CATEGORICAL OR DIMENSIONAL? DIFFERENTIATION OF TREATMENT TECHNIQUES IN SHORT AND LONG-TERM PSYCHODYNAMIC AND PSYCHOANalytic THERAPIES

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# TABLE OF CONTENTS

1. **Introduction**........................................................................................................................................... 1
   1.1 Psychoanalytic therapy research................................................................. 1
   1.1.1 The six stages of treatment research....................................................... 4
   1.2 Methods of psychoanalytic process research................................................. 6
   1.2.1 The use of audio- or video-recordings...................................................... 7
   1.2.2 Triadic Methods: Patient-Therapist-Process............................................... 7
   1.3 The ‘Psychotherapy Process Q-set’ (PQS)..................................................... 13
   1.3.1 Past research with the PQS method......................................................... 16
   1.4 Therapeutic techniques.................................................................................. 27
   1.4.1 Introduction to therapeutic techniques..................................................... 27
   1.4.2 Operationalization of therapeutic techniques by the PQS....................... 29
   1.5 Hypothesis and research questions.............................................................. 48
   1.5.1 Hypotheses................................................................................................ 48
   1.5.2 Research questions................................................................................... 48

2. **Method and Material**............................................................................................................................. 50
   2.1 Study framework.............................................................................................. 50
   2.2 Description of the sample.............................................................................. 51
   2.2.1 Psychoanalysis (PA).................................................................................. 51
   2.2.2 Long-term psychodynamic psychotherapies (LTDP)................................. 53
   2.2.3 Short-term psychodynamic psychotherapies (STDP)............................... 55
   2.3 Study procedures............................................................................................ 57
   2.3.1 Selection criteria for analyzed sessions.................................................... 57
   2.3.2 Learning experience and rating with the PQS.......................................... 59
2.3.3 Protocol for rating therapy session with the PQS

2.4 Description of data analysis

2.4.1 The PQS methodology

2.4.2 Different statistical approaches

3. Results

3.1 Comparison of most and least characteristic items of the samples

3.1.1 Description of PA sample in comparison with LTDP and STDP

3.1.2 Description of LTDP sample in comparison with STDP and PA

3.1.3 Description of STDP sample in comparison with LTDP and PA

3.2 Comparison of techniques items

3.3 Variable items during therapeutic process of STDP, LTDP and PA

3.4 Variable technique items during therapeutic process

3.5 Explorative Procedure: 'Discriminant analysis'

3.6 Comparison of the samples with the psychoanalytic PQS prototype

4. Discussion

4.1 Similarities among STDP, LTDP and PA

4.2 Differentiating aspects of each sample

4.3 Similarities in the usage of therapy techniques

4.4 Differences in the usage of therapy technique

4.5 Variance of therapeutic factors throughout therapeutic process

4.6 Surprising amount of psychoanalytic features in STDP

4.7 The PA sample is not prototypical but what is prototypical?

4.8 Limitations of the study

4.9 Recommendations for further research

5. Summary
6. References

Appendix
Acknowledgements
Curriculum Vitae
LIST OF ABBREVIATIONS

APsaA American Psychoanalytic Association
CALPAS California Psychotherapy Alliance Scale
CCRT Core Conflictual Relationship Theme
CAPS Columbia Analytic Process Scale
CBT Cognitive Behavioral Therapy
DFG Deutsche Forschungsgemeinschaft (German Research Association)
DSM-IV Diagnostic and Statistical Manual of Mental Disorder IV
DSM-V Diagnostic and Statistical Manual of Mental Disorder V
HCVRCS Hill Counselor Verbal Response Category System
ICD-10 International Statistical Classification of Diseases and Related Health Problems, 10th Revision
IPT Interpersonal Psychotherapy
IPTAR Institute for Psychoanalytic Training and Research
LTDP Long-term psychodynamic psychotherapy
m Mean
N Number
NIMH National Institute of Mental Health
SCL-90 The Symptom Checklist -90
SD Standard deviation
SPSS 17 Statistical Package for Social Science 17.0
STDP Short-term psychodynamic psychotherapy
T Therapist
TDCRP Treatment of Depression Collaborative Research Program
TfP Transference-Focused Psychotherapy
TPI Therapeutic Procedures Inventory
TVII Therapist Verbal Intervention Inventory
P Patient
PA Psychoanalysis
PIRS Psychodynamic Intervention Rating Scale
PQS Psychotherapy Process Q-set
PTSD Post-traumatic stress disorder
q.v. quod vide (see also)
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>RF</td>
<td>Reflective Functioning</td>
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<tr>
<td>RCT</td>
<td>Randomized Controlled Trial</td>
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<td>USA</td>
<td>United States of America</td>
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<td>VPPS</td>
<td>Vanderbilt Psychotherapy Process Scales</td>
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<td>vs.</td>
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1 Introduction

In the field of psychoanalysis prevails a preference for categorical differentiation between psychoanalysis and psychodynamic psychotherapy in terms of technique, which has not been scientifically determined on the basis of the empirical analysis of the practiced technique (Kächele 2010). The present study will utilize the ‘Psychotherapy Process Q-set (PQS)’ (Jones 2000) method to differentiate and acquire a dimensional perspective on this issue. In this way, one will be able to look into what actually happens in clinical practice and not rely on what professionals say they do. The PQS ratings of actual therapies will be compared with the psychoanalytic prototype (according to Ablon & Jones 1998) to assess the degree of congruence between the therapeutic process (in psychoanalytic and psychodynamic therapies) and that of the psychoanalytic prototype. This study will gather an exceptionally large database of material for this field, leading to heightened scientific discussion surrounding the delimitation of psychoanalysis and psychodynamic psychotherapy.

1.1 Psychoanalytic Therapy Research

Scientific research on psychoanalysis often revolves around the notion of ‘analytic process’, although the multiplicity of meanings of this concept (Compton 1990) is confusing. It is like an image, an appearance without a uniform silhouette, that everyone among the field recognizes its existence but not many agree on what form it takes. It might be wise not looking for one sole analytic process but to try identifying various processes that are located at its different levels. Or pick definable ingredients, like therapist interventions or techniques, which are less ambiguous for observation and for comparison (among cases or sessions).

The search for the ‘real’ analytic process started long ago with Alexander & French (1946) by softening and deviating from canonized principles of psychoanalytic therapy. Rapidly the critics towards the technical modifications emerged and were highlighted by the ‘invention of the psychoanalytic ideal technique’ (Eissler 1953). Historically these disagreements marked the start of the long lasting attempt to distinguish psychoanalysis from psychodynamic psychotherapy. Gill (1954)
strongly advocated the distinction between ‘psychoanalysis proper’ and ‘dynamic psychotherapy’ (not real psychoanalysis), though he himself later abandoned this distinction (Gill 1982).

The lively discussion about the proper way to define psychoanalysis persists. Nevertheless, in 1993, the members of a committee of the ‘International Psychoanalytic Association’ (IPA), overcoming their theoretical divergences, could agree about the specific nature and consequences of analytic process (Freedman et al. 2003). For them, a psychoanalytical process includes transference, regression transference, interpretation, recognition of symbolic meanings and expert use of countertransference. Although psychoanalysts seem to agree in opinion, how does it look in their practice? Some critics and skepticism can still be heard towards psychoanalytic research being based on therapy recordings, because in their perspective the process needs to include the subjective understanding of the participating psychoanalyst. The observing third can never understand completely while standing outside the dyad. Still, conceptions concerning the differentiations of psychoanalytic treatments are not a theoretical and abstract issue, but are thoughts, which are part of psychoanalysts’ everyday work. This ideas are transmitted from generation to generation of psychoanalysts; often containing only metaphorical concepts from unspoken theories (Hamilton 1996). Sandler (1983) adequately demanded to make the private and unspoken dimensions of analytic process concept public. Therefore, it is necessary to conduct empirical and objective research.

Various psychoanalytic process definitions appeared during the past years: Kris (1956); Greenacre (1968); Boesky (1990); Rangell (1981); Compton (1990); Calef & Weinshel (1980), etc. Though Abend (1986) concluded: “this lack of accepted definition leads analysts to refer to ‘mysterious factors’, ‘magical explanations’ and to invoke a quasi mystical ‘process’ concept” (p. 210). More recently, Ablon & Jones (2005) while developing a psychoanalytic prototype base on the Psychotherapy Process Q-set (Jones 2000), found that “if psychoanalysts are given a common vocabulary and a relatively theory-free set of descriptors they can agree on what constitutes an ideal psychoanalytic process, at least at the level of a single session” (p. 563). More important is the fact that this consensual definition could lead to an empirical measure, thereby providing a scientific method for
evaluating the degree to which analytic process can be found in practiced psychoanalytic oriented treatments. Using their tool, the PQS, Ablon & Jones (2005) were able to identify the degree to which analytic process was fostered in psychoanalysis, long-term psychoanalytic psychotherapy and brief psychoanalytic psychotherapy.

While definitions of analytic process were formulated, other attempts were made, as the development of process-models based on theoretical concepts, to study the analytic process. Some of the well known models\(^1\) are: the ‘Kohut’s Process Model’ (1979), which is based on his theory of restoration of the self; The ‘Process Model of the Mount Zion Psychotherapy Research Group’ (Weiss & Sampson 1986)\(^2\) that characterizes the course of psychoanalytic treatment as a conflict between the patient's need to express his unconscious pathogenic beliefs and the analyst's efforts to pass these critical situations (called ‘tests’) in such a way that the patient\(^3\) does not experience any confirmation of his negative expectations. Finally, the ‘Ulm Process Model’ was presented in the first volume of the Ulm Textbook (Thomä & Kächele 1987) and is based on French (1954) and Balint’s et al. (1972) ‘concept of focus’. The focus is the central interaction topic, created during therapeutic work, as a result of the material presented by the patient and the understanding of the analyst. A graphic representation of the ‘Ulm Focus Model’ (fig.1) can be seen bellow:

Fig. 1: The Ulm Focus-Model (adapted from Thomä & Kächele 1987).

\(^1\) For detailed description of the models please see chapter 9.3 ‘Models of the Psychoanalytic Process’ from Thomä, H., & Kächele, H. (1987).

\(^2\) Nowadays, this research group is known as the ‘San Francisco Psychotherapy Research Group’

\(^3\) Only the masculine form will be used throughout the text, meant are always man and women.
The concept of psychoanalytic treatment process presented by the ‘Ulm Focus Model’ was the result of an exhaustive confrontation with the growing field of systematic therapy research. Since long, the Ulm authors vindicate that psychoanalytic process research must transgress subjective positions, which rest only on the conviction of individual analysts. Clinical psychoanalysis has to set free from some of Freud’s ideas and develop as an empirical science. Many authors like Luborsky, Dahl, Bucci, Meyer, etc. have established the field of psychoanalytical-empirical therapy research (Dahl 1988). However, Tuckett (1994) still insists that psychoanalytical facts can only be created with participation of the involved analyst in the analytic process. Hence, without dismissing the role of a ‘participating analyst’ in research of clinical psychoanalytic therapy, the following features need to be present:

- Descriptive analysis of therapeutic interactions (to develop theoretical generalizations);
- How unconscious fantasies are expressed verbally and non-verbally (Krause et al. 1992);
- Studying internal processes from the analyst (Kächele 1985; König 2000) and from the patient, also outside the clinical setting, specially the internalization of the therapeutic experience. This can be captured with instruments like the inter-session questionnaire (Orlinsky 1990; Arnold et al. 2004).

1.1.1 The six stages of treatment research

The ‘Ulm Psychoanalytic Process Research Program’ (founded in 1970) has compiled extensive and rich experience. Following their suggestion it seems useful to distinguish six different stages, which occupy different positions in methodological terms, not serving the same purposes, goals and research questions. Those six stages are represented on the figure bellow (fig.2):
Fig. 2: Stages of treatment research

The present study belongs to the ‘Stage I - Descriptive Studies’, as a descriptive and comparative study of psychoanalytic processes. The urge of knowing how psychoanalysis and psychodynamic psychotherapy look from the inside will be pursued here. Therefore, a quantitative and qualitative group description using the ‘Psychotherapy Process Q-set’ (PQS) method from Jones (2000) will be applied. How do these groups of treatments resemble and differ from each other? Do the therapeutic interventions or techniques differentiate from setting to setting? Special attention will be given to the used techniques in these three different treatment groups.

Glover and Brierley (1940) initiated the study of technique in psychoanalysis. Using a survey-method, he asked members of the British Psychoanalytic Society about various features of their ‘technique’. A first summarizing research report about descriptive elements of psychotherapy was compiled by Mowrer (1953). Almost 20 years later, with the first edition of the ‘Handbook of Psychotherapy and Behavior Change’ (Bergin & Garfield 1971), the presentation of descriptive findings secured such an approach. This volume contained systematic information about patient and therapist characteristics, correlation of therapeutic
characteristics with outcome, etc. The 5th edition of this handbook summarizes more than 50 years of process and outcome research (Orlinsky et al. 2004).

1.2 Methods of Psychoanalytic Process Research

Psychoanalytical or psychotherapy process in general compromise patient’s and therapist’s behaviors and attitudes, and their interaction. Kächele (2009) describes the different methodologies to study the patient and therapist; here, only some triadic measures will be presented.

Overviews of research findings on psychodynamic therapeutic processes have been presented a number of times (Miller et al. 1993; Orlinsky et al. 2004; Levy & Ablon 2009). All these research efforts have followed Luborsky and Spence (1971) important claims towards the use of primary data, where:

"Ideally, two conditions should be met: the case should be clearly defined as analytic, meeting whatever criteria of process and outcome a panel of judges might determine; and the data should be recorded, transcribed, and indexed so as to maximize accessibility and visibility" (1971, p. 426).

When this requirement was spelled out, Hartvig Dahl from New York already had started to record the case of Ms C. The development of the ‘Ulm Textbank’ in the early Eighties was the first systematic attempt of installing an open data base architecture (Mergenthaler 1986; Mergenthaler & Kächele 1994). The ‘Berkeley Psychotherapy Archive’ started its activity little before 1985. In the mean time, other primary data archives were created: the New York Psychoanalytic Research Consortium (Waldron 1989); Penn Psychoanalytic Treatment Collection (Luborsky et al. 2001); Data archives that gather material for a specific research question (or diagnosis) are more frequent, consequently carrying low naturalistic validity for other studies. The value of research based on such data sets is enormous so that the following illustrations only include research approaches that are supported by such data sets.
1.2.1 The use of audio- or video-recordings

The introduction of audio recordings into the psychoanalytic situations has brought a lot of pros and cons argumentations. For us this discussion seems outdated or saturated, although this discussion has not really found its end yet (e.g. Josephs et al. 2004). Fifty years ago, only a few researchers were supportive of this initiative (Shakow 1960; Gill et al. 1968; Wallerstein & Sampson 1971). In Germany, the innovative merit goes to E. A. Meyer and H. Thomä in 1967, which with help of this technology, introduced a new era of research of the psychoanalytic process.

Despite the possible criticisms of the traditional process of data collection as a base for psychoanalytic research, it would be wrong to consider audio-recordings the only scientifically valid research material. In two projects, Wallerstein and Sampson (1971) observed the bidirectional influence of data documentation and research interest (see also Sargent 1961). Regular notes about a whole treatment, compared to compact case reports, have the advantage of usually representing systematic, open accessed observation-series made by an expert, whose methodological status is unclear. The scientific value of these could be increased if the criteria of subjective selection was articulated and defined (Tuckett 1994). The methodologies presented in the next section only use of tape recording or transcripts.

1.2.2 Triadic Methods: Patient-Therapist-Process

The ‘Psychotherapy Process Q-set’ (PQS)

To study clinical variables there is need for methodologies that are able to reduce clinical phenomena of qualitative nature into quantifiable dimensions. These methods should ideally be able to capture the uniqueness of a single case as well as allow the comparison between different cases and different samples. A methodological approach that tries to satisfy this requirement is the Q-methodology originally conceived by the physicist and psychologist Stephenson (1953; q.v. Müller & Kals 2004). The definite establishment of the Q-methodology as a method in the social sciences was accomplished by Block (1961), who completed the technique and demonstrated its utility. After a boom in the sixties, the method was rediscovered by Enrico E. Jones (in Berkley) for use in
psychoanalytic therapy research. He successfully launched the ‘Psychotherapy Process Q-set’ with a single case study based on Mrs. C\textsuperscript{4} psychoanalysis (Jones & Windholz 1990); meanwhile many group designs studies profited from this method. This instrument will be described in more detail in section 1.3.

‘The Analytic Process Scales’

A working group of Waldron and other experienced psychoanalysts (at the New York Psychoanalytic Institute) developed the ‘The Analytic Process Scales’, which can be used to analyze single audio taped sessions of psychoanalytic treatments (Waldron et al. 2004a, b). The scale investigates the respective contribution of patient and analyst, and their interaction. The analyst’s contribution refers to how well he can establish a relationship in which he can offer clarification and interpretation of transference and defenses. The patient’s contribution includes the articulation of experiences, the expression of feelings, and the reflection on what it means for him or her to offer appropriated self-reflection on information about conflicts, needs, and wishes. Further on, interaction characteristics can be used to capture how both participants in the process contribute to the relationship. As differentiation between a psychodynamic therapy and a psychoanalytic therapy, the authors assume that in psychoanalytic work unconscious elements come into awareness “as they are related to the patient’s suffering, whether these elements are intrapsychic conflicts, losses, pathological defenses, or deficits in the development of the self, or of the functions of the ego” (Waldron 2004b, p. 445).

The authors were inspired by previously existing instruments developed to analyze psychodynamic therapies, including the ‘Psychodynamic Intervention Rating Scale’ (PIRS) (Cooper & Bond 1998), the ‘Vanderbilt Psychotherapy Process Scales’ (VPPS) (O’Malley et al. 1983), the ‘Therapist Verbal Intervention Inventory’ (TVII) (Koenigsberg et al. 1988) and the aforementioned ‘Psychotherapy Process Q-set’ (Jones 2000).

The method divides the text of a session into significant segments, and with training – so far only conducted within the developers’ working group – a relatively

\textsuperscript{4} Mrs. C was treated by Hartvig Dahl (New York); she is considered the first audio recorded psychoanalytic case in the Anglo-American linguistic area and was multiply studied as the USA Specimen Case (q.v. Malcom 1980).
satisfactory reliability is achievable. The question about using the whole or only segments of a session was discussed some years ago (Mintz & Luborsky 1971) and remains controversial. In the first study three patient-therapist dyads with very different outcomes were analyzed (Waldron 2004a). Reliability values were presented, and as expected, the variance was determined by the degree of inference in the items, as Strupp et al. (1966) had already demonstrated.

Columbia Analytic Process Scale

After conceptual pre-works (Vaughan & Roose 1995), the Columbia Psychoanalytic Center Working Group among Roose – in open rivalry with other approaches like the one from Waldron (2004a) or from Jones (2000) – developed their own scale. As a consequence of the diverging perspectives among the COPE-working-group5 three different components of analytic process were considered to construct the scale: a) free association; b) interpretation and c) working through. For the free association concept, they referred to Bordin’s (1966) scales; for the interpretation component, they incorporated Pipers et al. (1987) classification into Gill and Hoffman’s (1982) useful differentiation between relation-oriented (R) and not-relation-oriented interventions (q.v. Hoffman & Gill 1988); for the working through component, no previously accepted definition was available. They decided to consider working through the moment when the patient shows insight or understanding about one of the following elements: a) an observation about the self; b) fantasy; c) transference or d) genetic reconstruction. Working through is defined as a cognitive process that involves the explication of meaning in a variety of situations and circumstances by creating links and parallels that serve to integrate experiences.

The Columbia Analytic Process Scale is constituted by the aforementioned components – free association, interpretation and working-through - and one value of ‘manifest’ or ‘absent’ is given by evaluators for each session. The inter-rater reliability between the two authors of this scale was with kappa in the range of .5, which in therapy research on such constructs is considered satisfactory. However, an unpleasant surprise came when 10 analysts attempted to classify 5 therapy

5 ‘Committee on Psychoanalytic Education’ (COPE) of APsaA
sessions to reach construct-validity (see Vaughan et al. 1997). The experiment result was that the biggest amount of the variance (two factor random effects linear model, ANOVA) is due to ‘error term’. This means that the variance is neither explainable by the idiosyncratic rating, nor by the ambiguity of the session material, but by an indefinable ambiguity of the analytic process concept. The conclusion, which the authors could not avoid, was that “there is no meaningful consensual definition of the term ‘analytic process’ among a group of training and supervising analysts from the ‘Columbia Center for Psychoanalytic Training and Research’ (p. 964). This raises the question: if not there, where else? Would expanding this study to members from other institutes, or even other countries, be worthwhile? Or are similar results predictable? The PQS, instead, has shown reliability inside and outside its study group and is accumulating evidence for applicability outside the USA.

The clinical field favors and highly values global and holistic concepts, which are not empirically verifiable (Kächele 2009). Certainly, one can reliably and validly evaluate well-delimited concepts that may also be manualized. This includes Bordins’ ‘free association scales’, as shown by Hölzer et al. (1988), the ‘Core Conflictual Relationship Theme’ (CCRT; Luborsky and Diguer 1990), ‘emotional insight’ (Hohage 1986) and others. However, Kächele believes that because of the ambiguity of the construct, ‘analytic process’ should no longer be used to distinguish psychoanalysis from non-psychoanalytic psychotherapies. In opposition, Ablon and Jones (2005) found that analysts could agree on what and analytic process is if they were given a common and simple language. Distinguishing the analytic process from different analytic schools could be an ambitious project to pursue. For this purpose, it would be better to follow a dimensional approach rather than relying on categorical differentiation – as suggested in the discussion of the new DSM-V – represented in the following figure (fig.3):
With such an approach, each session, each week, each month, and even each year can be described using these three dimensions (Kächele 1995). It is then an issue of conventional accordance – from when and to what extend the work on transference or with transference can be considered genuinely psychoanalytic.

An example for this is the transference-focused psychotherapy (TfP) from Kernberg’s study group, in which the aim is to detect as early as possible intensive signals of negative transference in the current interaction and to interpret it (Clarkin et al. 2000). In contrast, the ‘psychotherapy, related to structure’ by Rudolf (2004) can be mentioned here that explicitly defends a very contained use of transference work; true also for the mentalization-based psychotherapy by Batman and Fonagy (2004).

The problem with most of the measurement instruments outlined here is that the attempt to locate the process is on the level of individual hours. Targeting process development over time could be done with the adoption of Orlinsky’s differentiations of micro-, meso- and macro-processes (Orlinsky et al. 2004). Rarely are approaches presented that capture a therapeutic process in its length and then inform how much work on each transference constellation was done. Even the USA specimen case, Mrs. C, was only elaborated based on session level data analysis (e.g. Bucci 1988, 1997; Dahl 1988; Jones & Windholz 1990; Sammons & Siegel 1999; Spence et al. 1993; Weiss & Sampson 1986).
Finally, it is important to remember an older methodological position referred by Kächele (2009). A working group from the IPTAR Institute in New York, conceptualized analytic process as a variation in the organization of the psychic structures:

“It is based on the view that controlled regression, the ability of the working ego to tolerate unmanageable tension states, is a precondition for assimilating experiences not previously held in consciousness” (Freedman et al. 2003, p. 208).

Freedman et al. point out that primarily psychoanalytic research must be filtered through clinical thinking about psychoanalytic history, and the evaluation of the process must be made first by the treating psychoanalyst, and then by using the chosen secondary methods, from peer-review to supervision by external psychoanalysts. “Only then would these essentially clinical procedures receive external validity through the study of recorded text” (p. 207).

This research is explicitly based on – sita venia verbo – ‘internal psychoanalytical validity’; only the treating psychoanalyst’s judgment can show the direction to the researchers. Given the already discussed lack of consensus among clinicians (Thomä et al. 1976), this is a strange, openly politically-motivated explanatory figure. This controversy illustrates how the diverse approaches of psychoanalytic research can be conceived. Also Fonagy (2003) points to the failure of Freud’s clinician-researcher model:

“The source of the problems of theoretical diversity lies in the how we collect our information. As is well known, the word data is not the plural of anecdote. Psychoanalytic practice has profound limitations as a form of research, particularly the problem of induction. Our own theory precludes the possibility that we can be adequate observers of our clinical work. The discovery of the pervasiveness of countertransference has totally discredited Freud’s clinician-researcher model (p. 222)”.

Our position is very clear; if research is designated to offer new perspectives on a complex issue like psychoanalytic treatment, it requires a methodological approach to deal and work with the psychoanalytic discourse independently.

The research strategy should study concrete records of treatments so that processes can be identified, which permit the hypothesis testing of evidence. Naturally mixed strategies are also possible. Freedman et al. (2003) first chose the research object through the participating analyst; others prefer an approach that prioritizes the recorded dialogue rather than the analyst’s perspective. Both
perspectives are comparable in terms of the fruitfulness of their contributions, and their presentation of future challenges.

1.3 The ‘Psychotherapy Process Q-set’

One solution to the consensus problem is to attempt to refine ordinary clinical judgment. An approach that does this in a sophisticated manner is the Q-sort methodology (Stephenson 1953; Block 1978). The Q-technique is a method of measurement with a broad range of potential applications, but it is particularly well suited for the description of qualitative data. A Q-sort consists of a set of items, each of which describes a significant psychological or behavioral feature of an individual or situation. The specific content of the items depends upon the particular objectives of the research and the nature of the individuals or situations to be studied. For example, to study the characteristics of personality disorders, Shedler (2002) developed a diagnostic Q-sort, which included items concerning patients' emotional states, interpersonal relationships, defenses and other phenomena relevant to psychoanalytic thought. There is no standard Q-sort; rather, the goal is to provide a set of items that can capture as comprehensively as possible the critical dimensions of variation among cases under study.

The ‘Psychotherapy Process Q-set’ (PQS; Jones 2000) is a 100 items rating instrument designed to provide a basic language for the description and classification of therapy processes in a form suitable for quantitative analysis. The PQS allows clinical judges to formalize and render explicit what usually remains informal, implicit, or intuitive, and helps clinical judges to achieve reliable descriptions of complex treatment processes. It provides a standard format that all clinical judges can use to describe the material under study. The instrument is designed to analyze recorded treatment hours, as the unit of observation. Many rating scales rely on segments of recorded therapy sessions of varying length, forcing judges to rate a dimension of presumed relevance on the basis of relatively brief impressions (e.g. Angus et al. 1999; Waldron et al. 2004a). Most often, these data are then aggregated without consideration for meaningful

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6 The following section is adapted from the chapter “The Psychotherapy Process Q-set and Amalia X, Session 152” (Levy, Ablon, Ackerman & Seybert 2008) of the German book “Der Psychotherapie Prozess Q-Set von Enrico E. Jones” (Albani et al. 2008); The research instrument is named ‘Psychotherapy Process Q-set’, ‘Q-set’ is not a typo although it is a Q-sort methodology.
factors of timing and context. The application of the Q-technique to a treatment hour in its entirety has the advantage to allow clinical judges to study the material carefully for evidence supporting alternative conceptualizations, and to assess the gradual unfolding of the meaning of events within the hour. The Q-method can subsume and describe multiple time frames. Since the Q-method is anchored on the therapy hour, as a natural time frame for inquiry into process, successive hours, or groups of hours can be rated, so that the temporal range used for descriptive purposes (given the basic unit of the treatment hour) is limited only by statistical or quantitative considerations.

The 100 items that comprise the PQS represent an empirically guided selection from a pool of several hundred items gathered from previously existing process measures, as well as new items constructed by a panel of experts. Several versions of this Q-set were tested in a series of pilot studies conducted on scores of transcripts, videotapes and audiotapes of psychotherapy and psychoanalytic treatment hours. Each item was individually discussed with respect to its clarity, its importance for psychotherapy and psychoanalysis, and its implications for the sufficiency of the total Q-set. Items were amplified or rewritten for conciseness and jargon and ambiguous language was eliminated. Items were eliminated if they showed little variation over a wide range of subjects and therapy hours, were redundant, or had low inter-rater reliability. Whenever some facet of therapy process judged to be important and proved not to be captured or expressed by existing items, revisions were made or appropriate items were added. The Q-set captures a wide range of phenomena in the domain of psychoanalytic and psychotherapeutic process, including transference manifestations, resistance, reconstruction, the therapist’s activity (e.g. clarification, interpretation) and the patient’s affective states, such as anxiety, depression or other symptomatic behavior. The standard language provided by the Q-set, the careful definition of items, and its structured format all serve to guide clinical judgments in the direction of reliable, measurable statements.

The Q-method encompasses many of the operations the clinician performs in attempting to analyze the verbal meanings of the analyst-patient discourse. Holt

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7 The reader is referred to Jones, Cumming, and Horowitz (1988) for a detailed description of the development of the PQS.
(1978) distinguished several kinds of `internal analyses' of verbal texts that the clinical thinker might perform. These analyses include: summarizing content meanings by way of selection and abstraction; collating verbal messages by examining them for internal consistency and inconsistency; interpreting or translating the content of verbal messages; observing one's affective reaction to the verbal message, and discerning causal relations. Many of these operations are built into the Q-method. The therapist, for example, attempts to type or categorize the patient's behavior; the Q-sort similarly asks judges to identify the form or content of a communication and identify it with a conceptual system or code (the Q-sort). The clinician assesses the frequency with which a kind of event or behavior occurs, or its intensity; similarly, the Q-sort requires judges to rank order or scale the salience of a particular aspect of the therapeutic process. There is, in other words, a direct line of logical continuity from the qualitative classification of the clinical thinking to Q-sort ratings. The Q-sort simply attempts to codify and systematize processes of clinical inference and judgment. Incidentally, causal analysis, the most controversial and difficult to verify in the study of verbal meanings, is not an important aspect of the Q-method, since it is usually not essential in the description and construction of meaning for a given hour. When a causal statement is called for, it is usually interpersonal in nature, rather than an attempt to explain the patient's behavior in terms of underlying dynamic structure or inferred motives. In this case, it is readily deduced from overt behavior, as in the Q-item: "When the interaction with the patient is difficult, the therapist accommodates in an effort to improve relations".

The PQS can capture the uniqueness of each treatment hour while also permitting the assessment of the similarities or dissimilarities between hours and patients. It has been used in research involving group comparison designs, in which Q-ratings of groups of cases (or hours) selected on some dimension of interest are compared (Jones & Pulos 1993; Ablon & Jones 1998, 1999, 2002, 2005; Coombs et al. 2002; Ablon et al. 2006; Karlsson & Kermott 2006) as well as in N=1 designs (Jones & Windholz 1990; Jones et al. 1993a; Jones et al. 1993b; Albani et al. 2001; Pole et al. 2008, etc.). The instrument has demonstrated high levels of inter-rater reliability, item reliability, concurrent and predictive validity across a range of studies and treatment samples. Interrater reliability, which is
calculated by correlating the Q sorts of multiple raters across all 100 items of the PQS, ranges from .83 to .89. 8

1.3.1 Past research with the PQS method 9

Early research: Process predictors of what works for whom

One of the first studies conducted with the PQS verified Jones’ belief that common or non-specific factors were not solely responsible for therapeutic change, but rather that specific processes would predict outcome depending on their context. Specifically, he hypothesized that distinct processes might operate differently depending on variables such as patient characteristics, therapist characteristics, presenting problems, symptom severity and phase of treatment. Jones et al. (1988) investigated the treatments of 40 patients with post-traumatic stress disorder (PTSD) receiving 12 sessions of psychodynamic psychotherapy in order to examine the effects of specific therapist actions and techniques. At the beginning of the treatment, patients were separated into two groups depending on the severity of their symptoms. Results showed that different PQS-items were associated with therapeutic success in each group. Specifically, the authors found that specific PQS-items, in interaction with patient pretreatment disturbance levels, predicted treatment outcome. In fact, successful therapies with less disturbed patients were described by observers using the PQS as expressively oriented, as therapists emphasized patient feelings to help him experience them more deeply, made connections between the therapeutic relationship and other relationships, and drew attention to patient’s nonverbal behaviors. In contrast, successful therapies with more severely disturbed patients were shown to be more supportive in nature, as therapists gave more explicit advice and guidance, acted to strengthen defenses, reassured patients, and behaved in a teacher-like (didactic) manner. The diverse therapeutic strategies described with the PQS in the two groups seemed similar to what to Sifneos (1972) described as ‘anxiety

8 These extremely high correlations were only observed between members of Jones’ research group. Nowadays, in our perspective, the good inter-rater reliabilities are around .70 (Pearson correlation coefficient).

9 The contributions of the PQS to psychotherapy research will be published as a chapter in Levy, R., Ablon, S. L., & Kächele, H. (Eds.), in press. Psychodynamic Psychotherapy: Practice Based Evidence and Evidence Based Practice. New York: Humana Press.
suppressive’ vs. ‘anxiety provoking’ or the ‘supportive’ vs. ‘expressive’ techniques delineated by the Menninger Study (Wallerstein 1986).

How treatment process changes over time

In another early landmark study, Jones et al. (1992) studied the development of process over time by applying the PQS to another sample of 30 patients with a range of neurotic disorders who received 16 sessions of short-term psychodynamic treatment in a naturalistic setting. Process findings confirmed the importance of technical features traditionally considered integral to brief dynamic treatments, including transference and defense interpretations, the importance of the therapy relationship, and reformulation of patients’ in-session behavior. The change in process over time suggested that these treatments were characterized by a gradual shift from an external, reality-oriented construction of personal difficulties to an emphasis on inner experience and on the relationship with the therapist. The PQS-items associated with positive outcomes included: Patient achieves a new understanding or insight; Patient is introspective; Patient readily explains inner thoughts and feelings; Patient’s aspirations or ambitions are topics of discussion, and Patient feels helped. Negative correlates of outcome included: Patient resists examining thoughts, reactions and motives, and Patient is controlling.

Comparing process in different types of theoretical treatment orientations

Jones and Pulos (1993) then used the PQS to compare the process in the aforementioned sample of 30 patients receiving 16 sessions of psychodynamic treatment to a sample of 32 patients receiving 16-session CBT. They found that the two treatments were similar in terms of important patient characteristics, since out of the 38 PQS-items not distinguishing the two treatments, as many as 26 were descriptive of patient attitudes and emotional states, e.g. anxiety, guilt, inadequacy, depression, degree of trust in therapist and sense of feeling understood by therapist.

10 The same archive sample will be analyzed in this study in comparison with two other samples.
In line with the authors’ hypothesis, important differences distinguished the two treatments in terms of therapist stance and technique, however. The techniques employed by psychodynamic clinicians were consistent with that orientation’s theoretical frame, and included evocation of affect, bringing troublesome feelings into awareness, integrating current difficulties with previous life experiences, and using the therapist-patient relationship as a change agent. Different techniques characterized the cognitive-behavioral therapies, including controlling negative affect through the use of intellect, vigorous encouragement, support and reassurance.

Factor analysis of PQS-items: Associations with outcome

In addition to producing the above findings, the study by Jones and Pulos (1993) represented an important methodological advance through the use of factor analysis to identify underlying factors across the two treatments.

Using a principal components analysis, the authors found four conceptually interpretable factors, including 1) Psychodynamic Technique (e.g. Therapist is neutral; Therapist interprets warded-off or unconscious wishes; feelings, or ideas, see Table 1 below); 2) Cognitive-Behavioral Technique (e.g. Therapist actively exerts control over the interaction; There is discussion of specific activities or tasks for patient to attempt outside of session); 3) Patient Resistance (e.g. Patient rejects vs. accepts therapist's comments and observations; Patient resists examining thoughts, reactions or motivations related to problems) and 4) Negative Patient Affect (Patient feels sad or depressed; Patient feels inadequate or inferior). To the investigators’ surprise, psychodynamic technique was significantly correlated with four out of five measures of patient improvement in CBT (and showed a near-significant trend with outcome in the psychodynamic treatment). In contrast, cognitive-behavioral technique was found to have little or no relationship with outcomes in CBT, but showed a negative association with one of four outcomes in the dynamic treatment.
Tab. 1 PQS-items factor loadings for ‘psychodynamic technique’ factor (adapted from Jones & Pulos 1993).

<table>
<thead>
<tr>
<th>Item #</th>
<th>Item Description</th>
<th>Factor score</th>
</tr>
</thead>
<tbody>
<tr>
<td>81</td>
<td>T emphasizes P’s feelings to help him experience them more deeply.</td>
<td>.81</td>
</tr>
<tr>
<td>93</td>
<td>T is neutral.</td>
<td>.80</td>
</tr>
<tr>
<td>67</td>
<td>T interprets warded-off or unconscious wishes, feelings, or ideas.</td>
<td>.70</td>
</tr>
<tr>
<td>36</td>
<td>T points out P’s use of defensive maneuvers (e.g. undoing, denial).</td>
<td>.62</td>
</tr>
<tr>
<td>92</td>
<td>P’s feelings or perceptions are linked to situations or behavior of the past.</td>
<td>.61</td>
</tr>
<tr>
<td>50</td>
<td>T draws attention to feelings regarded by P as unacceptable (e.g. anger, envy, or excitement).</td>
<td>.58</td>
</tr>
<tr>
<td>91</td>
<td>Memories or reconstructions of infancy and childhood are topics of discussion.</td>
<td>.57</td>
</tr>
<tr>
<td>100</td>
<td>T draws connection between the therapeutic relationship and other relationships.</td>
<td>.50</td>
</tr>
<tr>
<td>82</td>
<td>P’s behavior during the hour is reformulated by T in a way not explicitly recognized previously.</td>
<td>.50</td>
</tr>
<tr>
<td>62</td>
<td>T identifies a recurrent theme in P’s experience or conduct.</td>
<td>.50</td>
</tr>
</tbody>
</table>

Note: PQS: Psychotherapy Process Q-set; T = Therapist; P = Patient.

Rapid vs. slow response to treatment

Another unique study using the PQS was conducted by Comninos and Grenyer (2008), who compared the early sessions of ‘rapid responders’ and ‘gradual responders’ in 16 weekly sessions of supportive-expressive dynamic psychotherapy (Luborsky et al. 1995). The process findings revealed that the rapid responders were better able to work with intensive feelings (e.g. guilt) in early stages of therapy. In contrast, the gradual responders had high ratings of defensiveness and externalization early in treatment, despite no differences in early working alliance, which confirms prior findings regarding the importance of focusing on affect in treatment while utilizing different treatment processes depending on patient characteristics.

The PQS in relation to other measures of process

While the PQS has primarily been used to examine process and outcome in psychotherapy studies, the instrument has also been found to be helpful in
elucidating key constructs such as the therapeutic alliance and countertransference.

Price and Jones (1998) examined the PQS in relation to alliance using the archived sample of 30 brief psychodynamic treatments from Jones et al. (1992). They found that 19 PQS-items correlated significantly with alliance as measured by the CALPAS (Marmar et al. 1986), including: Patient feels helped (item 95); Patient conveys positive expectations about therapy (item 55); Patient achieves a new understanding or insight (item 32); Patient is committed to the work of therapy; Patient is introspective and readily explores inner thoughts and feelings (item 97) and Patient understands the nature of therapy and what is expected (item 72). The PQS-items were examined with a factor analysis, which detected three underlying factors, including one named patient-therapist-interaction that strongly predicted CALPAS scores. The items with the strongest factor loadings included those reflecting that the patient felt trusting, secure, and understood by the therapist, understood the therapist’s comments, accepted the therapist’s observations and had clearly positive feelings toward the therapist.

Tobin (2006) identified patterns of positive and negative countertransference as reported by therapists using the Feeling Checklist immediately following a therapy session. These patterns of countertransference were found to appear in relation to specific therapeutic interactions, and suggested that therapists’ countertransference feelings were determined primarily by how effective they believed they were in the session.

Heaton et al. (1995) took a novel approach, and examined the construct validity of the PQS with the Therapeutic Procedures Inventory (TPI; McNeilly & Howard 1989) and the Hill Counselor Verbal Response Category System (HCVRCS; Hill 1978). Therapist techniques such as interpreting, paraphrasing and giving directives were highly correlated between the PQS and TPI, which both assess process rated at the level of the entire therapy hour. Surprisingly, none of the clusters from the PQS were correlated with corresponding clusters on the HCVRCS, i.e., approval, directives, question, paraphrase, interpretation, confrontation and self-disclosure. The authors speculated that the reason for the findings may be that the HVRCS measures process at the level of the individual sentence or speaking turn aggregated up to the session level.
All in all, these findings highlight the importance of examining the PQS in relation to other measures of process (including more fine-grained measures), and suggest that much remains to be explored regarding how therapists and patients navigate the interpersonal process in the consulting room.

Application of prototypes in past studies

The finding from Jones and Pulos (1993) that psychodynamic strategies were positively correlated with therapeutic outcome across both CBT and psychodynamic treatment led to a systematic line of inquiry concerning the incidence and effect of borrowing treatment processes from one approach for use in another.

This new line of research began when Ablon and Jones (1998) used expert ratings of PQS-items to develop prototypes of ideal treatment process. Specifically, Ablon and Jones first gathered panels of experts in psychodynamic and cognitive-behavioral therapy, respectively, and asked them to use the PQS to describe the process of an ideal session that adhered to their theoretical principles. Cluster analysis was then used to determine whether the panels of experts had distinct views of therapy process. Regression scores were calculated to determine the degree to which each individual item of the PQS contributed to the experts’ view of ideal therapy process. Each factor array of 100 scores represented a prototype ideal treatment process according to the experts (see tab. 2 for the 20 items most characteristic of psychoanalytic treatment).
Tab. 2 Rank ordering of 20 PQS-items by factor scores of ideal psychoanalytic therapy (adapted from Ablon & Jones 1998).

<table>
<thead>
<tr>
<th>Item #</th>
<th>PQS-Item description</th>
<th>Factor score</th>
</tr>
</thead>
<tbody>
<tr>
<td>90</td>
<td>P’s dreams or fantasies are discussed.</td>
<td>1.71</td>
</tr>
<tr>
<td>93</td>
<td>T is neutral.</td>
<td>1.57</td>
</tr>
<tr>
<td>36</td>
<td>T points out P’s use of defensive maneuvers (e.g. undoing, denial).</td>
<td>1.53</td>
</tr>
<tr>
<td>100</td>
<td>T draws connections between the therapeutic relationship and other relationships.</td>
<td>1.47</td>
</tr>
<tr>
<td>6</td>
<td>T is sensitive to the P’s feelings, attuned to P; empathic.</td>
<td>1.46</td>
</tr>
<tr>
<td>67</td>
<td>T interprets warded-off or unconscious wishes, feelings, or ideas.</td>
<td>1.43</td>
</tr>
<tr>
<td>18</td>
<td>T conveys a sense of nonjudgmental acceptance.</td>
<td>1.38</td>
</tr>
<tr>
<td>32</td>
<td>P achieves a new understanding or insight.</td>
<td>1.32</td>
</tr>
<tr>
<td>98</td>
<td>The therapy relationship is a focus of discussion.</td>
<td>1.28</td>
</tr>
<tr>
<td>46</td>
<td>T communicates with P in a clear, coherent style.</td>
<td>1.24</td>
</tr>
<tr>
<td>50</td>
<td>T draws attention to feelings regarded by P as unacceptable (e.g. anger, envy, excitement).</td>
<td>1.17</td>
</tr>
<tr>
<td>11</td>
<td>Sexual feelings and experienced are discussed.</td>
<td>1.12</td>
</tr>
<tr>
<td>82</td>
<td>P’s behavior during the hour is reformulated by T in a way not explicitly recognized previously.</td>
<td>1.12</td>
</tr>
<tr>
<td>35</td>
<td>Self-image is a focus of discussion.</td>
<td>1.11</td>
</tr>
<tr>
<td>91</td>
<td>Memories or reconstruction of infancy and childhood are topics of discussion.</td>
<td>1.08</td>
</tr>
<tr>
<td>92</td>
<td>P’s feelings or perceptions are linked to situations or behavior of the past.</td>
<td>1.05</td>
</tr>
<tr>
<td>62</td>
<td>T identifies a recurrent theme in P’s experience or conduct.</td>
<td>.95</td>
</tr>
<tr>
<td>3</td>
<td>T’s remarks are aimed to facilitating P’s speech.</td>
<td>.92</td>
</tr>
<tr>
<td>79</td>
<td>T comment on changes in P’s mood or affect.</td>
<td>.88</td>
</tr>
<tr>
<td>22</td>
<td>T focuses on P’s feelings of guilt.</td>
<td>.87</td>
</tr>
</tbody>
</table>

Note: Factor scores derived from expert psychoanalysts (N = 11) ratings of the PQS. Item #: Item number of Psychotherapy Process Q-set; T = Therapist; P = Patient.

As the next step, using the same dataset as Jones and Pulos (1993), Ablon and Jones (1998) correlated observer ratings of actual sessions with the prototypes to determine the degree to which the actual treatments corresponded to the ideal, prototypical process prescribed by the psychodynamic and CBT experts. Finally, to determine which processes constituted the active ingredients of the treatments, they assessed the degree to which adherence to the prototypes correlated with outcome.
Surprising results emerged again, therapists in the psychodynamic treatments fostered processes consistent with both ideal psychodynamic and cognitive-behavioral treatment, while in contrast therapists in the CBT group fostered mostly CBT processes, and not psychodynamic processes, thus adhering more closely to prescribed techniques. These results suggest that the psychodynamic clinicians employed a more heterogeneous set of treatment strategies than their CBT colleagues. However, results furthermore showed that adherence to the CBT prototype was associated with positive outcome for only one of the six symptom measures across the psychodynamic and CBT samples, while degree of adherence to the psychodynamic prototype was consistently associated with positive outcome across the two groups. This was true despite very little adherence to the psychodynamic prototype in the CBT sample. Thus, the surprising finding that psychodynamic process emerged as a positive predictor of outcome in the CBT sample was a replication of previous findings in the same sample using different methods. This study also suggested, however, that the active ingredients in a treatment do not necessarily need to be the most characteristic ones. Even minimal adherence to certain therapy processes can be robust predictors of treatment outcome. These findings demonstrate the importance of studying the therapy process in addition to outcome. What is presumed by a cognitive-behavioral treatment may actually contain significant psychodynamic ingredients or vice versa, and these interventions may be among the active ingredients in the therapy process. This may help to explain why different forms of treatment achieve similar results in traditional outcome studies.

Following these findings, Ablon and Jones (1999, 2002) conducted a replication study using data from the NIMH Treatment of Depression Collaborative Research Program (TDCRP), at the time the state-of-the-art controlled clinical trial for depression (Elkin et al. 1989). Results revealed significant areas of difference in process between IPT and CBT, as well as important points of similarity in the processes of both approaches. Differences in process were consistent with the theoretical distinctions between the two orientations, and centered on the therapist’s stance, activity and technique. When prototype methodology was applied, however, it became evident that both treatments adhered equally strongly to the CBT prototype. Of note, while the CBT therapists fostered a robust CBT
process to the exclusion of other processes, the IPT therapists were found to be fostering both CBT and psychodynamic process. However, adherence to the CBT prototype correlated positively with treatment outcome across both groups. In summary, these results challenged the assumption that the two treatment approaches tested in the TDCRP relied on mutually distinct interventions and techniques and that positive outcomes validated their proposed mechanisms of change. The moral of this line of research seems to be that brand names of therapy can be misleading when it comes to actual treatment processes fostered and active ingredients promoting positive change.

Using the CBT and IPT archives from the TDCRP, Karlsson and Kermott (2006) investigated, which PQS process factors were associated with reflective functioning (RF; Fonagy et al. 1998). The authors found that the PQS-items most strongly associated with RF were T accurately perceives the therapy process, T draws attention to feelings regarded as unacceptable by the patient (e.g. anger, envy, or excitement), T is sensitive to the patient’s feelings, attuned, empathic, P brings up significant issues and material, P is committed to the work of therapy, and P achieves new understanding insight. These PQS-items were in turn significantly associated with positive outcomes. In contrast, the PQS-items associated with lower levels of RF were T actively exerts control over the interaction (e.g. structuring and/or introducing new topics), P does not initiate topics, is passive, P does not feel understood by the therapist, P feels weary or suspicious, and P rejects therapist’s comments and observations. These items were in turn significantly related to poorer outcomes.

Taken together, the PQS findings from the TDCRP shed important light on psychotherapy process and outcome in CBT and IPT treatments. The findings also revealed the significant limitations of controlled trials of manualized treatments when it comes to studying psychotherapy process. This realization led to the next wave of research using the PQS to study psychotherapy naturalistically. While RCTs maximize internal validity, Jones and colleagues proposed the study of naturalistic treatments as an important complement to controlled studies in an effort to study psychotherapy process from a more ecologically valid perspective.
Adherence to Prototypical Treatment Processes in Naturalistic Treatments

In order to complement the research from the TDCRP and other RCTs, Ablon et al. (2006) studied 17 naturalistic treatments of panic disorder by seven self-identified psychodynamic clinicians delivering treatment as usual. Using the PQS, they found that the therapists employed a large spectrum of interventions, and the treatments included process variables typically associated with CBT. In fact, adherence to the CBT prototype was stronger than adherence to the psychodynamic and IPT prototypes, despite the self-identified psychodynamic orientation of the clinicians. However, adherence to IPT and psychodynamic process was most associated with positive outcomes. In other words, the most predominant processes were not the active ingredients of the treatment, a replication of findings from prior studies.

Ablon & Jones (2005) also used the PQS to compare therapy process from three different treatment settings: two psychoanalyses (N=130 sessions), three long-term analytic therapies (two sessions weekly; N=229 sessions) and two short-term dynamic therapy samples (N=122 sessions). The authors calculated each sample’s degree of adherence to the psychodynamic prototype, and found that the two psychoanalyses demonstrated a significantly greater correlation with the prototype, while the psychoanalytic psychotherapy treatments showed a weaker correlation and the short-term dynamic therapies an even weaker correlation. The differences between each sample were statistically significant, providing the first empirical evidence that psychoanalysis proper fosters more of an analytic process than psychodynamic psychotherapy (see fig. 4).
With the construction and application of the psychoanalytic prototype, the authors demonstrated that given a homogeneous descriptive language a consensus among psychoanalysts is possible about what constitutes a psychoanalytic process. This study motivates future research to look closer at which items differentiate psychoanalyses from the long-term psychotherapies. Overall, the authors of the prototype methodology hope that it will facilitate empirical research in the psychoanalytic field.

The second part of this study was based on an explorative factor analysis of the 100 PQS-items (without the prototype methodology) to enable the identification of interaction structures between patient and therapist in the two psychoanalytic cases. The results showed the uniqueness of each psychoanalytic process although being considered similar since both cases correlated highly with the psychoanalytic prototype. The design of the first part of the study will be followed in our study to foster the presence of analytic process not in a group of sessions but on treatment samples of the same types of treatments.
1.4 Therapeutic techniques

1.4.1 Introduction to therapeutic techniques

One of the factors that constitute the therapeutic process is the range of therapeutic techniques used in each treatment. Different techniques are taught to therapists in training of different therapy schools and consequently therapists attribute a different degree of confidence in the effect such techniques have for the process of change (Orlinsky et al. 2004). The usage of specific therapeutic techniques and its frequency of application are part of each treatment methodology. Thus, in order to look deeper into the different therapeutic processes, it is useful to study the techniques, therapeutic interventions and their interaction with the patient, setting etc.

In the ‘Handbook of Psychotherapy and Behavior Change’ (Lambert 2004, chapter 8, pp. 307-389), therapist interventions or techniques are defined as “formal and deliberate responses that therapists make to help resolve their patient’s personal difficulties, based on their expert understanding of the patient’s presentation and the recommendations of the treatment model they follow” (p. 337). In this chapter, a considerable amount of studies (some will be cited here) are presented, concerning therapeutic techniques and its correlation to therapy outcome done over the past 60 years.

Other authors concentrated on more specific investigations of therapeutic techniques like the therapists’ ‘questioning’ (Stiles & Shapiro 1994; Russel et al. 1996, etc.), ‘reflection and feedback’ (Claiborn et al. 2002, etc.), ‘prescriptiveness, guidance and advice’ (Hayes & Strauss 1998, etc.), ‘support’ and ‘evocative exploration’ (Gaston et al. 1998, etc.), ‘experiential confrontation’ (Schmidtchen 2001, etc.), ‘activation of patients resources’ (Dick 1999, etc.) and ‘therapist self-disclosure’ (Barret & Berman 2001, etc.).

The aim of interpretation is to make the patients aware of things that are currently outside their consciousness (Gabbard 2009, p. 51). Usually this requires the therapist to explain something that is ‘not clear’ or not in awareness to the patients through, for example, connecting two ideas that were not linked by the patients before. The technique of interpretation continued to receive attention from several researchers (Høglend 1993; Høglend et al. 1994; Norville et al. 1996; Stiles &
Shapiro 1994; etc). Certain interesting results relatively to its effect on outcome need to be clarified:

“On the one hand, it is important to note that 24 previous studies have found the use of ‘interpretation in general’ to be fairly consistently, and occasionally strongly, associated with positive therapeutic outcome. On the other hand, there is consistent evidence, cited in the review by Henry et al. (1994) and confirmed by recent studies, that the use of ‘transference interpretations’ specifically in brief psychotherapies is associated with negative therapeutic outcome and ought to be avoided. The use of transference interpretation was developed as a way of dealing with transference resistances in the context of long-term psychoanalytic treatment (Freud 1912a), and needs a stable positive alliance to really work well. Whatever its value may be in that context, its use as a technique in brief psychotherapies probably should be abandoned… (Orlinsky et al. 2004, pp. 341-342)”.

This excerpt shows the psychotherapeutic techniques’ influence on the therapeutic process, and how influences’ quality varies according to the treatment setting or orientation. This would possibly lead us to one important discussions of the present study, namely the use of interpretation while comparing long-term and psychodynamic psychotherapy with its short-term version. Is interpretation less characteristic in short-term psychodynamic psychotherapy than in long-term?

It is wide spread and recognized that therapeutic alliance is the most important therapeutic technique among all therapeutic orientations (from CBT to psychoanalysis) and consequently is the most frequent studied phenomena. The influence on therapeutic change is more due to therapeutic alliance than technique (Kächele 2007, p. 3). Nevertheless, we concentrate on techniques because one may argue that the quality of patient and therapist relationship can be less influenced, and therapeutic techniques and interventions instead can be specifically learned and applied, parallel to existing alliance, by any trained therapist to meliorate therapeutic process and favor therapeutic change. The existing alliance can be described through a defined constellation of PQS-items, based on positive and negative predictors of therapeutic alliance studied by Price and Jones (1998).

The impact of therapeutic techniques on outcome has been fairly studied, but in psychoanalytic tradition more attention has been given to idealized conceptualizations of therapists’ intervention. The result is that therapeutic techniques of
this field are well defined\textsuperscript{11}. However, to which extent and to which specific form they are practiced has not been sufficiently studied to satisfy empirical-analytical standards of research. Several reasons could have led to this research gap.

Curiously the divergence between the ideals of a treatment orientation and their actual practice can be seen through the application of prototypes that represent a modeled conception of an analytic hour. Ablon and Jones (2005) with help of the ‘Psychotherapy Process Q-set’ (PQS) developed a prototype of an ideal psychoanalytic hour by interviewing experienced psychoanalysts\textsuperscript{12}. The correlation of that prototype with actual psychoanalytic sessions showed a fairly high correlation ($r=.58$), though not yet a so-called ‘perfect match’ (like a high correlation of $r=.70$). What would happen if we would only correlate those items that represent the analyst’s techniques (since the PQS has 2/3 of other items representing other aspects of therapy like the patients behaviors and the interaction with the therapist)? Would we obtain a comparable correlation? Would it be higher or lower?

In the last decades, the ‘categorical and dimensional’ differentiation of techniques used in psychodynamic psychotherapies or psychoanalysis has been increasingly debated. Nowadays, the ‘Psychotherapy Process Q-set’ method allows these differentiations to acquire a dimensional perspective; in other words, to obtain a quantifiable classification. We believe this method can help us to fill this research gap and clarify some of the possible differences or similarities in the usage of therapeutic techniques in different oriented therapy settings.

\subsection*{1.4.2 Operationalization of therapeutic techniques by the PQS}

The identification of techniques is our chosen approach to distinguish and compare between psychoanalysis, long and short-term psychodynamic psychotherapy. Among the 100 items from the ‘Psychotherapy Process Q-set’

\textsuperscript{11}Within psychodynamic psychotherapy independently to preferred theoretical models, Gabbard (2009) names some fundamentals of technique: “therapeutic alliance, specific types of interventions (like interpretation, observation, confrontation, clarification, encouragement to elaborate, empathic validation, psycho educational intervention, advice and praise), transference, countertransference, resistance, working-through and termination” (p. 44).

\textsuperscript{12}The construction of the prototype will be described in the method section. For the original construction of the prototype see Ablon & Jones (1998, pp. 5-8).
which will be applied on each of the three treatment samples, several items can be identified describing psychotherapeutic techniques. Aim of this section is to discuss individual techniques in association with corresponding PQS-items. In this way the reader is acquainted with the therapeutic techniques that will be observed in this study.

1.4.2.1 Interpretation

The technique of interpretation is the mostly associated to psychoanalytic tradition. Among actual professionals of this field, interpretation is still considered a core technique because of its assumed insight producing character. The aim of interpreting is to “bring to conscious something that was previously unconscious, or (they) may explain a linkage that was outside of the patient’s awareness in a way that produces insight. (...) Interpretation usually involves explaining something to the patient” (Gabbard 2009, p. 52). An unusual definition from a discourse analyst, Ehlich (1990), has been pointed out by Kächele (2007, p. 13), “an interpretation is the response to a question the patient was not able to elaborate himself” (translated by author, p. 12).

Leichsenring (2005) suggests understanding the concept of interpretation embedded in other interventions like clarification, confrontation, which are central for psychodynamic work (both discussed further in this text) because both share a preparing character for interpretations. For the interpretation to have a beneficial effect, it needs to be accepted by the patient. The patient’s accepting attitude needs to be prepared emotionally and cognitively. Nevertheless, interpretation must be clearly distinguished from other techniques (Leichsenring 2005). An interpretation aims to offer a new and unknown context for an actual or experienced occurrence or emotion of the patient, so the patient can ‘go one step further’ in terms of acknowledging something that until then he was unaware of.

Besides all attention around interpretation, this therapeutic technique is not, as demonstrated through research, ‘an everymen or every occasion dress’. For example, Blatt and Shahar (2004) showed that two different types of patients profit differently from interpretations. The ‘introjective patients’, more preoccupied with their self-concept, could take more from an interpretation and insight, than the
‘anaclitic patients’, that are more focused on relatedness and consequently benefit more from the therapeutic relationship itself, than from interpretation. Blatt showed empirically that in therapy there is a ‘patient personality – therapeutic technique fit’ (Blatt et al. 2006 in Fonagy & Kächele 2009, p. 17).

Easily one can follow Fonagy & Kächele’s (2009) questioning attitude about the exaggerated importance given to interpretation. From a psychoanalytic and psychodynamic perspective they discuss the suitability of interpretation depending on therapeutic context and on the type of the interpretation delivered. Nowadays one can look back to the time where too high admiration and intellectual value was attributed to interpretation technique, which probably contributed to the current restricted-usage of interpretation. Even students of the field have often the misconception that interpretations need to enclose special ‘intellectualized’ formulations like, for example, a complex metaphor. But is there only interpretation of that kind? In addition, it is not always helpful to make the patient aware of deep unconscious material through interpretation; one must consider the therapeutic context and the patient’s ability to accept or to understand the therapist’s elaborations. There is a timing, a type of patient, a type of diagnose that also needs to be considered.

Nevertheless, there are different types of interpretations that can be chosen “depending on the conflict they aim to address: defense, anxiety or underlying wish or feeling. Or its classification can depend on the content of interpretation, whether it relates to external reality, the transference relationship or childhood relationships” (Fonagy & Kächele 2009, p. 31).

Early classifications of interpretation types, by Bibring (1954), created a controversial discussion at that time. Nowadays a classification like the one from Leichsenring (2005) is generally accepted and identifies diverse types of interpretation that link a certain content (e.g. transference, past, etc) with the actual experience, offering a new meaning to the patient:

- ‘genetic-reconstructive interpretation’ (relating the actual experience with its root or its first appearance);
- ‘transference interpretation’ (linkage between the experience of the actual therapeutic relation and biographical significant old relational experiences; will be discussed separately in 1.4.2.2);

- ‘dream interpretation’ (connection of diverse elements of a dream telling and so far unconscious motives or unaccepted affects);

- ‘symptom interpretation’ (relation between symptom and unconscious impulses).

Part of this differentiation of interpretations, may be also useful to better understand the interpretations captured by the ‘Psychotherapy Q-set (PQS)’ (Jones 2000) although other types of interpretations may be added. An interpretation ‘per se’ (in a global sense) includes observing interpretation of unconscious wishes, feelings, thoughts, impulses or ideas (item 67). It is expected, that the therapist draw patient’s attention to this aspects that may not be clearly in awareness. The extent to which the mental content is in awareness may be taken from the context of the observed hour and the patient’s reaction. The material must be outside the awareness of the patient to be considered by this item.

The ‘genetic-reconstructive interpretation’ (Leichsenring 2005) is considered by the PQS, when during therapy patient's feelings or perceptions are linked to situations or behaviors of the past (item 92). The connections are made between the patient's current emotional experience or perception of events with those of childhood and early experience. For example, therapist points out (or patient realizes) that current fears of abandonment are derived from the loss of a parent during childhood. A discussion of current and past experiences would not be considered by this item, if not linked (instead item 69 for actual life and item 91 for descriptions of the past).

As Fonagy & Kächele (2009) pointed out that Steiner (1993) “distinguished analyst-centered from patient-centered interpretations”. The first concerns patient’s ideas about the analyst’s thoughts and the second is the analyst’s understanding of the unacquainted material in patient’s mind. Both help the patient to understand how minds interact in the context of social relationships. If the analyst only delivers patient-centered interpretation it may happen that the patient perceives the therapist as persecutory and as not comprehensive of patient’s
struggle with intimacy with others. The PQS distinguishes between generalized and specific interpretations, as interpretations that refer to patient's relationships or interaction with others. It may be the relationship with the therapist or with people outside therapy. The patient’s way to relate or react with others can be very meaningful for understanding the patient’s internal functioning. Item 40 captures exactly if the therapist makes interpretations specifically referring to actual people in patient's life e.g. the therapist may say: “You felt hurt and angry when your mother criticized you”. Or if the therapist favors general or impersonal interpretations: "You seem to be inclined to withdraw when others become close”. These can also refer to other aspects of the patient’s life.

At this point, one can recognize how helpful the PQS is in capturing different types of interpretation. This is also true for the following therapeutic techniques.

1.4.2.2 Transference interpretation

Still within technique of interpretations, the interpretation of transference will be discussed separately, as more attention can be dedicated to the explanation of transference. Transference is a central construct of psychoanalytic theory of etiology and theory of treatment. Psychodynamic therapists recognize and use therapeutically the interpersonal level of therapy; this means the relational patterns between the therapist and patient. Those relational patterns have been created during the patient’s past, through repetition of interaction patterns with the patient’s family and past interpersonal history. Those relational patterns that are dysfunctional and repetitive are both object of treatment and research (Kächele 2007, p. 5). Nevertheless, interpretation of transference is a complex form of interpretation to discuss, since different theoretical orientations, within psychoanalysis, attribute to transference different mechanisms or dynamics (Fonagy & Kächele 2009). But first, what is transference? Transference itself can be defined as a

“… displacement of feelings or thoughts associated with a figure in the patient’s past onto the therapist. Transference is often unconscious, at least initially, and the patient is bewildered by behavior towards the therapist because it does not make sense, based on who the therapist really is. (...) Whereas the original definition assumed that a kind of template in the unconscious was taken from the patient’s mind and superimposed on the therapist without much alteration, today the prevailing view is that the
therapist’s actual behavior in always influencing the patient’s experience of the therapist (Hoffman 1998). Hence the transference to the therapist is partly based on real characteristics and partly on figures from the patient’s past – combination of old and new relationships” (Gabbard 2009, p. 56).

Consequently, interpretation of transference is a demonstration to the patient that what happens in the therapeutic relationship can be similar to happenings outside the therapy, e.g. the feelings the patient may have regarding his therapist may be the same the patient felt towards a significant figure of his life. The therapeutic setting and the therapist’s behavior should stimulate the origination of transference (Thomä & Kächele 2006, p. 332). The use of transference interpretations should be cautious, since patients easily feel ‘trapped’ or embarrassed by understanding their repetition in their behavior (Gabbard 2009, p. 57). After some research on this concept, a new cautious attitude towards the application of transference interpretation in low-frequency therapies is accepted (Kächele 2007, p. 13). How much and how soon one should work with patient’s transference has been a lively debate for long. A common approach is not to deliver interpretation of transference to early. The transference interpretation can only be done when transference is sufficiently intensive, differentiated or formed (Thomä & Kächele, 2006). Other professionals argue that one should only work with it, when it becomes a resistance for the therapeutic process and when the transference is proximate to patient’s awareness (Gabbard 2004; Leichsenring 2005). Thomä & Kächele (2006) describe the process of transference interpretation as work jointly done by patient and therapist, but where the therapist points out the similarities and common aspects between transference relation and specific relations from outside therapy. The analyst offers the patient – in an indirect, unknown and unintended way, but inevitably – through different stimulus and moments, the possibility for the patient to experiment and develop different and flexible relationship patterns in the therapeutic situation. At the end, the patient will have to experiment the changed or more flexible behavioral patterns (‘learned’ and ability was confirmed inside therapy), to use them in adapted form in situations outside therapy (Thomä & Kächele 2006, p. 332).

Instead of getting more into detail about types of transference and its origins, it matters to understand how transference interpretation can be observed in a therapy hour. With help of the PQS, transference interpretation is simply registered
when the therapist draws connections between the therapeutic relationship and other relationships (item 100). The therapist has to include in his comment the links between the patient's feelings about the therapist and feelings toward other significant individuals in his or her life. This may include attempts to link the interpersonal aspects of therapy with experiences in current, past or present relationships. For example, therapist remarks that she thinks the patient is sometimes afraid she will criticize her just as her mother does (parent link).

1.4.2.3 Countertransference

Associated to transference is the occurrence of countertransference, which is a counter-reaction or emotional reaction from the therapist towards patient's emotional state or emotional reactions in therapy. Not until a twist in reasoning about countertransference, marked by Heimann (1964), this phenomena was considered a therapeutic barrier (Kächele 2007, p. 15). Now it is widely accepted that the analyst's feelings and thoughts contain important clues about the patient's unconscious mental state, and countertransference started to be taken into serious consideration, as part of the analyst's therapeutic armamentarium (Fonagy & Kächele 2009, p. 27). Nowadays this concept is no longer understood, as a unilateral phenomenon as Freud did in 1910, but as something that is created by both, patient and therapist, and includes the emotional reaction of the therapist towards the patient (Gabbard 2009, p. 58).

According to Kächele (2007, p. 16) it is helpful to understand countertransference in three phases. First, the therapist attempts to reach control over all his action, speech and even feelings (which can lead to certain constrains). In the second phase, the therapist falls into resistance against his countertransference while taking the risk of assuming a dismissive attitude. When the therapist overcomes this feelings, possibly stage 3 begins, where he defeats countertransference. In this sense, it recommends the therapist to continuous oscillation between free play of fantasy and critic appraisal.

Fonagy and Kächele (2009, p. 27) argue that especially in intensive long-term treatment the therapist susceptibility to this emotional reaction towards the patient's current experience may serve to either illuminate or obscure this process.
It is from this perspective of disturbance or not disturbance of the therapeutic relationship the PQS captures countertransference in a therapy session. Following this reasoning, the PQS observes if the therapist's own emotional conflicts intrude into the relationship (Item 24). It refers to situations where the therapist responds to the patient in a somehow ineffective or inappropriate way, and when this response does not stem solely from the therapy encounter, but conceivably derives from the therapist's own emotional or psychological conflicts (the countertransference reaction). For example, the therapist seems to avoid or shows personal interest in certain affects or issues, which the patient expresses. The PQS only observes if the countertransference has an effect on the therapeutic relationship and does not refer to the meaning or possible interpretation of it.

1.4.2.4 Observation

In contrast to interpretation, the technique of therapeutic observation does not invoke some covered meaning (Gabbard 2009, p. 54). Observation is restricted to pointing out something that was outside patient’s awareness. It is comparable to a pointing finger, expressing ‘there is or maybe something’. A common focus is nonverbal communications or unconscious enactments that are only or more evident to therapist’s perception. This is captured by the PQS when the patient's behavior during the hour, is reformulated by the therapist in a way not explicitly recognized previously (item 82). The therapist rephrases the patient's behavior in a way that appears to shed new light on it. For example, the therapist suggests that the patient's late arrival for the hour may have a meaning; or therapist notes that whenever the patient begins to talk about emotional topics, he quickly shifts to another focus. The therapist points out that there may be a meaning but does not formulate it.

Although psychoanalytic oriented therapists tend to give a special meaning to the identification of a recurrent theme in the patient's experience or conduct (item 62), the PQS captures this intervention merely as an observation from the therapist without reference to the meaning it might enclose. This is captured by the PQS when the therapist points out a recurrent pattern or theme in the patient's life experience or behavior. For example, the therapist notes that patient repeatedly seeks out unavailable sexual partners.
1.4.2.5 Confrontation

The technique of confrontation focuses on “something that is being avoided but that is within the conscious awareness of the patient” (Gabbard 2009, p. 54). Confronting the patients with avoided material can lead to productive work or not. Leichsenring (2005, p. 79) argues that confrontation can lead to an interpretation and suggests using the term ‘demonstration’ instead, while fearing a connotation of aggressiveness to the technique. Fonagy and Kächele (2009) explain this technique, as residing in the middle of a continuum, between a directive and an interpretive approach: “At its gentlest, confrontation may involve the therapist simply identifying an inconsistency in the patient’s communication and bringing this to patient’s attention. For example, you seem to express no sadness about this loss, yet in the past you claimed to have cared a great deal for him” (p. 22).

There is no specific PQS-item that explicitly captures the technique of confrontation, though we suggest a combination of items that represent confrontation\(^\text{13}\). For instance, when the therapist raises questions about the patient's view (item 99) or somehow raises a question about the patient's view of an experience or an event. E.g. therapist might say: "How is that so?" or "I wonder about that," or simply utter an "Oh?". This item does not refer to interpretations or reframing in the sense of providing a new or different meaning to the patient's discourse, but instead refers simply to somehow raising a question about the patient's viewpoint.

\(^{13}\) In 2009, I asked S. Ablon for advice concerning this possible item constellation for the confrontation technique.
1.4.2.6 Clarification

The aim of clarification, as a therapeutic technique, is to emphasize the origin of an affect, a fantasy, an impulse or a thought, while holding a demonstrating character (Leichsenring 2005, p. 79). Most of therapist's activity is to clarify or reformulate. It may lead the patient towards something he was trying to get at, or to introduce another technique, e.g. interpretation. Frequently, patients are unclear or insecure in expressing their feelings and thoughts. Therefore, the therapist ‘repackages’ the patient’s communication, so that the clarification serves both patient and therapist, which may have a questioning tone sometimes (Gabbard 2009, p. 54).

According to Fonagy and Kächele (2009), “clarification stands in between supportive and interpretive interventions. It is a restatement in the therapist’s words of the patient’s communication. It may also be crucial in offering a verbal (symbolic) label for a confused set of internal experiences which the patient is poorly equipped to coherently represent” (Fonagy & Kächele 2009, p. 22).

In a therapy session, the PQS captures the clarification technique, when the therapist restates or rephrases the patient’s communication in order to clarify its meaning (item 65). The therapist's activity must be restating or rephrasing the patient's affective tone, statements, or ideas in a somewhat more recognizable
form in order to render their meaning more evident. For example, the therapist remarks: "What you seem to be saying is that you're worried about what therapy will be like".

1.4.2.7 Encouragement to elaborate

A supportive and directive technique in psychotherapy is the therapist’s encouraging the patient to elaborate, or to provide more information. Although this intervention is characterized by the therapist doing everything “to stimulate the patient’s uncensored, open reporting of whatever comes to mind” (Gabbard 2009, p. 55), one should not confuse this with the therapist motivating patient’s ‘free association’. The technique of elaboration can be more or less directive in specifying a topic of interest, “but at the same time may be crucial antecedents to interpretive work” (Fonagy & Kächele 2009, p. 22). This technique is essential therapeutic work in general. What would a therapist do with a patient that ‘is mute’? When a patient does not share information or contribute to the therapeutic process the therapist must find a solution. The most common intervention to make the patient share information is: “Could you tell me more about that?” (Gabbard 2009, p. 55). This is exactly what the PQS aims to capture with item 31: “Therapist asks for more information or elaboration”. Here, the therapist formulates questions designed to elicit information, or even pressing the patient for a more detailed description of an occurrence. For example, the therapist asks about the patient's personal history, or inquires what thoughts went through the patient's mind when he met an acquaintance by chance on the street. Another PQS-item also captures a more subtle way, but not less effective manner to elicit patient communication. This are all therapist's responses or behaviors that indicate he is listening to the patient and encouraging to continue, such as: um-hmm, yeah, sure, right, and the like (item 3: Therapist's remarks are aimed at facilitating patient speech).

1.4.2.8 Empathic validation

Empathic validation is based on one of the most important concepts for any type of human interaction: empathy. In case of therapeutic interaction, Leichsenring (2005, p. 70) describes empathy as a complex affective and cognitive process that
permits the therapist to conclude, in a reasonable manner, about how in a certain situation the patient may think, feel and perceive and how patient’s actions and statements derive from that. Empathy must be distinguished from intuition because contrary to empathy, intuition cannot be explained and not reflected about (Lichtenberg et al. 1984). If the therapist thinks about his intuition, the intuitive moment is transformed into the starting point of a reflective process of empathy. Three aspects that nourish empathy: therapist's available life experience, patient acquaintance (patient’s interpersonal relational patterns, defense mechanisms, life world, social reality) obtained through the diagnostic and therapeutic process and the therapist’s theoretical knowledge (Leichsenring 2005, p. 70). Thus the therapist gains the ability to place himself into the patient’s position and comprehend his feelings, thoughts and perception.

The PQS captures therapists’ emphatic behavior when he is sensitive to the patient's feelings, attuned to the patient (item 6). The therapist possessing the ability to be empathic is not enough; therapist’s empathic comprehension must be shared or demonstrated to the patient to be considered an emphatic validation.

The therapist must display the ability to sense the patient's ‘private world’ as if it was his own. Not only is it important that the therapist is sensitive to the patient's feelings and experience, but also being able to communicate this understanding in a way that seems attuned to the patient, for example, the therapist makes a statement that indicates an understanding of how the patient felt and experienced a certain situation. In this context, Gabbard (2009) points out that “often patients have had their internal experiences invalidated or denied by parents as they grew up, leading to a need to present façade or a false self to the family. Therapists can be particularly helpful when they validate that the patient has a right to certain feelings and that the patients response is legitimate in light of what has happened to the patient” (p. 55).
1.4.2.9 Psycho-educational intervention

The misconception about psychodynamic therapy not favoring psycho-educational interventions is frequent. Nowadays psychodynamic authors agree on the existence of this supportive technique, but differ in its content or definition.

In a more general understanding of this term “dynamic psychotherapy always has an educational aspect because patients learn about themselves in the process of trying to express the nature of their problems” (Gabbard 2009, p. 55). Still from a psychodynamic view, but more specific, psycho-education is the patient’s learning about their pathology, the therapy goals and limitations. Hence, a more precise definition for psycho-educational intervention is given by Leichsenring (2005, p. 91). He names them ‘informative interventions’ where the patient receives information about the working process expected in a psychoanalytic oriented therapy. This information is almost obligatory at the beginning of therapy. Beside that, it is also adequate to give information to the patient, information he could find elsewhere or are urgent for the patient to know. Often, patients understand information delivered by the therapist as advice.

Two PQS-items capture the two forms of psycho-educational interventions. One form, when the therapist explains rationale behind his technique, treatment approach or suggests that the patient uses certain techniques (item 57). For example, therapist may reply in response to a direct question or request of the patient that he prefers not to answer immediately, since this would provide a better opportunity to explore thoughts or feelings associated with the patient’s question. This may include the therapist answering questions about treatment process and explanations about the rationale behind the technique or other aspects of the treatment.

The other and more extreme form of the psycho-educational technique item considers situations when the therapist behaves in a teacher-like (didactic) manner (item 37). This means that the therapist’s attitude or stance toward patient is like that of a teacher to a student, therapist does assume a tutor-like role in relation to the patient. This can be judged independently of specific content, i.e. therapist can impart information to make suggestions without behaving in a didactic or teacher way, and alternative interpretations can be offered in the form of instruction.
1.4.2.10 Advice

Advice is one of the most supportive interventions in psychodynamic psychotherapy (Gabbard 2009, p. 56) among other techniques of explicit support, like consolation, suggestion and persuasion, all used in healing processes across many ages and societies. Schachter and Kächele (2007) suggest including this techniques into psychoanalysis. Although classical psychoanalysts insist of not making explicit use of this range of supportive techniques, in order not to compromise their almost sacred psychoanalytic ‘neutrality’, it is hard to accept that a helping therapist does not make use of support at least implicitly. The same authors point out Freud’s contradictory example of using even explicit support in the treatment of the ‘Rat Man’ as assuming the role of a ‘befriending educator’ (Mahoney 1986). Consequently, the opinion of contemporary psychoanalysts about the use of support is heterogeneous (Schachter & Kächele 2007).

Psychodynamic therapists may offer advice to the patient on a particular course of action. For instance, patients who are in a state of crisis may need specific advice (Gabbard 2009, p. 56). The PQS codes this technique when the therapist gives explicit advice or makes particular suggestions guiding the patient (item 27). It is meant that the patient is than free to accept or ignore the therapists’ suggestion. For example, the therapist may say: "You know, you might find it helpful to consult a lawyer about how to handle your inheritance". Or therapist might guide patient to consider a range of options and to explore each alternative. Another way is the therapist pointing out possibilities that the patient overlooks and direct patient to explore possible consequences of each line of action, which would be considered a looser attitude of advice giving from the therapist.

1.4.2.11 Praise

Similarly to advice, praise is a very supportive intervention (Gabbard 2009, p. 56) where in certain situations the therapist may praise the patient’s specific behaviors

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14 Curiously, authors that described many of the other therapeutic techniques mentioned here did not consider the psychotherapeutic techniques of advice and praise. We decide to include both in our observation because of its importance for psychoanalytic or psychodynamic process; other psychoanalysts openly share this view (Schacter & Kächele 2007).

15 See last footnote (nr.14).
or comments. Praise can facilitate the therapeutic alliance and can help the patient feel that he is participating in therapy adequately.

The PQS captures praise when the therapist adopts a supportive stance (item 45), in which he may even assume an advocate-like posture toward the patient. This may take the form of approval of something the patient has done, or of encouragement. The therapist must show agreement with the patient's positive self-statement, or emphasize the patient's strengths, for example: "You did this in the past, and you can do it again".

1.4.2.12 Resistance

In all psychodynamic treatments resistance can be observed; whether it occurs more frequently and intensely in the middle of treatment process in longer treatments, as some clinicians claim, is empirically unproven. Paradoxically for patients searching for help by therapy, resistance is an unconscious force against the progress of the therapeutic process (Leichsenring 2005, p. 81). “In fact, the presence of resistance is implied by the term dynamic, which suggests psychic forces both pulling against and pushing towards change” (Fonagy & Kächele 2009, p. 23). Resistance is an expression of the patient's defense mechanism to protect from uncomfortable feelings that can occur during the process of change (Gabbard 2009, p. 65) and is developed when a central aspect of the patients' self is questioned and the ego-synchrony is threatened (Leichsenring 2005, p. 81). All different forms of resistance have the function to maintain the 'somehow' achieved psychic balance16.

Working with resistance and defense is part of the treatment technique in all psychoanalytic oriented therapies. In this context, the PQS focuses on the therapeutic work with defenses, when the therapist points out patient's attempts to ward off awareness of threatening information or feelings (item 36). This must concern the defensive maneuvers (e.g. undoing, denial) used by the patient to ward off awareness of threatening information or feelings. For example, the therapist formulates about the patient being compelled to profess love for his father directly after having made critical remarks about him. Here a resistance is

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16 See Kächele (2007, p.15) for several concluding aspects about resistance.
taken into account where the patient is repressing the thought or acceptance of certain ideas or feelings. The different types of resistances will not be differentiated here.

### 1.4.2.13 Working through

Fonagy and Kächele (2009) define the technique of ‘working through’ in therapy, as “a process of both unlearning and learning: Actively discarding prior misconceptions and assimilating learning to work with new constructions” (p. 16). The concept of working through defines the great effort to transform the obtained insight, through the process of clarification and interpretation, into behavioral change. The therapist must be attentive to concretely observe how the patient applies and uses the obtained insight or understanding inside therapy, outside therapy, e.g. in relationships with others than the therapist (Leichsenring 2005, pp. 81-82).

The technique of working through depends on the therapist working systematically with patient’s materials, like for example the “patterns of defenses and internal object relations (that) emerge again and again in different contexts, and are repetitively clarified, confronted, observed, and interpreted (…) As a result the patient starts to feel more like the creator of his own life experience. Much of the working-through involves systematic analysis of the patient’s conscious and unconscious fantasies as they emerge in the treatment, as well as recurrent themes in their dreams” (Gabbard 2009, pp. 60-61). In long-term treatments the therapists have a better chance of following patient’s insight for longer and in a consistent manner. Working through is a combination of techniques and interactions and not a sole aspect that can be observed ‘on one dot’.

None of the PQS-items comprise this technique individually, but we believe the combined observation of two items, during the same therapy hour, permits to capture this ‘working through’ technique. Concomitantly, one can observe the patient achieving a new understanding or insight (item 32) while the therapist accurately perceives the therapeutic process (item 28). This combines the occurrence of two events. One is the patient’s gain of new perspective, or new connection or attitude, or warded-off content during the course of the hour. For example, after the therapist's remark, the patient appears thoughtful and says: "I
think that’s true, I had never really thought about the situation that way before”. Item 28 captures the therapist accuracy in perceiving the therapeutic process, this is, perceiving patient’s emotional state, intent of his speech, or patients’ experience of therapy relationship. This should be inferred from the therapist’s comments, interventions, or general stance toward the patient. Judgment must be independent of the type of therapy (i.e. cognitive-behavioral, psychoanalytic) being conducted; the rater must attempt to assess the process in the observed hour.

1.4.2.14 Neutrality and abstinence

Neutrality and abstinence are only considered as part of psychoanalytic technique, although controversial among vanguard psychoanalyst (Schachter & Kächele 2007). These two concepts are associated to each other, since “the primary function of abstinence is to ensure the neutrality of the therapist” (Fonagy & Kächele 2009). Abstinence means that the therapist must abdicate from satisfying his wishes in the relationship with the patient. Not only the exclusion of intimate and sexual relationships between patient and therapist is meant, but also a distanciation of other hidden or subtler relational aspects that exist in any interaction or relationship, like a possible gratification of narcissistic needs, economic benefit or power (Leichsenring 2005, pp. 68-69). Along with patient’s expectation about the therapist having an attitude of sincere curiosity, empathy and concern towards the patient, the therapist must equally resist directing patient’s associations or react ‘personally’ and overtly to the patient’s experience or fantasies. From a psychoanalytic perspective this also includes “the analyst’s stance of resisting the patient’s curiosity or using the therapeutic relationship in any way that consciously or unconsciously could be seen as motivated by the need to gratify their own hidden desires” (Fonagy & Kächele 2009). The idea that the analyst would not give in to the temptation of gratifying the patient’s sexual desire is an ethical standard and not a technical issue. In the very past, the sexual connotation was an issue, when the description of this concept started with Freud in 1915.

The therapist’s neutrality is one of the wide spread caricatures of the psychoanalyst position: The world of the patient collapses and the therapist’s dry and sober comment is “hmm, hmm” giving the impression of being unaware of the
here and now, e.g. patients’ suffering. Although this is not the psychoanalysts’ intent, one must seriously take into account that neutrality at its extreme may deny the expression of sensitivity, which may have serious consequences for the therapeutic alliance. Fonagy and Kächele (2009) assertively pointed out, based on recent literature about process and outcome of psychotherapy that, when therapist’s genuine concern for the patient is manifest, significant therapeutic change can be achieved (Lambert 2004, in Fonagy & Kächele 2009). It is almost an established fact that the quality of alliance is one of the best predictors of outcome (Orlinsky et al. 2004). One may think that alliance could be negatively influenced by an orthodox conception of abstinence or when patients are not aware of the benefit associated to this dynamic tool. In context of an elaborate discussion of pros and cons of the controversial use of neutrality, Schachter and Kächele (2007) adequately suggest a reconsideration of the concept of neutrality. They point out that not all analysts understand neutrality the same way and “whether the analyst will experience his feeling or action as deviation from a prescribed technique will vary with the analyst’s own interpretation of neutrality” (p. 12). According to these authors Rohstein (2005), a classical analyst acknowledges how inter-subjectivity (between patient and therapist) limit the objectivity of neutrality. Interestingly the deviation from neutrality may evoke some discomfort and even guilt in the analyst, which deprives him to comfortably exam the occurrences in the therapeutic interaction (Schachter & Kächele 2007). In the same train of thoughts, if an analyst does not express anything related to his feelings, the patient may feel uncomfortable in doing so (p. 23). In psychodynamic psychotherapies this issue may be handled differently according to therapist’s training. Leichsenring (2005, p. 68) considers the usage of ‘neutrality’ different in psychodynamic psychotherapy than in psychoanalysis. From the psychoanalytical structural model perspective the therapist should keep the same distance to instances like the ‘ego’, ‘id’ and ‘super ego’. This means that the therapist should not work alone towards adapting to given realities, towards gaining possibilities for satisfaction of desires or drive needs or towards a more mature norm and values orientation. This is similar in psychoanalysis and psychodynamic psychotherapy, but in the later more attention from the therapist is given to the ego and not so much work is done related to drive oriented needs and desires. Implicit is the fear of transforming the therapeutic process into a psycho-educational intervention.
The PQS captures the therapist being neutral (item 93) when he refrains from stating opinions or views of topics patient discusses. The therapist assumes role of neutral commentator, and the patient’s view of matters is made pre-eminent in the dialogue. For example, the therapist asks how it would be for the patient if he, as the therapist, approved of his expressing his anger, and subsequently inquires how it would be for him if he disapproved. The PQS offers attention to the fact that neutrality is not synonymous with passivity. The therapist can be active and still maintain a neutral stance.

The following table resumes all discussed ‘Psychotherapy Process Q-set’ items related to therapeutic technique:

**Tab. 3 ‘Psychotherapy Process Q-set’ items describing therapeutic techniques**

<table>
<thead>
<tr>
<th>Item #</th>
<th>Technique Items description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>T's remarks are aimed at facilitating P speech.</td>
</tr>
<tr>
<td>6</td>
<td>T is sensitive to the P's feelings, attuned to the P; empathic.</td>
</tr>
<tr>
<td>24</td>
<td>T own emotional conflicts intrude into the relationship.</td>
</tr>
<tr>
<td>27</td>
<td>T gives explicit advice or guidance (vs. defers even when pressed to do so).</td>
</tr>
<tr>
<td>28</td>
<td>T accurately perceives the therapeutic process.</td>
</tr>
<tr>
<td>32</td>
<td>P achieves a new understanding or insight.</td>
</tr>
<tr>
<td>31</td>
<td>T asks for more information or elaboration.</td>
</tr>
<tr>
<td>36</td>
<td>T points out P's attempts to ward off awareness of threatening information or feelings.</td>
</tr>
<tr>
<td>37</td>
<td>T behaves in a teacher-like (didactic) manner.</td>
</tr>
<tr>
<td>40</td>
<td>T makes interpretations referring to actual people in the patient's life</td>
</tr>
<tr>
<td>45</td>
<td>T adopts supportive stance.</td>
</tr>
<tr>
<td>57</td>
<td>P discusses experiences as if distant from his or her feelings.</td>
</tr>
<tr>
<td>62</td>
<td>T identifies a recurrent theme in the P's experience or conduct.</td>
</tr>
<tr>
<td>65</td>
<td>T restates or rephrases the patient's communication in order to clarify its meaning.</td>
</tr>
<tr>
<td>67</td>
<td>T draws the P's attention to wishes, feelings, or ideas that may not be in awareness.</td>
</tr>
<tr>
<td>82</td>
<td>P's behavior during the hour is reformulated by the T in a way not explicitly recognized previously.</td>
</tr>
<tr>
<td>92</td>
<td>P's feelings or perceptions are linked to situations or behavior of the past.</td>
</tr>
<tr>
<td>93</td>
<td>T refrains from stating opinions or views of topics the patient discusses.</td>
</tr>
<tr>
<td>99</td>
<td>T raises questions about the P's view</td>
</tr>
<tr>
<td>100</td>
<td>T draws connections between the therapeutic relationship and other relationships.</td>
</tr>
</tbody>
</table>

Note: Item #: Item number; P: Patient; T: Therapist
This overview of the armamentarium of therapeutic techniques, in psychoanalytic oriented treatments, connects the PQS-items that will support the observations of this study. Will the three groups of therapy differentiate in their techniques or will there be other PQS-items that establish greater diversification between psychoanalysis, short and long term psychodynamic psychotherapies?

1.5 Hypothesis and research questions

1.5.1 Hypotheses

Null Hypothesis: No significant differences in therapeutic factors and therapeutic techniques can be found between the three patient samples because there is more influence of patient, therapist or situational characteristics than from the applied therapy methodology.

Hypothesis 1: Differences between at least two of the three samples will be found:

- It may be that the psychoanalytic sample differs from the short-term psychodynamic and not from the long-term psychodynamic sample;
- It may be that psychoanalytic sample differs equally from the long-term psychodynamic and the short-term psychodynamic sample;
- Or it could also be that all three groups of treatment differ from each other.

Hypothesis 2: The PQS prototype methodology is used to determine how much psychoanalytic process can be fostered in these therapies. We expect that the ‘psychoanalytic prototype’ will correlate higher with the therapy sessions from the psychoanalytic sample than the sessions from the two other psychodynamic samples.

1.5.2 Research questions

Research Question 1:

The main research question is whether one can find differences and similarities between the psychoanalytic and the other psychodynamic short-term and long-term psychotherapy samples. Three clinical groups, with patients suffering from a range of disorders, will be taken into account. Referring to the possible influence of
patient, therapist or situational influence over treatment methodology we do not expect (or slightly but statistically non-significant) differences among the samples. We are particularly interested in looking for both, differences and similarities, in the application of therapeutic techniques among the different therapeutic orientations.

Since not all issues examined in this study can be formulated in terms of testable hypothesis some research questions concerning differences and similarities between treatment samples will be treated in an exploratory base: Will we find similarities and differences among the variance of process variables in the three samples? Special attention will be given to the following exploratory, but well known, question “Does time matter?”. We would like to compare the characteristic and uncharacteristic aspects of process at the beginning of the treatments (measuring point 1) with the later points in time (measuring point 2, 3 and 4) cross-samples. The most variable therapy processes throughout therapy will be fostered and compared among the three groups. The three samples have different lengths, which is associated with the type of therapy. Are the differences more associated with the variable time than with the setting or type of treatment?

For example, T3 is the end of STDP, but are the therapist techniques more similar to the ending sessions (T4) or to T3 of PA and LTDP? Is T3 from STDP comparable to T2 because of the similarity of the session number?

Research Question 2:

Additionally, the psychodynamic PQS prototype of an ideal psychoanalytic session, developed by Ablon and Jones (1998), will be applied to the three treatment samples. Which sample will correlate the most with the analytic prototype? Is the analytic process defined by the PQS prototype when fostered in practiced therapy independent of the ‘therapy label’, e.g. psychoanalysis, psychodynamic psychotherapy? The degree to which these treatments foster an analytic process as represented by the prototype will be measured quantitatively. What happens if we only look at the technique items? For example, only correlate the technique related items of the psychoanalytic prototype with the technique items in the samples.
2 Method and Material

2.1 Study framework

The present study analyses the therapeutic process in 202 therapy sessions from a total of 58 treatments with the ‘Psychotherapy Process Q-set Method’ (PQS; Jones 2000). Extensive recorded data from 3 different clinical data archives was gathered for this study through collaborative work between different psychotherapy process research groups. One of the treatment samples includes data from the German ‘Ulm Textbank’\(^{17}\) (Ulm, Germany) and the North American ‘Berkeley Psychotherapy Research Program Archive (Berkeley-Boston, USA)\(^{18}\), which is now housed in the Department of Psychiatry at MGH and administered by the Massachusetts General Hospital Psychotherapy Research Program – Harvard Medical School\(^{19}\). The psychoanalytic sample of patients has been provided by the ‘Munich Attachment- and Effectiveness Project (MBWP)\(^{20}\). All the therapy sessions have been q-sorted by reliably trained PQS-raters and master raters, as the main researcher of this study and her colleague\(^{21}\).

Further on, the general characteristics of the patients, from each of the 3 samples, will be described separately. A clarification of the heterogeneity of the sample, due to the different proveniences, will be shortly commented here.

\(^{17}\) This archive was developed in the context of the German ‘Special Research Collaborative Program 129 Psychotherapy Processes’ (funded by the German Research Association (DFG) and includes an unusual large number of psychoanalytic and psychotherapeutic materials.

\(^{18}\) This archive has been collected over a period of twenty-five years from the original home of the PQS method in Berkley (USA) by Enrico Jones. The archive is the most extensive collection – transcripts, audiotapes and videotapes – of psychoanalyses, psychodynamic psychotherapies and cognitive behavioral psychotherapy in the Nord-American territory. From this large material 18 to 20 treatments are complete psychoanalysis or psychodynamic psychotherapies. With the untimely passing of Dr. Enrico E. Jones, the archive has been transferred to one of his disciples, Dr. Stuart Ablon (Boston).

\(^{19}\) There, Dr. Stuart Ablon and Dr. Raymond A. Levy trained thoroughly the main researcher of this project for the application of the ‘Psychotherapy Process Q-set’ (Jones 2000), which is the essential evaluation method for the studied clinical data here.

\(^{20}\) This project and gathered data is a product of the joint effort between the ‘Department of Psychology’ from the ‘Ludwig-Maximilians-University’ and the ‘Academy for Psychoanalysis und Psychotherapy München e.V’. Special thanks go to Prof. Dr. Mertens and Dr. Hörz, the heads of the project.

\(^{21}\) I want to thank Dipl. Psych. Ingrid Erhardt for all the collaborative work, co-motivation and support given to always pursue our goals, also when they seem unreachable.
Comment on the heterogeneous nature of the sample

The heterogeneous nature of the study sample in terms of origin, diagnoses and therapists conducting therapy, is obvious. It was important to secure the quality of the collected data by carefully choosing the contacted archives. Consequently, the archives, where our data was collected from, are part of respected research groups (described above). The therapies were conducted in Germany (Ulm and Munich) and USA (Berkeley) in the local languages; it did not constitute any barrier to the raters when analyzing the material due to their high proficiency in both languages (native speakers were also involved).

2.2 Description of the sample
The 3 sets of archived treatment samples used in this study are:

- 13 psychoanalyses (PA);
- 15 long-term psychodynamic psychotherapies (LTDP);
- 30 short-term psychodynamic psychotherapies (STDP).

2.2.1 Psychoanalysis (PA; N=13)
The psychoanalytic sample includes 13 audiotaped and transcribed psychoanalytic therapies. All treatments were conducted 3 times a week (lying down on a couch), for an average of 5 years (range of 3 to 7 years), for an average of 340 sessions (range of 250 to 450 sessions). The patients were 9 females and 4 males, with an average age of 33 (range of 21 to 48 years). The diagnoses were given by the therapists and codified according to ICD-10. Outcome assessment was based on multiple instruments, results only for SCL-90 will be considered. According to the GSI pre-post treatment scores (t-test), a significant symptom reduction was observed. The psychoanalysts conducting the treatment were all members of the ‘Academy for Psychoanalysis and Psychotherapy Munich’. The treatments were recorded for a research project (‘Munich Attachment and Effectiveness Project – MBWP’). A total of 4 sessions were selected to capture different points throughout the treatment process (T1: 22 This psychoanalytic institute was founded in 1946 that is not associated with the International Psychoanalytic Association (IPA) but with the “Deutsche Gesellschaft für Psychoanalyse, Psychotherapie, Psychosomatik und Tiefenpsychologie (DGPT) e.V.”, which is well respected in Germany.)
baseline, T2: 80 session of treatment, T3: 160 session, T4: 240 session). These 4 sessions per treatment were rated with the PQS by 2 independent raters. The composite scores (mean between each of the 2 raters’ ratings) will be used for data analysis. The following table offers this information for each patient.

<table>
<thead>
<tr>
<th>P#</th>
<th>Diagnoses</th>
<th>Duration and Frequency</th>
<th>Age and Gender</th>
<th>Sessions total</th>
<th>T 1 2%</th>
<th>T 2 33%</th>
<th>T 3 67%</th>
<th>T 4 98%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F34.1 Dysthymia</td>
<td>3 years; 3xweek LD</td>
<td>38F</td>
<td>340</td>
<td>#1 (6.2)</td>
<td>#80 (112.2)</td>
<td>#163 (227.8)</td>
<td>#242 (333.2)</td>
</tr>
<tr>
<td>2</td>
<td>F40.1 Soc. Phobia; F32.9 Depressive episode</td>
<td>3.5 years; 3xweek LD</td>
<td>23F</td>
<td>330</td>
<td>#2 (6.6)</td>
<td>#81 (108.9)</td>
<td>#162 (221.1)</td>
<td>#243 (323.4)</td>
</tr>
<tr>
<td>4</td>
<td>F63.9 Disorder of impulse control</td>
<td>5 years; 3xweek LD</td>
<td>38F</td>
<td>401</td>
<td>#1 (8.2)</td>
<td>#89 (132.3)</td>
<td>#165 (268.7)</td>
<td>#244 (392.98)</td>
</tr>
<tr>
<td>5</td>
<td>F65.5 Sexual Masochism; F64.9 Disorder of sexual orientation</td>
<td>5 years; 3xweek LD</td>
<td>30M</td>
<td>450</td>
<td>#1 (9)</td>
<td>#84 (148.5)</td>
<td>#163 (301.5)</td>
<td>#240 (441)</td>
</tr>
<tr>
<td>11</td>
<td>F32.x recurrent depressive disorder; F45.0 Somatoform disorder</td>
<td>45 months; 3xweek LD</td>
<td>38F</td>
<td>300</td>
<td>#18 (6)</td>
<td>#80 (99)</td>
<td>#164 (201)</td>
<td>#246 (294)</td>
</tr>
<tr>
<td>12</td>
<td>F32.x recurrent depressive disorder, single episode</td>
<td>5 years; 3xweek LD</td>
<td>31F</td>
<td>315</td>
<td>#2 (6.3)</td>
<td>#83 (103.95)</td>
<td>#153 (211.1)</td>
<td>#242 (308.7)</td>
</tr>
<tr>
<td>13</td>
<td>F34.1 Dysthymia; F40.1 Soc. Phobia</td>
<td>3 years; 3xweek LD</td>
<td>46M</td>
<td>320</td>
<td>#6 (6.4)</td>
<td>#92 (105.6)</td>
<td>#188 (214.4)</td>
<td>#283 (313.6)</td>
</tr>
<tr>
<td>14</td>
<td>F43.1 PTBS; F33.2 recurrent depressive disorder</td>
<td>4 years; 3xweek LD</td>
<td>48F</td>
<td>340</td>
<td>#1 (6.2)</td>
<td>#82 (112.2)</td>
<td>#164 (227.8)</td>
<td>#241 (333.2)</td>
</tr>
<tr>
<td>16</td>
<td>F40.1 Soc. Phobia; F43.2 adjustment disorder</td>
<td>3.5 years; 3xweek LD</td>
<td>23F</td>
<td>300</td>
<td>#13 (6)</td>
<td>#74 (99)</td>
<td>#161 (201)</td>
<td>#240 (294)</td>
</tr>
<tr>
<td>17</td>
<td>F34.1 Dysthymia; F33.x recurrent depressive disorder</td>
<td>4 years; 3xweek LD</td>
<td>24F</td>
<td>300</td>
<td>#1 (6)</td>
<td>#83 (99)</td>
<td>#161 (201)</td>
<td>#248 (294)</td>
</tr>
<tr>
<td>18</td>
<td>F32.9 Depression F45.1 Undifferentiated somatoform</td>
<td>7 years; 3xweek LD</td>
<td>38F</td>
<td>250</td>
<td>#51 (5)</td>
<td>#83 (82.5)</td>
<td>#162 (167.5)</td>
<td>#219 (245)</td>
</tr>
</tbody>
</table>
2.2.2 Long-term psychodynamic psychotherapies (LTDP; N=15)

From the 15 long-term psychodynamic psychotherapies (LTDP) included in this sample, 11 treatments are video taped (Boston archive) and 4 are audiotaped (‘Ulm Textbank’ archive). All are twice-weekly treatments and the 15 patients will be described here as a group. All patients are female (F), except 3 males (M), and were diagnosed with major depression disorder. The majority of diagnoses are based on intake interviews conducted by independent clinical evaluators and patients’ responses to a range of psychiatric screening tests, four diagnoses were based on clinical assigned diagnoses from the therapists and codified according to DSM-IV. Patients’ ages range from 21 to 44 years (average age is 33). The treatments were all conducted twice a week by experienced psychoanalytically oriented therapists or psychoanalysts, for a period of 15 months to a maximum of 3 years. The minimum amount of therapy sessions was 70, but all the other patients received over 100 therapy sessions, being the upper limit 210 sessions (average is 160 therapy sessions). Outcome was assessed for each treatment individually and therapies were overall successful (short comment bellow).

For each treatment of this sample, 4 measuring points (T1, T2, T3 and T4) were calculated in terms of percentage of the whole process for each treatment. At each measuring point a therapy session was selected and PQS rated. This means one session was taken from the beginning T1 (2%), other from towards the middle T2 (33%), another from the middle T3 (67%) and the last from towards the end T4 (98%) of the treatment process. This means for example, in case of a 2 ½ years

<table>
<thead>
<tr>
<th></th>
<th>disorder</th>
<th>5 years; 3xweek LD</th>
<th>24M</th>
<th>250</th>
<th>#20 (5)</th>
<th>84 (82.5)</th>
<th>#170 (167.5)</th>
<th>#231 (245)</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>F11.x Disorder in context of Opiate; F32.9 Depressive episode, NNB depressive disorder</td>
<td>6.25 years; 3xweek LD</td>
<td>31M</td>
<td>400</td>
<td>#1 (8)</td>
<td>82 (132)</td>
<td>#165 (286)</td>
<td>#243 (392)</td>
</tr>
</tbody>
</table>

Tab. 4 Information about psychoanalytic sample
Note: P#: Patient number; F: Female; M: Male; #: Number of selected session; T1, T2, T3, T4: First, second, third and fourth time point; FXX.X: ICD-10 coding; 3xweek: 3 therapy sessions per week; LD: Laying down on couch).
long treatment of Patient 101, that T1 is session #4, T2 is session #68, T3 is session #140 and T4 is session #204 from a total of 208 sessions.

A total of 60 sessions, from these 15 LTDP cases, were rated with the PQS by 2 independent raters. The composite scores (mean between 2 raters ratings) will be used for the data analysis. The following table offers this information for each patient.

<table>
<thead>
<tr>
<th>P#</th>
<th>Diagnoses</th>
<th>Duration and Frequency</th>
<th>Age and Gender</th>
<th>Sessions total</th>
<th>T 1 2%</th>
<th>T 2 33%</th>
<th>T 3 67%</th>
<th>T 4 98%</th>
</tr>
</thead>
<tbody>
<tr>
<td>101</td>
<td>Depression</td>
<td>2.5 years; 2/week (f2f)</td>
<td>35 F</td>
<td>208</td>
<td>#4 (4.16)</td>
<td>#68 (68.64)</td>
<td>#140 (139.36)</td>
<td>#204 (203.84)</td>
</tr>
<tr>
<td>109</td>
<td>Depression</td>
<td>2.5 years; 2/week (f2f)</td>
<td>29 M</td>
<td>208</td>
<td>#4 (4.16)</td>
<td>#68 (68.64)</td>
<td>#140 (139.36)</td>
<td>#204 (203.84)</td>
</tr>
<tr>
<td>113</td>
<td>Depression</td>
<td>21 months; 2/week (f2f)</td>
<td>21 F</td>
<td>126</td>
<td>#4 (2.52)</td>
<td>#42 (41.58)</td>
<td>#84 (84.42)</td>
<td>#122 (123.48)</td>
</tr>
<tr>
<td>115</td>
<td>Depression</td>
<td>15 months; 2/week (f2f)</td>
<td>25 F</td>
<td>125</td>
<td>#4 (2.5)</td>
<td>#42 (41.25)</td>
<td>#84 (83.75)</td>
<td>#121 (122.5)</td>
</tr>
<tr>
<td>201</td>
<td>Depression</td>
<td>15 months; 2/week (f2f)</td>
<td>29 F</td>
<td>125</td>
<td>#5 (2.5)</td>
<td>#41 (41.25)</td>
<td>#83 (83.75)</td>
<td>#121 (122.5)</td>
</tr>
<tr>
<td>202</td>
<td>Depression</td>
<td>20 months; 2/week (f2f)</td>
<td>24 M</td>
<td>111</td>
<td>#3 (1.94)</td>
<td>#29 (32.01)</td>
<td>#71 (64.99)</td>
<td>#88 (95.06)</td>
</tr>
<tr>
<td>203</td>
<td>Depression</td>
<td>37 months; 2/week (f2f)</td>
<td>26 F</td>
<td>193</td>
<td>#4 (3.86)</td>
<td>#64 (63.69)</td>
<td>#130 (129.31)</td>
<td>#188 (189.14)</td>
</tr>
<tr>
<td>303</td>
<td>Depression</td>
<td>1.5 years; 2/week (f2f)</td>
<td>51 M</td>
<td>142</td>
<td>#4 (2.48)</td>
<td>#45 (46.86)</td>
<td>#93 (95.14)</td>
<td>#139 (139.16)</td>
</tr>
<tr>
<td>305</td>
<td>Depression</td>
<td>2 years; 2/week (f2f)</td>
<td>29 M</td>
<td>196</td>
<td>#4 (3.09)</td>
<td>#64 (64.68)</td>
<td>#130 (130.64)</td>
<td>#192 (191.1)</td>
</tr>
<tr>
<td>306</td>
<td>Depression</td>
<td>1.5 years; 2/week (f2f)</td>
<td>30 M</td>
<td>145</td>
<td>#4 (2.9)</td>
<td>#48 (47.85)</td>
<td>#98 (97.15)</td>
<td>#142 (142.1)</td>
</tr>
<tr>
<td>401</td>
<td>Depression</td>
<td>3 years; 2/week (f2f)</td>
<td>32 F</td>
<td>189</td>
<td>#5 (3.78)</td>
<td>#61 (62.37)</td>
<td>#130 (126.63)</td>
<td>#186 (185.22)</td>
</tr>
<tr>
<td>12</td>
<td>Depression</td>
<td>3 years; 2/week (f2f)</td>
<td>23 F</td>
<td>210</td>
<td>#4 (4.2)</td>
<td>#70 (69.3)</td>
<td>#140 (140.70)</td>
<td>#205 (205.80)</td>
</tr>
<tr>
<td>13</td>
<td>Depression</td>
<td>3 years; 2/week (f2f)</td>
<td>44 F</td>
<td>168</td>
<td>#4 (3.36)</td>
<td>#56 (55.440)</td>
<td>#112 (112.56)</td>
<td>#164 (164.64)</td>
</tr>
<tr>
<td>14</td>
<td>Depression</td>
<td>3 years; 2/week (f2f)</td>
<td>43 F</td>
<td>168</td>
<td>#6 (3.36)</td>
<td>#56 (55.440)</td>
<td>#112 (112.56)</td>
<td>#164 (164.64)</td>
</tr>
<tr>
<td>15</td>
<td>Depression</td>
<td>2 years; 2/week (f2f)</td>
<td>38 F</td>
<td>79</td>
<td>#4 (1.58)</td>
<td>#26 (26.07)</td>
<td>#52 (52.93)</td>
<td>#76 (77.42)</td>
</tr>
</tbody>
</table>

**Tab. 5 Information about long-term psychodynamic sample**

Note: P#: Patient number; F: Female; M: Male; #: Number of selected session; T1, T2, T3, T4: First, second, third and fourth time point; 3xweek: 3 therapy sessions per week; (f2f): Face-to-face setting.
2.2.3 Short-term psychodynamic psychotherapies (STDP; N=30)

The third sample contains 30 short-term psychodynamic psychotherapies (LTDP) conducted once a week, for 16 sessions (3 recorded sessions). The treatments have been collected by the ‘Mount Zion Psychotherapy Research Group’ (San Francisco – California) and are also part of the ‘Berkeley Psychotherapy Research Program Archive’. This archival sample has been previously described in detail (Jones et al. 1992; Jones & Pulos 1993; Price & Jones 1998) and has been investigated from different perspectives, e.g. was compared with other samples (Ablon & Jones 1998, 2005; Karlsson & Kermott 2006).

The present study includes 30 of the selected patients by this archive, from which 20 are female (F) and 10 male (M). The mean age of the patients is 51 years, ranging from 20 to 81 years. The intention of those who collected this sample was to acquire a relatively heterogeneous sample to represent a range of neurotic disorders. All the patients were seen for a total of 16 sessions, and treatment outcomes at termination were quite successful (see Jones et al. 1992). The 15 treating therapists had all received specialized training in brief psychodynamic therapy (exception of one therapist) and all considered the psychodynamic model to be their primary theoretical orientation. Treatments were non-manualized LTDP.

Concerning the measuring points, this sample is different from the psychoanalytic and long-term psychodynamic samples. In the brief psychodynamic psychotherapy sample only 3 measuring points were considered (instead of 4), thus 3 sessions

---


24 On the basis of intake interviews conducted by independent clinical evaluators, and each individual’s responses to psychiatric screening tests, the sample included a range of psychological disorders, such as depression, dysthymia and general anxiety disorder (atypical depression, phobic disorder, panic disorder, generalized anxiety disorder, obsessive-compulsive disorder, conversion disorder, psychogenic pain disorder, hypochondriasis, dissociative disorder, and psychosexual dysfunctions (DSM-III, American Psychiatric Association, 1980; in Jones et al. 1992).

25 The use of treatment manuals in studies of psychotherapy tries to ensure that treatments are consistently applied across cases. As the Mount Zion Group, the present study prefers to describe (using the PQS) what therapists actually did in their private practice and not what the therapist was prescribed to do by a manual. Unlike most treatment studies, patients were seen in psychotherapists’ private offices in order to maintain a natural a setting.
from each treatment were q-sorted which nevertheless counts a total of 90 treatment hours (vs. 60 and 52 sessions from the other 2 samples). The main reason for the differing amount of measuring points is the general lack of recorded of short-term psychodynamic material. In addition, working with archive data means one has to work with what is available, which means in this case only 3 sessions out of 16 sessions were recorded and consequently only this session were rated.

Nevertheless, we could find excellent reasons to include this valuable data in our study. First, the STDP therapies are a considerable shorter treatment, thus the process is well represented by 3 sessions instead of four. They are the 1\textsuperscript{st}, 5\textsuperscript{th} and 14\textsuperscript{th} sessions (from a total of 16 sessions) what in percentages is respectively 6.25\%, 31.5\% and 87.5\% from the whole treatment. A parallel exists between the T3 of the LTDP and the mean of T3 and T4 of the 2 longer samples (PA and LTDP). The average of the percentage between T3 (67\%) and T4 (98\%) from the 2 samples is 82.5\%, which is not far situated in process from the 87.5\% that is the actual T3 in the STDP sample. Therewith, the rational of our selection criteria of our sample both in quantity of measuring points and their frequency through the process is considered justified.

Due to the large amount of patients only an overview is given about the group. This sample is homogeneous and has been repeatedly investigated as a group of treatments, without differentiating each patient.

<table>
<thead>
<tr>
<th>P#</th>
<th>Diagnoses</th>
<th>Duration a. Frequency</th>
<th>Age Gender</th>
<th>Sessions total</th>
<th>T 1 6.25% (2%)</th>
<th>T 2 31.5% (33%)</th>
<th>T 3 87% (67%/98%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-30</td>
<td>Range of neurotic disorders</td>
<td>16 weeks; 1xweek (f2f)</td>
<td>20-81yr (m=51); 20F and 10M</td>
<td>16</td>
<td>#1</td>
<td>#5</td>
<td>#14</td>
</tr>
</tbody>
</table>

Tab. 6 Information about short-term psychodynamic sample
Note: P#: Patient number; F: Female; M: Male; #: Number of selected session; T1, T2, T3: First, second, third time point; 3xweek: 3 therapy sessions per week; (f2f): Face-to-face setting.
Comment concerning the heterogeneity of diagnostic assessment
The amount of patient’s treatments required data from the mentioned 3 different archives. Consequently the patient diagnoses were accessed differently from research group to research group but all are well documented. In the PA sample all diagnostic assessment is based on therapists’ clinical evaluation. For many years, this was the current method in clinical practice. In the LTDP sample all treatment are based on diagnostic instruments, apart from 4 treatments (from the ‘Ulm Textbank’). All the patients in the LTDP were suffering from depression. The outcome data is only available for the LTDP sample, but the assessment instruments (e.g Symptom-Checklist-90-Revised (SCL-90-R; Derogatis 1977); Global Assessment of Functioning (DSM-IV; American Psychiatric Association, 2000) are not homogeneously administrated to all individuals from the sample, to enable reasonable process-outcome correlations.

2.3 Study procedures
2.3.1 Selection criteria for analyzed sessions
At the very beginning of this study the main question was whether to choose to conduct a ‘single-case study’ or plan a ‘group-analysis design’ to answer our research questions. Due to economic reasons we had to decide whether to include fewer subjects and more sessions per case, or the other way around. Several reasons lead us the inclusion of a larger amount of different treatments (N= 58) and consequently fewer sessions per case (e.g. 4 sessions):

a) Extensive experience in rating data sets with the PQS, showed that sometimes variability of ratings among different sessions of the same case can be quite minute. High variability among cases is a factum. First, we suspected that the characterization of the analyzed therapeutic sessions in our sample with the PQS-items would not wary as much from session to session when picked one after the other. In that case it would make more sense to choose a block of sessions in different points of the treatment process as in the PQS study of Amalia X from Albani et al. (2001), where 2 blocks, one from the beginning and the other from the end of treatment, were compared. Nevertheless, this lead us to the idea that items within the block would be more or less the same and
bigger differences are expected between different points of time during treatment. So we decided to pick only 1 session per measuring time, which makes a total of 4 sessions per treatment.

**Fig. 6 Possible session selection strategies**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Sessions in the course of treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategy 1</td>
<td>S1 S2 S3 S4 S5 S6 S7 S8 S9 S10 S11 S12 S13 S14 ETC</td>
</tr>
<tr>
<td>Strategy 2</td>
<td>S1 S2 S3 S4 S5 S6 S7 S8 S9 S10 S11 S12 S13 S14 ETC</td>
</tr>
<tr>
<td>Strategy 3</td>
<td>S1 S2 S3 S4 S5 S6 S7 S8 S9 S10 S11 S12 S13 S14 ETC</td>
</tr>
</tbody>
</table>

Note: This figure is only a depiction of the presented ideas; S: session.

b) Our selection criterion corroborates with the aim of this study to only take a ‘snapshot’ of all 58 different treatments among psychoanalyses, long-term and short-term psychodynamic psychotherapies, and compare them (in fig.1 strategy 3). In other words, we aim to take a ‘photo’ of each treatment in order to find differences and similarities between treatment orientations. We will compare 100 items that describe the therapeutic process of 58 treatments.

c) At the beginning, six measuring times per treatment, this is 6 therapeutic sessions evaluated with the PQS method per treatments, seemed ideal to offer a closer look into the ongoing therapeutic process. This idea was abandoned for 2 practical reasons. The measuring points of the third sample (STDP), which were 3 (session 1, 5 and 14 out of a total of 16 sessions), were already established. 3 sessions per treatment were recorded. So we compromised from 6 to 4 measuring points, which was consensual with the sample of psychoanalysis from the Munich research group.

d) Afterwards, the point in time the session should be taken from was established. Like in other studies this decision was also influenced by availability of sessions and reasoning demonstrated in past studies. In the present sample the length of treatments varies from a very low maximum of 16 sessions for the LTDP to over 240 sessions for the 2 other samples. The possibility of choosing the session with same session-number from the different therapies had to be put aside. For example, picking session number 140 in a psychodynamic
psychotherapy could mean having a snapshot of the end; in the case of psychoanalysis with a total of 240 sessions it would be the middle of the analytic process. In order to find the ‘correspondent’ sessions from each treatment beside their different length, we favored to decide based on proportions. In this way the 4 ‘measuring points’ were established at 2%, 33%, 67%, 98% of the process.

e) Intentionally, we tried not to include the first and last sessions of therapy because of our greater interest in analyzing sessions that are already deeper in process work. Additionally, our experience in rating first therapy sessions demonstrated that the ratings tend to be extremely similar because of the predominant ‘interviewing character’ these sessions have. The first session is not fully representative of the therapeutic process. In the case of our STDP sample, we had to include the first therapeutic session because only 3 sessions per treatment were recorded. Nonetheless, a first interview with the therapist was conducted, so we could assume that the ‘first session effect’ is attenuated.

2.3.2 Learning experience and rating with the ‘Psychotherapy Process Q-set’

It must be clear that learning a research method properly is fundamental for an adequate application of the instrument, to secure the quality of the deriving data analysis. According to our experience with the PQS, an application of the method without adequate training can lead to erroneous results because reading the PQS manual is insufficient and can result in different interpretation and application of the items. The nuances of the instrument, which add to its uniqueness and specificity, can only be fully understood when repeatedly applied. Ideally, the learner should have the opportunity to discuss, clarify and question one’s difficulties with an experienced rater (named senior or master-raters). The PQS method can be learned in several different contexts. In this section, we will

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26 For a full version of the learning procedure (only in German) please see “Learning experience and rating examples with the Psychotherapy Process Q-set (Hörz, Seybert & Mertens 2009)”, chapter of a book created to facilitate the learning of the PQS method.
describe the learning experience in the group and dyadic setting (Hörz, Seybert & Mertens 2009 for the PQS learning in individual setting).

Group setting

Usually a three-day intensive workshop or seminar is sufficient for untrained participants to acquire a first understanding of the procedure. Following a detailed introduction to the methodology and presentation of the items and the rating-process, the seminar moves on to practical application of the method. The senior-rater (teacher) illustrates the method based on recorded therapy sessions (transcripts, audio- and video-recordings), which permits an immediate application and training of the method. In addition, participants are asked to complete ‘homework’, this is, transcripts that are rated at home for the next day. On each following day, the ratings are discussed item-by-item. In addition, participants discuss thoroughly about uncertainties and discrepancies in ratings that allows them to attain a profound knowledge of the rating process and the item contents. In order to evaluate the training transcripts, the inter-rater reliability between each of the participants and the master-rater ratings are calculated. This is also calculated during the training and items with higher discrepancies are prioritized in the discussion. The necessary requirement for the successful conclusion and subsequent obtainment of the certification on this training (in any learning setting) is to achieve an inter-reliability value over .5 for at least five of the individually concluded PQS-ratings (after the training). This goal requires from all participants great dedication to the learning process.

Dyadic setting

Learning the PQS-method individually with a senior-rater is more effective. This approach offers more room for questions and clarifications of individual difficulties, which in a group may be diluted. The individual discussion is concentrated and focused on the trainee’s difficulties. Such a procedure can occur ‘in situ’ or on a long-distance basis, facilitated through new communication technologies as the

\[\text{Pearson-correlation coefficient is recommended.}\]
Internet. The second option will be described here, since participating in a PQS-training 'in situ' is not always possible.

The procedure is simple and manageable. First, an email is sent with the theoretical introduction (power-point presentation) to the trainee and examined with the senior-rater through synchronous communication (e.g. online-phone) during 90 minutes (including time for answering questions). In this manner, the utility and applicability of the PQS is presented to the rater and the content of the 100 PQS-items and its rating procedure are explained. Afterwards, timely before each encounter with the senior-rater, the trainee receives a therapy session to prepare (transcript, audio- or video-recording). Before the second encounter, the trainee must prepare himself individually and take notes of the registered therapeutic session. At the beginning of the meeting, the trainee summarizes the therapeutic session, focusing on its process (not on content), to discuss the general understanding of the therapy session (15 minutes). Afterwards, the senior-rater enumerates the 5 extremely characteristic items and the 5 extremely non-characteristic items and discusses them one-by-one with the trainee. During this review, a useful clarification of additional items, not mentioned in the referred ten items, takes place. In this meeting, it is important for the trainee to start developing certain sensitivity for the rating scale (from 1 to 9) and to enlarge his comprehension of the 100 items.

On the following meetings, the trainee must prepare individually the therapy session sent by the senior-rater and evaluate the session based on the 100 PQS-items. The notes of the rater during preparation are very important and should include concrete examples that will help to argument the ratings. While coding audio- or video-recorded sessions, these notes gain a special value because sometimes raters encounter difficulties due to not having written material available (such as transcripts). The rater must send his rating to the senior-rater before their encounter so that the correlations are available. In addition to the calculation of the overall correlation of the learning rater with the senior-rater, a correlation for each item will also be determinate in order to recognize and discuss the largest discrepancies between both ratings. Before each meeting a 4 column excel sheet is sent to the trainee, which represents the item description, the rater and senior-rater rating for each item and the respective correlation values. At this point, it is
helpful to highlight the largest correlation discrepancies that will be later discussed with the senior-rater. On average, a total of 25 items with differing coding and the 5 most and less characteristic items are discussed in one meeting. The content and meaning of each of the items is clarified and the possible subjective interpretation tends to be reduced. Emphasis is given to the nuances of the rating scale, with its specific number of items sorted into each category.

The procedure described here will be repeated in each of the following training meetings. There is no recommended amount of training sessions but a sufficient reliability should be achieved in 8 to 10 sessions. The necessary amount of sessions depends on the raters learning process, which is mainly related to 3 variables: therapy sessions’ degree of difficulty; familiarity with the language (of audio, video or transcript); and ability of the rater.

Commentaries towards adequate application of the PQS-items

An adequate application of the PQS method is strongly related to a good comprehension of the content of each 100 items. The PQS includes 100 statements that describe the therapeutic process. Those PQS-items describe behaviors and attitudes of patient (40 items) and therapist (41 items) and their interaction (19 items). The PQS-items are linked to linguistic clues that are recognizable in recordings of therapeutic sessions. Raters are trained to perceive these specific clues. The rater is asked to take the position of an ‘external third’, this is, the position of an observer that feels himself standing between patient and therapist, nevertheless watches the interaction from a distance.

The detailed description of the items is available in the manual by Jones (2000). Each item includes specific instructions and many give examples to distinguish between uncharacteristic, characteristic and neutral ratings. These examples help to reduce different interpretations of the same items. In fact, they have been proven to be so useful that some experienced raters would subscribe an extension of the manual\textsuperscript{28}. In this way, every item would include an example rather than just some of them.

\textsuperscript{28} The revision of the manual happened during my working period at the Psychotherapy Research Program (MGH-Boston) in which I actively participated.
The rating process of the 100 items is simplified when the rater almost memorizes them. This may appear impossible when confronted for the first time with the 100 extensive items, but experienced raters admit having the items’ meaning extremely present in their memory. In our perspective is not recommended to memorize the items through grouping them. It is extremely important that during the rating process the rater thinks of the items independently. While applying the PQS-method, one can get the impression that certain items always ‘go together’. This should definitely not be understood this way. When Jones (1985) developed the 100 PQS-items, he gave special attention to the independence of items; the items that appeared in association with each other were combined (as one item) or one of them was excluded. If the impression of such a connection emerges anyways, it is important to understand that this may occur only in certain therapy sessions or processes and that this item constellation can change immediately in any following rating.

Regarding the item description, it is important to distinguish between unipolar and bipolar ratings. Unipolar items describe a specific event that can be rated in continuity from 1 to 9 (extremely characteristic to uncharacteristic), for example the “therapist clarifies, restates, or rephrases patient’s communication (item 65)”. In contrast, a bipolar item has 2 different meanings when rated 1 or 9. An example is item 1: “Patient verbalizes negative feelings (e.g. criticism, hostility) toward therapist (vs. makes approving or admiring remarks)”. In this case, an extreme uncharacteristic rating (1) means not only that the patient does not express negative feelings towards the therapist, but also that the patient articulates positive or even admiring remarks to the therapist. Hence, a bipolar item has an additional significance when rated as uncharacteristic and does not only mean that negative feelings towards the therapist or other aspects are absent. These item features are important for the understanding of PQS studies results, when uncharacteristic items are listed.

Particularities of the PQS rating procedure

There are several aspects that deserve attention when rating the PQS-items. While coding each item, it should also be evaluated how the rated content influenced the interaction. In other words, how a behavior or attitude of the patient
influences the therapist and how a behavior or attitude of the therapist influences the patient and, consequently, how both and their interaction influence the therapeutic process.

One of the most important aspects is to learn how to understand and apply the ‘concept of salience’, which concerns the significance of a specific item in the context of the rated therapy hour. The PQS-items are rated according to their salience in relation to other rated items in a session, and not relatively to other therapy sessions. It is thus very helpful and beneficial to keep the concept of salience in mind during the rating process in order to have a clear view of the weight of each item. Moreover, it is useful to consider how often, how characteristic and how salient each item is for the therapeutic process of the rated session.

Additionally relevant is the differentiation between a rating of category 1 and 5. This issue is usually discussed and practiced in detail during training. A common mistake is to rate 1 (extremely uncharacteristic or salient) when an item is not relevant to the therapeutic process. A rating 1 is only given, when the content of an item is extremely uncharacteristic or the absence of this content is highly relevant for this specific session. In the case of the non-occurrence or the insignificance of a particular content for the therapeutic process, a 5-rating (neutral or irrelevant for the session) is indicated. For example, one rater may be persuaded to rate as a 1 the not occurring of the patient gaining a new insight with item 32 "Patient achieves a new understanding or insight". However, one should only chose this rating (1) if the patient could, yet did not, gain a new insight and this influenced the other processes occurring during the session.

This example illustrated the importance of finding the balance between the weight of one happening and its significance for the whole session. When the understanding of one specific content influences the rest of the session, greater significance should be given to this item (salience). One should also rate this item as highly characteristic in case the patient gains new understandings on several subjects during the same session. To sum up, the rater must always balance between the weight of a single event and the whole session.
2.3.3 Protocol for rating therapy session with the PQS

The application procedure of the PQS method will be described here in order to add clarification about some aspects not detailed in its coding manual compiled by Jones (2000). The manual includes a short introduction to the rating process, which is considered too short by the majority of raters. Therefore, the first German researchers working closely with this instrument compiled a booklet “Der Psychotherapy Prozess Q-set von Enrico E. Jones” (Albani et al. 2008\(^\text{29}\)) with the aim to offer a better understanding of the application of the PQS method. Although the book is mostly written in German, translated parts by the author will be integrated in the following sections of this chapter.

The PQS compromises 100 items, which describe the patient’s and therapist’s behaviors, attitudes and their interaction. Examples of items describing the therapist includes attitudes like “Therapist conveys a sense of nonjudgmental acceptance (item 18)” or behaviors as “Therapist clarifies, restates or rephrases patient’s communication (item 65)” and “Therapist encourages patient to try new ways of behaving with others (item 85)”. Items directing to the patient can be “Patient brings up significant issues and material (item 88), “Patient is tense and anxious (item 7)” and “Patient feels helped (item 95)”. And interaction items include “Patient’s treatment goals are discussed (item 4)”, “The therapy relationship is a focus of discussion (item 98)” and “There is discussion of scheduling of hours, or fees (item 96)”. Each of the 100 items is worded in neutral, descriptive language, and tied to specific behavioral and linguistic cues, in order to minimize the amount of inference from the rater.

The PQS method can be applied to verbatim transcripts, audio- and videotapes of therapeutic sessions\(^\text{30}\) from all therapeutic orientations. Different from other process measures in the field, which typically examine segments of the therapeutic hour (e.g. Angus et al. 1999, Waldron et al. 2004b), the PQS uses an

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29 My contributions (chapter 2, 5 and 6) to this book are included in the present work.

30 The application of the PQS method on process notes has showed little success, since the instrument was developed to analyze objectively what is going on in the therapeutic session from an observers’ perspective. Process notes from the therapist make it difficult to observe for example his behavior ‘from the outside’. Intensive experimentation from my part demonstrated that many items could not be rated. Consequently, it is proven that the PQS cannot be applied in its whole on therapy notes.
entire session as the unit of analysis, thereby facilitating a more representative view of the session.

It is essential that always 2 independent raters rate the same material and when sufficient reliability is not achieved (below .50 Pearson correlation coefficient) a third and senior rater is added. The 2 reliable ratings are then item averaged to create a single rating for research use. It is this item averaged set of ratings for a session that is used in all subsequent data analysis.

After studying the transcript (or video- or audiotape) of a treatment hour, a clinical judge (also called rater) orders the 100 items of the PQS, each printed separately on cards to permit easy arrangement and re-arrangement. Nowadays an excel-sheet with a sorting tab facilitates the manual sorting system of the 100 cards for the PQS-items. All 100 items are sorted into 9 piles on a continuum from least characteristic or negatively salient (category 1) to most characteristic or salient (category 9). The middle pile (category 5) is used for items deemed either neutral or irrelevant to the particular session being rated. This distribution of items approximates a normal curve.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Number of Items</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>5</td>
<td>extremely characteristic or salient</td>
</tr>
<tr>
<td>8</td>
<td>8</td>
<td>quite characteristic or salient</td>
</tr>
<tr>
<td>7</td>
<td>12</td>
<td>fairly characteristic or salient</td>
</tr>
<tr>
<td>6</td>
<td>16</td>
<td>somewhat characteristic or salient</td>
</tr>
<tr>
<td>5</td>
<td>18</td>
<td>relatively neutral or unimportant</td>
</tr>
<tr>
<td>4</td>
<td>16</td>
<td>somewhat uncharacteristic or negatively salient</td>
</tr>
<tr>
<td>3</td>
<td>12</td>
<td>fairly uncharacteristic or negatively salient</td>
</tr>
<tr>
<td>2</td>
<td>8</td>
<td>quite uncharacteristic or negatively salient</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>extremely uncharacteristic or negatively salient</td>
</tr>
</tbody>
</table>

The reasons for utilizing a fixed distribution generating a normal distribution are provided at length by Block (1978), but are summarized briefly here. First, the fixed distribution eliminates certain biases in rating procedure; some judges, for example, systematically avoid making extreme judgments while others

31 This was extremely rare in this study.
dichotomize their judgments into one extreme or the other. Second, the fixed distribution ensures that judges will make multiple discriminations among items while sorting the right number of items into each category. By ensuring multiple discriminations, another common response bias, the ‘halo effect’, is reduced; that is, judges cannot simply group together all favorable or unfavorable items without making distinctions among them. Third, a distribution with relatively fewer items in the extreme categories throws into greater relief the most important features of the description; the extreme items effectively receive the greatest emphasis. Finally, if all Q-sorts have the same distribution, statistical analyses of the data are greatly facilitated.

When considering one’s approach to ratings, it is also essential to recognize that the PQS is an ‘ipsative method’. Its items are ordered within a specimen, from those most characteristic of the therapy session described to that least characteristic. The distinctiveness of this procedure is perhaps best understood by contrasting it with the more conventional normative mode of scaling typical of most psychological tests. In normative scaling, comparisons are made between individuals on some dimension of variation. If, for example, we have a scale of some psychological feature, such as level of anxiety, individuals are ordered relative to each other, or relative to a norm. It could then be said that patient A is more anxious than patient B, or that patient A is among the most anxious that a given therapist has seen. Ipsative scaling, on the other hand, takes no account of how an individual compares to others or to a norm (however derived); what matters is how the various dimensions to be described relate to each other within the case under study. For example, is patient A more insightful than he is anxious? Or is he more insightful than emotionally expressive? A judgment can be made, for example, whether the therapist has made more interpretations of defensive maneuvers than clarifying comments, or more frequent (or significant) transference interpretations than he has defense interpretations within the session. Each session is consequently described by a particular patterning of the dimensions, i.e. the PQS-items.

Each item of the PQS contains a description of the 2 opposite ends of the continuum along which the items are to be rated. It is important to note that placement in the uncharacteristic direction does not signal that a particular
behavior or experience is irrelevant. On the contrary, an uncharacteristic ranking signals that the absence of the item is meaningful and important to capture in the PQS description. Most items have specific instructions that provide examples of the distinction between uncharacteristic and neutral ratings. For example, PQS-item number 17 describes the therapist as "actively exerting control over the interaction, e.g. structuring and/or introducing new topics" when rated in the characteristic range. However, when rated in the uncharacteristic range, the item indicates that the therapist was "following the lead of the patient; helping the patient to follow his train of thought". Only if the item is irrelevant to the description of the session, would it be placed in the neutral range (category 5).

Judges rate the frequency, intensity and estimated importance or salience of each of the 100 statements. The already mentioned coding manual (see Jones 2000) provides the 100 items and their definitions, along with examples in order to minimize potentially varying interpretations of the items. The PQS-items themselves are anchored, as far as possible, to behavioral and linguistic cues that can be identified in recordings of sessions, and more abstract terms are avoided. For example, clinical judges are not asked to identify the presence or absence of a defense mechanism in the patient. The term ‘defense mechanism’ connotes a type of mental functioning; it is a relatively abstract notion, and it is often difficult for clinicians to agree on the presence or absence of a particular ‘mechanism’. Instead, clinical judges are asked to notice whether or not the therapist makes a defense interpretation. The items are tied to actual behavior that can be identified in a transcript or other recording. Judges are trained to look for specific evidence. When rating, judges are asked to take the position of a ‘generalized other’, i.e. an observer who stands mid-way between patient and therapist and who views the interaction from the outside. In placing each item, judges are instructed to ask themselves: Is this attitude, behavior or experience clearly present (or absent)? If the evidence is not compelling, the judge is asked to search for specific evidence of the extent to which it is present or absent. Since the items are not closely bound to particular theoretical concepts, but rather to notions of therapeutic process, the influence of observers' theory on their descriptions of the process is subdued within the framework provided by the PQS. Although inference is sometimes needed for certain items, the inference emanates from observable behavior rather
than a theoretical perspective. Therefore, the benefit of the PQS is that it describes what actually occurs or does not occur in a treatment session and does not place itself in alliance with any set of theoretical approaches. No matter what one’s theoretical orientation is, whether psychoanalysis or cognitive behavioral therapy or interpersonal therapy, it is important to subdue one’s personal theoretical preference when rating. Raters can encounter psychotherapy sessions from all treatment orientations, and we ask ourselves to consider only the linguistic and behavioral cues of the session as data in the interest of impartial, scientific rating.

During and after an initial reading, listening or viewing of a session, one notes the critical content of the session but emphasize to a greater degree the process of the session, remembering that the PQS was created to help clinicians and researchers describe the critical process variables. The rater should take notes during our reading, listening or viewing of sessions to help with later coding. We find it useful to summarize the session after reading. Again, the process variables should be emphasized as well as noting the content to recreate the session in the description of the session. For example, emphasizing aspects of the patient’s (P) and therapist’s (T) contribution to the session as well as the interaction (P-T) that has been observed. Among other processes that the PQS assesses, one should notice who initiates and controls during the session; what the patient’s affect is and whether the therapist comments on it during the session; what the specific interventions of the therapist are and are not; whether the rater feels the therapist understands the therapeutic process, whether the discussion is focused, whether the patient is resisting the therapist’s attempts to do the work of the session and how the patient and the therapist respond to and interact with one another. One should consider questions such as: Does the patient respond with deepening of material after an interpretation or is there a silence or an increase in self-protection or withdrawal as a result? How does the therapist proceed after patient being increasingly reluctant to proceed or is confused? Does the therapist adjust his style to accommodate the patient or does the therapist continue with his chosen form of interventions? Does the session appear to deepen or develop in a productive manner? Is this because of the connection of patient and therapist or does the patient have some resilience or momentum that seems independent of the connection with the therapist in this session? Is there data to suggest that patient has been helped in this particular session?
In considering these questions and others related to specific PQS-items, we think only of the session under consideration. If a rater is familiar with other sessions of the same treatment, he must try to exclude this knowledge and data from immediate rating criteria. And of course, a rater is blind to the order of the sessions, or where they fall in an extended treatment. The rater must try to be aware of subjective reactions to the therapist and the patient, and separate these reactions from his consideration of the objective data while rating. We have found that raters’ affective reactions to therapists need to be carefully self-monitored as they have the potential to bias one’s ratings.

When conducting the actual rating procedure, the rater can choose between paper and electronic versions of the PQS, which has been translated into German (Albani et al. 2000), Japanese, Norwegian, Italian, Portuguese (Serralta et al. 2007) and Spanish. The electronic version is generally considered to be more convenient and efficient (and also reduces data entry labor and errors), but some raters prefer to see and feel items written on cards that are then distributed into the piles from 1 to 9. For those who proceed with paper, the original sorting after reading the treatment session under consideration is done by placing items in one of 3 pile: highly characteristic and salient, neutral and saliently uncharacteristic. After this initial sorting, items are then distributed to the specific 1 to 9 piles based on the rater’s determination of how characteristic and salient each is in the session. If the electronic version is used, the rater can proceed in a similar fashion, placing items in one of 3 groupings to be distributed later. Once raters become more experienced with the measure, some prefer to place items in exact piles and then make necessary shifts according to the demands of the Q-sort distribution the second time through. The number of items in each pile is visible on the electronic Excel sheet. When a rater has reviewed ratings and completed his work, he assesses the ratings by reviewing the extreme rating piles (1 and 9), re-telling the story of the session with these 10 items and determining if the ‘story’ of the session as told by these items conforms to the rater’s ultimate observation.
2.4 Description of data analysis

2.4.1 The PQS methodology

The psychotherapy process measurement chosen to evaluate and compare short-term, long-term psychodynamic psychotherapy and psychoanalysis is the already presented and discussed ‘Psychotherapy Process Q-set’ method (Jones 2000). Therapy sessions (transcripts, audios and videos) of all treatments of the samples (number of sessions = 202) were randomized in each archive, and independent ratings were completed with the PQS. Four sessions (T1, T2, T3, T4) were selected for each patient in the PA and LTDP samples and 3 sessions (T1, T2, T3) for each treatment of the STDP sample. When recordings or transcripts of the chosen sessions were not available, the next closest session was selected. A pool of research-oriented psychotherapists, master’s-level graduate students in a clinical psychology and students of doctoral programs (including the main researcher of the present study) completed the PQS ratings for this study. All raters were officially and successfully trained in the application of the PQS technique. The judges were blind toward the modality of treatment and order of sessions. The inter-rater reliability was always over .50 (ranged from .54 to .94). In case reliability was bellow .05 (Pearson correlation coefficient), a third rater was added32. The reliable independent Q-sorts of 2 judges for each session were averaged to composite scores for each session (as in previous PQS studies). Only the composite scores are used for data analysis.

2.4.2 Different statistical approaches to examine PQS data from this study

The rating procedure of the PQS (description see above) avoids missing data and guarantees that the item responses are normally distributed. This means that the nature of the data does not restrict data-analytic techniques. All described analyses here are accomplished with SPSS 17.033. First we computed means and standard deviations for all PQS-items in the 3 samples. We compared the means in the different samples by applying t-tests.

32 In the present study this was barely the case.
33 Best thanks to my much valued colleague, Dr. Mattias Desmet, psychotherapy researcher and statistician at Gent University. His research interest includes empirical single case research on psychodynamic therapy, personality research and methodological research. All statistical analyses of this research project are conducted under his advice and supervision.
Second, we determined the match of the therapies in the 3 samples with the psychoanalytical prototypical therapy. In doing this, we strictly follow the method proposed by Jones and Ablon (1998). In short, this method correlates the scores on the PQS-items of a particular session with the PQS scores of a prototypical psychodynamic session. The higher the observed correlations, the closer the resemblance of this session with a prototypical psychoanalytic session. A more thorough description of the prototypes methodology has been provided in the introduction.

Third, we performed repeated measures analysis, which model the evolutions of the scores on the different items throughout the therapy (also called variance). These analyses yield F tests, which evaluate the movement of the PQS-items and represents the movement of the items on graphs.

Fourth, as exploratory procedure we perform a step-by-step discriminant analysis to determine, which PQS-items differentiate between the 3 therapeutic groups. These analyses yield so-called discriminant functions to stipulate which items contribute to the differentiation between the groups.

Comment on the use of ‘ipsative measure’ for group design
Frequently, in the PQS literature, this instrument is described and celebrated as an ‘ipsative measure’. Ipsatization refers to a process in which the mean score of a subject on a series of items is subtracted from all individual item scores. In this way, the subjects’ responses are corrected for his general tendency to score high or low on these items. For the PQS, a similar effect is obtained by the rating procedure, which forces the mean score (and the standard deviation) on the PQS-items to be the same across all sessions. This implies that items are always rated in reference to the other item scores for that session, and not in reference to the item scores of other sessions. Consequently, one may think that the PQS can only capture the uniqueness of each treatment hour on itself and is not suited for comparisons across sessions (as applied in the present study). Nevertheless, the session evaluated with the PQS does not lose its comparable character. Several single characterization of one session can be averaged and be very descriptive of

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34 The past PQS prototype studies use a z-transformed correlation value. We also calculated the z-transformation in order to compare our correlation with past studies.
a patient or even of a group of patients. Additionally, different moments of the therapeutic process can be evaluated and are represented in the final averaged ratings scores. When a treatment is studied intensively, one can observe what changed in the course of therapeutic process of a group of treatments. In fact, some nuances (captured by the evaluation of a single session) may be averaged out when observing groups of sessions; nevertheless a lot of information about the process remains available and offers a picture of a broader clinical frame, e.g. whole treatment. The PQS developers defend that the instrument permits “the assessment of similarities or dissimilarities between sessions and patients. It has been used in research involving group comparison design, in which Q-ratings of group of cases (or sessions) selected on some dimension of interest are compared (Jones & Pulos 1993; Ablon & Jones 2002), as well as in N=1 designs (Jones & Windholz 1990) does not mean that it is inadequate to analyze a group of sessions or even of treatments” (p. 548, Ablon & Jones 2005). In fact, in our group comparison each patient’s treatment will be first described according to the 100 PQS-items, result of mostly 4 sessions ratings along the time of treatment. The 100 items characterization of each treatment will contribute to define, for example, which items that describe therapeutic techniques are more characteristic for a group of therapy. The detailed description of each will help to give an impression of the group of treatments, which then will be compared with the other 2 groups.
3 Results

3.1 Comparison of most and least characteristic items of the three samples

The ten most and less characteristic items of each sample are presented here in comparison with each other (t-test). Part of the most characteristic and uncharacteristic items is the same in the three analyzed samples. From the ten most characteristic items, five items are common in the three samples. In the PA sample, three items are shared with one of the other samples, and two items are just present among the most characteristic items in the PA sample. The same distribution of common items is observed in the STDP sample. In the LTDP sample four characteristic items are also part of the most characteristic items in another sample and two items are only characteristic for the LTDP sample.

Relatively to the ten most uncharacteristic items, six are shared by all samples. In the PA sample, three items are also present in another sample and one item is only uncharacteristic for this sample. Four uncharacteristic items of the LTDP sample are shared with another sample and none are only uncharacteristic for this sample. In the STDP sample, three uncharacteristic items are the same in another sample and one item is only uncharacteristic in this sample.

In this manner, the following items are characteristic for all three samples, although not in the same rank order:

- Item 6: T is sensitive to the P's feelings, attuned to the P; empathic.
- Item 28: T accurately perceives the therapeutic process.
- Item 63: P's interpersonal relationships are a major theme.
- Item 65 T restates or rephrases the P’s communication in order to clarify its meaning.
- Item 69: P's current or recent life situation is emphasized in the session.

The following items are uncharacteristic for all three samples even if not in the same rank order:

- Item 5: P has difficulty understanding the T's comments.
- Item 9: T is distant, aloof (vs. responsive and affectively involved).
- Item 14: P does not feel understood by T.
- Item 15: P does not initiate or elaborate topics.
- Item 42: P rejects (vs. accepts) T's comments and observations.
• Item 77: T is tactless.
• Item 89: T intervenes to help P avoid or suppress disturbing ideas or feelings.

Fig. 7 Distribution of characteristic PQS-items in the STDP, LTDP and PA sample

Fig. 8 Distribution of uncharacteristic PQS-items in the STDP, LTDP and PA sample.
Special attention needs to be given to the understanding of uncharacteristic items, which are rated on the uncharacteristic side (rating in category 1 to 4). PQS-items can be uni- and bi-polar. Unipolar items describe a specific event that can be rated in continuity from 1 to 9 (extremely characteristic to uncharacteristic), for example the “therapist clarifies, restates, or rephrases patient’s communication (item 65)”. Bipolar items are different because they include two different meanings when rated 1 or 9. An example is item 1: “Patient verbalizes negative feelings toward therapist (vs. makes approving or admiring remarks)”. In this case, an extreme uncharacteristic rating (1) means not only that the patient does not express negative feelings towards the therapist, but that the patient articulates positive or even admiring remarks to the therapist. Hence, a bipolar item has an additional significance when rated as uncharacteristic and does not only mean that negative feelings toward the therapist or other aspects are little or even absent. This will be taken into account in the text to facilitate the reader’s understanding. When describing uncharacteristic items, the item name will be reformulated or adapted to its meaning when rated as uncharacteristic (different from the tables).

Overall what distinguishes the samples, based on most and least characteristic aspects, is for the PA sample that the dialogue has a specific focus (item 23: m=7.79; sd=.63) and that the psychoanalyst conveys a sense of non-judgmental acceptance towards the patients (item 18: m=6.87; sd=.80). The patients in psychoanalysis are willing to examine thoughts, reactions related to their role in creating or perpetuating problems (item 58: m=2.76; sd=1.47). Only for LTDP therapists it is extremely characteristic that the therapist draws patient’s attention to wishes, feeling or ideas that may not be in awareness (item 67: m=7.04; sd=1.39) and point out patients’ attempts to ward of threatening information or feelings (item 36: m=6.94; sd=1.37). Their communication with the patients is more characterized by a clear and coherent style (item 46: m=6.91; sd=.93). Finally, the STDP therapists are characterized by identifying recurrent themes in patient’s experience or behavior (item 62: m=6.98; sd=1.02) and the patient’s feelings or perceptions are linked to situations or behaviors of the past (item 92: m=6.75; sd=1.37). The STDP sample has also less silences occurring during therapy sessions. Nevertheless among the extremely characteristic and
uncharacteristic features of PA, LTDP and PA samples more sharing could be found when analyzing their therapy process. Now let’s look deeper into what distinguishes them or gradually differentiates them.

### 3.1.1 Description of PA sample in comparison with LTDP and STDP sample

Tab. 8 Ten most and least characteristic items of PA sample (N=13) in comparison to LTDP sample (N=15) and STDP sample (N=30)

<table>
<thead>
<tr>
<th>PQS#</th>
<th>Item Description</th>
<th>Mean Rating (SD)</th>
<th>t (26) diff PA-LTDP</th>
<th>p value</th>
<th>t (41) diff PA-STDP</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Most Characteristic Items of PA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>T is sensitive to the P’s feelings, attuned to the P; empathic.</td>
<td>7.86 (0.88)</td>
<td>-1.90</td>
<td>.08</td>
<td>-4.02</td>
<td>.00</td>
</tr>
<tr>
<td>23</td>
<td>Dialogue has a specific focus.</td>
<td>7.79 (0.63)</td>
<td>-1.89</td>
<td>.08</td>
<td>-10.38</td>
<td>.00</td>
</tr>
<tr>
<td>69</td>
<td>P’s current or recent life situation is emphasized in the session.</td>
<td>7.67 (0.79)</td>
<td>-1.85</td>
<td>.08</td>
<td>-2.28</td>
<td>.79</td>
</tr>
<tr>
<td>63</td>
<td>P’s interpersonal relationships are a major theme.</td>
<td>7.63 (0.80)</td>
<td>-2.17</td>
<td>.04</td>
<td>-1.55</td>
<td>.13</td>
</tr>
<tr>
<td>88</td>
<td>P brings up significant issues and material.</td>
<td>7.53 (0.46)</td>
<td>-4.00</td>
<td>.00</td>
<td>-4.00</td>
<td>.00</td>
</tr>
<tr>
<td>35</td>
<td>Self-image is a focus of the session.</td>
<td>7.16 (0.67)</td>
<td>-1.88</td>
<td>.07</td>
<td>-1.32</td>
<td>.19</td>
</tr>
<tr>
<td>65</td>
<td>T restates or rephrases the P’s communication in order to clarify its meaning.</td>
<td>7.13 (0.85)</td>
<td>-0.60</td>
<td>.55</td>
<td>-0.79</td>
<td>.44</td>
</tr>
<tr>
<td>18</td>
<td>T conveys a sense of non-judgmental acceptance.</td>
<td>6.87 (0.80)</td>
<td>-3.97</td>
<td>.00</td>
<td>-1.79</td>
<td>.08</td>
</tr>
<tr>
<td>28</td>
<td>T accurately perceives the therapeutic process.</td>
<td>6.85 (1.14)</td>
<td>1.57</td>
<td>.13</td>
<td>-0.70</td>
<td>.50</td>
</tr>
<tr>
<td>86</td>
<td>T acts confident or self-assured.</td>
<td>6.75 (0.76)</td>
<td>.99</td>
<td>.33</td>
<td>-1.63</td>
<td>.11</td>
</tr>
<tr>
<td></td>
<td><strong>Least Characteristic Items of PA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>P rejects T’s comments and observations.</td>
<td>1.65 (0.61)</td>
<td>2.37</td>
<td>.03</td>
<td>3.99</td>
<td>.00</td>
</tr>
<tr>
<td>15</td>
<td>P does not initiate or elaborate topics.</td>
<td>1.66 (0.53)</td>
<td>.72</td>
<td>.48</td>
<td>1.13</td>
<td>.26</td>
</tr>
<tr>
<td>14</td>
<td>P does not feel understood by T.</td>
<td>1.71 (0.65)</td>
<td>1.54</td>
<td>.14</td>
<td>2.80</td>
<td>.01</td>
</tr>
<tr>
<td>9</td>
<td>T is distant or aloof.</td>
<td>1.94 (0.75)</td>
<td>.89</td>
<td>.38</td>
<td>1.83</td>
<td>.07</td>
</tr>
<tr>
<td>5</td>
<td>P has difficulty understanding the T’s comments.</td>
<td>2.06 (0.32)</td>
<td>-.06</td>
<td>.95</td>
<td>2.35</td>
<td>.02</td>
</tr>
</tbody>
</table>
77  T is tactless.  2.42  -.60  .55  1.08  .29 (0.61)
44  P feels wary or suspicious of the T.  2.48  .67  .51  4.14  .00 (0.81)
58  P does not examine thoughts, reactions or motivations related to his or her role in creating or perpetuating problems.  2.76  .34  .74  2.91  .01 (1.47)
51  T condescends to or patronizes the P.  2.78  1.05  0.3  -.61  .54 (0.63)
20  P is provocative, tests limits of the therapy relationship.  2.96  -.06  .95  3.99  .00 (1.22)

In the psychoanalytic sample the therapists are mostly characterized by their empathic behavior (item 6: m=7.86; sd=.88), which is less characteristic for the short-term psychodynamic therapists (item 6: t=-4.02; p=.00). Only highly characteristic for the psychoanalytic sample is the dialogue having a special focus (item 23: m=7.97; sd=.63), which is much less the case in the STDP sample (item 23: t=-10.38; p=.00). The psychoanalysts convey more a sense of non-judgmental acceptance towards their patients (item 18: m=6.87; sd=.80) than the long-term psychodynamic therapists (item 18: t=-3.97; p=.00).

Extremely salient at the uncharacteristic side of the rating categories for this psychoanalytic sample are patient behaviors. The patients accept the therapist’s comments and observations (item 42: m=1.65; sd=.61), they are willing to initiate and elaborate topics of discussion (item 15: m=1.66; sd=.53), they feel understood by the therapist (item 14: m=1.71; sd=.65) and have no difficulty in understanding the therapist comments (item 5: m=2.06; sd=.32). Those patient behaviors are also salient at the uncharacteristic side of the other two samples. But only psychoanalytic patients are characterized here by examining thoughts, reactions or motivations related to their role in creating or perpetuating problems (item 58: m=2.76; sd=.63), differing from the patients in the STDP sample (item 58: t=2.91; p=.01). The patients in psychoanalysis feel more trusting and secure (item 44: m=2.48; sd=.81) than in the STDP sample (item 44: t=4.14; p=.00).
### Description of LTDP sample in comparison with STDP and PA sample

Tab. 9 Ten most and least characteristic items of LTDP sample (N=15) in comparison to PA sample (N=13) and STDP sample (N=30)

#### Most Characteristic Items of LTDP

<table>
<thead>
<tr>
<th>PQS#</th>
<th>Item Description</th>
<th>Mean Rating (SD)</th>
<th>t (43) diff LTDP-STDSP</th>
<th>t (26) diff LTDP-PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td>T accurately perceives the therapeutic process.</td>
<td>7.59 (1.35)</td>
<td>-3.49 .00</td>
<td>1.57 .13</td>
</tr>
<tr>
<td>6</td>
<td>T is sensitive to the P's feelings, attuned to the P; empathic.</td>
<td>7.24 (.87)</td>
<td>-2.05 .05</td>
<td>-1.85 .08</td>
</tr>
<tr>
<td>69</td>
<td>P's current or recent life situation is emphasized in the session.</td>
<td>7.14 (.80)</td>
<td>1.52 .14</td>
<td>-1.77 .09</td>
</tr>
<tr>
<td>67</td>
<td>T draws the P's attention to wishes, feelings or ideas that may not be in awareness.</td>
<td>7.04 (1.39)</td>
<td>-2.36 .02</td>
<td>1.90 .07</td>
</tr>
<tr>
<td>63</td>
<td>P's interpersonal relationships are a major theme.</td>
<td>7.04 (.64)</td>
<td>.90 .90</td>
<td>-2.17 .04</td>
</tr>
<tr>
<td>86</td>
<td>T acts confident or self-assured.</td>
<td>7.03 (.76)</td>
<td>-2.96 .01</td>
<td>.99 .33</td>
</tr>
<tr>
<td>65</td>
<td>T restates or rephrases the P's communication in order to clarify its meaning.</td>
<td>6.95 (.71)</td>
<td>2.32 2.32</td>
<td>-6.60 .55</td>
</tr>
<tr>
<td>36</td>
<td>T points out P's attempts to ward off awareness of threatening information or feelings.</td>
<td>6.94 (1.37)</td>
<td>-4.08 .00</td>
<td>4.21 .00</td>
</tr>
<tr>
<td>31</td>
<td>T asks for more information or elaboration.</td>
<td>6.92 (.53)</td>
<td>-1.76 .09</td>
<td>1.00 .33</td>
</tr>
<tr>
<td>46</td>
<td>T communicates with P in a clear, coherent style.</td>
<td>6.91 (.93)</td>
<td>-4.28 .00</td>
<td>.64 .53</td>
</tr>
</tbody>
</table>

#### Least Characteristic Items of LTDP

<table>
<thead>
<tr>
<th>PQS#</th>
<th>Item Description</th>
<th>Mean Rating (SD)</th>
<th>t (43) diff STDP-LTDP</th>
<th>t (26) diff LTDP-PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>P does not initiate or elaborate topics.</td>
<td>1.84 (.80)</td>
<td>.16 .88</td>
<td>.72 .48</td>
</tr>
<tr>
<td>89</td>
<td>T intervenes to help P avoid or suppress disturbing ideas or feelings.</td>
<td>1.90 (.98)</td>
<td>2.32 .03</td>
<td>-3.18 .01</td>
</tr>
<tr>
<td>14</td>
<td>P does not feel understood by T.</td>
<td>2.16 (.87)</td>
<td>.90 .37</td>
<td>1.54 .14</td>
</tr>
<tr>
<td>9</td>
<td>T is distant, aloof.</td>
<td>2.21 (.81)</td>
<td>.85 .40</td>
<td>0.89 .38</td>
</tr>
<tr>
<td>77</td>
<td>T is tactless.</td>
<td>2.27 (.76)</td>
<td>1.72 .10</td>
<td>-5.58 .57</td>
</tr>
<tr>
<td>42</td>
<td>P rejects (vs. accepts) T's comments and observations.</td>
<td>2.47 (1.17)</td>
<td>.63 .53</td>
<td>2.37 .03</td>
</tr>
</tbody>
</table>
Most characteristic for the long-term psychodynamic sample is therapists accurately perceiving the therapeutic process (item 28; m=7.59; sd=1.35), which is less the case in the STDP sample (item 28: t=-3.49; p=.00). Only characteristic for the LTDP sample are three therapists’ behaviors. In this sample, therapists draw more patient’s attention to wishes, feelings or ideas that may not be in their awareness (item 67; m=7.04; sd=1.39) and point out patient's attempts to ward off awareness of threatening information or feelings (item 36; m=6.94; sd=1.37), the latter is less characteristic in both other samples (STDP: t=-4.08; sd=.00; PA: t=4.21; sd=.00). Also do the therapists of the LTDP sample communicate with patient in a substantial clearer and coherent style (item 46; m=6.91; sd=.93) when compared with the STDP therapists (t=-4.28; p=.00).

Among the extremely uncharacteristic items of the long-term psychodynamic sample less significant differences with the other samples can be observed. No item is only uncharacteristic for the LTDP sample. Very salient for LTDP therapists is to intervene very little to suppress disturbing feelings of the patients (item 89: m=1.90; sd=.98), differently from the psychoanalysts (item 89: t=-3.18; p=.01). Instead patients in the LTDP sample tend to feel more trusting and secure (item 44:m=2.75; sd=1.32) than in the STDP sample (item 44: t=2.61; p=.01). Additionally, patients in the LTDP sample are characterized by easily understanding their therapists’ comments (item 5: m=2.77; sd=.77) although this is even more the case for patients in the psychoanalytic sample (item 5: t=3.30; p=.00).
3.1.3 Description of STDP sample in comparison with LTDP and PA sample

Tab. 10 Ten most and least characteristic items of STDP sample (N=30) in comparison to LTDP sample (N=15) and PA sample (N=13)

<table>
<thead>
<tr>
<th>PQS #</th>
<th>Item Description</th>
<th>Mean Rating (SD)</th>
<th>t (43) diff STDP-LTDP</th>
<th>p value</th>
<th>t (41) diff STDP-PA</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Most Characteristic Items of STDP</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>69</td>
<td>P's current or recent life situation is emphasized in the session.</td>
<td>7.59 (1.01)</td>
<td>1.52</td>
<td>.14</td>
<td>-2.28</td>
<td>.079</td>
</tr>
<tr>
<td>31</td>
<td>T asks for more information or elaboration.</td>
<td>7.28 (.71)</td>
<td>1.76</td>
<td>.09</td>
<td>2.27</td>
<td>.04</td>
</tr>
<tr>
<td>63</td>
<td>P's interpersonal relationships are a major theme.</td>
<td>7.16 (1.11)</td>
<td>.40</td>
<td>.69</td>
<td>-1.55</td>
<td>.13</td>
</tr>
<tr>
<td>62</td>
<td>T identifies a recurrent theme in P's experience or conduct.</td>
<td>6.98 (1.02)</td>
<td>.34</td>
<td>.74</td>
<td>1.44</td>
<td>.16</td>
</tr>
<tr>
<td>65</td>
<td>T restates or rephrases the P's communication in order to clarify its meaning.</td>
<td>6.91 (.72)</td>
<td>-.16</td>
<td>.87</td>
<td>-.79</td>
<td>.44</td>
</tr>
<tr>
<td>88</td>
<td>P brings up significant issues and material.</td>
<td>6.87 (.58)</td>
<td>1.38</td>
<td>.18</td>
<td>-4.00</td>
<td>.00</td>
</tr>
<tr>
<td>35</td>
<td>Self-image is a focus of the session.</td>
<td>6.81 (1.04)</td>
<td>.35</td>
<td>.73</td>
<td>-1.32</td>
<td>.19</td>
</tr>
<tr>
<td>6</td>
<td>T is sensitive to the P's feelings, attuned to the P; empathic.</td>
<td>6.75 (.71)</td>
<td>-2.05</td>
<td>.05</td>
<td>-4.02</td>
<td>.00</td>
</tr>
<tr>
<td>92</td>
<td>P's feelings or perceptions are linked to situations or behavior of the past.</td>
<td>6.75 (1.37)</td>
<td>2.13</td>
<td>.04</td>
<td>1.97</td>
<td>.06</td>
</tr>
<tr>
<td>28</td>
<td>T accurately perceives the therapeutic process.</td>
<td>6.62 (.53)</td>
<td>-3.49</td>
<td>.00</td>
<td>-.70</td>
<td>.50</td>
</tr>
</tbody>
</table>

|       | **Least Characteristic Items of STDP**                                            |                  |                        |         |                      |         |
|-------|-----------------------------------------------------------------------------------|------------------|------------------------|---------|                      |         |
| 15    | P does not initiate or elaborate topics.                                          | 1.88 (.59)       | .16                    | .88     | 1.13                 | .26     |
| 25    | P has difficulty beginning the hour.                                              | 2.09 (.74)       | -2.91                  | .01     | -4.75                | .00     |
| 9     | T is distant, aloof (vs. responsive and affectively involved).                    | 2.42 (.80)       | .85                    | .40     | 1.83                 | .07     |
| 14    | P does not feel understood by T.                                                  | 2.43 (.99)       | .90                    | .37     | 2.80                 | .01     |
| 5     | P has difficulty understanding the T's comments.                                  | 2.47 (.82)       | -1.23                  | .31     | 2.35                 | .02     |
| 89    | T intervenes to help P avoid or suppress disturbing ideas or feelings.            | 2.59 (.87)       | 2.32                   | .03     | -1.88                | .08     |
| 12    | Silences occur during the hour.                                                   | 2.65 (1.40)      | -3.64                  | .00     | -6.17                | .00     |
From the STDP sample fewer items will be highlighted here, since many already have been mentioned before in the two other sample sections. Highly characteristic, only for the STDP sample, is the therapists identifying a recurrent theme in patient’s experience or conduct (item 62: m=6.98; sd=1.02) and the patient’s feelings and perceptions being linked to situations of the past (item 92: m=6.74; sd=.53). In both items no significant difference towards the other LTDP and PA samples can be observed.

Only in the STDP sample, the occurrence of silence during the therapy session is uncharacteristic (items 12: m=2.65; sd=1.40), differing significantly from the other two samples (LTDP: t=-3.64; p=.00; PA: t=-6.17; p=.00). Also the STDP patients tend less to accept the therapists comments and observations (item 42: m=2.70; sd=1.10) than in the PA sample (item 42: t=3.99; p=.00). Whether the patients in the PA sample tend to have less difficulty beginning the hour (item 25: m=2.09; sd=.74) than in the STDP sample (item 25: t=-4.75; p=.00).
3.2 Comparison of techniques items

Tab. 11 List of therapeutic technique items with mean scores for STDP (N=30), LTDP (N=15) and PA (N=13) and comparison between samples

<table>
<thead>
<tr>
<th>PQS #</th>
<th>Item Description</th>
<th>STDP Mean (SD)</th>
<th>LTDP Mean (SD)</th>
<th>PA Mean (SD)</th>
<th>t (43) diff STDP-LTDP (p val.)</th>
<th>t (41) diff STDP-PA (p val.)</th>
<th>t (26) diff PA-LTDP (p val.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>T’s remarks are aimed at facilitating P speech.</td>
<td>6.23 (.13)</td>
<td>5.98 (.76)</td>
<td>6.38 (.78)</td>
<td>.76 (.45)</td>
<td>-.44 (.66)</td>
<td>-1.37 (.18)</td>
</tr>
<tr>
<td>6</td>
<td>T is sensitive to the P’s feelings attuned to the P; empathic.</td>
<td>6.75 (.71)</td>
<td>7.24 (.87)</td>
<td>7.86 (.88)</td>
<td>-2.05 (.05)</td>
<td>-4.37 (.00)</td>
<td>-1.85 (.08)</td>
</tr>
<tr>
<td>22</td>
<td>T focuses on guilt.</td>
<td>5.39 (1.09)</td>
<td>5.01 (.78)</td>
<td>4.50 (.89)</td>
<td>1.21 (.23)</td>
<td>2.59 (.01)</td>
<td>1.61 (.12)</td>
</tr>
<tr>
<td>24</td>
<td>T’s own emotional conflicts intrude into the relationship.</td>
<td>3.04 (.64)</td>
<td>4.08 (.59)</td>
<td>4.15 (.49)</td>
<td>-5.26 (.00)</td>
<td>-5.60 (.00)</td>
<td>-.38 (.71)</td>
</tr>
<tr>
<td>27</td>
<td>T gives explicit advice or guidance (vs. defers even when pressed to do so).</td>
<td>3.89 (.86)</td>
<td>4.81 (.97)</td>
<td>4.54 (1.21)</td>
<td>-3.21 (.00)</td>
<td>-1.99 (.05)</td>
<td>.65 (52)</td>
</tr>
<tr>
<td>28</td>
<td>T accurately perceives the therapeutic process.</td>
<td>6.62 (.53)</td>
<td>7.59 (1.35)</td>
<td>6.85 (1.14)</td>
<td>-2.70 (.02)</td>
<td>.70 (.50)</td>
<td>1.57 (.13)</td>
</tr>
<tr>
<td>32</td>
<td>P achieves a new understanding or insight.</td>
<td>5.56 (.93)</td>
<td>5.65 (.79)</td>
<td>5.14 (.79)</td>
<td>-.31 (.76)</td>
<td>1.41 (.17)</td>
<td>1.68 (.11)</td>
</tr>
<tr>
<td>31</td>
<td>T asks for more information or elaboration.</td>
<td>7.28 (.71)</td>
<td>6.92 (.53)</td>
<td>6.63 (.94)</td>
<td>1.76 (.09)</td>
<td>2.54 (.02)</td>
<td>1.04 (.31)</td>
</tr>
<tr>
<td>36</td>
<td>T points out P’s attempts to ward off awareness of threatening information or feelings.</td>
<td>5.41 (1.08)</td>
<td>6.94 (1.37)</td>
<td>5.14 (.85)</td>
<td>-4.08 (.00)</td>
<td>.79 (.43)</td>
<td>4.07 (.00)</td>
</tr>
<tr>
<td>37</td>
<td>T behaves in a teacher-like (didactic) manner.</td>
<td>3.87 (.75)</td>
<td>4.18 (1.02)</td>
<td>3.43 (.70)</td>
<td>-1.14 (.26)</td>
<td>1.80 (.08)</td>
<td>2.21 (.04)</td>
</tr>
<tr>
<td>40</td>
<td>T makes interpretations referring to actual people in the P’s life.</td>
<td>6.32 (.80)</td>
<td>6.06 (.85)</td>
<td>6.33 (.99)</td>
<td>1.00 (.32)</td>
<td>-.04 (.97)</td>
<td>-.77 (.45)</td>
</tr>
<tr>
<td>43</td>
<td>T suggests meaning of other’s behavior.</td>
<td>4.67 (.78)</td>
<td>4.61 (.78)</td>
<td>5.38 (1.44)</td>
<td>.25 (.81)</td>
<td>-1.68 (.11)</td>
<td>-1.80 (.08)</td>
</tr>
<tr>
<td>45</td>
<td>T adopts supportive stance.</td>
<td>4.64 (1.02)</td>
<td>4.11 (1.64)</td>
<td>5.50 (1.65)</td>
<td>1.35 (.19)</td>
<td>-1.73 (.10)</td>
<td>-2.23 (.04)</td>
</tr>
<tr>
<td>50</td>
<td>T points out P’s unacceptable feelings.</td>
<td>6.15 (1.18)</td>
<td>5.99 (1.02)</td>
<td>5.06 (.93)</td>
<td>.44 (.66)</td>
<td>2.97 (.01)</td>
<td>2.52 (.02)</td>
</tr>
<tr>
<td>57</td>
<td>T explains rationale behind his or her technique or approach to treatment or suggests that the P use certain techniques.</td>
<td>4.01 (.51)</td>
<td>4.72 (42)</td>
<td>4.73 (.36)</td>
<td>-4.62 (.00)</td>
<td>-4.56 (.00)</td>
<td>-.08 (.94)</td>
</tr>
</tbody>
</table>
Overall, a similar application of the following techniques can be identified in the three therapy groups: facilitating patients’ speech (item 3), interpretation referring to actual people in patient’s life (item 40), identifying recurrent theme in the patients experience or conduct (item 62), raising questions about the patients’ view (item 99), drawing connection between therapeutic relationship and other relationships (item 100) and restating or rephrasing patient’s communication in order to clarify its meaning (item 65), where the latter is among the most characteristic aspects of all therapy groups.

When looking at the therapeutic techniques that are part of most characteristic aspects of all three therapy samples, some differences can be found. For example, the highly characteristic technique of empathy was less characteristic in the STDP sample than in the PA sample (item 6: t=-4.37; p=.00). Also the therapist accurately perceiving the therapeutic process was highly characteristic in
the three samples, but it was more characteristic among LTDP therapists (item 28: t=-2.70; p=.00) than STDP therapists. In connection to this technique, the patient achieving a new understanding or insight (item 32) is characteristic and not significantly different between samples.

Other significant differences can be registered in the usage of therapy techniques among STDP, LTDP and PA samples. For instance, it is more characteristic for STDP therapists to refrain from giving advice or guidance (item 27: t=-3.21; p=.00) and emphasize patients’ feelings to deepen them when compared to the LTDP sample (item 81: t=2.39; p=.02) and specially in comparison to the PA sample (item 81: t=1.86; p=.07). The STDP therapists’ emotional conflicts intrude less into the therapy relationship than in the LTDP (item 24: t=-5.26; p=.00) and PA sample (item 24: t=-5.60; p=.00). The therapists in the STDP sample tend more to refrain from stating their opinion on topics the patients discuss than the LTDP therapists (item 99: t=2.19; p=.04) and the STDP therapists tend to link more patients feelings or perceptions to situations or behaviors of the past than the LTDP therapists (item 92: t=2.56; p=.02). The STDP therapist also slightly ask for more information or elaboration (item 31: t=2.54 p=.02), point out unacceptable feelings more often (item 22: t=2.59; p=.01) and focus more on guilt (item 50: t=2.59; p=.01) than the psychoanalysts. This technique is part of the most characteristic aspects of therapy in both, STDP and LTDP therapy groups. Different is the usage of pointing out defenses in the LTDP sample in comparison with STDP (item 36: t=-4.08; p=.00) and PA sample (item 36: t=4.07; p=.00), in both latter this technique is less characteristic. Also in the LTDP sample the teacher-like or didactic behavior is slightly more characteristic than in the PA sample (item 37: t=2.21; p=.04). The support technique is a little more used by the psychoanalysts than by LTDP therapists (item 45: t=-2.23; p=.04). The interpretation technique is one of the most characteristic aspects in the LTDP sample, which is less used in the PA (item 67: t=1.90; p=.07) and STDP sample (item 67: t=-2.00; p=.06). A significant difference is observed between the STDP and PA sample (item 82: t=3.03; p=.00) and between LTDP and PA sample (item 82: t=4.39; p=.00), where it was less characteristic to reformulate the patients behavior in a way not explicitly recognized previously during psychoanalysis, than in the STDP or LTDP sessions. The therapist refraining from intervening to help the patient to avoid or suppress
disturbing ideas or feelings is almost significantly different in the three samples, the biggest difference is found between the PA and LTDP sample, where in the latter this absence is more extreme (item 89: t=-3.26; p=.00).

The techniques rated in the neutral range will not be commented here, also when significant differences are observed (e.g. a significant difference in the STDP sample in relation to LTDP and PA samples can be observed in not explaining the rational behind therapy technique and not suggesting the patient to use certain techniques (item 57: STDP-LTDP t=-4.62; p=.00; STDP-PA t=-4.56 p=.00).

3.3 Variable items during therapeutic process of STDP, LTDP and PA

Tab. 12 Variability of all 100 PQS-items in STDP (N=30), LTDP (N=15) and PA (N=13) with rank ordered F values

<table>
<thead>
<tr>
<th>PQS #</th>
<th>Most variable items at different time points</th>
<th>Sample</th>
<th>F value; Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>T asks for more information or elaboration.</td>
<td>STDP</td>
<td>44.54 (.00)</td>
</tr>
<tr>
<td>75</td>
<td>Termination of therapy is mentioned or discussed.</td>
<td>STDP</td>
<td>32.81 (.00)*</td>
</tr>
<tr>
<td>75</td>
<td>Termination of therapy is mentioned or discussed.</td>
<td>LTDP</td>
<td>19.81 (.00)*</td>
</tr>
<tr>
<td>40</td>
<td>T makes interpretations referring to actual people in the P's life.</td>
<td>STDP</td>
<td>18.17 (.00)</td>
</tr>
<tr>
<td>96</td>
<td>There is discussion of scheduling of hours or fees.</td>
<td>STDP</td>
<td>15.98 (.00)</td>
</tr>
<tr>
<td>4</td>
<td>P's treatment goals are discussed.</td>
<td>STDP</td>
<td>15.13 (.00)</td>
</tr>
<tr>
<td>4</td>
<td>P's treatment goals are discussed.</td>
<td>LTDP</td>
<td>6.66 (.00)</td>
</tr>
<tr>
<td>67</td>
<td>T draws the P's attention to wishes, feelings, or ideas that may not be in awareness.</td>
<td>STDP</td>
<td>14.29 (.00)</td>
</tr>
<tr>
<td>62</td>
<td>T identifies a recurrent theme in P's experience or conduct.</td>
<td>STDP</td>
<td>13.74 (.00)</td>
</tr>
<tr>
<td>80</td>
<td>T presents a specific experience or event in a different perspective.</td>
<td>STDP</td>
<td>13.42 (.00)</td>
</tr>
<tr>
<td>98</td>
<td>Therapy relationship is a focus of discussion.</td>
<td>STDP</td>
<td>10.93 (.00)</td>
</tr>
<tr>
<td>88</td>
<td>P brings up significant issues and material.</td>
<td>STDP</td>
<td>10.10 (.00)*</td>
</tr>
<tr>
<td>21</td>
<td>T self-discloses.</td>
<td>STDP</td>
<td>10.06 (.00)</td>
</tr>
<tr>
<td>47</td>
<td>When the interaction with the P is difficult, the T accommodates in an effort to improve relations.</td>
<td>STDP</td>
<td>9.46 (.00)</td>
</tr>
<tr>
<td>85</td>
<td>T encourages P to try new ways of behaving with others.</td>
<td>STDP</td>
<td>8.83 (.00)</td>
</tr>
<tr>
<td>12</td>
<td>Silences occur during the hour.</td>
<td>LTDP</td>
<td>8.78 (.00)</td>
</tr>
<tr>
<td>55</td>
<td>P conveys positive expectations about therapy.</td>
<td>STDP</td>
<td>8.36 (.00)</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Sample</td>
<td>Value</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------</td>
<td>--------</td>
</tr>
<tr>
<td>16</td>
<td>There is mention or discussion of body functions, physical symptoms, or health.</td>
<td>STDP</td>
<td>7.70 (.00)</td>
</tr>
<tr>
<td>50</td>
<td>T draws attention to feelings regarded by the P as unacceptable.</td>
<td>STDP</td>
<td>7.39 (.00)</td>
</tr>
<tr>
<td>43</td>
<td>T suggests the meaning of others' behavior.</td>
<td>STDP</td>
<td>7.30 (.00)</td>
</tr>
<tr>
<td>36</td>
<td>T points out P's attempts to ward off awareness of threatening information or feelings.</td>
<td>STDP</td>
<td>7.28 (.00)</td>
</tr>
<tr>
<td>32</td>
<td>P achieves a new understanding or insight.</td>
<td>STDP</td>
<td>7.17 (.00)</td>
</tr>
<tr>
<td>13</td>
<td>P is animated or excited.</td>
<td>LTDP</td>
<td>6.85 (.00)</td>
</tr>
<tr>
<td>64</td>
<td>Feelings about romantic love relationships are a topic of the session.</td>
<td>STDP</td>
<td>6.76 (.00)</td>
</tr>
<tr>
<td>3</td>
<td>T's remarks are aimed at facilitating P speech.</td>
<td>STDP</td>
<td>6.44 (.00)</td>
</tr>
<tr>
<td>76</td>
<td>T suggests that P accept responsibility for his or her problems.</td>
<td>STDP</td>
<td>6.27 (.00)</td>
</tr>
<tr>
<td>8</td>
<td>P is concerned or conflicted about his or her dependence on the T.</td>
<td>LTDP</td>
<td>5.64 (.00)</td>
</tr>
<tr>
<td>92</td>
<td>P's feelings or perceptions are linked to situations or behavior of the past.</td>
<td>PA</td>
<td>5.56 (.00)</td>
</tr>
<tr>
<td>17</td>
<td>T actively exerts control over the interaction.</td>
<td>PA</td>
<td>5.45 (.00)</td>
</tr>
</tbody>
</table>

Note: STDP df (2); LTDP df(3); PA df(3). The significance values marked with * are Greenhouse-Geisser corrected because Mauchly's test was significant. All the other values are 'Sphericity Assumed' significance values, where the Mauchly’s test was not significant. In this table only the highly significant (p=.00) items are presented. Bold marked items were identified as significant in another sample.

The table above shows that the most variable items throughout the different time points are not the same for the three samples. Exceptions are item 4 and 75, both variable among STDP and LTDP therapy process. Overall, more significant variance is observed in the STDP sample (22 items) than in the LTDP sample (5 items) and even less in the PA sample (2 items). The highly variable items are not only more in STDP therapy, but also present higher t-values. The most variable item during STDP therapies is the therapist asking for more information and elaboration (item 31; t=44.54 p=.00). It is interesting to observe in the graph below how the variable items move in the different time points of therapy and compare it the movement of the same item in the other samples. The item with higher variability is presented below (fig. 3).
In regard to the therapists asking for more information or elaboration, in the STDP sample, the higher variance is observed from time point T1 to T2. At therapy beginning (T1) it is extremely characteristic for the therapist to ask for more information and for the rest of the process this intervention decreases but stays as a characteristic aspect of therapy in T2, T3, T4. The same tendency can be observed in LTDP and PA, but with lower variance from T1 to towards the other time points. Apart from T1, the therapists’ asking for information is similarly characteristic among the samples.

In the following two figures two variant items for STDP and LTDP are presented and compared with the item movement in the PA sample. Item 4 concerns the discussion of patient's treatment goals (STDP: t=15.13; p=.00; LTDP: t=6.66; p=.00) and its movement is clearly different in the PA sample, which stays constant in the neutral range. In the two other samples were variability is observed, the movement is almost opposite. This is, at the beginning of STDP, the

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35 T4 does not exist for STDP sample, please read the ‘Sample description’ section. In all presented graphics, the value of T3 is presented as T4 in order to facilitate the understanding and comparison with therapy ending of the other samples.
discussion of treatment goals is highly characteristic and in the LTDP sample this is only the case towards the end of therapy.

Fig. 10 Item 4: The patient's treatment goals are discussed.
Fig. 11 Item 75: Termination of therapy is mentioned or discussed. Also highly variable is the discussion of therapy termination (item 75; STDP: t=32.81; p=.00*; LTDP: t=19.81; p=.00*). The biggest movement represented above (fig. 5) is the increase of discussion of therapy termination at the end of therapy in STDP and LTDP, whereas during therapy this item stayed neutral. From the beginning to the end of the psychoanalytic therapies this discussion was neutral or unimportant.
3.4 Variable technique items during therapeutic process of STDP, LTDP and PA

Tab. 13 Variability of only technique PQS-items in STDP (N=30), LTDP (N=15) and PA (N=13) with rank ordered F values

<table>
<thead>
<tr>
<th>PQS #</th>
<th>Most variable technique items at different time points</th>
<th>Sample</th>
<th>F value; Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>T asks for more information or elaboration.</td>
<td>STDP</td>
<td>44.54 (.00)</td>
</tr>
<tr>
<td>40</td>
<td>T makes interpretations referring to actual people in the P's life.</td>
<td>STDP</td>
<td>18.17 (.00)</td>
</tr>
<tr>
<td>67</td>
<td>T draws the P’s attention to wishes, feelings, or ideas that may not be in awareness.</td>
<td>STDP</td>
<td>14.29 (.00)</td>
</tr>
<tr>
<td>62</td>
<td>T identifies a recurrent theme in P’s experience or conduct.</td>
<td>STDP</td>
<td>13.74 (.00)</td>
</tr>
<tr>
<td>50</td>
<td>T draws attention to feelings regarded by the P as unacceptable.</td>
<td>STDP</td>
<td>7.39 (.00)</td>
</tr>
<tr>
<td>50</td>
<td>T draws attention to feelings regarded by the P as unacceptable.</td>
<td>LTDP</td>
<td>3.12 (.04)</td>
</tr>
<tr>
<td>43</td>
<td>T suggests the meaning of others’ behavior.</td>
<td>STDP</td>
<td>7.30 (.00)</td>
</tr>
<tr>
<td>36</td>
<td>T points out P’s attempts to ward off awareness of threatening information or feelings.</td>
<td>STDP</td>
<td>7.28 (.00)</td>
</tr>
<tr>
<td>32</td>
<td>P achieves a new understanding or insight.</td>
<td>STDP</td>
<td>7.17 (.00)</td>
</tr>
<tr>
<td>3</td>
<td>T's remarks are aimed at facilitating P speech.</td>
<td>STDP</td>
<td>6.44 (.00)</td>
</tr>
<tr>
<td>99</td>
<td>T raises questions about the P's view.</td>
<td>STDP</td>
<td>6.18 (.01)</td>
</tr>
<tr>
<td>92</td>
<td>P’s feelings or perceptions are linked to situations or behavior of the past.</td>
<td>PA</td>
<td>5.56 (.00)</td>
</tr>
<tr>
<td>92</td>
<td>P’s feelings or perceptions are linked to situations or behavior of the past.</td>
<td>STDP</td>
<td>4.06 (.02)</td>
</tr>
<tr>
<td>93</td>
<td>T refrains from stating opinions or views of topics the P discusses.</td>
<td>STDP</td>
<td>4.51 (.02)</td>
</tr>
<tr>
<td>22</td>
<td>T focuses on P’s feelings of guilt.</td>
<td>STDP</td>
<td>4.44 (.02)</td>
</tr>
<tr>
<td>65</td>
<td>T restates or rephrases the P’s communication in order to clarify its meaning.</td>
<td>STDP</td>
<td>4.16 (.02)</td>
</tr>
<tr>
<td>81</td>
<td>T emphasizes P’s feelings in order to help him or her experience them more deeply.</td>
<td>STDP</td>
<td>4.05 (.02)</td>
</tr>
<tr>
<td>82</td>
<td>P’s behavior during the hour is reformulated by the T in a way not explicitly recognized previously.</td>
<td>STDP</td>
<td>4.05 (.02)</td>
</tr>
<tr>
<td>6</td>
<td>T is sensitive to the P’s feelings, attuned to the P; empathic.</td>
<td>LTDP</td>
<td>3.70 (.02)</td>
</tr>
</tbody>
</table>

Note: STDP df (2); LTDP df(3); PA df(3). The significance values marked with * are Greenhouse-Geisser corrected because Mauchly’s test was significant. All the other values are ‘Sphericity Assumed’ significance values (were the Mauchly’s test was not significant). In this table only the highly significant (.00) items are presented.

In the table above the technique items are listed where movement can be observed in their application during therapy. Now concerning the technique items
more variability is only observed again in the STDP sample. Overall the t-values and their significance are lower than the ones presented in table 1. One of the most variable techniques is the therapist’s interpretations referring to actual people in patient's life in the STDP sample (item 40: t=18.17; p=.00). From the graph below (fig. 7) it is clear that the STDP therapist provided no interpretations at therapy beginning, but this technique becomes highly characteristic for the rest of therapy. In the LTDP sample interpretation decreased during therapy and became more characteristic again towards the end of the process. The psychoanalysts interpreted referring to actual people in patient's life throughout therapy without significant oscillation.

Fig. 12 Item 40: Therapist makes interpretations referring to actual people in patient's life.

Now two techniques will be described here that showed movement in at least two of the samples, as the already discussed ‘asking for more information or elaboration’ (item 31; STDP: t=44.54 p=.00; LTDP: t=19.81; p=.00*). The therapist drawing attention to feelings regarded by the patient as unacceptable was not a constant intervention, it became more characteristic among the STDP during the process (T1; T2; T3). The LTDP therapists started similarly as the STDP therapist
but at the end reduced its application (item 50; STDP: t=7.39; p=.00; LTDP: 
t=3.12; p=.04), as visible in the graph below (fig. 8).

![Graph showing estimated marginal means of STPD, LTPD, and PA over PQS-item 50.]

**Fig. 13 Item 50: Therapist draws attention to feelings regarded by the patient as unacceptable.**

The last presented technique concerns the linkage of patient's feelings or perceptions to situations of the past (item 92; see fig. 14) and is one of the few items where significant movement is observed in the PA sample. The psychoanalysts tend to decrease significantly this intervention (item 92: t=5.56; p=.00), as can be observed in the following graph. Contrary, in the STDP sample, connecting actual experiences with the past becomes characteristic in T2 and its application stays characteristic at the end of therapy (item 92: t= 4.06; p=.02).
Fig. 14 Item 92: Patient's feelings or perceptions are linked to situations or behavior of the past.
3.5 Explorative procedure: ‘Discriminant analysis’

Through the discriminant analysis procedure on the technique PQS-items among STDP, LTDP and PA, several items are found that distinguish the samples. In the table below we can see which technique items mostly differentiate each sample. PA and LTDP have the same number of distinguishing item as STDP and PA, but much higher differences are observed between PA and LTDP. Less and lower differences are observable between STDP and LTDP.

Tab. 14 Discriminant analysis of means for STDP, LTDP and PA samples.

<table>
<thead>
<tr>
<th>Item 24: T’s own emotional conflicts intrude into the relationship.</th>
<th>Item 24: T’s own emotional conflicts intrude into the relationship.</th>
<th>Item 82: P’s behavior during the hour is reformulated by the T in a way not explicitly recognized previously.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 36: T points out P’s attempts to ward off awareness of threatening information or feelings.</td>
<td>Item 57: T explains rationale behind his technique or approach to treatment, or suggests that the P use certain techniques.</td>
<td>Item 37: T behaves in a teacher-like (didactic) manner.</td>
</tr>
<tr>
<td>Item 81: T emphasizes P feelings in order to help him or her experience them more deeply.</td>
<td>Item 37: T behaves in a teacher-like (didactic) manner.</td>
<td>Item 28: T accurately perceives the therapeutic process.</td>
</tr>
<tr>
<td>Item 6: T is sensitive to the P’s feelings, attuned to the P; empathic.</td>
<td>Item 67: T draws the P’s attention to wishes, feelings, or ideas that may not be in awareness.</td>
<td>Item 89: T intervenes to help patient avoid or suppress disturbing ideas or feelings.</td>
</tr>
<tr>
<td>Item 31: T asks for more information or elaboration.</td>
<td>Item 89: T intervenes to help patient avoid or suppress disturbing ideas or feelings.</td>
<td>Item 100: T draws connections between the therapeutic relationship and other relationships.</td>
</tr>
</tbody>
</table>

Note: k = standardized canonical discriminant function coefficient; m= mean of respective sample
Highly differentiating psychoanalyses from the LTDP therapies is that it is more characteristic for LTDP therapists to accurately perceive therapeutic process (k=2.13), draw more patient’s attention to unconscious wishes, feelings or ideas (k=-1.92) and behave less in a teacher-like manner (k=2.06). Also LTDP therapist, refrain more from helping patient to suppress disturbing ideas or feelings (k= -1.29) when compared with the psychoanalysts’ way of intervention.

The following table (tab.15) does not present individually each item that defers in each of the samples, but gives an overall score for differentiation (group centroids). Overall, when analyzing the whole therapy process, PA and LTDP samples differ most. Though, if we look into the discriminant analysis of these three samples at four different time points, the highest differentiations between samples varies from time point to time point: at T1 more difference is observable between STDP and PA; at T2 more differentiation occurs between PA and LTDP (which is the overall trend); at T3 the highest difference is between STDP and PA (as in T1) and at the last time point (T4) STDP and LTDP differ most. Special attention needs to be given to the results concerning T3 and T4, because for the STDP sample T3 is the end of therapy (there is no 4th point in time). The therapy ending of LTDP and PA is T4, which is then analyzed in the discriminant analysis with the end of therapy (T3) of the STDP sample. In this way, in regard to T4 results, the STDP therapy ending (T3) differs more from the ending of LTDP (T4).
Tab. 15 Overall differentiation through function at ‘group centroids’

<table>
<thead>
<tr>
<th>Functions at Group Centroids for each sample and time points</th>
<th>STDP vs. LTDP</th>
<th>STDP vs. PA</th>
<th>PA vs. LTDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>All T.</td>
<td>-.83</td>
<td>-1.18</td>
<td>2.72</td>
</tr>
<tr>
<td></td>
<td>d=2.50</td>
<td>d=3.90</td>
<td></td>
</tr>
<tr>
<td>T1</td>
<td>-1.24</td>
<td>2.48</td>
<td>-1.40</td>
</tr>
<tr>
<td></td>
<td>d=3.82</td>
<td>d=4.62</td>
<td></td>
</tr>
<tr>
<td>T2</td>
<td>.70</td>
<td>-1.41</td>
<td>-.82</td>
</tr>
<tr>
<td></td>
<td>d=2.11</td>
<td>d=2.71</td>
<td></td>
</tr>
<tr>
<td>T3</td>
<td>-.88</td>
<td>1.77</td>
<td>-.85</td>
</tr>
<tr>
<td></td>
<td>d=2.65</td>
<td>d=2.82</td>
<td></td>
</tr>
<tr>
<td>T4</td>
<td>1.25</td>
<td>-2.51</td>
<td>-.64</td>
</tr>
<tr>
<td></td>
<td>d=3.76</td>
<td>d=2.12</td>
<td></td>
</tr>
</tbody>
</table>

Note: Unstandardized canonical discriminant functions evaluated at group means with d (total difference in function values of each sample comparison); T4 in STDP are replaced by values for T3, because no T4 exists in STDP.

Considering the results of discriminant analysis of the three samples at different time points, only the time point with more and higher differentiation is presented here (T1) with discriminate item values. For the other three time points, the discriminant analysis formula is illustrated at the end of this section.
Tab. 16 Discriminant analysis at T1 for STDP, LTDP and PA

<table>
<thead>
<tr>
<th>STDP vs. LTDP</th>
<th>STDP vs. PA</th>
<th>LTDP vs. PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 28: T accurately perceives the therapeutic process. k=.73 (STDP: m=6.67; LTDP: m=7.80)</td>
<td>Item 24: T’s own emotional conflicts intrude into the relationship. k=.76 (STDP: m=3.00; PA: m=4.27)</td>
<td>Item 89: T intervenes to help P avoid or suppress disturbing ideas or feelings. k=1.00 (LTDP: m=2.07; PA: m=3.69)</td>
</tr>
<tr>
<td>Item 36: T points out P’s attempts to ward off awareness of threatening information or feelings. k=1.06 (STDP: m=4.62; LTDP: m=6.57)</td>
<td>Item 82: The P’s behavior during the hour is reformulated by the T in a way not explicitly recognized previously. k=-.80 (STDP: m=4.70; PA: m=4.35)</td>
<td></td>
</tr>
<tr>
<td>Item 43: T suggests the meaning of others’ behavior. k=.78 (STDP: m=4.02; LTDP: m=4.87)</td>
<td>Item 100: T draws connections between the therapeutic relationship and other relationships. k=.89 (STDP: m=4.30; PA: m=5.38)</td>
<td></td>
</tr>
<tr>
<td>Item 81: T emphasizes P feelings in order to help him or her experience them more deeply. k=-.60 (STDP: m=6.10; LTDP: m=5.57)</td>
<td>Item 31: T asks for more information or elaboration. k=-1.04 (STDP: m=8.37; PA: m=7.08)</td>
<td></td>
</tr>
<tr>
<td>Item 31: T asks for more information or elaboration. k=-.61 (STDP: m=8.37; LTDP: m=7.33)</td>
<td>Item 28: T accurately perceives the therapeutic process. k=.89 (STDP: m=6.67; PA: m=7.04)</td>
<td></td>
</tr>
<tr>
<td>Item 22: T focuses on P’s feelings of guilt. k=.59 (STDP: m=4.55; LTDP: m=5.47)</td>
<td>Item 50: T draws attention to feelings regarded by the P as unacceptable. k=-.60 (STDP: m=5.43; PA: m=4.46)</td>
<td></td>
</tr>
<tr>
<td>Item 67: T draws the P’s attention to wishes, feelings, or ideas that may not be in awareness. k=.72 (STDP: m=5.25; LTDP: m=6.60)</td>
<td>Item 45: T adopts supportive stance. k=.46 (STDP: m=4.30; PA: m=5.81)</td>
<td></td>
</tr>
</tbody>
</table>

Note: k = standardized canonical discriminant function coefficient; m= mean of respective sample.

The first time point is more differentiated between STDP and PA techniques, followed by differences between STDP and LTDP (also visible in tab. 2). In the table above it is clear that much more items differentiate STDP from PA and LTDP than between PA and LTDP. At therapy beginning, STDP therapists ask more for information and elaboration than psychoanalysts (k=-1.04). Among LTDP therapist
it is more characteristic at T1 to point out patient’s attempts to ward off awareness of threatening information of feelings right than for STDP therapist (k=1.06). Overall LTDP therapist do that more frequently than STDP therapist (k=.74).

Tab. 17 Discriminant analysis at T2 for STDP, LTDP and PA

<table>
<thead>
<tr>
<th>STDP vs. LTDP</th>
<th>STDP vs. PA</th>
<th>LTDP vs. PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 57: T explains rationale behind his or her technique or approach to treatment, or suggests that the P use certain techniques. k=.47 (STDP: m=3.87; LTDP: m=4.58)</td>
<td>Item 6: T is sensitive to the P's feelings, attuned to the P; empathic. k=1.05 (STDP: m=6.62; PA: m=8.15)</td>
<td>Item 89: T intervenes to help P avoid or suppress disturbing ideas or feelings. k=1.00 (LTDP: m=1.63; PA: m=3.42)</td>
</tr>
<tr>
<td>Item 89: T intervenes to help P avoid or suppress disturbing ideas or feelings. k=.68 (STDP: m=2.67; LTDP: m=1.63)</td>
<td>Item 57: T explains rationale behind his or her technique or approach to treatment, or suggests that the P use certain techniques. k=.62 (STDP: m=3.87; PA: m=4.85)</td>
<td>Item 6: T is sensitive to the P's feelings, attuned to the P; empathic. k=1.02 (LTDP: m=7.04; PA: m=8.15)</td>
</tr>
<tr>
<td>Item 6: T is sensitive to the P's feelings, attuned to the P; empathic. k=.76</td>
<td>Item 40: T makes interpretations referring to actual people in the P's life. k=-.66 (STDP: m=6.62; PA: m=6.23)</td>
<td>Item 68: Real vs. fantasized meanings of experiences are actively differentiated. k=.96 (LTDP: m=4.92; PA: m=5.15)</td>
</tr>
<tr>
<td>Item 92: P's feelings or perceptions are linked to situations or behavior of the past. k=.68 (STDP: m=7.00; LTDP: m=5.63)</td>
<td>Item 57: T explains rationale behind his or her technique or approach to treatment, or suggests that the P use certain techniques. k=.52 (STDP: m=3.87; PA: m=4.85)</td>
<td>Item 27: T gives explicit advice or guidance (vs. defers even when pressed to do so). k=-1.14 (LTDP: m=4.72; PA: m=4.31)</td>
</tr>
</tbody>
</table>

Note: k = standardized canonical discriminant function coefficient; m= mean of respective sample.

In T2 bigger difference is observed between PA and LTDP (d= 4.89), specially at item 89 (k=1.00) since the LTDP therapist refrain from suppressing disturbing ideas or feelings than the psychoanalysts (LTDP: m=1.63; PA: m=3.42). Item 6 differentiates STDP (k=1.05) and LTDP (k=1.02) from the PA sample, meaning
that psychoanalysts show more empathy towards the patients than STDP and LTDP therapists (STDP: m=6.62; LTDP: m=7.04; PA: m=8.15).

Tab. 18 Discriminant analysis at T3 for STDP, LTDP and PA.

<table>
<thead>
<tr>
<th>STDP vs. LTDP</th>
<th>STDP vs. PA</th>
<th>LTDP vs. PA</th>
</tr>
</thead>
</table>
| Item 36: T points out P's attempts to ward off awareness of threatening information or feelings.  
  \( k = \frac{.58}{(STDP: m=5.62; LTDP: m=7.37)} \) | Item 6: T is sensitive to the P's feelings, attuned to the P; empathic.  
  \( k = \frac{.57}{(STDP: m=6.65; PA: m=7.92)} \) | Item 36: T points out P's attempts to ward off awareness of threatening information or feelings.  
  \( k = \frac{1.00}{(LTDP: m=5.62; PA: m=4.54)} \) |
| Item 24: T's own emotional conflicts intrude into the relationship.  
  \( k = \frac{.81}{(STDP: m=2.90; LTDP: m=4.10)} \) | Item 50: T draws attention to feelings regarded by the P as unacceptable.  
  \( k = \frac{-.46}{(STDP: m=6.82; PA: m=4.58)} \) |
| Item 28: T accurately perceives the therapeutic process.  
  \( (k = \frac{.76}{(STDP: m=6.75; LTDP: m=7.93}) \) | Item 24: T's own emotional conflicts intrude into the relationship.  
  \( (k = \frac{.57}{(STDP: m=2.90; PA: m=4.12}) \) |
| Item 50: T draws attention to feelings regarded by the P as unacceptable.  
  \( k = \frac{-.55}{(STDP: m=6.82; LTDP: m=7.93)} \) | Item 37: T behaves in a teacher-like (didactic) manner.  
  \( k = \frac{-.52}{(STDP: m=3.97; PA: m=3.27)} \) |

Note: \( k \) = standardized canonical discriminant function coefficient; \( m \) = mean of respective sample.

Overall, not many or high differences are observed in T3. Differentiation is only observed between STDP and the other two samples, where T3 is not the ending of therapy. If we look into the next table (Tab. 9), where all therapy-ending phases are compared, the differentiation is higher between STDP and LTDP.
<table>
<thead>
<tr>
<th>STDP vs. LTDP</th>
<th>STDP vs. PA</th>
<th>LTDP vs. PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 24: T’s own emotional conflicts intrude into the relationship. k = -.58 (STDP-T3: m=2.90; LTDP: m=4.57)</td>
<td>Item 6: T is sensitive to the P’s feelings, attuned to the P; empathic. k = .79 (STDP-T3: m=6.65; PA: m=7.96)</td>
<td>Item 82: The P’s behavior during the hour is reformulated by the T in a way not explicitly recognized previously. k = .93 (LTDP: m=5.30; PA: m=4.58)</td>
</tr>
<tr>
<td>Item 81: P’s feelings in order to help him or her experience them more deeply. k = .73 (STDP-T3: m=7.02; LTDP: m=5.30)</td>
<td>Item 92: P’s feelings or perceptions are linked to situations or behavior of the past. k = -.58 (STDP-T3: m=7.13; PA: m=6.04)</td>
<td>Item 37: T behaves in a teacher-like (didactic) manner. k = 1.00 (LTDP: m=4.63; PA: m=3.39)</td>
</tr>
<tr>
<td>Item 36: T points out P’s attempts to ward off awareness of threatening information or feelings. k = -.85 (STDP-T3: m=5.62; LTDP: m=6.80)</td>
<td>Item 62: T identifies a recurrent theme in the P’s experience or conduct. k = .96 (STDP-T3: m=7.78; LTDP: m=6.63)</td>
<td>Item 28: T accurately perceives the therapeutic process. k = .85 (LTDP: m=7.27; PA: m=6.81)</td>
</tr>
<tr>
<td>Item 28: T accurately perceives the therapeutic process. k = -.45 (STDP-T3: m=6.75; LTDP: m=7.27)</td>
<td>Item 93: T refrains from stating opinions or views of topics the P discusses. k = .51 (STDP-T3: m=5.47; LTDP: m=4.53)</td>
<td></td>
</tr>
</tbody>
</table>
3.6 Comparison of the samples with the psychoanalytic PQS prototype

Tab. 20 STDP, LTDP and PA correlations with psychoanalytic PQS prototype

<table>
<thead>
<tr>
<th>Sample</th>
<th>Psychoanalytic PQS prototype (All Items; n=100)</th>
<th>Psychoanalytic PQS prototype (Technique Items; n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>raw correlation</td>
<td>z-transformed correlations</td>
</tr>
<tr>
<td>STDP</td>
<td>r= .55</td>
<td>r= .62</td>
</tr>
<tr>
<td>LTDP</td>
<td>r= .54</td>
<td>r= .60</td>
</tr>
<tr>
<td>PA</td>
<td>r= .50</td>
<td>r= .55</td>
</tr>
</tbody>
</table>

All three samples achieve a correlation of .50 or higher with the ‘Psychoanalytic PQS-Prototype’. In the table above the z-transformed correlations show even higher correlations, but the raw scores will be taken into consideration. The STDP sample correlated the most with the prototype (r=.55), followed by the LTDP sample (r=.54) and the lowest correlation is observed with the PA sample (r=.50). When only correlating the technique items of the samples and the PQS prototype, the order of higher correlation is maintained, but the correlation scores are higher for all samples. The technique items of the STDP sample achieve the highest correlation of .76 with the technique items included in the psychoanalytic prototype. In the graph below (fig. 15) it becomes clear that the differences of psychoanalytic process and technique fostered are not striking.

![Samples' Correlation with PQS-Prototype](image)

Fig. 15 STDP, LTDP and PA samples' correlations with psychoanalytic PQS prototype
4 Discussion

As expected, the main finding of this study is that the three therapy modalities show a lot more resemblances than differences. Possibly more differences could be found if we would look into the micro-level of each patient-therapist interaction; however, those results would require a qualitative research approach. Here, a broader picture of psychodynamic and psychoanalytic treatments is the focus; a quantitative comparison of qualitative aspects of treatments with the question if these therapies can be distinguished in a dimensional approach?

4.1 Similarities among STDP, LTDP and PA

Overall psychoanalysis, long-term and short-term psychodynamic psychotherapies have more in common than differences.

The most characteristic aspects shared by all therapies are features that do not specifically describe psychodynamic or psychoanalytic treatments, but characterize any type of psychotherapy. These characteristics pertain equally the patients, the therapists’ behaviors and the significantly discussed contents, like patients’ actual life or interpersonal relationships. Contents like these are probable to be discussed in any type of therapy. In addition, the characteristics found to describe the patients are attributes expected in psychotherapy: patients can easily understand their therapists, initiate and are willing to elaborate topics, accept therapist’s comments and are active. Even the therapists, which work in different settings (PA, LTDP and STDP), share the most characteristic features: empathy, sensitivity, active responsiveness and affective involvement. All therapist accurately perceive therapeutic process and all therapists make use of the same technique of rephrasing and clarifying patients’ communication. Again, these aspects are not specific to a psychodynamic or psychoanalytic therapeutic technique.

Hence, when mentioning the similarity of the analyzed long-term and short-term psychotherapies in question, one must not forget their shared educational background, which is based on the conceptual homogeneity of the therapists. The three studied therapy types derive from the psychoanalytic field, although the
differentiation among them is so often disputed. Both, psychoanalysis and psychotherapies are divided in numerous schools that favor one or another aspect leading even to schism or splitting in the ‘American Psychoanalytic Association’ (Alexander & French 1946; Gill 1954).

It is striking that considering this tendency to segregation among therapists, also when sharing basic theoretical backgrounds but practicing in different settings (short vs. long-term; face to face vs. laying down), the characteristics that are more salient for each of their practice, as seen empirically in our study, are general characteristics for any therapy.

To control for this overall similarity it is useful taking a step deeper because these therapy types may have a lot in common; still some nuances that differentiate them were found, also among their most salient aspects. We defend the importance of looking carefully into differences to enlarge our understanding about each type of therapy. One reason for the shrinking acceptance of psychoanalysis and the certain dislike sometimes felt towards psychodynamic therapy may be due to the lack of transparency, which could be partially corrected by psychodynamic empirical research (see Shedler 2010). The question is: what is it actually that psychoanalysts do, besides making the patients talk about their problems and sufferings? Therefore we need to open the door to the consultation room for researchers to be able to look inside.

Before discussing the differences in more detail we remind the reader of one broad influencing reason contributing to therapy differences: the patient as object being treated. There is no doubt about the uniqueness of each dyad and its influence to the process no matter of which theoretical frame, but we will keep an independent look, as far this is possible, towards our patients included in the analyzed therapies.

4.2 Differentiating aspects of each sample

Focusing on the most characteristic aspects of the studied therapies – in terms of the instrument applied here –, differentiating aspects could be found, which are specially considered typical for each of the practical treatment orientation. Special for psychoanalytic treatments was to convey a sense of non-judgmental
acceptance. We understand this reluctance of judgment and opinion in the sense of neutrality. We suspect that the item that should capture neutrality specifically is outdated. This item was considered unimportant by our raters for all analyzed sessions (always rated in the neutral range), or should we ask if the concept itself is outdated? Among vanguard psychoanalyst the technique of abstinence has become controversial (Schachter & Kächele 2007) and is reconsidered especially among the so called relational psychoanalysts (Mitchell 1988). Recent literature about process and outcome showed that manifest and genuine concern from side of the therapist towards his patients contributes to significant therapeutic change (Beutler & Harwood 2002; Beutler et al. 2004). Giving up a bit of the neutral stance rejecting abstinence as distance could make the therapist’s concern more manifest and perceptive for the patient (Hill 2010).

Consequently, the position of the psychoanalytic community towards the use of neutrality needs to change36 or recognize that the new generation is possibly practicing a new approach (here apparent in the observers position, the raters of LTDP and PA). This would include the observation of therapist non-judgmental acceptance (item 18), as a fundamental part of the neutrality that maybe desired by a patient towards his therapist.

Characteristic only for the LTDP therapists were to interpret unconscious wishes, feelings or ideas and pointing out defensive mechanisms, both of which are part of the psychoanalytic armamentarium of technique. Interesting is that these techniques would be expected to be more characteristic in the PA sample, which in our study was not the case.

During STDP therapy sessions, as would be expected, it was salient that no silences occurred. Verbal exchange between patient and therapists dominated the sessions. This finding corresponds to recent results where CBT therapists showed a rather extensive participation in the verbal dialogue with depressive patients in comparison to psychodynamic and psychoanalytic therapists (Huber et al. 2011). Could it be that planned time-limited therapies induce the patient and therapist to

---

36 We do not have any intention to mitigate or forget the danger of dependency development in therapy, if the therapist and patient relationship transforms into an long-term counseling relationship, where the patient looses the capacity to think independently. We not only believe in an equilibrium, but also that this would be much more the case with to much use of the advice giving technique, than affect or involvement of the therapist.
fill each session with as much talk as possible? Are silences understood as unproductive work in STDP? Which would go against the multi-faceted psychoanalytic understanding of silence (see Cremerius 1969).

For Freud, silences were as important as discursive features; silences in a psychoanalytic hour are implicit to evoke thought and sometimes may be seen as resistances towards upsurge of memories (Groth 1982). These ideas remain among psychoanalytic thought, which could lead us to the wrong idea about the analyzed short-term psychodynamic psychotherapies: in 16 session-‘short’ therapies no use of psychoanalytic technique should be made. Surprisingly, it is highly characteristic for STDP therapist to make use of an almost ‘trade mark technique’ of psychoanalytic theory. It was extremely characteristic for STDP therapist to link patients’ actual feelings and perceptions to situations or experiences of the past. Later we will discuss the nature of short-term psychodynamic therapy represented in our analyzed sample.

4.3 Similarities in the usage of therapy techniques in STDP, LTDP and PA

Now specifically observing therapists technique, our results show that many therapeutic interventions are equivalently applied in the three therapy types. Not only general techniques were highly characteristic for all therapists, as therapists reformulating patients’ communication or therapist facilitating patient’s speech but also specific techniques from psychoanalytic background were similarly applied independently from setting. The therapists in STDP did not behave in a more didactic way than psychoanalysts and LTDP therapists. This technique, which is more common in cognitive-behavioral therapies, was fairly uncharacteristic and irrelevant in all our samples showing the sharing psychoanalytic background of our therapies.

Homogenous was the level of patients achieving a new understanding or insight, which would signalize therapy progression and is thought as a result of the therapist accurately perceiving the therapeutic process, but no association could be found. All therapists accurately perceived the therapeutic process to some extend. This was even more the case among the LTDP therapist, but LTDP patient did not gain significantly more insight than the other patients. Maybe the item is
not adequate to captures the complexity of the therapist understanding the ongoing process.

No significant differences were found in the application of ‘the’ psychoanalytic technique of interpretation. All therapists tended to interpret unconscious wishes or feelings, and less interpretations referred to actual people in patients’ life. Still in regard to interpretation, the therapists suggesting the meaning of others behavior was almost neutral or irrelevant in all three samples. All therapists did not frequently connect the therapeutic relationship and other relationships.

Remarkably is that psychoanalytic techniques were not less used among the shorter psychodynamic therapies, as one may have expected from the research literature, since for example interpretation is highly psychoanalytical and its application is often discussed to be handled with care in brief therapies (Henry et al. 1994; Orlinsky et al. 2004). Some psychoanalytic techniques were even more characteristic for our STDP sample: not only the work with patients’ past experiences was more characteristic for STDP, but also identification of recurrent themes are more characteristic for the STDP interventions than in LTDP and PA technique.

4.4 Differences in the usage of therapy technique in STDP, LTDP and PA

Nuances differentiate our therapy samples feeding the leading idea of this study of a dimensional concept. Therefore we look closer into the most characteristic aspects of STDP, LTDP and PA samples and their significant differences. Although empathy is core technique for any therapist (Lichtenberg et al. 1984), the psychoanalysts showed more empathy than STDP therapists. The difference between the PA and LTDP was not significant; most likely this confirms the idea of empathy being easier to develop in longer lasting personal interactions. Time seems to be an important factor in how patient and therapist get to know each other. Empathy is the ability to understand the other (as being able to be in others ‘person skin’); an empathic therapist may conclude, to a certain extend, about how the patient may think, feel and perceive certain situations (Lichtenberg et al. 1984) which is important for various aspects of therapeutic process. In STDP therapy empathy was observed as well, but not to the same extend as in the two longer
therapy groups. Curiously, patients in psychoanalysis showed more openness in contemplating their role in creating or perpetuating problems and were more trusting and secure than the patients in the STDP. Could this be understood as a consequence of the higher empathy shown by psychoanalysts, that patients felt more secure and consequently more comfortable to reflect about their responsibility in problematic behavior? It does not surprise us that longer treatment seems to favor the trust in the therapeutic relationship or alliance, which is vital for good therapeutic work (Orlinsky et al. 2004).

Overall, fewer differences in technique application were found between LTDP and PA. It seems that length of treatment influences more the resemblance of these two therapy techniques than its setting (face-to-face vs. laying down). Among psychoanalysts it is expected that the laying down on the couch not only affects the patient-analyst communication, but also the therapeutic contents and consequently the applied technique. The lack of eye contact could free the patient from analysts’ ‘judgment’, while loosening defensive systems, allowing the easier recovery of memories and dreams and generally favor free association and regression (Lable et al. 2011). Unfortunately ‘free association’ per se cannot be observed through any of PQS-items, but free association may be visible through discussed contents by the patient, or be reflected, among other aspects, by therapists’ passivity. In our study we could observe that psychoanalysts were significantly more passive than STDP and LTDP therapists (which were almost the same). Is this due to the supine position in psychoanalysis? Since we do not want to fall into mere speculations, other aspects, possibly related to free association, can be better described with the PQS. Interestingly, only part of those aspects could be observed in our PA sample: discussion of dreams was significantly more characteristic for PA and neutral or unimportant in LTDP and STDP; instead the STDP and LTDP therapists refrained more from stating opinions, whether curiously this was considered unimportant in the PA sample, however as pointed out before, psychoanalysts showed more non-judgmental acceptance; relatively to contents that should emerge more while laying down, as childhood memories and associations to the past were much more characteristic during the face-to-face and short PD treatments than PA; focus on defenses was more characteristic in the LTDP sample. Our results seem to counter the assumptions about the use of the
couch described in psychoanalytic literature (apart from the occurrence of dream discussion in PA). In our study the different setting in PA and LTDP does not seem to influence the applied technique. It is known, among psychoanalysts that the laying position is not taken so conservatively anymore, patient may change from the sitting to the laying position, and the other way round, possibly more than once during the same therapy process. The actual heterogeneity of practiced psychoanalysis makes it more and more difficult to control for that in research. Lable et al. (2011) suggests several research designs to fill the gap of empirical studies on the effect of the couch in psychoanalysis; this need was also expressed by Schachter and Kächele (2010).

Not surprisingly, the most and more significant differences among technique were found between STDP and LTDP (9 items on technique), followed by differences between STDP and PA (7 items on technique), which would support the idea that length of treatment has more influence on the applied techniques than the setting. The STDP therapies differ in comparison with LTDP and PA, they are much shorter (16 vs. e.g. 400 sessions) and the setting is clearly different (face-to-face vs. laying down).

Without going into more detail about further therapeutic techniques, the same kind of results could be observed: STDP therapists’ focusing more on guilt than psychoanalysts; pointing out defenses was similarly used in PA and STDP and was more characteristic in LTDP; STDP therapists pointed out unacceptable feelings more frequently than PA and LTDP therapists; therapists emphasizing P feelings to deepen them was more characteristic in STDP than LTDP; patients’ behavior in the hour was more reformulated by STDP and LTDP therapists than psychoanalysts; finally, LTDP and STDP therapists refrained more from suppressing patients’ disturbing feelings than psychoanalysts.

4.5 Variance of therapeutic factors throughout therapeutic process

Further results concerning variability of therapy factors at different points in time showed that more variance was observed among the STDP therapies than in LTDP and PA sample. At this point a limitation of the study has to be noted: the differences in sample size of our therapy groups (30 vs. 15 vs. 13) seemed to
influence the repeated measurement procedure, which served to analyze variance between the four time points. Since repeated measurement is a type of regression analysis, sample size has an influence. The STDP sample is almost twice as big as the LTDP and PA samples, consequently more variances were found among STDP time points. We experimentally doubled the sample size of our PA sample and much more significant F values could be found, confirming the influence of n size. We oriented our discussion on the significant variances found in STDP, but always in comparison with the other samples, and of course included the significant variances of our smaller samples (PA and LTDP).

Nonetheless, our results show interesting reasoning behind the repeated measuring analysis. For example, termination of therapy was one of the most variable items in LTDP and STDP therapeutic process, which is expected (probably it is only mentioned once). Highly variable for LTDP was the occurrence of silences. In PA, the association with patients past and therapists’ control of the interaction were the most variable factors in therapy. The highest variance was observed among STDP therapists asking for more information or elaboration. These results tell us which items show highest variability during therapy.

More interesting is to observe at what time point throughout therapeutic process this variability occurs in comparison with the other samples. Subsequently in the graphic representation one could see that sometimes the movements of certain techniques and therapeutic factors were similar in the other samples, although the movement was always more abrupt in the STDP therapies (higher variability). For example, at therapy beginning, all therapists (STDP, LTDP and PA) asked for more information and elaboration, which is characteristic for any therapy beginning. During the rest of therapy this therapeutic intervention diminished gradually among PA and LTDP therapists and abruptly among STDP therapists. Questioning is a structured intervention to elicit information, which is more characteristic for short-term therapies. Long-term psychodynamic therapists and specially psychoanalysts are known to be less directive; it is also more likely that they have more time for information gathering during therapeutic process. In the same way, this divergence in therapeutic directivity among our therapy groups can be observed in the manner treatment goals are handled by therapists. During the whole psychoanalytic process this issue does not seem to gain importance.
(always rated in the neutral range). Although a little bit more characteristic, LTDP therapies seem to follow this trend of constant and only relative importance. Only at the very end the discussion of therapy goals become abruptly highly characteristic in LTDP. Instead, in STDP, this topic is one of the first important topics discussed and in the course of the short therapy it almost recedes into neutrality. The therapeutic goals of STDP seem all to be discussed in the first phase of treatment. Relatively to the discussion of therapy termination, the same tendency is shown in STDP and LTDP therapies: it becomes highly characteristic at the end of therapy. In psychoanalysis this topic remains neutral throughout the process. Structuring topics, as therapy goals and therapy termination, seem to be less frequently discussed during psychoanalyses than in the psychotherapies.

We do not want to argue against this last finding, but there may be an influence of larger time frames (more sessions) in between observational points in PA and LTDP, whether this aspects are easier caught in STDP. In treatments with more sessions there is more time to discuss therapy termination or therapeutic goals.

The influence of more sessions in between seems to be even more evident in the observation that only in the PA and LTDP samples interpretation is already delivered at the beginning of therapy, although during therapy this technique is suddenly more characteristic for STDP. At the beginning no interpretative work can be observed in STDP, which would meet Leichsenring’s (2005) suggestion that the patient’s accepting attitude for an interpretation needs to be prepared emotionally and cognitively. The question seems pertinent: why do long-term therapists and psychoanalysts not prepare for delivering interpretations? We strongly believe that the PA and LTDP patients already had more time to establish a secure relationship in which their patients can accept interpretations, because more therapy sessions occurred from the very beginning of therapy until the observance point of therapy beginning (than in STDP).

Highly variable among psychoanalysis is the application of the therapeutic technique of linking patient’s feelings and perceptions to the past. In STDP therapy process this technique becomes more and more characteristic during therapy, the same occurs during psychoanalysis but with a surprising difference. After the mid point of PA process, the application of this technique decreases drastically, which is not the case in STDP. We remind that this technique was among the most
characteristic aspects of STDP (and not for PA), although being a profoundly psychoanalytic technique and expected to be always highly characteristic during psychoanalytic process. These results suggest that part of the technique trait of certain type of therapy may be the timing the technique is applied and not the technique itself.

Here the point is reached where our analyzed STDP sample must be discussed in order to clarify its astonishing psychoanalytic features.

### 4.6 Surprising amount of psychoanalytic features in STDP

The provenience of the sample may clarify some of the surprising results relatively to the STDP. Our STDP sample is an archival data set collected by the Mount Zion Psychotherapy Research Group in San Francisco, where Joe Weiss, Alan Rappoport, George Silberschatz, developed the ‘control mastery theory’. In regard to the participating therapists, we know that “with the exception of one therapist, all had received specialized training in brief psychodynamic therapy” (Jones et al. 1992, p. 19). In none of the articles describing this sample is the type of short-term therapy further specified than in the latter citation. Though we suspect that those therapists have been all been trained at this center to follow a psychodynamic model, thus all were especially motivated in applying psychoanalytic techniques. All therapists had an average of 6 years of private practice experience (1 to 19 years). The treatments were all conducted in psychotherapists’ private offices in order to maintain the setting as natural as possible. Although treatments were not manualized, we may assume high similarity in the way of treating their patients with a special focus on applying psychoanalytic technique even within STDP.

One cannot generalize that all so called short-term psychodynamic psychotherapy apply this great amount of psychoanalytic techniques, but we can definitely conclude that short does not mean non-psychoanalytic. This group of treatments shows that psychoanalytic techniques can be applied in a short-term setting without harming the patients. The controversy of using the interpretation technique in brief therapies, described by Orlinsky et al. (2004), seems not to apply here. Overall these therapies had a positive outcome. Unfortunately, transference interpretation is not specifically captured by the PQS, which has been reported as
the psychoanalytic technique mostly associated with negative outcome in shorter therapies (Henry et al. 1994). However a more recent study by Høglend et al. (2011) counters this long held position.

Another confounding aspect arises in relation the STDP sample origin. The raters evaluating the STDP material with the PQS were all ‘disciples’ of Enrico Jones, the developer of the PQS method, supposedly with a strong psychodynamic background. The raters of the other samples can almost all be considered second generation raters, meaning they learned the method from the disciples and not from Enrico Jones himself. Although the PQS is to be applied objectively we should not underestimate the role of raters’ inference. The PQS instrument is a valid attempt to quantify qualitative material, in other words, objectify subjective material. However are ratings not only influenced to some extend by raters clinical experience or background, as may ratings be influenced by whom the method was learned from? We do not think that these nuances would compromise overall reliabilities, but this should be tested. In order to confirm between raters reliability, our raters should have rated at least one session from the STDP sample.

Still concerning raters’ inferences we would like to mention a broader concern of ours. PQS raters possible recognition of therapy orientation could influence the rating process. For example, if a rater recognizes psychoanalytic treatment because the couch is discussed, the rater may be alert to typical psychoanalytic techniques as interpretations. We believe this should be tested among a group of raters: after observing a therapy session, raters should ‘guess’ the type of therapy. Nevertheless, we believe that accurate PQS training and frequent rater meetings help controlling this possible bias.

4.7 The PA sample is not prototypical but what is prototypical?

One of the most controversial results of this study concerns the correlation of STDP, LTDP and PA samples with the psychoanalytic PQS-prototype. Some reasons that influenced the STDP therapies to correlate higher with the analytic prototype have been discussed in the prior section (and will be continued here). But first we would like to point out that LTDP therapies share almost the same high correlation with the PQS-prototype as STDP. Astonishing is that the
psychoanalysis had the lowest correlation. The order of the correlation amount remained the same also when only analyzing the therapeutic techniques. Higher correlation values could be observed when correlating the smaller amount of technique items. Definitely the used techniques of our samples represent more of the psychoanalytic prototype than the remaining patient or therapist aspects compromised in the 100 PQS-items.

Now we ask what is the psychoanalytic PQS-prototype about? In the first chapter (introduction) the most defining aspects of the analytic PQS-prototype are ranked ordered. In the appendix the reader can find this table modified with the mean value added for each of the 20 higher rank ordered items. Here a certain extremeness, in the conception about what psychoanalytic is, becomes clear. The highest factor is the discussion of patients' dreams (interestingly this was neutral or irrelevant in STDP and LTDP samples and characteristic for PA). Consequently one must ask who were the 11 American psychoanalysts that constructed this prototype years ago? Which psychoanalytic orientation did they represent? No information relatively to this issue could be found or obtained after innumerous requests. In addition, American psychoanalysis may be differently practiced than in Europe (our PA sample is from Germany). Does the wide spread ego-psychology in America (and less in Europe) reflect on the prototype, in this way explaining the weak correlation of our European PA sample with the PQS prototype? For psychoanalytic research it would be worth to construct a prototype for the different psychoanalytic schools.

Still in regard to the low correlation of the PA samples with the PQS prototype, we would like to put aside the possible, critical thought of a low quality of psychoanalytic work delivered in the observed sample. Therefore we compared the SCL-90 values pre and post therapy and a significant symptom reduction could be observed. Also if not highly psychoanalytic, in terms of the PQS prototype, these psychoanalyses were overall successful according to the GSI scores of all patients.

An additional surprise rises when our results are compared to previous studies using the PQS prototypes. Ablon and Jones (2005) gathered sessions from different treatments in groups of STDP (122 sessions from 68 patients), LTDP (229 sessions from 3 patients) and PA (130 sessions from 2 patients) and
correlated them with the PA prototypes. Their results represent what would be normally expected: PA sample attain the highest correlation (r=.58), followed by LTDP (r=.45) and STDP (r=.37) has the ‘expected’ low correlation. The correlations are presented as z-transformed, the explanation for that is not clear. In comparison with z-transformed correlations of our samples, their correlations are overall lower. This makes our PA correlation value comparable to their finding (.55 vs .58). The LTDP sample in our study correlates higher with the prototype than the LTDP sample of Ablon and Jones. At the end it is evident that our results do not confirm the results obtain in similar previous studies.

Curious remains our high correlation achieved by the STDP sample (r=.62) specially when confronted with the low correlation of their STDP sample (r=.37), which includes the same STDP sample and additional 38 treatments of manualized therapy for patients suffering from stress responsive disorder. In our understanding this confirms our thought presented in the previous section (4.4): Not all so called short-term psychodynamic treatments include the same amount of psychoanalytic process (based on the prototype). We suspect that the second STDP sample (only included in Ablon and Jones study) used so little psychoanalytic process that the high correlation achieved by the sample (also our STDP sample) was ‘washed out’.

Fact is that the analyzed STDP sample in our study correlated higher with the psychoanalytic PQS prototype than the PA sample. If we look back to other results, characterizing this STDP sample was that no silences occurred during therapy. At this point we ask: how is it possible that during a therapy process where patient and therapist spoke uninterruptedly it is still considered to be more psychoanalytic, where silences are a fundamental tool? It is possible that a psychoanalytic prototype of the whole process is rather a difficult aim to realize because different phases of psychoanalytic process would correlate very differently to the prototype. Albani et al. (2001) while comparing sessions from the beginning and termination phase found quite different patterns within the same patient.
Discriminant analysis on our samples:

The discriminant analysis in this study was conducted on an exploratory base to assess differences in therapeutic technique between the STDP, LTDP and PA samples. Overall, the results obtained from the discriminant analysis were diffuse, showed low significance and little convergence with the results of the t-tests. Strictly speaking, the size of our sample was not large enough for discriminant analysis; four or five times more treatments than variables are needed for reliable application of discriminant analysis (25 variables, the techniques, would requisite at least 100 patients). This suggests that the results of the t-tests should be considered more reliable than the results of the discriminant analysis.

An additional assumption for discriminant analysis, which shows the same mathematical structure as regression analysis, is the orthogonality of the independent variables. The independence of the 100 PQS-items, however, is a controversial issue. When the measure was developed, Jones and his colleagues wrote “Factorial validity for the Q-sort is irrelevant because the measure was constructed in a manner that insured independence among items. Indeed, a factor analysis, making use of different types of factor rotation, revealed an absence of factor structure, which is highly desirable from the standpoint of Q-methodology (Jones et al 1988, p. 51). Later on, the independence of the PQS-items was questioned, as is explained by the developer himself: “The Q-items are only more or less independent, since item placements are determined by patient and therapist behaviors that are mutually influenced. However, the underlying strategy of the Q-method itself reflects the actuality that processes in psychotherapy are not separate and discrete, but define and give meaning to each other” (Jones et al. 1992, p. 28). In our sample, preliminary analysis revealed Pearson correlations up to .71 in our sample. Furthermore, a substantial part of the observed correlations was > .40. This finding questions the independence of the PQS-items and the reliability of the discriminant analysis results.

4.8 Limitations of the study

The limitations are located on several levels of the present study. The most compromising is the heterogeneity of the samples. First, the diagnoses of the
samples are not homogeneously distributed, which could have given a naturalistic character to the study, representing actual clinical practice. Though the LTDP sample was only constituted of depressed patients, while the STDP and PA sample included a variety of diagnoses. After all it would have been better to control for the diagnoses of the included patients, since technique application seems to be very dependent on the patient personality and diagnosis (Thomä & Kächele 2006). We know that in the case of this study it would have been too ambitious to do so, since recorded data is still very rare and not easily shared between researchers.

Relatively to the study of therapeutic techniques it would have been important not only control for the diagnosis of the patient, but also the participating therapists. It is known that each therapist may have his own style, within his therapeutic orientation.

As a result of lacking available recorded data, the samples are also compromised by cultural bias. The psychoanalyses are German, while 11 LTDP therapies are American and the other 4 are German. The STDP sample includes only American therapies. Consequently the raters of the therapy material are also from different origin, although this rater nationality difference is for the most part between STDP and LTDP; PA included a German group of raters.

The size of the sample is obviously too small to obtain generalizable results. Furthermore, the sample sizes between treatments types were differing. Two patients in the PA sample are missing due to logistical issues that could not been resolved within our time frame.

Finally, concerning the instrument to analyze the different therapeutic processes few items seem not to fully capture what is meant and important aspects of psychoanalytic technique need to be deepened. The PQS only captures if transference interferes in the therapeutic process or not (item 24). In order to distinguish psychoanalysis from long-term psychodynamic psychotherapy one can rely on other aspects than the setting (use of the couch). Respected psychoanalysts, as Gill and Fosshage, suggest “any treatment that focuses on the analysis of transference constitutes psychoanalytic treatment” (cited by Kächele & Schachter 2010). Unfortunately no item among the 100 PQS-items seems to
capture transference interpretation specifically. The item, the therapist draws connections between the therapeutic relationship and other relationships (item 100) touches the aspect of patients’ transference towards his therapist, but still no transference interpretation is captured. Since the PQS aims to be a pantheoretical instrument, to be applied in various therapy forms, an item that observes transference would be presumably useless for research of other therapy approaches. For our study it may have been essential (although we could see that treatment length had more impact on differentiations between therapy types). Nevertheless, other instruments that capture those missing aspects should be applied in parallel to the PQS: for ‘free association’ Bordin’s methodology (1966) and transference measurement instruments as the ‘Central Core Relationship Theme’ (Luborsky & Diguer 1990).

Items that showed weakness in their application during the rating process were already discussed: “Therapist accurately perceives the therapeutic process (item 28)” and “Therapist refrains from stating opinions or views of topics the patient discusses (item 93)”. We do not want to get into detail about how to specify ad clarify their content for better capturing, but only remind that possibly a emphasis on the meaning of this items in PQS trainings would ameliorate their application.

Methodological thoughts about the PQS concerning our findings

The PQS was able to capture a great amount of information making it possible to compare STDP, LTDP and PA therapies in our study without neglecting the observation of fine features of therapeutic process on empirical material. Nevertheless, issues concerning the PQS accuracy during the study and rating process with the PQS came up. At the same time we recognize the PQS’ advantage to be an ‘ipsative measure’ (detailed explanation in chapter 2), which highlights the most characteristic und uncharacteristic aspects of a therapy session in comparison with the session itself and not with other session, we would like to comment the possible disadvantages of this attribute. When establishing comparisons with other sessions or cases the categories may not have the same meaning. For example, what for one session is a 9 in interpretation may represent something different in another session. According to our rating experience, rating a 9 for interpretation in
one session means there where a lot and significant interpretations, so interpretation is a salient characteristic of the hour. In another session with less interpretations, one or two interpretations where so meaningful and oriented the whole session supporting also a rating of a 9 for interpretation technique. The rating is given according to the rated session, so the same rating in another session may have a different meaning. When we compare the sessions or groups of treatments we may be comparing slightly different things. Possibly the PQS is less an ipsative measure and more a ‘hybrid measure’, which analyzes qualitative data, transforming it into quantitative information. As said before, the PQS is a valuable and useful attempt to quantify qualitative data, but still has its limitations, which should be always taken in account. We can apply the most sophisticated research tools, but will never benefit of an ultimate truth.

Relatively to the use of the PQS for a group comparison study another possible limitation became manifest during the calculation of our results. The fact that the PQS ratings of four (or three) sessions from different patients were averaged could conduct to a lost of valuable details and information in this procedure (what could explain the lack of extremely high or low ratings in our results). The same could be said when averaging 4 sessions from very different times in therapy process. Possibly this is the price of generalization or group characterizations.

4.9 Recommendations for further research
The observed tendency of low differentiations between therapy types within the same theoretical background of psychoanalysis may suggest that no more studies concerning PA and LTDP, STDP differentiations are needed. However the limitation of generalization of our results must be considered. Therefore a ‘cleaner’ study with larger samples should be aspired, which not only includes a large homogeneous sample but also better controlled measuring points, treatment lengths, diagnosis and outcome assessment. In such a study it would be interesting to study LTDP and PA, as a group, in comparison with STDP and PA would be compared to STDP and LTDP, as a group, to attain more accurate information about the controversial issue of treatment length and setting (use of the couch or face-to-face therapy).
In regard of the already gathered data it seems a great opportunity for qualitative research. Single cases of each patient (or small group of patients) can be analyzed in more detail following the PQS single case studies tradition, developed by Enrico Jones. The PQS is also a helpful methodology for beginners in clinical work or psychology student. With a deeper look in each of the patient-therapist interaction some meaningful clinical differentiation may be found. By means of items’ cluster analysis interesting interaction structures might be studied.

Another worthwhile project would be the development of a new psychoanalytic prototype. First, we would suggest rethinking the assessment methodology of such a prototype. It would important to test the empirical validity of a PQS prototype based on questionnaires, even if the N of asked psychoanalyst would be mandatory expanded and further specified (e.g. psychoanalytic school, nationality, active researcher or not, etc.). The existing PQS prototype includes the idealization of what should constitute a psychoanalytic hour. We suggest a practiced oriented prototype, which would answer the question about how psychoanalysis is actually practiced. Our suggestion is an empirical construction of a prototype based on existing therapy sessions, possibly factor analyzing already existing PQS rated PA sessions.

Concerning the control of cultural bias, which seems to have large influence, it would be imperative to construct two prototypes: One European and one American prototype (this could be extended to other continents). Or would a ‘transatlantic prototype’ be more suited for our times, which could be valid for our global psychoanalytic community, in order to adapt to the growing globalized way of life and (possibly one day) clinical practice. While constructing this global prototype it would be still interesting and not labor intensive to compare the gathered material in regard of differentiations and similarities of cultures and psychoanalytic schools.
5 Summary

In the field of psychoanalysis there is still a preference for categorical differentiation between psychoanalysis and psychodynamic psychotherapy, which has not been scientifically determined on the basis of the empirical analysis of the practicing technique. Today, the ‘Psychotherapy Process Q-set’ (PQS) method allows these differentiations to acquire a dimensional perspective; in other words, to obtain a quantifiable classification. By this means, it becomes possible to look into what actually happens in clinical practice and not rely on what professionals say they do.

The aim of this dissertation was to compare process variables in 13 psychoanalyses (PA), 15 long-term and 30 short-term psychodynamic psychotherapies (LTDP; STDP) using as instrument the ‘Psychotherapy Process Q-set’. For each of the treatments, four (in STDP three) therapy sessions were selected and analyzed with the PQS. The three therapy samples were described and compared as a whole and at different points of therapeutic process. Special attention was given to differentiation and similarities in usage of therapeutic techniques in the three different forms of therapy. In addition, with support of the PQS prototype methodology, psychoanalytic process was fostered in these treatments. Each therapy sample was compared with the psychoanalytic PQS prototype. This allowed us to access whether there is congruence between the therapeutic process (in psychoanalytic and psychodynamic therapies) and that of the psychoanalytic prototype.

This study used an exceptionally large database of material for this field, leading to an interesting discussion surrounding the delimitation of psychoanalysis and psychodynamic psychotherapy. Overall, more similarities then differences between PA, STDP and LTDP were found. Common aspects of therapy characterized the three types of therapy. Nevertheless, on a dimensional perspective, nuances differentiated the samples; differentiating aspects that characterize each of the samples were found. Not only general therapy techniques were similarly applied in all samples, but also techniques with a specific psychoanalytic background, as interpretation. Striking was the amount of psychoanalytic techniques applied in the STDP sample. Fewer differences could
be found between PA and LTDP, suggesting a greater influence of therapy length than setting. Surprising results derived from the sample correlations with the psychoanalytic PQS prototype: The PA sample showed the lowest correlation with the prototype. Although the STDP sample was characterized by not including any moments of silence, it correlated the highest with the psychoanalytic prototype. Consequently, the accuracy of the PQS prototype methodology is discussed while asking „what is prototypical?“ In addition, several methodological features regarding the ‘Psychotherapy Process Q-set’ are also discussed. Finally, the study could show empirically more similarities among PA, STDP and LTDP than differences.

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APPENDIX
Appendix 1: The ‘Psychotherapy Process Q-set’ Coding Manual from Enrico E. Jones (University of California, Berkeley April, 1985; published in 2000; Revised April, 2009 by Psychotherapy Research Program – MGH, Boston\textsuperscript{37})

The purpose of the 100 items of the Psychotherapy Process Q-set is to provide a basic language for the description and classification of therapy process. While built on general assumptions of psychotherapy as an interpersonal process, it is intended to be neutral with respect to any particular theory of therapy, and should permit the portrayal of a wide range of therapeutic interactions. It is hoped that the use of a standard language and rating procedure will provide the means for systematically characterizing patient-therapist interaction. Rather than focusing on small segments of patient or therapist communications, raters Q-sort entire therapy sessions, allowing judges a greater opportunity to capture events of importance, and providing them with the possibility of rating assimilated or digested impressions of therapy process. The general purpose of the instrument is to provide a meaningful index of the therapeutic process, which may be used in comparative analyses or studied in relation to pre-and post-therapy assessments.

The procedure is relatively simple. After studying the process data, and arriving at some formulation of the material, look through the 100 items. Sort these statements into nine categories, placing at one end those items you believe to be the \textit{most characteristic} with respect to your understanding of the material, and, at the other end, those items you believe to be \textit{most uncharacteristic} with reference to your formulation.

A convenient method of sorting is to first form three categories of items – those items deemed characteristic, those items deemed uncharacteristic, and those items that are relatively unimportant to the session. No attention need be paid to the number of items falling into each of these three groupings at this time. When the three categories of items have been created, they can be further divided, this

\textsuperscript{37} The author of the presented work was part of the PQS revision working group.
time into their proper proportions. The number of items to be placed in each category are:

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of cards</th>
<th>Label of category</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>5</td>
<td>extremely characteristic or salient</td>
</tr>
<tr>
<td>8</td>
<td>8</td>
<td>quite characteristic or salient</td>
</tr>
<tr>
<td>7</td>
<td>12</td>
<td>fairly characteristic or salient</td>
</tr>
<tr>
<td>6</td>
<td>16</td>
<td>somewhat characteristic or salient</td>
</tr>
<tr>
<td>5</td>
<td>18</td>
<td>relatively neutral or unimportant</td>
</tr>
<tr>
<td>4</td>
<td>16</td>
<td>Somewhat uncharacteristic or negatively salient</td>
</tr>
<tr>
<td>3</td>
<td>12</td>
<td>fairly uncharacteristic or negatively salient</td>
</tr>
<tr>
<td>2</td>
<td>8</td>
<td>quite uncharacteristic or negatively salient</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>Extremely uncharacteristic or negatively salient</td>
</tr>
</tbody>
</table>

You may feel some discomfort at the constraints imposed upon you by the Q-set items and the sorting procedure. As is true of other systems of content analysis, the Q-set is designed to reduce complex interaction to manageable proportions, and to achieve research economy. No instrument of this kind perfectly fits or captures all therapeutic interactions. It should also be noted that assignment of a fixed number of items to each category has been shown empirically to be a more valuable procedure than the situation in which a clinician can assign any number of items to a category. The Q-items themselves represent a good deal of reflection and advice. While not all characteristics or events of a particular therapy can be expressed by the of two or more of the items. The intent of the Q-set is to allow the description extremeness of placement of certain statements, they can be captured by a conjunction of dimensions of psychotherapy process by means of the suitable placement of items and the configuration of statements that is consequently built.

The Q-set comprises three types of items: (1) items describing patient attitude and behavior or experience; (2) items reflecting the therapist actions and attitudes; and (3) items attempting to capture the nature of the interaction of the dyad, or the climate or atmosphere of the encounter. The definitions, or descriptions, of the items in this manual, and the examples provided, are intended to minimize potentially varying interpretations of the items. It should be carefully studied, and
the full rating description of each item should be used when rating, rather than just
the item name. Judges are asked to take the position of a "generalized other" i.e.
an observer who stands mid-way between patient and therapist and who views the
interaction from the outside. In placing each item, raters should ask themselves: Is
this attitude, behavior, or experience clearly present (or absent)? If the evidence is
not compelling, raters should ask themselves: To what extent is it present or
absent? Search for specific evidence. Try to be as open-minded and objective as
possible. Avoid, for example, judgments of whether a particular therapist activity is
effective or ineffective, or desirable or undesirable from a particular theoretical
orientation. Be aware of preconceived ideas you may have about 'ideal'
therapeutic interactions. In particular, try not to be influenced by your personal
reactions to either therapist or patient; for example, avoid the tendency for your
ratings to be influenced by whether you would like to have this person as your
therapist, or by how you might react to the patient if you were the therapist.

Raters are sometimes uncertain as to whether a particular item should be placed
in the relatively neutral or unimportant category, or in one of the categories
reflecting that it is uncharacteristic of the hour. An item should be placed in the
neutral category when it is truly irrelevant or inconsequential in relation to the
interaction. A more extreme placement of the item in the uncharacteristic direction
signals that absence of a particular behavior or experience is salient and should
be captured in the Q-set description of the hour. In other words, an event whose
absence would be important to mark in order to achieve a more complete
description of the hour can be captured by an item placement in an
uncharacteristic rather than neutral category. Many items have specific
instructions about this in their definitions.

Raters may occasionally feel that there is insufficient evidence to make a judgment
of this kind (as well as to make other kinds of item placements) with good
confidence. Also, there are several items in which both the characteristic and
uncharacteristic ends of the continuum are represented in a single hour. In these
cases, the rater must determine whether one end of the continuum is significantly
more salient than the other and rate the item accordingly. Otherwise, a rating in
the neutral range is appropriate. However, extensive work has already demonstrated that with patience and care, high inter-rater reliability of Q-descriptions can be achieved.

**Item 1: Patient expresses, verbally or non-verbally, negative feelings (e.g. criticism, hostility) toward therapist (vs. makes approving or admiring remarks).**
Place toward *characteristic end* if patient expresses, verbally or non-verbally, feelings of criticism, dislike, envy, scorn, anger, or antagonism toward therapist. E.g. patient rebukes therapist for failing to provide enough direction in the therapy.
Place toward *uncharacteristic end* if patient expresses, verbally or non-verbally, positive or friendly feelings about therapist, e.g. makes what appear to be complimentary remarks to therapist.

**Item 2: Therapist draws attention to patient's non-verbal behavior, e.g. body posture, gestures, tone of voice.**
Place toward *characteristic end* if therapist draws attention to patient's non-verbal behavior, such as facial expressions, blushes, or body movements. E.g. therapist points out that although patient says s/he is angry, the patient is smiling.
Place toward *uncharacteristic end* if there is little or no focus on non-verbal behavior.

**Item 3: Therapist's remarks are aimed at facilitating patient speech.**
Place toward *characteristic end* if therapist's responses or behavior indicate that he or she is listening to the client and encouraging him or her to continue, such as: um-hmm, yeah, sure, right, and the like.
Place toward *uncharacteristic end* if therapist does not respond in such a manner as to facilitate patient talk (does not refer to questions, exploratory comments).

**Item 4: The patient's treatment goals are discussed.**
Place toward *characteristic end* if there is talk about what the patient wishes to achieve as a result of therapy. These wishes or goals may refer to personal or `inner' changes (E.g. "I started therapy in order to get over my depressions") or change in life circumstances ("I wonder if therapy will result in my getting married").
Place toward *uncharacteristic end* if there is no reference or allusion by therapist or patient to the possible consequences of the therapy.

**Item 5: Patient has difficulty understanding the therapist's comments.**
Place toward *characteristic end* if patient seems confused by therapist's comments. This may be defensive or a result of therapist's lack of clarity. E.g. patient repeatedly says "What?" or otherwise indicates that s/he doesn't know what the therapist means.
Place toward *uncharacteristic end* if patient readily comprehends therapist's comments.
Item 6: Therapist is sensitive to the patient's feelings, attuned to the patient; empathic.
Place toward characteristic end if therapist displays the ability to sense the patient's 'private world' as if it was his or her own; if the therapist is sensitive to the patient's feelings and can communicate this understanding in a way that seems attuned to the patient, e.g. therapist makes a statement that indicates an understanding of how the patient felt in a certain situation.
Place toward uncharacteristic end if therapist does not seem to have a sensitive understanding of patient's feelings or experience.

Item 7: Patient is anxious or tense (vs. calm and relaxed).
Place toward characteristic end if patient manifests tenseness or anxiety or worry. This may be demonstrated by direct statements, e.g. "I feel nervous today," or indirectly by stammers, stuttering, etc., or other behavioral indicators.
Place toward uncharacteristic end if patient appears calm or relaxed or conveys a sense of ease.

Item 8: Patient is concerned or conflicted about his or her dependence on the therapist (vs. comfortable with dependency, or wanting dependency).
Place toward characteristic end if patient appears concerned about dependency, e.g. shows a need to withdraw from the therapist, or in some manner reveals a concern about becoming dependent on the therapy.
Place toward uncharacteristic end if patient does not convey concern about dependency. This may take the form of expressions of helplessness; or the patient may appear either comfortable or gratified by a dependent relationship with the therapist.
Place toward the neutral range if patient experiences a sense of relative independence in the therapy relationship.

Item 9: Therapist is distant, aloof (vs. responsive and affectively involved).
Place toward characteristic end if therapist's stance toward the patient is cool, formal, and detached, or marked by emotional retreat or withdrawal.
Place toward uncharacteristic end if therapist is genuinely responsive and affectively involved.

Item 10: Patient seeks greater intimacy with the therapist.
Place toward characteristic end if patient appears to either wish or attempt to transform the therapy relationship into a more social or personal and intimate relationship. E.g. patient expresses concern about the therapist; or attempts to gain knowledge of the therapist's personal life.
Place toward uncharacteristic end if patient does not appear to seek greater closeness with the therapist.

Item 11: Sexual feelings and experiences are discussed.
Place toward characteristic end if the patient's sexuality is discussed. This can take the form of a discussion of sexual problems, or the patient's sexual feelings or fantasies or actual sexual experiences. E.g. patient talks of wanting to have sex with a romantic partner more frequently.
Place toward uncharacteristic end if patient does not discuss sexual or erotic material.
Item 12: Silences occur during the hour.
Place toward characteristic end if there are many periods of silence during the hour, or a few extended periods of silence.
Place toward uncharacteristic end if there are few silences.

Item 13: Patient is animated or excited.
Place toward characteristic end if patient directly expresses, or behaviorally displays, a feeling of excitation or appears aroused in some way. E.g. patient becomes animated in response to therapist's interpretation.
Place toward uncharacteristic end if patient appears bored, dull, or lifeless.

Item 14: Patient does not feel understood by therapist.
Place toward characteristic end if patient expresses concern about feeling misunderstood by the therapist or assumes that the therapist cannot understand his or her experience or feelings. E.g. a widow doubts the therapist's ability to understand her plight since he has never been in her situation.
Place toward uncharacteristic end if patient somehow conveys the sense that the therapist understands his or her experience or feelings. E.g. patient comments, in response to therapist's remarks, "Yes, that's exactly what I mean."

Item 15: Patient does not initiate or elaborate topics.
Place toward characteristic end if patient does not initiate or elaborate topics for discussion, brings up problems, or otherwise fails to assume some responsibility for the hour. E.g. patient states that s/he doesn't know what to talk about.
Place toward uncharacteristic end if patient is willing to break silences, or supplies topics either spontaneously or in response to therapist's probes, and actively pursues or elaborates them.

Item 16: There is mention or discussion of body functions, physical symptoms, or health.
Place toward characteristic end if discussion emphasizes somatic concerns or physical symptoms. E.g. patient may complain of fatigue or illness, or of having headaches, menstrual pains, poor appetite, and the like.
Place toward uncharacteristic end if physical complaints are not an important topic of discussion. A more extreme, uncharacteristic placement indicates that the absence of discussion is salient.

Item 17: Therapist actively exerts control over the interaction (e.g. structuring, introducing new topics).
Place toward characteristic end if therapist intervenes more than is usually expected in the therapeutic context. Do not rate on the basis of perceptiveness or appropriateness of interventions. E.g. rate as very characteristic if therapist is so active that he or she frequently interrupts to ask questions or make a point.
Place toward uncharacteristic end if therapist intervenes relatively infrequently, and makes little effort to structure the interaction; or if therapist tends to follow the lead of patient, e.g. allowing patient to introduce main topics for discussion and subsequently helping patient to follow his or her train of thought.
Item 18: Therapist conveys a sense of non-judgmental acceptance. (N.B. Placement toward uncharacteristic end indicates disapproval, lack of acceptance).

Place toward characteristic end if therapist refrains from overt or subtle negative judgments of the patient; "unacceptable" or problematic behavior of the patient may be explored while conveying the sense that the patient is worthy. Therapist displays "unconditional positive regard."

Place toward uncharacteristic end if therapist's comments or tone of voice convey criticism, a lack of acceptance, or objection to the patient's behavior. A more extreme placement indicates therapist communicates that patient's character or personality is somehow displeasing, objectionable or disturbed.

Item 19: There is an erotic quality to the therapy relationship.

Place toward characteristic end if the therapy relationship seems somehow sexualized. This could range from the presence of a warm, erotically tinged relationship to coy, or seductive behavior on the part of the patient, to overtly stated wishes for sexual gratification. E.g. patient talks of sexual experiences in such a way as to invite the sexual interests of the therapist.

Place toward uncharacteristic end if therapy relationship seems basically unsexualized; a more extreme placement in this direction indicates that patient (or therapist) avoid topics or behavior which might be viewed as betraying a sexual interest; or, that there is an attempt to manage or suppress erotic feeling.

Item 20: Patient is provocative, tests limits of the therapy relationship. (N.B. Placement toward uncharacteristic end implies patient behaves in a compliant manner).

Place toward characteristic end if patient seems to behave in a manner aimed at provoking an emotional response in the therapist. E.g. patient may invite rejection by the therapist by behaving in a way which might anger him or her, or by violating one or another aspect of the therapy contract.

Place toward uncharacteristic end if patient is particularly compliant, deferential, or seems to be playing the role of the "good patient" as a way of courting the therapist.


Place toward characteristic end if therapist reveals personal information, or personal reactions to the patient. E.g. therapist tells patient where he or she grew up, or tells the patient "I find you a very likable person."

Place toward uncharacteristic end if therapist refrains from such self-disclosure. More extreme placement in this direction indicates therapist does not self-disclose even when patient exerts pressure for therapist to do so. E.g. therapist does not answer question directly when patient asks whether the therapist is married.

Item 22: Therapist focuses on patient's feelings of guilt.

Place toward characteristic end if therapist focuses on, or somehow draws attention to, patient's guilty feelings, particularly when there is an intent to help alleviate such feelings. E.g. therapist remarks that patient appears to feel guilty
when she occasionally does not respond to one of her daughter's incessant requests for help.
Place toward uncharacteristic end if therapist does not emphasize patient's feelings of guilt.

**Item 23: Dialogue has a specific focus.**
Place toward characteristic end if when reflecting upon the hour the rater can identify a single or several clear foci. E.g. the foremost topic of the hour was the patient's feeling that throughout the course of his life, and in many different ways, he has failed to live up to his father's expectations of him.
Place toward uncharacteristic end if discussion or dialogue seems somewhat diffuse.

**Item 24: Therapist's own emotional conflicts intrude into the relationship.**
Place toward characteristic end if therapist appears to respond to the patient in a somehow ineffective or inappropriate way, and when this response does not stem solely from the therapy encounter, but conceivably derives from the therapist's own emotional or psychological conflicts (e.g. countertransference reaction). E.g. therapist seems to avoid or shows personal interest in certain affects or issues which the patient expresses or needs to express.
Place toward uncharacteristic end if therapist's personal emotional responses do not intrude in the therapy relationship inappropriately.

**Item 25: Patient has difficulty beginning the hour.**
Place toward characteristic end if patient manifests discomfort or awkwardness in the initial moments or minutes of the session. E.g. There is a lengthy silence or the patient says "Well, I don't know what to talk about today."
Place toward uncharacteristic end if patient begins hour directly without lengthy pauses, difficulty beginning, or prompting questions from the therapist.

**Item 26: Patient experiences discomforting or troublesome (painful) affect during the session.**
Place toward characteristic end if patient experiences discomforting or troublesome affect. Placement toward the extreme ends indicates intensity of affect.
Place toward uncharacteristic end if patient does not experience troublesome feelings.

**Item 27: Therapist gives explicit advice or guidance (vs. defers even when pressed to do so).**
Place toward characteristic end if therapist gives explicit advice or makes particular suggestions which patient is then free to accept or ignore. E.g. therapist says, "You know, you might find it helpful to consult a lawyer about how to handle your inheritance." Or therapist might guide patient to consider a range of options and to explore each alternative. E.g. therapist may point out possibilities the patient overlooks and direct patient to explore possible consequences of each line of action.
Place toward uncharacteristic end if therapist refrains from giving advice; extreme placement in this direction indicates that the therapist does not supply such
guidance despite pressure from the patient to do so, or when it might be useful to do so.

**Item 28: Therapist accurately perceives the therapeutic process.**  
Place toward **characteristic** end if the therapist seems to accurately perceive the patient's emotional state, intent of his or her speech, or experience of the therapy relationship. This should be inferred from the therapist's comments, interventions, or general stance toward the patient. Judgment should be independent of the type of therapy (i.e. cognitive-behavioral, psychoanalytic) being conducted; rather the rater should attempt an assessment of the process observed in this particular hour.  
Place toward **uncharacteristic** end if the therapist appears in some manner to misperceive the patient's emotional state, the intent of his or her speech, or the nature of the interaction between them, or if the therapist tends to inaccurately formulate the problem.

**Item 29: Patient talks of wanting to be separate or distant from someone (excludes therapist).**  
Place toward **characteristic** end if patient talks about wanting greater distance or a sense of independence from someone (excludes therapist) e.g. states wish to finally be free of his or her parents' influence.  
Place toward **uncharacteristic** end if patient does not talk of wanting to be separate, independent, or detached.

**Item 30: The content of the session centers on cognitive themes, i.e. ideas or belief systems.**  
Place toward **characteristic** end if dialogue emphasizes particular conscious ideational themes, beliefs or constructs used to appraise others, the self, or the world. E.g. therapist suggests they look more closely at a patient's idea or belief that unless he accomplishes everything he attempts perfectly, he is worthless.  
Place toward **uncharacteristic** end if there is little or no discussion of such ideas or constructs.

**Item 31: Therapist asks for more information or elaboration.**  
Place toward **characteristic** end if the therapist asks questions designed to elicit information, or presses the patient for a more detailed description of an occurrence. E.g. therapist asks about the patient's personal history, or inquires what thoughts went through the patient's mind when s/he met an acquaintance by chance on the street.  
Place toward **uncharacteristic** end if therapist does not actively elicit information.

**Item 32: Patient achieves a new understanding or insight.**  
Place toward **characteristic** end if a new perspective, or new connection or attitude, or warded-off content emerges during the course of the hour. E.g. following the therapist's remark, the patient appears thoughtful and says, "I think that's true. I had never really thought about the situation that way before."  
Place toward **uncharacteristic** end if no evidently new insight or awareness emerges during the hour.
Item 33: Patient talks of feeling close to or wanting to be close to someone (excludes therapist).
Place toward characteristic end if patient talks about being, or wanting to be, close or intimate with someone (excluding therapist). E.g. patient states he or she is lonely, and would like to be with someone.
Place toward uncharacteristic end if patient does not make statements about being or wanting to be close and intimate.

Item 34: Patient blames others, or external forces, for difficulties.
Place toward characteristic end if patient tend to externalize, blaming others or chance events for difficulties. E.g. patient claims his or her problems with work stem from the fact that he or she has had bad luck with employees.
Place toward uncharacteristic end if patient tends to assume responsibility for his or her problems, e.g. noting that his or her unhappiness in romantic relationships may be the result of choosing unsuitable partners.

Item 35: Self-image is a focus of the session.
Place toward characteristic end if a topic discussed by the patient and/or the therapist is the patient's concept, feelings, attitudes, or perceptions of him or her self, whether positive or negative. E.g. patient talks of how it is sometimes difficult (to her) to stand up for herself because she then experiences herself as being too aggressive.
Place toward uncharacteristic end if images of the self play little or no part in the dialogue.

Item 36: Therapist points out patient's attempts to ward off awareness of threatening information or feelings.
Place toward characteristic end if a major topic is defensive maneuvers (e.g. undoing, denial) used by the patient to ward off awareness of threatening information or feelings. E.g. the therapist points out how the patient is compelled to profess love for his father directly after having made critical remarks about him.
Place toward uncharacteristic end if this sort of interpretation of defenses plays little or no role during the hour.

Item 37: Therapist behaves in a teacher-like (didactic) manner.
Place toward characteristic end if therapist's attitude or stance toward patient is like that of a teacher to a student. This can be judged independently of specific content, i.e., therapist can impart information to make suggestions without behaving in a didactic or teacherly way, and alternative interpretations can be offered in the form of instruction.
Place toward uncharacteristic direction if therapist does not assume a tutor-like role in relation to the patient.

Item 38: There is discussion of specific activities or tasks for the patient to attempt outside of session.
Place toward characteristic end if there is discussion of a particular activity the patient might attempt outside of therapy, such as testing the validity of a particular
belief or behaving differently than s/he might typically do, or reading books. E.g. there is talk about the patient facing a feared situation or object that s/he usually avoids.
Place toward uncharacteristic end if there is no talk about the patient attempting particular actions of this sort outside of therapy.

**Item 39: There is a competitive quality to the relationship.**
Place toward characteristic end if either patient or therapist seems competitive with the other. This may take the form of boasting, "one-upping," or putting the other down. E.g. the patient suggests that therapists live a cloistered life while s/he is out living and working in the real world.
Place toward uncharacteristic end if there is little or no feeling of competitiveness between patient and therapist.

**Item 40: Therapist makes interpretations referring to actual people in the patient's life** (N.B. Placement toward uncharacteristic end indicates therapist makes general or impersonal interpretations.)
Place toward characteristic end if therapist's interpretations refer to particular people the patient knows. E.g. therapist says, "you felt hurt and angry when your mother criticized you."
Place toward uncharacteristic end if interpretations do not refer to particular people, or refer to other aspects of the patient's life. E.g. therapist comments, "You seem to be inclined to withdraw when others become close."

**Item 41: Patient's aspirations or ambitions are topics of the session.**
Place toward characteristic end if patient talks about life projects, goals, or wishes for success or status. E.g. patient talks about his or her hopes to become a lawyer and earn a substantial income.
Place toward uncharacteristic end if patient shows a constriction of future expectations, whether in the form of realistic planning or wishful thinking.

**Item 42: Patient rejects (vs. accepts) therapist's comments and observations.**
Place toward characteristic end if patient typically disagrees with or ignores therapist's suggestions, observations, or interpretations. E.g. after the therapist made a major interpretation, the patient casually remarked that s/he didn't think that was quite it.
Place toward uncharacteristic end if the patient tends to agree with therapist's remarks.

**Item 43: Therapist suggests the meaning of others' behavior.**
Place toward characteristic end if therapist attempts to interpret the meaning of the behavior of people in the patient's life. E.g. the therapist suggests that the patient's romantic partner has problems with intimacy.
Place toward uncharacteristic end if therapist does not make comments about the meaning of the behavior of others.
Item 44: Patient feels wary or suspicious of the therapist (vs. trusting and secure).
Place toward characteristic end if patient appears, wary, distrustful, or suspicious of the therapist. E.g. patient wonders whether the therapist really likes him or her, or if there is another, hidden meaning in the therapist's remarks.
Place toward uncharacteristic end if patient seems to be trusting and unsuspicious.

Item 45: Therapist adopts supportive stance.
Place toward characteristic end if therapist assumes a supportive, advocate-like posture toward the patient. This may take the form of approval of something the patient has done, or encouraging, for example, the patient to assert him or herself. Or the therapist may agree with the patient's positive self-statement, or emphasize the patient's strengths, e.g. "You did this in the past, and you can do it again."
Place toward uncharacteristic end if therapist tends not to assume a supportive role of this sort.

Item 46: Therapist communicates with patient in a clear, coherent style.
Place toward characteristic end if therapist's language is unambiguous, direct, and readily comprehensible. Rate as very characteristic if therapist's verbal style is evocative, and marked by a freshness of words and phrasing.
Place toward uncharacteristic end if therapist's language is diffuse, overly abstract, jargon-laden, or stereotypic.

Item 47: When the interaction with the patient is difficult, the therapist accommodates in an effort to improve relations.
Place toward characteristic end if therapist appears willing and open to compromise and accommodation when disagreement occurs, or when conflicts arise in the dyad. E.g. when the patient becomes annoyed with the therapist, he or she makes some effort to mollify the patient.
Place toward uncharacteristic end if therapist does not exert an effort to improve matters when the interaction becomes difficult.

Item 48: The therapist encourages independence of action or opinion in the patient.
Place toward characteristic end if therapist urges patient to think for him or herself and to take action based on what he or she thinks best. E.g. therapist notes that he has now heard from the patient what her mother and colleagues think she should do, but it's not clear what she wants or thinks.
Place toward uncharacteristic end if therapist does not introduce the issue of independence or initiative as a topic.

Item 49: The patient experiences ambivalent or conflicted feelings about the therapist.
Place toward characteristic end if patient expresses mixed feeling about the therapist or if the patient's overt verbalizations about the therapist are incongruent with the tone of his or her behavior or general manner, or if there seems to be some displacement of feelings. E.g. the patient cheerfully agrees with the therapist's suggestions, but then goes on to express hostility toward people who tell him or her what to do.
Place toward *uncharacteristic* end if there is little expression of patient ambivalence towards therapist.

**Item 50: Therapist draws attention to feelings regarded by the patient as unacceptable (e.g. anger, envy, or excitement.)**
Place toward *characteristic* end if therapist comments upon or emphasizes feelings that are considered wrong, inappropriate, or dangerous by the patient. E.g. therapist remarks that patient sometimes feels a jealous hatred of his more successful brother.
Place toward *uncharacteristic* end if therapist tends not to emphasize feeling reactions that the patient finds difficult to recognize or accept.

**Item 51: Therapist condescends to or patronizes the patient.**
Place toward *characteristic* end if therapist seems condescending toward patient, treating him or her as if less intelligent, accomplished, or sophisticated. This may be inferred from the manner in which therapist delivers comments, or offers advice.
Place toward *uncharacteristic* end if therapist conveys by his or her manner, tone of voice, or comments, that s/he does not assume an attitude of superiority.

**Item 52: Patient relies upon therapist to solve his/her problems.**
Place toward *characteristic* end if patient appears to present problems to the therapist in a manner which suggest a hope or expectation that the therapist will offer specific suggestions or advice in the way of a solution. E.g. patient states uncertainty as to whether or not to break up with a romantic partner and asks the therapist what he or she should do. Note that the appeal for a solution need not be explicitly stated but may be implied by the manner in which the patient discusses the problem.
Place toward *uncharacteristic* end if patient does not appear explicitly or implicitly to rely on the therapist to solve problems.

**Item 53: Patient is concerned about what therapist thinks of him or her.**
Place toward *characteristic* end if patient seems concerned with what the therapist might think of his or her behavior, or is concerned about being judged. E.g. the patient might comment, "You are probably thinking that was a stupid thing to do." Rater may also infer this from patient behavior, e.g. patient boasts of accomplishments in order to favorably impress the therapist.
Place toward *uncharacteristic* end if patient does not seem concerned with the kind of impression s/he is creating, or appears unworried about being judged by therapist.

**Item 54: Patient expresses himself or herself in a clear and organized fashion.**
Place toward *characteristic* end if patient expresses him or herself in a manner which is easily understandable, and relatively clear and fluent.
Place toward *uncharacteristic* end if patient’s speech is characterized by rambling, frequent digression, or vagueness. This can sometimes be judged by the rater's inability to readily follow the connections between topics the patient discusses.
Item 55: Patient conveys positive expectations about therapy.
Place toward characteristic end if patient expresses the hope or expectation that therapy will be of help. A more extreme placement in this direction indicates that the patient expresses unrealistically positive expectations, i.e. therapy will solve all of his or her problems and will be a protection against future difficulties. E.g. client may convey hope that therapy will provide quick results.
Place toward uncharacteristic end if patient expresses criticisms of therapy, e.g. conveys a sense of disappointment that therapy is not more effective or gratifying. A more extreme placement indicates patient expresses skepticism, pessimism or disillusionment about what can be accomplished in therapy.

Item 56: Patient discusses experiences as if distant from his or her feelings.
Refer to patient's attitude toward the material spoken, how much he or she appears to care about it, as well as how much overt affective expression there is.
Place toward characteristic end if patient displays little concern or feeling, and is generally flat, impersonal, or half-heartedly indifferent (tension may or may not be apparent).
Place toward uncharacteristic end if affect is apparent and patient is emotionally involved with the material. Place toward very uncharacteristic end if patient expresses sharp affect, or outbursts of emotion, and deeply felt concern.

Item 57: Therapist explains rationale behind his or her technique or approach to treatment, or suggests that the patient use certain techniques.
Place toward characteristic end if therapist explains some aspect of the therapy to the patient. E.g. therapist may reply in response to a direct question or request by the patient that s/he prefers not to answer immediately, since this would provide a better opportunity to explore thoughts or feelings associated with the question. Also includes the therapist answering questions about treatment process.
Place toward uncharacteristic end if little or no explanation is made by the therapist to explain the rationale behind some aspect of the treatment, even if there is pressure, or there may be some utility in doing so.

Item 58: Patient does not examine thoughts, reactions or motivations related to his or her role in creating or perpetuating problems.
Place toward characteristic end if patient is reluctant to examine his or her own role in perpetuating problems, e.g. by balking, avoiding, blocking, or repeatedly changing the subject whenever a particular topic is introduced.
Place toward uncharacteristic end if patient actively contemplates, or is able to pursue, trains of thoughts regarding his or her role in creating or perpetuating problems.

Item 59: Patient feels inadequate and inferior (vs. effective and superior).
Place toward characteristic end if patient expresses feelings of inadequacy, inferiority, or ineffectiveness. E.g. patient states that nothing he attempts really turns out the way he hopes it will.
Place toward uncharacteristic end if patient expresses a sense of effectiveness, superiority, or even triumph, e.g. recounts personal achievements, or claims attention for a personal attribute or skill.
Item 60: Patient has cathartic experience (N.B. rate as uncharacteristic if emotional expression is not followed by a sense of relief).
Place toward characteristic end if patient gains relief by giving vent to suppressed or pent-up feeling. E.g. patient cries intensely over the death of a parent, and then tells the therapist s/he feels better or appears to feel better as a result of expressing feelings.
Place toward uncharacteristic end if the experience of strong affect is not followed by a sense of relaxation or relief.
Rate as neutral if cathartic experience plays little or no role in the hour.

Item 61: Patient feels shy and embarrassed (vs. unselfconscious and assured).
Place toward characteristic end if patient appears shy, embarrassed, or not self-assured, or at the extreme, humiliated or mortified.

Place toward uncharacteristic end if patient appears unselfconscious, assured, or certain of him or herself.

Item 62: Therapist identifies a recurrent theme in the patient's experience or conduct.
Place toward characteristic end if therapist points out a recurrent pattern in the patient's life experience or behavior. E.g. therapist notes that patient repeatedly seeks out unavailable sexual partners.
Place toward uncharacteristic end if therapist does not identify such a theme or recurrent pattern.

Item 63: Patient's interpersonal relationships are a major theme.
Place toward characteristic end if a major focus of discussion is the patient's social or work relationships, or personal, emotional involvements (excludes discussion of therapy relationship [see Item 98] and excludes discussion of love or romantic relationships [see Item 64]). E.g. patient discusses at some length his or her distress over conflicts with a boss.
Place toward uncharacteristic end if a good portion of the hour is devoted to discussion of matters that are not directly connected to relationships, e.g. the patient's compulsion to work, or drive to achieve, or his/her preoccupation with food and eating.
N.B.: Item does not refer to discussion of relationships in the distant past. (See Item 91, Memories or reconstructions of infancy and childhood are topics of discussion.)

Item 64: Feelings about romantic love relationships are a topic of the session.
Place toward characteristic end if romantic or love relationships are talked about during the hour. E.g. patient talks about feelings toward a romantic partner.
Place toward uncharacteristic end if love relationships do not emerge as a topic.

Item 65: Therapist restates or rephrases the patient's communication in order to clarify its meaning.
Place toward characteristic end if one aspect of the therapist's activity is restating or rephrasing the patient's affective tone, statements, or ideas in a somewhat
more recognizable form in order to render their meaning more evident. E.g. therapist remarks, "What you seem to be saying is that you're worried about what therapy will be like."

Place toward uncharacteristic end if the therapist seldom employs this kind of clarifying activity during the hour.

**Item 66: Therapist is directly reassuring (N.B. Place in uncharacteristic direction if therapist tends to refrain from providing direct reassurance).**

Place toward characteristic end if therapist attempts to directly allay patient's anxieties and instill hope that matters will improve. E.g. therapist tells patient there is no reason for worry; he or she is sure the problem can be solved.

Place toward uncharacteristic end if the therapist tends to refrain from providing direct reassurance of this kind.

**Item 67: Therapist draws the patient's attention to wishes, feelings, or ideas that may not be in awareness.**

Place toward characteristic end if therapist draws the patient's attention to feelings, thoughts, or impulses that may not be clearly in awareness. Rater must attempt to infer the quality of mental content (i.e. the extent to which it is in awareness) from the context of the hour (excludes interpretation of defensive maneuvers: see Item 36).

Place toward uncharacteristic end if therapist focuses on material that appears to be clearly in the conscious awareness of the patient.

**Item 68: Real vs. fantasized meanings of experiences are actively differentiated.**

Place toward characteristic end if therapist or patient notes differences between patient's fantasies about an occurrence and the objective reality. E.g. therapist points out that although the patient may have harbored death wishes toward the deceased, he or she did not, in reality, cause the heart attack. Distortions and erroneous assumptions should also be included, e.g. therapist asks where patient got that idea when he or she repeatedly describes the world as dangerous.

Place toward uncharacteristic end if little of the activity of the therapy hour is concerned with distortions of reality.

**Item 69: Patient's current or recent life situation is emphasized in the session.**

Place toward characteristic end if patient or therapist emphasizes very recent or current life events. E.g. patient talks about depression over a spouse's recent death.

Place toward uncharacteristic end if discussion of current life situation is not an important aspect of the hour.

**Item 70: Patient struggles to control feelings or impulses.**

Place toward characteristic end if patient attempts to manage or control strong emotions or impulses. E.g. patient fights to hold back tears while obviously distressed.

Place toward uncharacteristic end if patient does not attempt to manage or control emotions or impulses.
Item 71: Patient is self-accusatory; expresses shame or guilt.
Place toward characteristic end if patient expresses self-blame, shame, or guilt.
E.g. that patient claims that if s/he had paid more attention to a spouse’s low moods, the spouse might not have committed suicide.
Place toward uncharacteristic end if patient does not make statements reflecting self-blame, a sense of shame, or pangs of conscience.

Item 72: Patient understands the nature of therapy and what is expected.
Placement toward characteristic end reflects the extent to which the patient appears to comprehend what is expected of him or her in the situation and what will happen in therapy.
Placement toward uncharacteristic end suggests that the patient is uncertain, confused or misunderstands his or her role in therapy and what is expected in the situation.

Item 73: The patient is committed to the work of therapy.
Place toward characteristic end if patient seems committed to the work of therapy. May include willingness to make sacrifices to continue this endeavor, in terms of time, money, inconvenience; may also include genuine desire to understand more about the self in spite of the psychological discomfort this may entail. E.g. a patient was so interested in beginning treatment that he or she was willing to give up a weekly golf game to keep his/her appointments.
Place toward uncharacteristic end if patient seems ambivalent about therapy, or unwilling to tolerate the emotional hardships that therapy might entail. May be expressed in terms of complaints about the expense of therapy, in scheduling conflicts, or statements of doubt about the effectiveness of treatment, or uncertainty about wanting to change.

Item 74: Humor is used.
Place toward characteristic end if therapist or patient display humor during the course of the hour. This may appear as a defense/coping mechanism in the patient; or the therapist may use wit or irony to make a point or to facilitate development of a working relationship with the patient. E.g. patient demonstrates an ability to laugh at herself or her predicament.
Place toward uncharacteristic end if the interaction appears grave, austere or somber.

Item 75: Termination of therapy is mentioned or discussed.
Place toward characteristic end if patient or therapist talks of the end of therapy. Includes all reference to termination, i.e. whether it is wished for, feared, or threatened.
Place toward uncharacteristic end if discussion of termination seems to be avoided. E.g. the upcoming termination is mentioned, but neither patient nor therapist pursues the subject.
Rate as neutral if no reference to termination is made.
Item 76: Therapist suggests that patient accept responsibility for his or her problems.
Place toward characteristic end if therapist attempts to convey to the patient that s/he must take some action, or change somehow, if his or her difficulties are to improve. E.g. therapist comments, "Let's look at what you may have done to elicit that response (from another person).
Place toward uncharacteristic end if therapist's actions are in general not aimed at persuading patient to assume greater responsibility.

Item 77: Therapist is tactless.
Place toward characteristic end if therapist's comments seem to be phrased in ways likely to be perceived by the patient as hurtful or derogatory. This lack of tact or sensitivity may not be a result of therapist's annoyance or irritation, but rather a result of lack of technique, polish, or verbal facility.
Place toward uncharacteristic end if therapist's comments reflect kindliness, consideration, or carefulness.

Item 78: Patient seeks therapist's approval, affection, or sympathy.
Place toward characteristic end if patient behaves in a manner that appears designed to make therapist like him or her, or to gain attention or reassurance.
Place toward uncharacteristic end if patient does not behave in this fashion.

Item 79: Therapist comments on changes in patient's mood or affect that occur during the hour.
Place toward characteristic end if therapist makes frequent or salient comments about shifts in the patient's mood or quality of experience during the hour. E.g. therapist notes that in response to his comments, patient has shifted from a 'devil may care' attitude to feeling hurt but working more seriously on his or her problems.
Place toward uncharacteristic end if therapist tends not to comment on changes in patient's states of mind during the hour.

Item 80: Therapist presents a specific experience or event in a different perspective.
Place toward characteristic end if therapist restates what the patient has described in such a way that the patient is likely to look at the situation differently ('reframing' or 'cognitive restructuring'). A new (and usually more positive) meaning is given to the same content. In rating this item, a particular event or experience that has been 'reframed' should be identified. E.g. After a patient berates him or herself for having started an ugly quarrel with a romantic partner, the therapist says that this is his or her way of expressing what he or she needs in that relationship.
Place toward uncharacteristic end if this does not constitute an important aspect of the therapist's activity during the hour.

Item 81: Therapist emphasizes patient feelings in order to help him or her experience them more deeply.
Place toward characteristic end if therapist stresses the emotional content of what the patient has described in order to encourage the experience of affect. E.g. therapist suggests that the interaction the patient has just described in a storytelling manner probably made her or him feel quite angry.
Place toward *uncharacteristic* end if therapist does not emphasize the experience or affect, or appears interested in patient's objectified descriptions.

**Item 82: The patient's behavior during the hour is reformulated by the therapist in a way not explicitly recognized previously.**
Place toward *characteristic* end if therapist makes frequent or a few salient comments about the patient's behavior during the hour in a way that appears to shed new light on it. E.g. therapist suggests that the patient's late arrival for the hour may have a meaning; or therapist notes that whenever the patient begins to talk about emotional topics, he or she quickly shifts to another focus.
Place toward *uncharacteristic* end if therapist tends not to reformulate the patient's behavior during the session.

**Item 83: Patient is demanding.**
Place toward *characteristic* end if patient makes multiple demands/requests of the therapist or pressures therapist to meet a specific request. E.g. patient makes multiple demands such as evening appointments, medication, or requests more structure or more activity on therapist's part.
Place toward *uncharacteristic* end if patient is reluctant or hesitant to make usual or appropriate requests of the therapist, e.g. fails to ask for another appointment despite a schedule conflict with another, highly important event.

**Item 84: Patient expresses angry or aggressive feelings.**
Place toward *characteristic* end if patient expresses resentment, anger, bitterness, hatred or aggression verbally or non-verbally (N.B. excludes such feelings directed at therapist: see Item 1).
Place toward *uncharacteristic* end if the verbal or non-verbal expression of such feelings does not occur.

**Item 85: Therapist encourages patient to try new ways of behaving with others.**
Place toward *characteristic* end if therapist suggests alternative ways of relating to people. E.g. therapist asks patient what he thinks might happen if he were to be more direct in telling his mother how it affects him when she nags. More extreme placement implies that the therapist actively coaches patient on how to interact with others, or rehearses new ways of behaving with others.
Place toward *uncharacteristic* end if therapist tends not to make suggests about how to relate to others.

**Item 86: Therapist acts confident or self-assured (vs. uncertain or defensive).**
Place toward *characteristic* end if therapist's manner indicates a feeling of confidence and competence.
Place toward *uncharacteristic* end if therapist appears uncertain, embarrassed, or at a loss.
Item 87: Patient is controlling.
Place toward characteristic end if patient exercises a restraining or directing influence in the hour, e.g. patient dominated the interaction with compulsive talking, or interrupted the therapist frequently.
Place toward uncharacteristic end if patient does not control the interaction, working with therapist in a more collaborative fashion.

Item 88: Patient brings up significant issues and material.
Place toward characteristic end if the rater judges that what the patient brings up and talks about during the hour is importantly related to patient's psychological conflicts, or are topics of real concern.
Place toward uncharacteristic end if discussion seems unrelated to or somehow removed from issues of central concern.

Item 89: Therapist intervenes to help patient avoid or suppress disturbing ideas or feelings.
Place toward characteristic end if therapist's stance is characterized by a calm, attentive compliance intended to avoid upsetting the patient's emotional balance or to strengthen the patient's defenses.
Place toward uncharacteristic end if therapist does not act to shore up defenses or suppress troublesome thoughts or feelings.

Item 90: Patient's dreams or fantasies are mentioned or discussed.
Place toward characteristic end if a topic of discussion is dream content or fantasy (day-dreams or night-dreams) material. E.g. patient and therapist explore the possible meanings of a dream the patient had the night before starting therapy, or the patient talks of what life would have been like if she'd chosen a different romantic partner.
Place toward uncharacteristic end if there is little or no discussion of dreams or fantasy during the hour.

Item 91: Memories or reconstructions of infancy and childhood are topics of discussion.
Place toward characteristic end if some part, or a significant part, of the hour is taken up by a discussion of childhood or memories of early years of life.
Place toward uncharacteristic end if little or no time is devoted to a discussion of these topics.

Item 92: Patient's feelings or perceptions are linked to situations or behavior of the past.
Place toward characteristic end if several links or salient connections are made between the patient's current emotional experience or perception of events with those of the past. E.g. therapist points out (or patient realizes) that current fears of abandonment are derived from the loss of a parent during childhood.
Place toward uncharacteristic end if current and past experiences are discussed, but not linked.
Place toward neutral category if these subjects are discussed very little or not at all.
Item 93: Therapist refrains from stating opinions or views of topics the patient discusses.
Place toward characteristic end if therapist tends to refrain from stating opinions or views of topics patient discusses. Therapist assumes role of neutral commentator, and the patient's view of matters is made pre-eminent in the dialogue. E.g. therapist asks how it would be for the patient if she, as the therapist, approved of his expressing his anger, and subsequently inquires how it would be for him if she disapproved.
Place toward uncharacteristic end if therapist expresses opinions, or takes positions either explicitly or by implication. E.g. therapist tells patient that it is very important that he learn how to express his anger; or comments that the relationship the patient is in right now is not a very good one, and that she should consider getting out of it.
N.B.: A stance of neutral commentator is not synonymous with passivity or disengagement. The therapist can be active and affectively engaged and still maintain a neutral stance.

Item 94: Patient feels sad or depressed (vs. joyous or cheerful).
Place toward characteristic end if patient's mood seems melancholy, sad, or depressed.
Place toward uncharacteristic end if patient appears delighted or joyful or somehow conveys a mood of well-being or happiness.

Item 95: Patient feels helped by the therapy.
Place toward characteristic end if patient somehow indicates a sense of feeling helped, relieved, or encouraged by the way the therapy is progressing.
Place toward uncharacteristic end if patient feel discouraged or frustrated with the way therapy is progressing (N.B. Item does not refer to events outside of therapy.)

Item 96: There is discussion of scheduling of hours, or fees.
Place toward characteristic end if therapist and patient discuss the scheduling or re-scheduling (times, dates, etc.) of a therapy hour; or if there is discussion of the amount of fee, time of payment, and the like.
Place toward uncharacteristic end if these topics are not taken up.

Item 97: Patient is introspective, readily explores inner thoughts and feelings.
Place toward characteristic end if patient appears unguarded, and relatively unblocked. In this instance the patient pushes beyond ordinary constraints, cautions, hesitancies or feelings of delicateness in exploring and examining thoughts and feelings.
Place toward uncharacteristic end if patient's discourse appears hesitant or inhibited, shows constraint, reserve or a stiffening of control, and does not appear loose, free, or unchecked.

Item 98: The therapy relationship is a focus of discussion.
Place toward characteristic end if therapy relationship is discussed. E.g. therapist calls attention to features of the interaction or interpersonal process between the patient and him or herself.
Place toward uncharacteristic end if therapist or patient does not comment on the nature of transactions between them, i.e. focuses on content.
Item 99: Therapist raises questions about the patient's view (vs. validates the patient's perceptions).
Place toward characteristic end if therapist somehow raises a question about the patient's view of an experience or an event. E.g. therapist might say "How is that so?" or "I wonder about that," or simply utter an "Oh?" This item does not refer to interpretations or reframing in the sense of providing a new or different meaning to the patient's discourse, but instead refers simply to somehow raising a question about the patient's viewpoint. Place toward uncharacteristic end if therapist somehow conveys a sense of agreement, concurrence with, or substantiation of the patient's perspective. E.g. therapist says, "I think you're quite right about that" or "You seem to have a good deal of insight into that."

Item 100: Therapist draws connections between the therapeutic relationship and other relationships.
Place toward characteristic end if therapist makes comments linking the patient's feelings about the therapist and feelings toward other significant individuals in his or her life. Includes current relationships, and past or present relationships with parents (transference/parent link). E.g. therapist remarks that she thinks the patient is sometimes afraid she will criticize her just as her mother does. Place toward uncharacteristic end if therapist's activity during the hour does not attempt to link the interpersonal aspects of therapy with experiences in other relationships.
Appendix 2: The PQS prototype with means of the three samples

<table>
<thead>
<tr>
<th>PQS #</th>
<th>PQS-item description</th>
<th>STDP mean (SD)</th>
<th>LTDP mean (SD)</th>
<th>PA mean (SD)</th>
<th>Factor score</th>
</tr>
</thead>
<tbody>
<tr>
<td>90</td>
<td>P’s dreams or fantasies are discussed.</td>
<td>4.83 (.69)</td>
<td>4.87 (.65)</td>
<td>5.57 (1.08)</td>
<td>1.71</td>
</tr>
<tr>
<td>93</td>
<td>T is neutral.</td>
<td>5.78 (1.12)</td>
<td>4.57 (1.99)</td>
<td>5.09 (1.73)</td>
<td>1.57</td>
</tr>
<tr>
<td>36</td>
<td>T points out P’s use of defensive maneuvers (e.g., undoing, denial).</td>
<td>5.41 (1.08)</td>
<td>6.94 (1.37)</td>
<td>5.14 (.85)</td>
<td>1.53</td>
</tr>
<tr>
<td>100</td>
<td>T draws connections between the therapeutic relationship and other relationships.</td>
<td>5.09 (1.32)</td>
<td>5.33 (.98)</td>
<td>5.36 (.78)</td>
<td>1.47</td>
</tr>
<tr>
<td>6</td>
<td>T is sensitive to the P’s feelings, attuned to P; empathic.</td>
<td>6.75 (.71)</td>
<td>7.24 (.87)</td>
<td>7.86 (.88)</td>
<td>1.46</td>
</tr>
<tr>
<td>67</td>
<td>T interprets warded-off or unconscious wishes, feelings, or ideas.</td>
<td>6.27 (.82)</td>
<td>7.04 (1.39)</td>
<td>6.01 (1.49)</td>
<td>1.43</td>
</tr>
<tr>
<td>18</td>
<td>T conveys a sense of nonjudgmental acceptance.</td>
<td>6.4 (.78)</td>
<td>5.59 (.89)</td>
<td>6.89 (1.14)</td>
<td>1.38</td>
</tr>
<tr>
<td>32</td>
<td>P achieves a new understanding or insight.</td>
<td>5.56 (.93)</td>
<td>5.65 (.79)</td>
<td>5.14 (.79)</td>
<td>1.32</td>
</tr>
<tr>
<td>98</td>
<td>The therapy relationship is a focus of discussion.</td>
<td>5.34 (1.26)</td>
<td>5.36 (1.19)</td>
<td>5.34 (1.26)</td>
<td>1.28</td>
</tr>
<tr>
<td>46</td>
<td>T communicates with P in a clear, coherent style.</td>
<td>5.93 (.61)</td>
<td>6.91 (.93)</td>
<td>5.93 (.61)</td>
<td>1.24</td>
</tr>
<tr>
<td>50</td>
<td>T draws attention to feelings regarded by P as unacceptable (e.g. anger, envy, excitement).</td>
<td>6.15 (1.18)</td>
<td>5.99 (1.02)</td>
<td>5.06 (.93)</td>
<td>1.17</td>
</tr>
<tr>
<td>11</td>
<td>Sexual feelings and experienced are discussed.</td>
<td>5.27 (1.19)</td>
<td>5.01 (1.03)</td>
<td>5.32 (1.19)</td>
<td>1.12</td>
</tr>
<tr>
<td>82</td>
<td>P’s behavior during the hour is reformulated by T in a way not explicitly recognized previously.</td>
<td>5.26 (.78)</td>
<td>5.47 (.66)</td>
<td>4.57 (.37)</td>
<td>1.12</td>
</tr>
<tr>
<td>35</td>
<td>Self-image is a focus of discussion.</td>
<td>6.81 (1.04)</td>
<td>6.71 (.61)</td>
<td>6.81 (1.04)</td>
<td>1.11</td>
</tr>
<tr>
<td>91</td>
<td>Memories or reconstruction of infancy and childhood are topics of discussion.</td>
<td>6.26 (1.07)</td>
<td>5.12 (.69)</td>
<td>6.26 (1.07)</td>
<td>1.08</td>
</tr>
<tr>
<td>92</td>
<td>P’s feelings or perceptions are linked to situations or behavior of the past.</td>
<td>6.75 (1.37)</td>
<td>5.93 (.77)</td>
<td>6.09 (.81)</td>
<td>1.05</td>
</tr>
<tr>
<td>62</td>
<td>T identifies a recurrent theme in P’s experience or conduct.</td>
<td>6.98 (1.02)</td>
<td>6.87 (1.12)</td>
<td>6.51 (.91)</td>
<td>0.95</td>
</tr>
<tr>
<td>3</td>
<td>T’s remarks are aimed to facilitating P’s speech.</td>
<td>6.23 (1.13)</td>
<td>5.98 (.76)</td>
<td>6.38 (.78)</td>
<td>0.92</td>
</tr>
<tr>
<td>79</td>
<td>T comment on changes in P’s mood or affect.</td>
<td>4.43 (.58)</td>
<td>4.53 (.68)</td>
<td>4.43 (.58)</td>
<td>0.88</td>
</tr>
<tr>
<td>22</td>
<td>T focuses on P’s feelings of guilt.</td>
<td>5.39 (1.09)</td>
<td>5.01 (.78)</td>
<td>4.50 (.89)</td>
<td>0.87</td>
</tr>
</tbody>
</table>

Note: Factor scores derived from expert psychoanalysts (N = 11) ratings of the PQS. PQS#: Item number of Psychotherapy Process Q-set; T = therapist, P = patient; mean (m) and standard deviation (SD) for all samples; PA: Psychoanalysis; STDP: short-term psychodynamic psychotherapy; LTDP: long-term psychodynamic psychotherapy.
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Curriculum Vitae

PERSONAL DETAILS

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EDUCATION

Oct 2007 – PhD candidate (Bio-Hum.), University Ulm, Germany
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Oct 2000-Jan 2006 M. Sc. Psychology, ISPA, Lisbon, Portugal (5 years degree)


PUBLICATIONS


**RESEARCH EXPERIENCE**

2010 PQS Supervisor for research group at ‘Zürcher Hochschule für Angewandte Wissenschaften’, Switzerland.

2009 PQS Supervisor for research group at University Innsbruck, Austria.

2008- **Research Associate** at “Psychotherapy Research Program” (Massachusetts General Hospital, Boston - Harvard Medical School).

2006 **Research Assistant**, project “Autonomie und Abhängigkeit – Bindungsrepräsentation und Mentalisierungsfähigkeit drogenabhängiger Frauen”.


**TEACHING AND WORK EXPERIENCE**

2006-2010 **Lecturer**, Medical Psychology and Medical Sociology Seminar (1st and 2nd Sem.). Integrated intensive course “Medical Psychology and Medical Sociology Seminar”; Seminar “Social competence and Conversational Skills” and Seminar “Pain” at University of Ulm, Germany.

2011 **Workshop** (PQS training at Psychotherapy Association “APRENDER” in Porto, Portugal) *in prep.*

2010 **Supervision** (PQS training at “ZHAW – Zürich Hochschule für Angewandte Wissenschaften” Department of Applied Psychology).

2010 **Workshop** (PQS training at ISPA Lisbon – Research Department).

2009 **Workshop** (PQS training at University Innsbruck – Psychology Department and PQS research consultancy).

2009 **Speaker** “The psychotherapy Process Q-set (PQS) and its application – study empirically the therapeutic process” (presented at APPSI Conference in Lisbon, Portugal, based on German specimen case Amalia X).

2007 Organization of the PQS-Training at University of Munich with Raymond A. Levy– MGH Harvard Medical School).

2005 **Tutor**, see seminar above; plus Doctor-patient interaction “Talk with me” (4th Sem.).

2004 – 2005 **Psychology trainee**, University Clinic, Ulm, Germany.

2003 **Psychology trainee**, Psychiatric und Psychotherapy of Lüdenscheid, Germany.

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38 Please notice that my full name is Carolina Seybert do Amaral Pinto Ferreira
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FUNDING & AWARDS
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2008  DAAD short-term scholarship (Germany)