CAN WE LEARN ON PSYCHOTHERAPEUTIC PROCESS DIMENSIONS WITH SINGLE CASE STUDY?

A Comprehensive Model of Change Processes Integrating Qualitative & Quantitative Methods derived from a case under Psychoanalytic Psychotherapy[1]

¿PODEMOS APRENDER SOBRE LAS DIMENSIONES DEL PROCESO PSICOTERAPÉUTICO CON UN ESTUDIO DE CASO ÚNICO?

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Abstract

Relational psychoanalysis states that an adequate management of the intersubjective processes displayed in psychotherapy are essential to promote effective change. ***Previous*** *research showed that the analysis of variables of the therapist and patient and the complex and co-determined interaction between them, give us new perspectives on the therapeutic process.*

Aims: To describe a single case psychotherapy process and to develop some inferences on therapeutic process along the whole treatment and their phases by means of a variety of classical and new research tools, studying the capacity of those methods to grasp the process of change with single case study. This analysis leads us to question some topics and consider from a new view the therapist's functions and the patient's roles within the therapeutic process. A group of researchers in Spain, Argentine, Mexico and Germany have worked along a decade (1997-2008) in the Salamanca-Barcelona-Madrid Project on Psychotherapy Process Research (SMBP; Ávila-Espada et al., 1998a; Ávila-Espada et al., 2002). This project, an study conducting single case research (´The Publicist´ case), along the main phases of complete treatment (up to 200 recorded sessions), have given us the opportunity to adquire a better knowledge on therapeutic process, through the content analysis of sessions and with qualitative data using a variety of procedures, suchs us Jones´ PQS (Jones, 1985, 2000, 2001) and Emotion & Abstraction Cycles Model (Mergenthaler, 1996); Emotion schemas through FRAMES method (Dahl, 1988; Dahl and Teller, 1994; Dahl et al., 1992); CCRT and CCRT-LU-S Patterns (Albani et al., 2002; López del Hoyo et al., 2004; Luborsky, 1977), and new methods (TLAP: Therapist Latent Action Plan Method, Ávila-Espada and Mitjavila, 2001, 2003), between others. 1) Emotional tone decreases along the successive periods of sessions, with a more clear reduction in Negative Emotion; 2) A clear increase in Abstraction appears from the first to second half of the treatment, more pronounced at the final phase; 3) CRA level do not differ across the phases of the treatment; 4) Adherence to classical technique style is higher at the initial phase than by Advanced phase; 5) Affirmative Style is related to promote working alliance in the first half of the treatment, whereas Directive Style is related to maintenance of working alliance in the second half of the treatment; 6) Higher cognitive implication of the patient can be predicted by higher CRA in the patient and lower presence of Countertransference enactments or positive affects of the therapist; 7) Neutral focal style of the therapist can be predicted by Affirmative Style; and 8) Lower negative emotion of the patient predicts Working Alliance. Crossing all the studied dimensions, we can propose a comprehensive model of change observed in the case object of study, considering all the approaches, both from quantitative and qualitative methods and process dimensions, both the contributions of the therapist and the patient to psychotherapeutic process. Results are discussed in the light of recent perspectives on active use of counter-transference as a therapist's tool to improve the psychoanalytic psychotherapy process, controlling negative aspects of countertransference collusions.

Keywords: *Therapist's variables, psychotherapy process dimensions, therapist's latent action plan (TLAP), PQS, emotion & abstraction cycles model, therapeutic change models*

Resumen

El psicoanálisis relacional afirma que un manejo adecuado de los procesos intersubjetivos desplegados en la psicoterapia es fundamental para promover un cambio efectivo. El análisis sobre algunas variables del terapeuta y el paciente y la interacción compleja y codeterminada entre ellas, nos brindan nuevas perspectivas sobre el proceso terapéutico. Este análisis nos lleva a cuestionar algunos temas y considerar desde una nueva mirada las funciones del terapeuta y los roles del paciente dentro del proceso terapéutico. Un grupo de investigadores de España, Argentina, México y Alemania han trabajado durante una década (1997-2008) en el Proyecto Salamanca-Barcelona-Madrid de Investigación en Procesos de la Psicoterapia (SMBP; Ávila-Espada et al., 1998a; 2002). Este proyecto, un estudio de investigación de caso único (sobre el caso de la Publicista), a lo largo de las principales fases del tratamiento completo (hasta 200 sesiones grabadas), nos ha brindado la oportunidad de adquirir un mejor conocimiento del proceso terapéutico, a través del análisis de contenido de sesiones y con datos cualitativos utilizando una variedad de procedimientos, como el PQS de Jones (Jones, 1985, 2000, 2001) y el Modelo de Ciclos de Emoción y Abstracción (Mergenthaler, 1996); Los Esquemas emocionales mediante el método FRAMES (Dahl, 1988; Dahl et al., 1992; Dahl y Teller, 1994); Patrones CCRT y CCRT-LU-S (Luborsky, 1977; Albani et al., 2002; López del Hoyo et al, 2004), y métodos nuevos (TLAP: Método del Plan de Acción Latente del Terapeita, Ávila-Espada y Mitjavila, 2001, 2003), entre otros. En este trabajo presentamos resultados relevantes y algunas inferencias sobre el proceso terapéutico derivadas principalmente de las dimensiones PQS y TLAP y sus correlaciones con palabras de emoción, tono emocional, palabras de abstracción y actividad referencial a lo largo de todo el tratamiento y sus fases. Atravesando todas las dimensiones estudiadas (Ciclos de Emoción y Abstracción, Mergenthaler, 1996), dimensiones PQS y TLAP), proponemos un modelo integral del cambio observado en el caso objeto de estudio, considerando todos los enfoques, tanto desde métodos cuantitativos como cualitativos y dimensiones del proceso, como sobre las contribuciones del terapeuta y del paciente al proceso psicoterapéutico. Los resultados se discuten a la luz de perspectivas recientes sobre el uso activo de la contratransferencia como herramienta del terapeuta para mejorar el proceso de la psicoterapia psicoanalítica, controlando los aspectos negativos de las colusiones contratransferenciales.

Palabras Clave: *Variable del terapéuta, dimensiones del proceso de psicoterapia, plan de acción latente del terapeuta (TLAP), PQS, modelos de ciclo de emoción y abstracción, modelos de cambios terapéutico*

To Horst Kächele (1944-2020),
Master and friend in the journey
by Psychotherapy Research

Since Freud (1909, 1912) stated that counter-transference was the neurotic transference from the analyst to the patient, a phenomenon that required elimination by the analyst's self-control, a varied range of theoretical and technical changes have succeeded in psychoanalysis. From the absolute domain of the "Rule of Abstinence", psychoanalysis has evolved to a style of conceive analytic process that considers also the 1counter-transference phenomenon as useful, operating with a broader concept that includes both the neurotic and psychotic aspects of counter-transference (Heimann, 1950; Racker, 1957; Winnicott, 1949) and refers to it as the whole of analyst's affective (and behavioral) responses (Heimann, 1950; King, 1978; Litlle, 1951, 1957). Various reviews have been devoted to this topic (Aburto et al., 1999; Ávila-Espada, 2016; Hinshelwood, 1999).

More recently, the counter-transference phenomenon and their processes have been placed in the center of attention as essential pieces in the explanation of change processes in psychoanalytic psychotherapy and psychotherapy in general, and have become the center of new research proposals (Hayes, 2004). Converging with those tenets, relational psychoanalysis stated more than two decades ago, that an adequate management of the intersubjective processes displayed in psychotherapy is essential to promote effective change (Stolorow et al., 1994). The question of whether induced change is a function of interpretations (like Kleinian and Freudian more classical thought states) or derives from a complex domain of influential relational processes, has centered the efforts and discussions of numerous clinicians and researchers. A variety of interconnected processes like enactment, contention, holding, mutuality, intersubjective codetermination, self-object transferences, mirroring processes, and unformulated experiences and so on… conform the present landscape around comprehensive discussions regarding therapeutic relationships, where developmental research have added a lot of evidences on the relevance of intersubjective processes both in human development and psychotherapy process (Boston Change Process Study Group, 2002, 2003, 2010; Stern et al., 1998).

A logical consequence of this perspective is to make the study of the therapist's style, his/her interventions and his/her personal contribution to the therapeutic change the focus of attention in psychotherapy research. Most of the studies carried out assumes that, in a treatment, the therapist develops actions that are determined by several factors: a) the theory of the technique he or she learned in training as a psychotherapist; b) the specific techniques chosen for the case regarding its singularity (if the format of the treatment allows those adjustments), and c) the weight of the "common factors" (Lambert et al., 1986) that appear in the behaviour, affects and attitudes that are characteristic to the therapeutic relationship in the intersubjective domain conformed by therapist and patient.

In previous research we have tried to find out the components that the therapist

provides to the common factors by means of his/her personal style, considering the possibility of differentiating useful and harmful counter-transference processes. For instance, a new research tool was proposed, that is, a category system called CTI System (*Coding Therapist Interventions*) used to infer the TLAP (*Therapist Latent Action Plan*); TLAP have had a first version: *Rational-Inductive* (Ávila-Espada, 2000), and a more refined one: *Empirical-Deductive* (Ávila-Espada & Mitjavila, 2001, 2003). TLAP Method studies the dimensions and phenomena of therapist's technical and personal styles, and the contribution to the progress (or not) of the treatment reaching its goals. Multidimensional and factor analyses of these variables in the case object of this study, show consistent patterns that allow us to describe the therapist's characteristic "own style", displayed at the initial phase of the treatment, in a useful way to explore the evolution of those patterns all along the treatment. The dimensions obtained were: I–Therapist display directive style [associated to his emotional implication in demanded vs. demanding conflict]; II-Therapist displays affirmative style (Killingmo, 1995) [regarding the oedipal-relational conflict with disclaiming vs. disblaming style] and III– Therapist develops working Alliance [both either rationally as empathically]. Although these three main factors are probably idiosyncratic to each therapist, case and treatment studied, it will be profitable to research them as general dimensions, since psychotherapeutic process are naturally intersubjective. Now we have contrasted these factor analytic scales that arise from our previous study with rational scales constructed by means of content analysis, with those that arises from PQS studies with the same case (Psychotherapy Process Q-sort method; Jones, 1985, 2000, 2001; Spanish translation Ávila-Espada et al., 1999), and those obtained with computerized content analysis by TMC (Emotion words, Abstraction words, Emotional Tone & computerized Referential Activity; Mergenthaler, 1996), and relating all of them with other constructs in the light of the theory of the psychoanalytical psychotherapy technique.

Method

The case material employed derives from the SMBP Project[2], that is, the psychotherapy treatment of a young woman, 22 years old labeled "The Publicist", with a clinical diagnosis at the beginning of the treatment of *Histrionic Personality Disorder* (Borderline Personality Organization, High level of functioning, following Kernberg´s criteria). The treatment performed could be nominated as psychoanalytically oriented psychotherapy, with 269 sessions carried out between 1994 and 2000; with one face to face session per week (twice on occasions), including the use of free association and combining in fact expressive and supportive strategies. The therapist, psychoanalytically trained, has 10 years of experience at the beginning of the treatment. All proper ethical guarantees have been observed. From the 269 sessions naturally performed, 199 were properly recorded, and 197 adequately transcribed under MSGAD protocol (Mergenthaler et al., 2003). The entire treatment was divided in four phases and nineteen seasonal periods[3] (figure 1):

Figure 1. *Phases and seasonal periods 90's*

Phase A (Initial): Session´s periods I to IV (Spring 94 to Summer 95)
Phase B (Intermediate): Session´s periods V to X (Autumn 95 to Summer 97)
Phase C (Advanced): Session´s periods XI to XVI (Autumn 97 to Summer 99)
Phase D (Final): Session´s periods XVII to XIX (Autumn 99 to Summer 00)

This single case research study follows the research policy described by Desmet et al. (2013) fulfilling all the main criteria proposed. Some descriptive and exploratory studies of our ´Publicist Case´ have been performed before the present, and we will not reiterate the descriptive data of the case again[4]. Mitjavila have performed descriptions of patient and therapist contributions to process, focusing in patient contents about significant people, therapist style, therapist´s interventions and the link between patient´s insight or introspective answers and therapist interpretations (see Mitjavila et al., 2002, 2003; Mitjavila & Ávila-Espada, 2008). In a complementary way, Ávila-Espada & Mitjavila (2003) have explored underlying dimensionality in the content of therapist´s interventions, whose detected dimensions have been used in the present study, as we have mentioned before.

Rampulla have applied FRAMES method to detect emotional maladjusted schemas in the sessions and changes observed in FRAMES along the treatment (Rampulla & Ávila-Espada, 2007, 2011). López del Hoyo have also categorized CCRT and CCRT-LU dimensions to describe conflictive relational patterms and their change along the treatment (López del Hoyo et al., 2008).

Vidal-Didier (2008) has performed computerized analysis of the verbatim transcriptions of all the registered sessions with the TMC (Mergenthaler, 1996) in order to explore if there are differences between phases in terms of levels of emotion words, emotional tone, abstraction words and referential activity components. Main data obtained have been used in this study to explore the variability and correlates of main change process dimensions.

And recently, in other separate study (see Toro et al., 2008) exploratory factor analysis was performed with all the PQS estimations of judges to a systematic and significant sample of transcripted psychotherapy sessions (23% of the whole of 261 sessions). This exploratory factor analysis was developed to identify main dimensions underlying the psychotherapeutic process for the whole treatment. Results showed five process factors[5] that explains the 22.5% of total variance: I "Empatic Attitude"; II "Resistance"; III "Technical Interventions"; IV "Neutrality Attitude" and V " Therapeutic Alliance - Process", that have been referenced as *Initial Process Dimensions* of the treatment. Multiple comparisons realized for these factors between differents phases of the treatment -initial / advanced / final phase; first vs. second half – showed characteristic trends that allows us to describe tentatively the treatment process. Results emphasizes the importance of relational factors, ("Empatic Attitude" and " Therapeutic Alliance - Process") and his interplay with Factor IV "Neutrality Attitude" for the development of the therapeutic process. But

these results were probably biased because the higher number of judges estimations corresponds to the first half of the treatment, and probably the components detected represents only the initial tendencies but not the whole process.

After the abovementioned studies, and for the purpose of this study, we have used a random sample of 66 sessions covering all the 19 periods of sessions of the treatment, and all phases (Initial, Intermediate, Advanced, Final). The variables considered in our study were: TMC variables for the 66 sampled sessions (Emotion words, Abstraction words, Emotional Tone –positive, negative, total- and Computer Referential Activity, both in therapist and patient); the three TLAP dimensions factor analytically derived from CTI categories (Ávila-Espada & Mitjavila, 2003); ten PQS dimensions factor analytically derived from items categories –using median scores from all jugdes estimations by item by session, in order not to bias the estimations between periods of sessions and phases; and two qualitative measures derived from observations through content analysis of sessions about the presence of two key phenomena; adherence of the therapist to "classic psychoanalytic technique principles", and presence of countertransference enactments . These scores were Likert-scale estimations (0 = *no adherence*; 4 = *maximum adherence for the variable* "Adherence to classical technique"; 0 = *no enactment*; 4 = *intense counter-transference enactment*) using a four judge team (properly trained in the category system but blind about the objectives of the study), whose estimates have been averaged, and with a range of congruence index between judges that correlate from .76 to .92.

Data analyses have included the following steps: 1) To explore the main psychotherapy process components, all along the whole treatment, Median PQS items judges´ estimations were factor analyzed across the 66 sampled sessions. The factors obtained were labeled *PQS components*; 2) Regression factor scores of this principal components conjointly with all the TMC variables for the same sessions, were newly factor analyzed to explore main dimensions and communalities of the treatment process across different methods of estimation. These factors were labeled *Psychotherapy Process Phenomena*; 3) Finally, Multivariate analyses were performed with the complete set of variables: *TLAP dimensions* (Ávila-Espada & Mitjavila, 2003); Qualitative estimations of *"Adherence to classic technique"* and *"Countertransference enactments"* (Ávila-Espada et al., 2004)*;* the identified *PQS components*; the *Psychotherapy Process Phenomena;* and the *TMC variables*. This analysis is carried out to explore the possibility to propose a model of change in the treatment studied across the phases and for the whole treatment.

Results

Main Conceptual Dimensions of the Psychotherapeutic Process (PQS components)

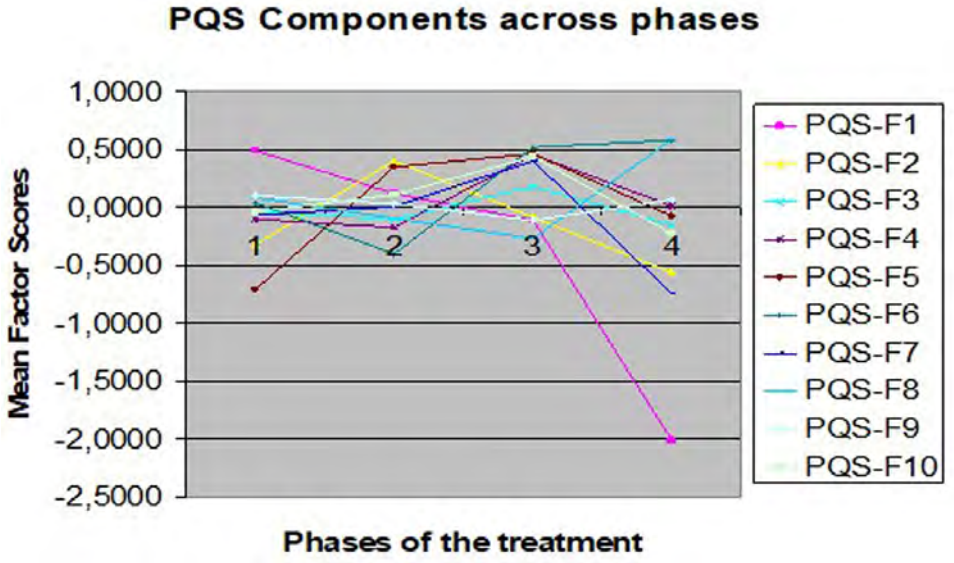
Exploratory factor analysis (Principal components, Varimax rotation, eigenvalues >3) yields ten factors that explains 54,01% of the variance. The first five factors explains 31.8% of the whole variance, with more wide explanatory power that IPD-PQS factors (only 22.5% in Toro et al., 2008 study). The new factors were labeled as follows (figure 2):

Figure 2. *PQS components*

PQS-F1: Neutral Focal Style (8.25%)
PQS-F2: Negative Transference and Resistance (6.49%)
PQS-F3: Involved Patient (both cognitive & emotionally) (5.83%)
PQS-F4: Rational Working Alliance & Supportive Strategy (5.68%)
PQS-F5: Therapist falls under Patient´ control (5.52%)
PQS-F6: Therapist centered in "here-and-now" (5.30%)
PQS-F7: Therapeutic Alliance (in depth) (4.90%)
PQS-F8: Passive-Dependent Attitude in the Patient (4.29%)
PQS-F9: Clarifying (as technical action) (3.90%)
PQS-F10: Patient concerned about guilt sentiments (3.81%)

Some of these factors are focused on ***Therapist Main Strategy*** (that can be described in terms of "Neutral focal style[6]" or "Supportive-Rational[7]", "centered in here-and-now themes" or "clarifying"). Other factors focusing in ***Process Indicators***: "Negative transference & Resistance[8]" or "Therapeutic Alliance[9]" in their classical concept; A third group of factors shows ***Patient Phenomena*** such us "Involved patient or Patient developing insight[10]"; and finally some others perhaps indicate a ***Conflictive nexus transference-countertransference*** (Therapist falls under patient´ control[11], Patient displaying a Passive-dependent attitude; or remains concerned about guilt sentiments). Considering the evolution of these components across the phases of the treatment (see graph 1) the most surprising phenomena detected is that the therapist loses his neutral attitute along the treatment, more deeply in the final phase, and the patient gains the control of the relationship recovering the control the therapist only in terms of working here-and-now. ANOVA tests confirms these differences, the only significatives. PQS-F1 (neutral) decreases significatively across phases ($F = 11.823$; $p < .000$) whereas PQS-F6 (here-and-now) increases ($F = 2.861$; $p < .031$) and PQS-F5 (Therapist under patient´control) fluctuates ($F = 3.753$; $p < .008$).

Graph 1. *PQS Components across phases of treatment*



Note: PQS-F1: Neutral Focal Style; PQS-F2: Negative Transference and Resistance; PQS-F3: Involved Patient (both cognitive & emotionally); PQS-F4: Rational Working Alliance & Supportive Strategy; PQS-F5: Therapist falls under Patient´ control; PQS-F6: Therapist centered in "here-and-now"; PQS-F7: Therapeutic Alliance (in depth); PQS-F8: Passive-Dependent Attitude in the Patient; PQS-F9: Clarifying (as technical action); PQS-F10: Patient concerned about guilt sentiments.

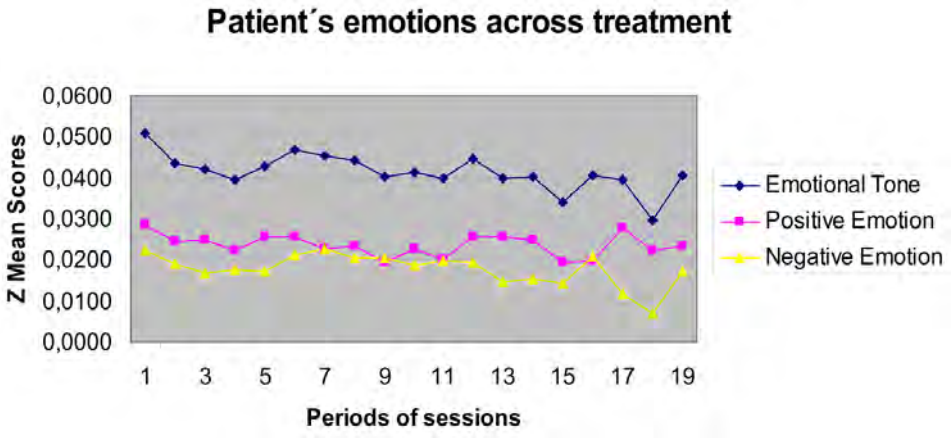
Multivariate Analysis of Treatment Process Variables

TMC Variables Changes Across the Treatment Process

The PQS method have allowed us to explore some main components of the process, but other variables and methods are needed to depict a wider portrait of the process of treatment. Fort this purpose we have used the Emotion & Abstraction Cycles Model (Mergenthaler, 1996), exploring trough TMC what can be described on patient variables, by means of computerized estimations on the content of verbatim transcriptions of the sessions sampled. The variables considered were: Abstraction words, Emotional Tone, Positive Emotion, Negative Emotion, and Computer Referential Activity. Main results derived from the analyses of these variables are the following:

1) Patient Negative Emotion decreases. TMC standarized estimations of Emotional Tone, Positive Emotion and Negative Emotion have been analyzed[12] throughout periods of sessions and phases of the treatment. Graph 2 shows the general tendency of Emotional Tone to decreases along the sucessive periods of sessions of the treatment, that is contingent with a more clear reduction in Negative emotion, whereas Positive Emotion remains oscilating in the same level.

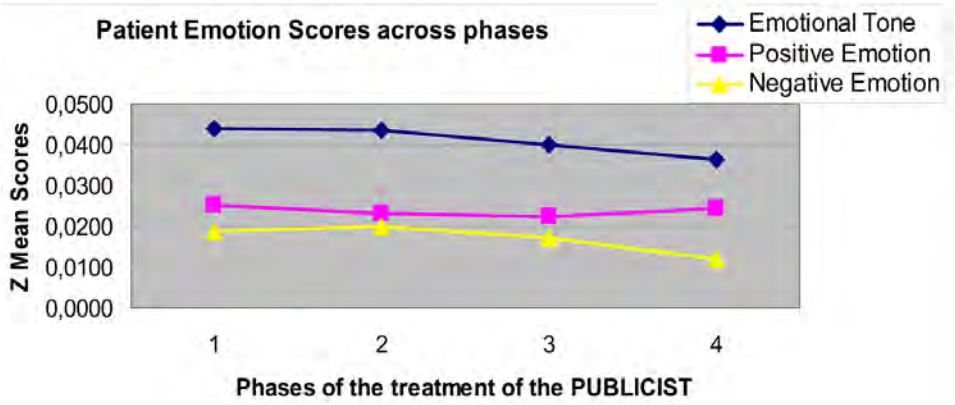
Graph 2. *Patient´s emotions across periods of sessions (ET, PE, NE variables from TMC)*



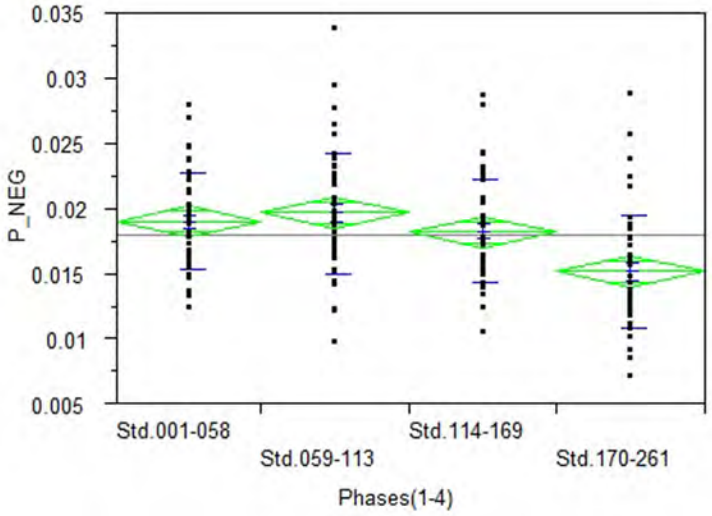
This tendency is more clearly appreciated comparing the evolution of emotions throughout the four main chronologic phases of the treatment (Initial, Intermediate, Advanced, Final; see graph 3) that reach statistical significance (ANOVA: Emotional Tone F = 3.973, $p < .012$; Negative Emotion F = 7.261 p < .000; Positive emotion do not differs). Take in mind -as showed in many studies- that negative emotion consistently increases situationally by the last period of the treatment and decreases to lowest levels at follow-up.

When the whole treatment is divided in four exact phases (aprox. the same number of sessions by phase), these results is replicated (see Graph 4), where we can observe that patient´s negative emotion decreases clearly only in the final phase (ANOVA: F estimation $p < .0001$; and ChiSquare estimation $p < .0001$), suggesting that changes in schemas (cognitive, emotional or interpersonal) occurs previously to a consistent change in emotion patterns. It´s important underline that positive emotions decreases also between the first and second half of treatment (see Graph 5; ANOVA: F <.03; ChiSquare <.03), suggesting that psychodynamic psychotherapy perhaps contribute more clearly to reduce progressively negative emotions, than to positive emotions. Emotional Tone decreases also significatively (ANOVA: F < .0001; ChiSquare < .0001).

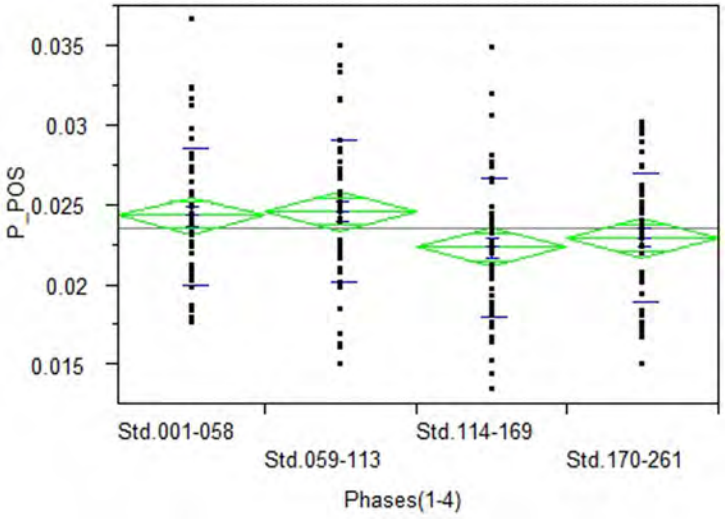
Graph 3. *Patient´s emotions across phases (ET, PE, NE variables from TMC)*



Graph 4. *Negative emotion throughout 4 "exact" phases of treatment (TCM estimations)*

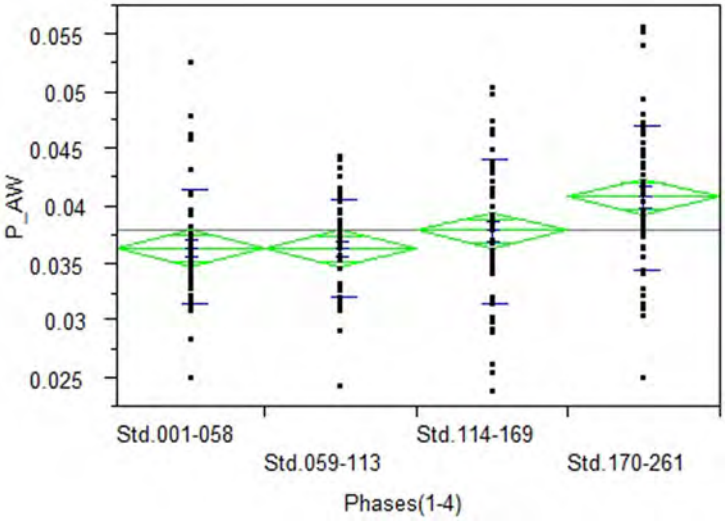


Graph 5. *Positive emotion throughout 4 "exact" phases of treatment (TCM estimations)*



2) Patient Abstraction Increases. The evolution of abstraction (under TCM estimations) shows that a clear increase in abstraction appears from the first to the second half of treatment (see graph 6), which becomes more pronounced at the final phase (Four "exact" phases, ANOVA: F <.0001; ChiSquare < .0002; Four "chronological" phases, ANOVA: F = 4.392; p < .007).

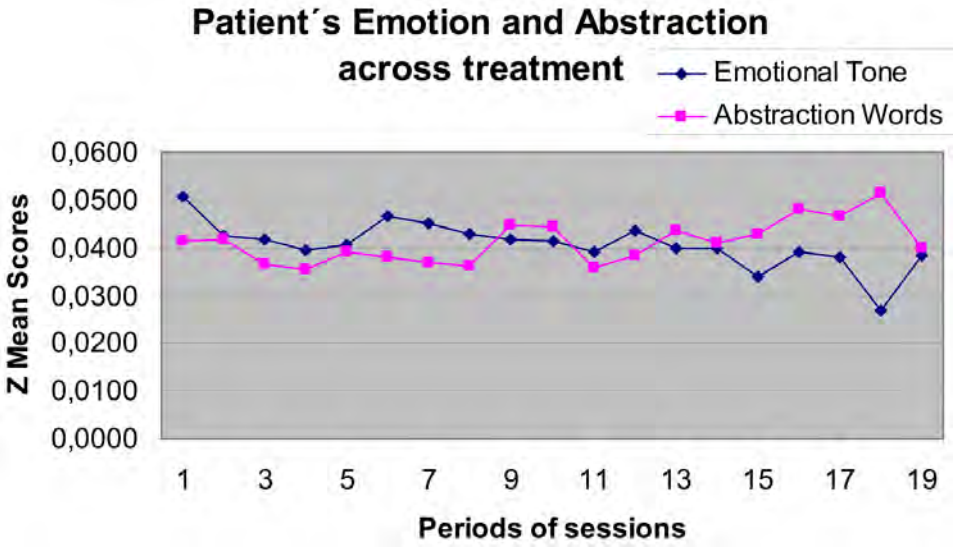
Graph 6. Patient´s abstraction level across "exact" phases of treatment (TCM estimations)



Comparing the evolution of Abstraction and Emotion across the all periods of sessions of the treatment (see graph 7) we can see that emotion decreases and

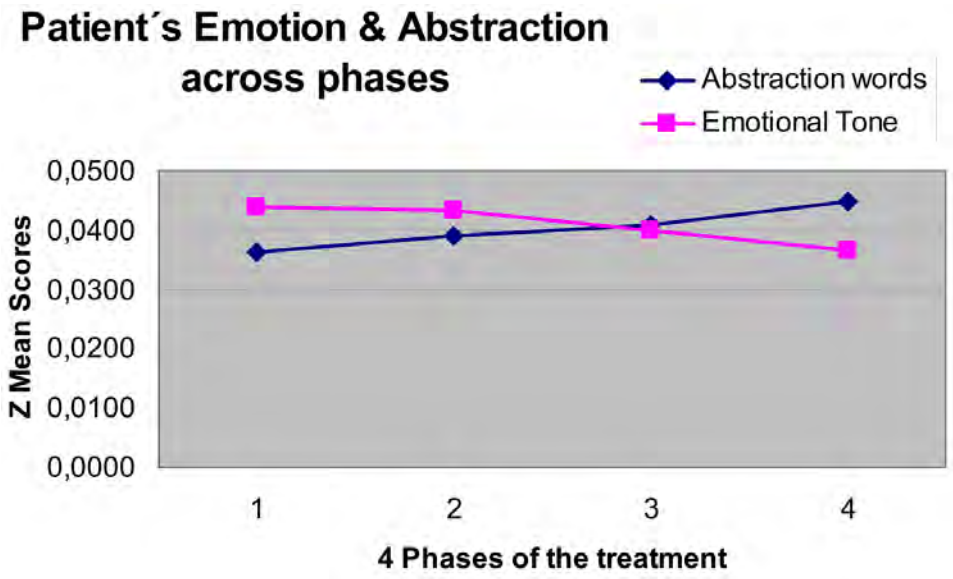
abstraction increases, specially in the second half of the treatment, where periods of sessions 9 & 10 precede a whole change of tendency, when abstraction clearly dominates from period 13 to the end of the treatment.

Graph 7. *Patient´s Emotion and Abstraction level across periods of sessions of treatment (TCM estimations)*



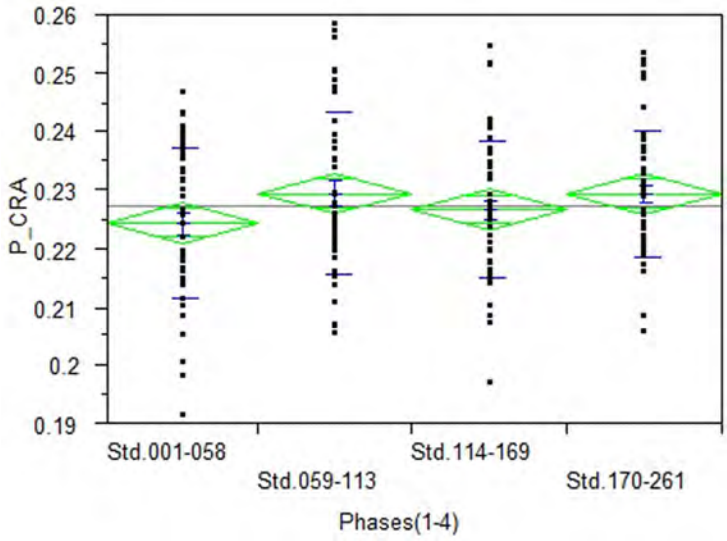
That phenomena can be observed clearly along the four chronological phases of the treatment (see graph 8). This result can be interpreted in terms of patient gaining probably higher mentalizing capacities (reflective function) with a more clear control of emotions, whose negative experiences can be put at the advanced and final phase of treatment under rational effective defences.

Graph 8. *Patient´s Emotion and Abstraction levels across the four main phases of the treatment (TCM estimations)*



3) Computer Referential Activity do not Differ Across the Phases of the Treatment. The increases in abstraction level are not followed by gainings in Computer Referential Activity. CRA level do not differ across the phases of the tratment (see graph 9), nor by "exact" phases (ANOVA: F < .12; ChiSquare < .24) or "chronological" phases (ANOVA: F = ,782; p < .508). This result can be also interpreted in terms of weakness of this measure, the procedure of estimation, or both. To register significant increases in CRA, it is necessary that the content of the sessions reflects an extensive associative-reflective activity, favored by the use of the interpretive strategy by the therapist. In the case studied, the strategy is not oriented mainly to work with interpretation but to the experience of relational participation, which is not expected to be measured by the CRA.

Graph 9. *Patient´s CRA level across phases of treatment (TCM estimations)*



Exploring Psychotherapy Process Phenomena (PPP components)

Once we have explored how behaves the main PQS and TMC variables, can be of interest to test if there´s some dimensions that could iluminate more clearly the understanding of the psychotherapy process in the case studied. For this purpose, the regression factor scores of the abovementioned PQS principal components for the 66 sample sessions were newly factor analyzed conjointly with all the TMC variables for whole sessions sampled. Factor extraction using principal components solution with Varimax Rotation (eigenvalues >1) yields 10 principal components that explains 74.77% of the variance. The first five factors explains 42.5% of the whole variance. The factors were labeled as follows (figure 3):

Figure 3. *PPP components*

PPP-F1:	Therapist displays Neutral Strategy Focused on Emotional Conflict (10.79%)
PPP-F2:	Therapist Over-Controled Rational Strategy (9.63%)
PPP-F3:	Conflictive Counter-transference: Therapist promotes (unconsciously?) patient dependency (7.47%)
PPP-F4:	Therapist displays Rational Strategy (Abstract & Emotionally balanced) (7.43%)
PPP-F5:	Conflictive Counter-transference: Therapist under past unresolved experiences (7.20%)
PPP-F6:	Therapist displays Supportive & Rational Strategy (6.91%)
PPP-F7:	Conflictive Counter-transference: Patient with guilt sentiments & Therapist verbalizing (6.83%)
PPP-F8:	Patient develops Cognitive & Emotional Insight (6.44%)
PPP-F9:	Therapeutic Alliance (6.38%)
PPP-F10:	Negative Transference & Resistance (5.65%)

A rational comparison of PPP and PQS components shows that some components remains inaltered despite the new variables included in the analyses. These are (figure 4):

Figure 4. *Comparison of PPP and PQS components*

Therapeutic Alliance (PQS-F7 & PPP-F9)
Negative Transference & Resistance (PQS-F2 & PPP-F10)
“Patient involved… develops insight” (PQS-F3 & PPP-F8)

Whereas other PPP components yields more explanatory power to identify specific phenomena of patient & therapist relationship, including correlates for displayed technique and conflictive countertransference.

These are for therapist´s technique election of main strategy (figure 5):

Figure 5. *Main strategy for therapist*

PPP-F1: Therapist displays Neutral Strategy Focused on Emotional Conflict
PPP-F2: Therapist Over-Controled Rational Strategy
PPP-F4: Therapist displays Rational Strategy (Abstract & Emotionally balanced)
PPP-F6: Therapist displays Supportive & Rational Strategy

And those others let allows us to identify conflictive components of countertransference (figure 6):

Figure 6. *Conflictive components of countertransference*

PPP-F3:	Conflictive Counter-transference: Therapist promotes (unconsciously?) patient dependency
PPP-F5:	Conflictive Counter-transference: Therapist under past unresolved experiences
PPP-F7:	Conflictive Counter-transference: Patient with guilt sentiments & Therapist verbalizing

This results showed a clear convergence with our previous studies with TLAP method (Ávila-Espada & Mitjavila, 2001, 2003; Ávila-Espada et al., 2001, 2004), that depicts a portrait of the over and covert behaviour of the therapist within the treatment process, including phenomena on tecnique displayed and countertransferential influences (conflictive or positive/active use of it). The main qualitative findings on this patterns have been included in the following section.

Qualitative Stimations of "Adherence to classic technique" and "contertransference enactments" and their covariance with TLAP Dimensions

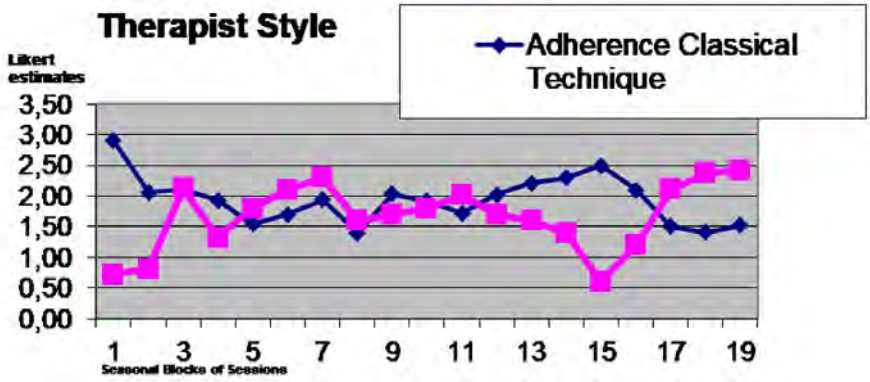
Measures of TLAP inferred dimensions in the case studied (Ávila-Espada & Mitjavila, 2001, 2003) were compared with qualitative estimations of "Adherence to classic technique" and "Countertransference enactments" obtained as described in the method section. The main data (Ávila-Espada et al., 2004) are displayed in graphs 10 to 13. All these variables differ across phases (See graph 14). Our data suggest:

1. ***Adherence to classical technique and Counter-transference enactments*** are variables that differ greatly at the Initial and Advanced-final Phases of the treatment and remains closer in the Intermediate and Advanced Phases of the treatment (see graph 10). Perhaps this data suggests that the main impact of counter-transference phenomenon is on the build-up of the binding with the patient but manifested later, and fall in the second half, recovering only by anticipation of separation anxiety associated with termination. The central phases of the treatment (periods 3 to 11) the therapist "fights" (conscious or unconsciously) between adherence to classical technique proposals or uses relational strategies.
2. The ***affirmative style*** is more characteristically associated with promoting the working alliance in the first half of the treatment, whereas the ***Directive style*** is more related with the maintenance of the working alliance in the second half (see graph 11). This result could be interpreted as the need to have affirmative experiences to establish initially a better working alliance (at least in this case), and as a consequence of the adequate satisfaction of affirmative needs, in a more emotional climate, tuning the subjective

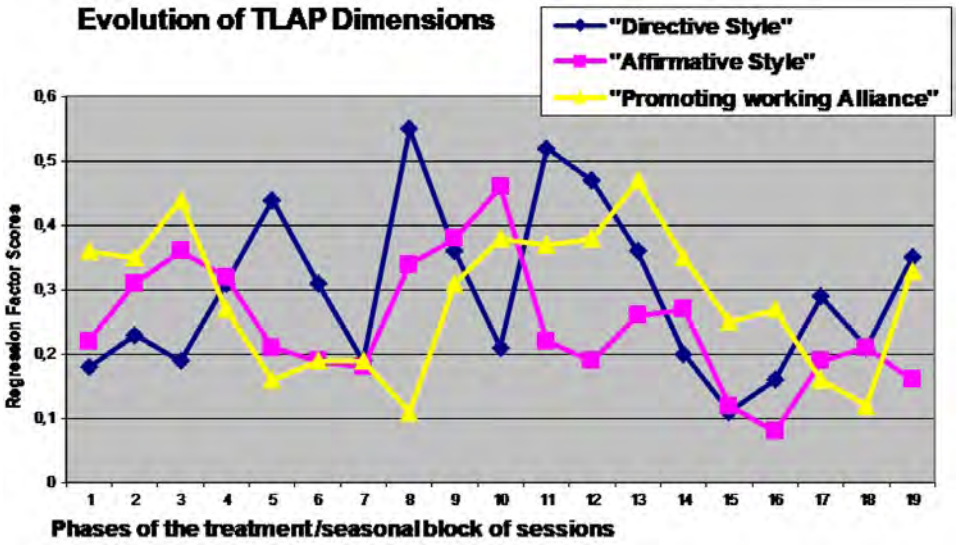
experiences of patient and therapist. In later phases this strategy is less necessary, and the more classical attitude of promote working alliance as a rational-directive collaboration dominates, activating more refined defence mechanisms, such as intellectualization.

3. Adherence to classical technique and the activity of the therapist in order to promote working alliance follows the same tendency (see graph 12). That is, a rational attitude to consistently maintain the working alliance, which follows it, tries to adhere to classical sequence of work in therapy: elicitation of material, confronting, clarification, like-interpretation, some interpretations –as exceptional intervention- and so on. Both variables show minor decreasing tendencies.
4. The affirmative style of the therapist is very important in the initial phase of the treatment, but shows a consistent tendency to decrease, whereas the Directive style shows a tendency to increases moderately but consistently throughout the treatment (see graph 13). A similar pattern is showed by the presence of counter-transference enactments throughout treatment and suggests that Directive style and counter-transference enactments covariate, at least in the case studied.
5. The evolution of therapist´s dimensions across phases show significative differences [Anova estimations: All the dimensions differs across phases; TLAP-1 (Directive Style) [$F = 4.497$; $p < .006$]; TLAP-2 (Affirmative Style) [$F = 7.954$; $p < .000$]; TLAP-3 (Therapist contributes to working alliance) [$F = 22.631$; $p < .000$]; Adherence to classic technique [$F = 22.041$; $p < .000$]; Countertransference enactments [$F = 17.000$; $p < .000$] suggesting that therapist´s variability is relevant in the understanding of the process. Those differences reduce their intensity from initial to final phase (see graph 14).

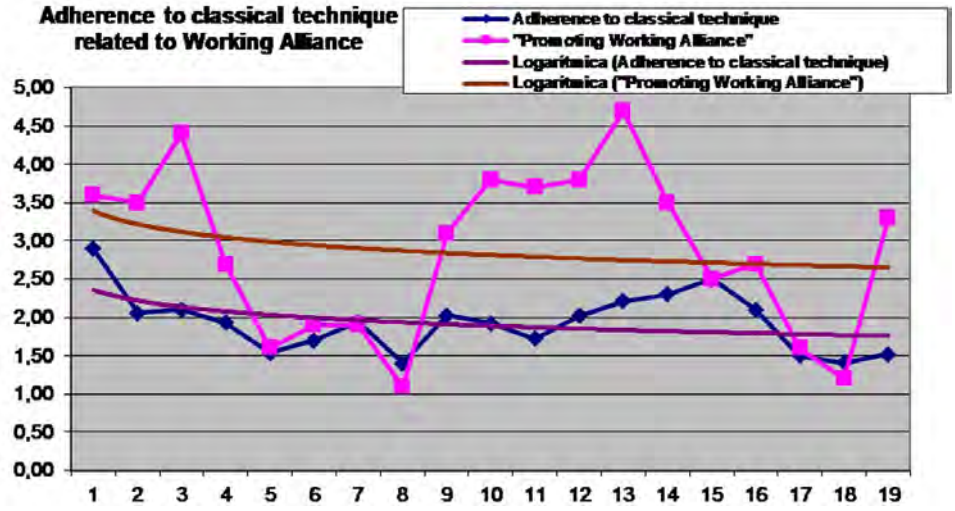
Graph 10. *Independent Qualitative Likert Estimations of the Behaviour of the Therapist in the treatment*



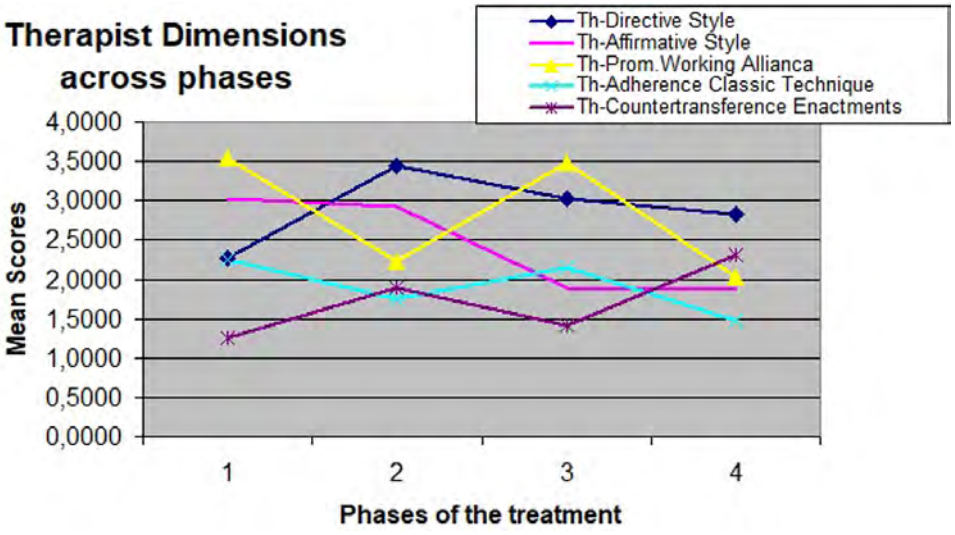
Graph 11. *Therapist´ Latent Action Plan (TLAP) Main Dimensions*



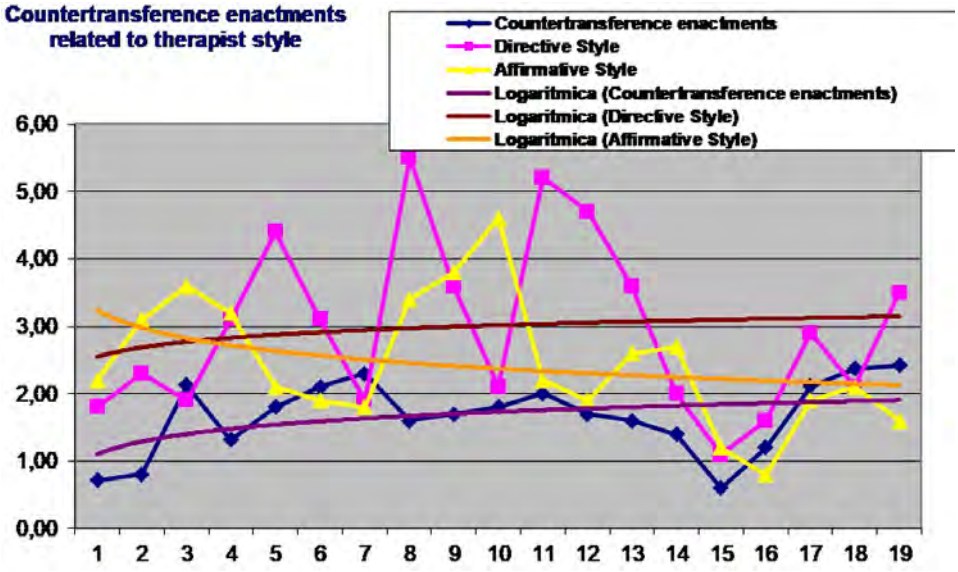
Graph 12. *Adherence to Classic Technique & Working Alliance*



Graph 13. *Styles of the therapist and Countertransference Enactments*



Graph 14. *TLAP & Observed Technique Dimensions and across phases*



Predicting Key Phenomena of the Process of Change: Some Evidences

Could be predicted some key phenomena of the process of treatment from quantitative or qualitative estimations? Linear regression analyses showed us some interesting evidence:

I. The higher cognitive implication of the patient in the treatment can be predicted by higher CRA in the patient and lower presence of Countertransference enactments or positive affects of the therapist.

- "Patient´s Computer Referential Activity" show tendency to predict "PQS-F3: Involved Patient (both cognitive & emotionally)" (.256; t = 1.967, p < .055), but more clearly predicts "PPP-F8: Patient develops Cognitive & Emotional Insight" (.722; t = 9.088, p < .000).
- The absence or low "Countertransference enactments (observed technique)" predicts "PQS-F3: Involved Patient (both cognitive & emotionally)" (.511; t = -2.551, p < .014).
- Lower Therapist Positive Emotion predicts "PPP-F8: Patient develops Cognitive & Emotional Insight" (-.222; t = -2.772, p < .008).

II. Neutral focal style of the therapist (PQS-F1) can be predicted by "TLAP-Affirmative Style" (.367; t = 2.909, p < .005) and observed "Adherence to classic technique" (.674; t = 2.499, p < .016).

III: Lower negative emotion of the patient predicts Working & Therapeutic Alliance (PQS-F7) (.439; t = -3.095, p < .003), a phenomena also predicted by higher verbal productivity of the patient (.302; t = 2.227, p < .027). Congruently, lower

Therapist´ Negative Emotion predicts more Clarifying activities of the therapist (FQS-F9) (-.482; t = -2,614, $p < .001$).

Finally, some comparisons across phases can be made with detected PPP components. ANOVA estimations showed some differences for PPP-F1 (Neutral strategy focused on emotional conflict) [F = 18.067; $p < .000$]; PPP-F2 (Over-controled therapist with Rational Strategy) [F = 3.733; $p < .016$]; PPP-F5 (Conflictive Counter-transference: Past unresolved experiences of the therapist) [F= 3,841; $p < .014$]; and PPP-F6 (Therapist displays supportive & rational strategy) [F = 3,127; $p < .032$]. These results confirm the variability in the therapist´s strategies.

Discussion

We have studied some rational and empirical dimensions of the behaviour of the therapist throughout the treatment of the case studied, covering the therapeutic process during 269 sessions, through sampling sessions, segmenting the treatment in seasonal periods, and grouping those periods in four main phases of the whole treatment. The possible interpretation of the therapeutic process phenomena observed must be taken as relative, since it belongs to a single case (with a specific patient and a given therapist). However, despite its methodological interest, our results are convergent with recent clinical and theoretical literature on the importance of enactment phenomenon in the process of change.

At the beginning of the treatment, therapist plans to develop and adequate working alliance mainly based on the rational collaboration of the patient, and displaying an affirmative style that increases contention of patient´s anxieties; that is an strategy more supportive than expressive. Also, from the beginning, latent tendencies originated probably by personal interferences in the therapist, promotes a directive strategy that can interfere with the "natural" development of psychoanalytic processes.

As have been detected by PQS components, these axes of the process remain all along the treatment as main dimensions that explains the evolution of the therapeutic relationship. **Therapist** main strategy can be described by a mixture of *Technical Elements* ("Neutral focal style" or "Supportive-Rational" , "centered in here-and-now themes" or "clarifying") related with *Process Indicators*: ("Therapeutic Alliance") mediated by a *Conflictive nexus transference-countertransference* ("Therapist falls under patient´ control"). **Patient** contributes to the process with two kinds of phenomena: Increasingly involved in the treatment, gaining abstraction level and developing insight, or displaying a passive-dependent attitude. Simultaneously patient´s negative emotion decreases, and the patient puts emotions under a better control.

To develop a theoretical "general model" for the psychotherapy process observed in the studied case, appears to be central the following axes:

- The therapist´s conscious election of the technical strategy (neutral, rational, supportive)

- The conflictive components of his countertransference (that biased him to promote dependency with directive actions).
- The resources of the patient to develop a positive working alliance and activate psychoanalytic process phenomena (transference & Resistance), that allows her to gain mentalizing capacities.

What can allow us to explain why patient gain the resources to improve structurally? From periods 3 to 14 of the sessions, therapist displays an active involvement in the intersubjective domain of the therapeutic relationship. During all this time of the process (3/4 of the whole treatment) enactments and mutuality experiences between therapist and patient are present (evidenced by verbal and non-verbal cues) where´s no easy or clear to differentiate between collusive or positive use of countertransference phenomena. Affirmative strategy by the therapist contribute to a positive emotional climate that promotes contention of anxieties, that later assures a good enough level of therapeutic alliance, that facilitates him to work with more classical attitudes, as regression analysis confirms.

Comparing samples of specific events during the treatment, that include mini-sequences where the therapist develops actions following classical technique, with others where a counter-transference enactment atmosphere dominates (conflictive or useful), we have found that this emotion-action sequences appears to precede changes in cognitive, emotion and interpersonal behaviors, observed by content analyses of the sessions. These needs to be illustrated by case material vignettes, and confirmed through other qualitative studies centered on change in emotion´s schemas (see FRAMES evidences: Rampulla & Ávila-Espada, 2011) or changes in relationship conflictive patterns (See CCRT & CCRT-LU-S evidences: López del Hoyo, Pokorny & Ávila-Espada, 2008).

The inference of "Technical style" of the therapist, conjointly with latent tendencies and phenomena that can be detected at the beginning of the treatment will be of interest to predict both positive or negative phenomenon that could affect the whole process of treatment. As we have learned in SMBP project and case, TLAP and PQS methods can be useful for clinicians and researchers to detect and perform descriptions of the psychotherapy process in single case studies, and to gain a more deep understanding of psychotherapy process phenomena.

Conclusions

The usefulness of PQS method to detect components relevant to psychotherapy process have been substantiated. Also, the relevance of CTI categories and the dimensions obtained by TLAP method. TLAP method is a tool to obtain a better knowledge of some of the identify structural dimensions[13] of the therapist contribution: *Comunicational axis*, v.g. Prevalence of the Knowledge vs. Emotion (To explain rationally vs. To be empathic) and *Activity of the Therapist* (Therapist that explores doubts and waits for the production of new material vs. Active therapist that intervenes clarifying, confronting, establishing relationships and comparisons).

The therapist (and the treatment) studied in this single case research have been described displaying: *Directive Style*, *Affirmative Styl*e and *Promotion of Working Alliance Activities*. In a third level, we could learn that the therapist follows two underlying axes related with two latent tendencies: *Adhere to classical technique propositions* and/or *expresses/uses counter-transference enactments* (from collusive or useful use of countertransference). Both the Patient and Therapist contributions to the process of change have been described trough the aids of PQS, TLAP, TCM and other qualitative methods, and inferences have been made with the aid of multivariate analyses of all data obtained. The picture that emerges for all these analyses let us to learn on key phenomena of this treatment, but potentially useful –at least at methodological level- to the understanding of any other psychotherapy process.

In a previous paper (Ávila-Espada & Mitjavila, 2003) we have analyzed potentially negative phenomena in the therapist studied with implications to the therapeutic process. For example, we were worried about the impact of an "elusiveness of guilty sentiments style, associated with the tendency to denial or minimize the impact of separation anxiety in the treatment". The study of the whole treatment process suggests that those tendencies of the therapist could not have been an absolute negative determinant within the process of the patient, which could have used the enactments of the therapist as positive events to manage her conflicts. Another suggested conclusion is that interpersonal-emotional processes could be much more important that cognitive learning activities during the treatment, as haved been suggested repeatedly (Stern et al., 1998; BCSPG, 2002, 2003, 2010; Ávila-Espada, 2005, 2015)

The enactment phenomenon was the focus of attention more a decade ago (Feldman, 1997). It could be seen as a derivation of containment, as a pressure over the therapist to actually perform the role of the patient's transference figure, where the patient has the opportunity to observe that the distress he/she suffers could be manageable by any other. Sandler (1976) with the concept of role-responsiveness states that the patient is instrumental to some degree in creating his/her own fantasies of the mind of the analyst. That relational situation derives in an object-relational play (Winnicott, 1949), following the tradition previously opened by Ferenczi and Balint to observe and describe the importance of these phenomena for psychotherapy. A complex interplay of transference projections and identifications with counter-transference enactments in the intersubjective context of the therapeutic relationship is the concrete world that we tried to reach trough these empirical and rational analyses. But much more work needs to be done, learning from more single case analyses of psychotherapy process. This kind of research contribute to fix the focus of our attention on the quality criteria of a psychotherapy based on the dialectic between real clinical practice and research (Ávila-Espada, 2020). This is the type of evidence that emerges from single case research like the developed in SMBP Project.

Resumo

A psicanálise relacional afirma que uma gestão adequada dos processos intersubjetivos apresentados na psicoterapia é fundamental para promover uma mudança efetiva. A análise de algumas variáveis do terapeuta e do paciente e a interação complexa e codeterminada entre eles, nos fornecem novas perspectivas sobre o processo terapêutico. Esta análise nos leva a questionar algumas questões e considerar sob uma nova perspectiva as funções do terapeuta e os papéis do paciente no processo terapêutico. Um grupo de pesquisadores da Espanha, Argentina, México e Alemanha trabalhou por uma década (1997-2008) no Projeto Salamanca-Barcelona-Madrid de Pesquisa em Processos de Psicoterapia (SMBP; Ávila-Espada, Vidal-Didier et al. , 1998a; Ávila-Espada, Gutierrez, Mitjavila & Poch, 2002). Este projecto, um estudo de caso único (no caso do Publicitário), ao longo das principais fases do tratamento completo (até 200 sessões gravadas), deu-nos a oportunidade de adquirir um melhor conhecimento do processo terapêutico, através da análise do conteúdo da sessão e com dados qualitativos usando uma variedade de procedimentos, como Jones' PQS (Jones, 1985, 2000, 2001) e o Emotion and Abstraction Cycles Model (Mergenthaler, 1996); Emotional Schemas using the FRAMES method (Dahl, 1988; Dahl and Teller, 1994; Dahl, Hölzer & Berry, 1992); Padrões CCRT e CCRT-LU-S (Luborsky, 1977; Albani et al., 2002; López del Hoyo et al, 2004) e novos métodos (TLAP: Método de plano de ação latente do terapeuta, Ávila-Espada & Mitjavila, 2001, 2003), entre outros. Neste trabalho apresentamos resultados relevantes e algumas inferências sobre o processo terapêutico derivadas principalmente das dimensões PQS e TLAP e suas correlações com palavras de emoção, tom emocional, palavras de abstração e atividade referencial ao longo de todo o tratamento e suas fases. Cruzando todas as dimensões estudadas (Ciclos de Emoção e Abstração [Mergenthaler, 1996], dimensões PQS e TLAP), propomos um modelo abrangente da mudança observada no caso em estudo, considerando todas as abordagens, tanto dos métodos e dimensões quantitativos quanto qualitativos o processo, bem como as contribuições do terapeuta e do paciente para o processo psicoterapêutico. Os resultados são discutidos à luz de perspectivas recentes sobre o uso ativo da contratransferência como uma ferramenta para o terapeuta melhorar o processo de psicoterapia psicanalítica, controlando os aspectos negativos dos conluios contratransferenciais.

Conflict of interest statement

The author declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as potential conflict of interest.

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8 Janine J. Vidal was a Fellow Researcher, University of Salamanca, Salamanca, Spain, during the time of the project.

Notes on the text

1 This paper is based on a previous one, now updated and completed, presented first time in the panel: A decade of Studies on Psychotherapy Process trough Single-Case Analysis (Moderator: Adela Leibovich de Duarte (SAP, IPA, Buenos Aires, R. Argentina; Discussants: Adela Leibovich de Duarte & Erhard Mergenthaler (U. Ulm, Ulm, Alemania) at the 39th Annual Meeting of the Society for Psychotherapy Research, 18 to 22 June, 2008. Barcelona, Spain.
2 The SMBP Project (Salamanca-Madrid-Barcelona-Project) has been developed from 1998 to 2008, with the title "The effects of psychotherapist's plans and interventions on the psychotherapeutic process through the intensive and extensive analysis of a single case under psychoanalytically oriented psychotherapy" in the *Research Unit in Clinical Psychology and Psychotherapy* of the *University of Salamanca*, sponsored by the *Research Advisory Board of the IPA*.
3 The criteria for "seasonal periods" used the break points of the treatment that includes "natural separations" derived of seasonal interruptions of the treatment: summer vacation (five weeks), Christmas vacation and Easter week. For TMC analyses we have used and "exact" division of the whole treatment in four periods.
4 Brief summary of the data case: A young woman, 22 years old at the beginning of the treatment, with a clinical diagnosis of Histrionic Personality Disorder (Borderline Personality Organization, High level of functioning, following Kernberg´s criteria). The treatment performed was psychoanalytically oriented psychotherapy, with 269 sessions carried out between 1994 and 2000; with one face to face session per week (twice on occasions), including the use of free association and combining in fact expressive and supportive strategies. The therapist, psychoanalytically trained, has 10 years of experience at the beginning of the treatment.
5 These exploratory PQS "process factors" will be referenced in this paper as *Initial Process Dim*ensions (IPD-PQS), and have been object of detailed explanation in other paper (See Toro, Gutiérrez and Ávila, 2008).
6 A kind of technical style configured as a therapist mainly "technical", that shows a distant and neutral attitude to the patient, verbalizing as way of structure material, self-assured, focus centered (on patient´s conflicts and relationships), promoting responsibility in the patient on his/her contents. This factor shared 7 PQS items with IPD-PQS Factor IV (Neutral Attitude).
7 The therapist displays an accepting, supportive and non confrontative strategy facing a patient that shows mainly rational Resistances, externalizing her problems, and ocassionally shows rage episodes or competitive actions, but in fact cooperative with the therapist and the treatment.
8 Patient verbalizing negative, hostility, ambivalence or contradictory sentiments to the therapist; she feels misunderstood, and reject the therapist´s interventions, with a mixture of paranoid and shame affects.
9 This factor shared 3 PQS items with IPD-PQS Factor V (Process & Therapeutic Alliance) and 4 PQS items with IPD-PQS Factor III (Therapeutic Interventions).
10 This is an Pro-Insight Factor (in terms of tendency or involved working of the patient in her treatment),

that is an essential patient´ component or her therapeutic alliance, showing introspective, reflective capacities that allows mentalization in the patient. This factor shared 4 PQS items with IPD-PQS Factor V (Process & Therapeutic Alliance)

11 Therapist fails in control or gives wide space to the patient, which gains the control of therapeutic relationship, and a variety of sentiments anteceding overt transference beginning to be showed.This factor share 5 PQS items with IPD-PQS Factor II (Resistance).

12 TMC main statistical analyses were performed with the invaluable aid of Prof. Erhard Mergenthaler and his assistants in the University of Ulm during a research stage of one of us (Janine J. Vidal-Didier) in Germany. Content analyses and later statistical tests were performed in Salamanca and Complutende Universities.

13 By means of Multidimensional Scaling, two ortogonal dimensions.

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