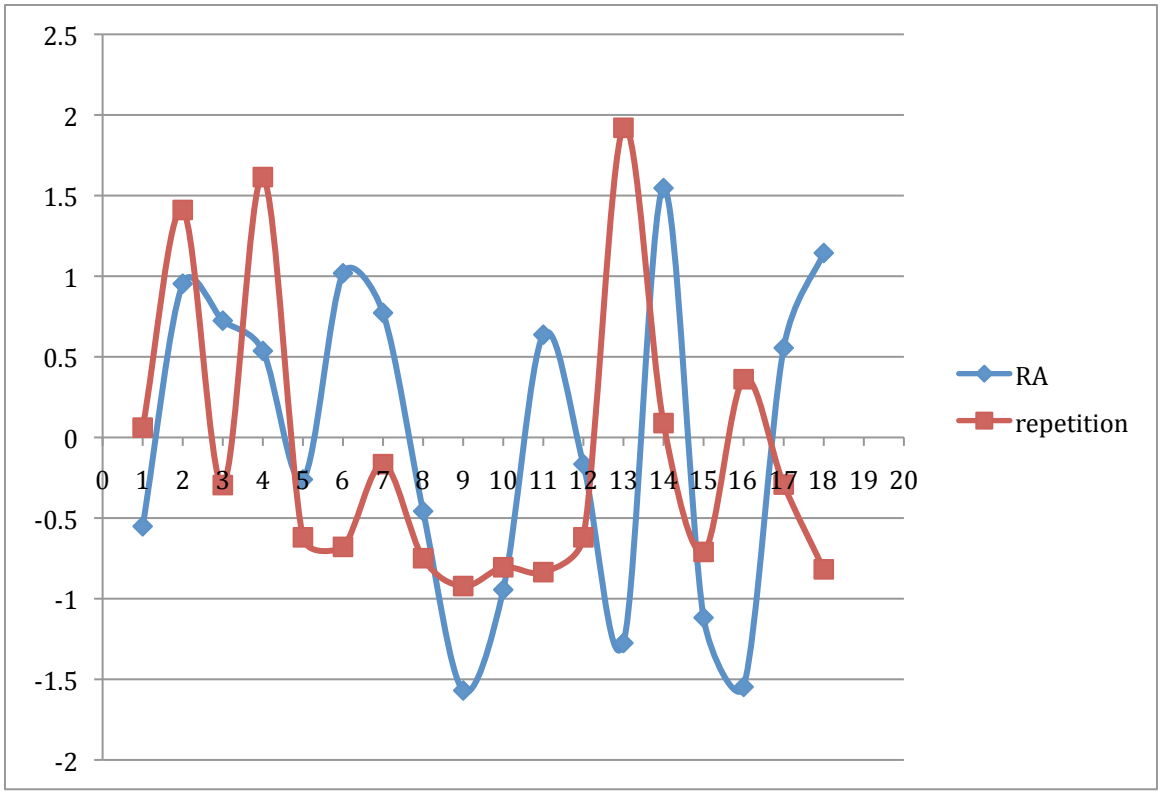

| UnitID | VerbCount | Repetitions | Weighted repetitions | Z-score (mean:0.8257 std:0.7907) | RA | zRA |
|---|---|---|---|---|---|---|
| 1 | 15 | 2 | 0.0417 | -0.9917 | 0.38671875 | 0.448594272 |
| 2 | 41 | 6 | 0.3417 | -0.6122 | 0.448673184 | 0.980135102 |
| 3 | 75 | 14 | 1.4583 | 0.8001 | 0.457649254 | 1.187131972 |
| 4 | 27 | 8 | 0.3000 | -0.6649 | 0.410904255 | 0.109146949 |
| 5 | 31 | 4 | 0.1722 | -0.8265 | 0.407703488 | 0.035334157 |
| 6 | 47 | 11 | 0.7181 | -0.1362 | 0.43185241 | 0.592231715 |
| 7 | 33 | 8 | 0.3667 | -0.5806 | 0.377737226 | 0.655716925 |
| 8 | 6 | 1 | 0.0083 | -1.0338 | 0.300925926 | 2.427060046 |
| 9 | 26 | 12 | 0.4333 | -0.4963 | 0.393973214 | 0.281299286 |
| 10 | 22 | 4 | 0.1222 | -0.8898 | 0.408333333 | 0.049858993 |
| 11 | 53 | 12 | 0.8833 | 0.0728 | 0.396039604 | 0.233646335 |
| 12 | 30 | 6 | 0.2500 | -0.7282 | 0.447303922 | 0.948558574 |
| 13 | 60 | 23 | 1.9167 | 1.3798 | 0.412846021 | 0.153925944 |
| 14 | 74 | 27 | 2.7750 | 2.4653 | 0.382506127 | 0.545741436 |
| 15 | 50 | 17 | 1.1806 | 0.4488 | 0.368489583 | 0.868976545 |
| 16 | 58 | 17 | 1.3694 | 0.6877 | 0.37808642 | 0.647664184 |
| 17 | 72 | 17 | 1.7000 | 1.1057 | 0.495169082 | 2.052375623 |

Figure A.9. Session 1000 Graph




| UnitID | VerbCount | Repetitions | Weighted repetitions | Z-score (mean:0.7785 td:1.2487) | RA | zRA |
|---|---|---|---|---|---|---|
| 1 | 23 | 3 | 0.0833 | -0.5567 | 0.481985294 | 1.328513274 |
| 2 | 31 | 12 | 0.4493 | -0.2637 | 0.412946429 | 0.15953111 |
| 3 | 30 | 7 | 0.2536 | -0.4203 | 0.358940972 | 0.754901865 |
| 4 | 61 | 16 | 1.1787 | 0.3205 | 0.403846154 | 0.005443138 |
| 5 | 150 | 29 | 5.2536 | 3.5838 | 0.450880984 | 0.801847846 |
| 6 | 94 | 26 | 2.9517 | 1.7403 | 0.435185185 | 0.536082921 |
| 7 | 28 | 9 | 0.3043 | -0.3797 | 0.389271654 | 0.241335699 |
| 8 | 12 | 4 | 0.0580 | -0.5770 | 0.435307018 | 0.538145815 |
| 9 | 47 | 12 | 0.6812 | -0.0780 | 0.439453125 | 0.608348673 |
| 10 | 6 | 1 | 0.0072 | -0.6176 | 0.399038462 | 0.075961829 |
| 11 | 52 | 15 | 0.9420 | 0.1310 | 0.398660714 | 0.082357934 |
| 12 | 3 | 1 | 0.0036 | -0.6205 | 0.323529412 | -1.35449866 |
| 13 | 13 | 2 | 0.0314 | -0.5983 | 0.246975806 | 2.650722149 |
| 14 | 24 | 5 | 0.1449 | -0.5074 | 0.378865979 | 0.417526999 |
| 15 | 34 | 7 | 0.2874 | -0.3933 | 0.358870968 | 0.756087197 |
| 16 | 17 | 2 | 0.0411 | -0.5906 | 0.463235294 | 1.011033903 |
| 17 | 61 | 12 | 0.8841 | 0.0845 | 0.498721228 | 1.611890001 |
| 18 | 65 | 10 | 0.7850 | 0.0052 | 0.394012945 | 0.161055047 |
| 19 | 30 | 12 | 0.4348 | -0.2753 | 0.345615672 | -0.98052896 |
| 20 | 47 | 14 | 0.7947 | 0.0130 | 0.455150463 | 0.874139658 |

Figure A.10. Session 1001 Graph




| UnitID | VerbCount | Repetitions | Weighted repetitions | Z-score (mean:0.8683 std:0.9421) | RA | zRA |
|---|---|---|---|---|---|---|
| 1 | 70 | 13 | 0.9257 | 0.0609 | 0.367140719 | 0.551174685 |
| 2 | 90 | 24 | 2.1974 | 1.4107 | 0.449709302 | 0.953523554 |
| 3 | 58 | 10 | 0.5900 | -0.2954 | 0.437131268 | 0.724306283 |
| 4 | 87 | 27 | 2.3896 | 1.6147 | 0.426835317 | 0.536676816 |
| 5 | 56 | 5 | 0.2848 | -0.6193 | 0.383098007 | -0.26037518 |
| 6 | 45 | 5 | 0.2289 | -0.6787 | 0.453254132 | 1.018123176 |
| 7 | 50 | 14 | 0.7121 | -0.1658 | 0.439777328 | 0.772527057 |
| 8 | 32 | 5 | 0.1628 | -0.7489 | 0.372282609 | 0.457470849 |
| 9 | 9 | 0 | 0.0000 | -0.9217 | 0.31127451 | 1.569259071 |
| 10 | 18 | 6 | 0.1099 | -0.8051 | 0.345552885 | -0.9445831 |
| 11 | 16 | 5 | 0.0814 | -0.8353 | 0.432352941 | 0.637227877 |
| 12 | 40 | 7 | 0.2848 | -0.6193 | 0.38829023 | 0.165754093 |
| 13 | 94 | 28 | 2.6775 | 1.9203 | 0.327433628 | 1.274781486 |
| 14 | 52 | 18 | 0.9522 | 0.0890 | 0.48225 | 1.546532762 |
| 15 | 28 | 7 | 0.1994 | -0.7100 | 0.336057692 | 1.117619847 |
| 16 | 66 | 18 | 1.2085 | 0.3611 | 0.3125 | 1.546926207 |
| 17 | 53 | 11 | 0.5931 | -0.2922 | 0.42784749 | 0.555122267 |
| 18 | 24 | 4 | 0.0977 | -0.8180 | 0.46015625 | 1.143904726 |

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