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RESEARCH ON THE PSYCHOANALYTIC PROCESS

THE OPENING CONFERENCE
ON PSYCHOTHERAPY RESEARCH

October 2, 1976
Langley Porter Institute
Psychotherapy Evaluation and Study Center

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Presentation to: Opening Conference* on Psychotherapy Research

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Harold Sampson, Ph.D.

PART I

The research group of Mount Zion Hospital and the San Francisco Psychoanalytic Institute consists not only of the three of us who are panelists today, but includes a dozen other part-time investigators. The group is carrying out a series of studies on a small number of treatment cases. These studies are interrelated, so that when taken together they may cast light on some fundamental questions about how therapy works.

We will present this afternoon an overview of current work, and of the ideas guiding that work. Inevitably, these presentations can serve only as an introduction to a line of work which has been going on for many years, and which includes a number of complex theoretical issues and interlocking empirical studies.

Our work is in the tradition of those scientific fields which develop powerful theories to account for certain phenomena, and then test these theories against alternative theories by seeking out those specific observations, in nature or in experiments, which can provide evidence for or against a theory.

For us then, formal research using objective measures and quantification has been the last step in a long and comprehensive process. We began our work many years ago by studying and re-studying the session-by-session notes of analyses and psychotherapies, and by attempting to fit various theoretical explanations to the patterns we observed. This was the way in which our own ideas and convictions about the therapeutic process developed.

In order to move from such case studies toward more formal, objective, and replicable research, we found it necessary to devote a sustained effort to the clarification of theory. We had to discover the often only implicit propositions about therapy which are embedded in psychoanalytic writings; and we had to compare and contrast some of these propositions to alternative ideas which we had begun to develop.

Our next task was to examine very closely the relationship between theories and observation. We had to discover just what observations, what patterns of behavior, lend support to certain propositions, and pose difficulties for others.

It was only then that we were able to turn to formal, quantitative research, and to devise a series of studies which may illuminate the clinical and theoretical issues which concern us.

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* Of Langley Porter Institute's new Psychotherapy Evaluation and Study Center.

It follows then, that our research begins with ideas. Dr. Weiss is going to discuss these ideas, and then he will spell out the logic by which we can link abstract psychoanalytic concepts about therapy to particular observations in the treatment situation.

Following that, I will suggest the scope and purpose of our current work by summarizing in broad outline several ongoing studies by which we hope to test alternative hypotheses about the therapeutic process.

Finally, Dr. Caston will present one of those studies in detail; specifically a pilot study on the immediate effects of an analyst's interventions. Dr. Caston will show how his findings, if verified in subsequent work, are compatible with out hypotheses and pose a challenge to certain other psychoanalytic hypotheses.

Presentation to: Opening Conference on Psychotherapy Research

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Joseph Weiss, M.D.

PART II

THE THEORY WHICH WE ARE TESTING AND THE EVIDENCE FOR IT

In my talk, I shall do two things: I shall discuss the theory which we are testing, and I shall indicate, in a general way, the kinds of findings which would be evidence for it.

Our theory is quite broad. It pertains to such questions as: How does analysis work? What does a patient do in analysis? How should the analyst try to help him? Our theory is relevant, not only to analysis, but also to other kinds of therapy, and despite being broad, it is, as Hal Sampson and Joe Caston will demonstrate, testable by rigorous and replicable research methods.

Our theory is an extension of Freud's Ego Psychology. It elaborates and develops Freud's Ego Psychology, and it contrasts with the traditional psychoanalytic theory of therapy and technique which Freud put forth before he developed Ego Psychology and which, despite Ego Psychology, is still the basis of the present-day theory of therapy and technique.

Let me state the major tenets of the theory which we are testing. It assumes that the patient exerts considerable control over his unconscious mental life and that his chief unconscious wish is to solve his problems by resolving the conflicts which underlie them. It assumes, too, that the patient works throughout his analysis to resolve his unconscious conflicts by attempting to make conscious the mental contents which he has warded off so that he can put them under conscious control.

A good way to make our theory clear is to contrast it with the traditional theory.

The traditional theory assumes that all the processes of therapy and, indeed, all mental processes, except for the reception of external stimuli, can be explained in terms of powerful psychic forces or drives, which interact, dynamically, beyond the patient's control. The ego itself, in its interactions with these forces or drives, behaves as such a force. It interacts dynamically with the drives and does not control them. Another way of saying this is that in the traditional theory, all mental processes are determined by psychic forces, each of which has a strength and a direction. These forces are additive like vectors. They interact with one another, cancelling out one another, reinforcing one another, etc. From their interactions, all behavior can be derived.

The theory which we are testing agrees with the traditional theory about the importance of powerful forces, or drives. However, in contrast to the traditional view, it assumes that the patient generally exerts at least a crude unconscious control over these forces, though he may at times lose his control over them.

In our view, then, behavior is not determined by the dynamic interactions of powerful forces, but is directed by the patient, who controls it in accordance with unconscious decisions and plans. He decides what he will do, he makes plans about how he will do it, and then he does it. In deciding what he will do and in planning how he will do it, he takes the forces, or drives, into account, but his decisions may be, as suggested by Hartmann, independent of the drives, and are not, as in the traditional theory, merely expressions of the drives and thus epiphenomena which have little or no effect upon behavior.

Let me put this contrast in the simplest possible terms: The traditional theory is a drive theory; behind every unconscious process it sees a dynamic interaction. For example, the traditional theory explains the development of the transference neurosis dynamically by assuming either that the transferences are intensified, or that the defenses which are warding them off are weakened, or that both of these things take place.

Our theory, on the other hand, besides assuming the importance of drives, also assumes the importance of decisions which are about drives but which may be independent of the drives.

Where the traditional theory would explain the expression of a drive, by saying that the drive is mobilized, we might say that the patient decided to express the drive. In our theory, the transference neurosis may develop in two ways. It may develop as described in the traditional theory--beyond the patient's control. This, however, in our view, happens rarely, and when it does happen, it is not therapeutic but disruptive. It causes the patient great anxiety, and does not lead to insight. We believe that, most of the time, the transference neurosis develops within the patient's control; it develops as a result of the patient's making his transferences prominent, as part of his working to make them conscious, and to master them.

This brings me to an additional contrast between the traditional theory and our views. The traditional theory sees the patient as motivated unconsciously to seek drive satisfaction and attributes no other kind of unconscious motivation to him. We, on the other hand, assume that the patient's most powerful unconscious wish is to solve his problems. We assume that he knows, unconsciously, that his problems stem from his poor control over the mental contents (that is, impulses, affects, ideas and attitudes) which he has warded off, and he knows, too, that to solve his problems, he must make these contents conscious and master them. Therefore, he works against his resistances to solve his problems by attempting to bring the unconscious contents to consciousness so that he may put them under conscious control.

Another way of explaining our theory is to describe a familiar phenomena which seems paradoxical, but which our concepts make comprehensible. It is the phenomena of crying at the happy ending. Years ago I found this phenomena illuminating. Let me describe a typical instance of it:

A person who is watching a movie about a love story experiences little, or no emotion as he observes the lovers quarrel and separate. He is deeply moved, however, when they are happily reunited. He shares their happiness, and at the same time begins to weep.

The moviegoer's reaction is paradoxical; one would expect him to become sad when the lovers separate, but not when they are reunited.

In the article which I wrote in 1952 about crying at the happy ending, I explained this paradox as follows: The moviegoer is saddened by the separation of the lovers. However, he is threatened by his sadness so that he wards it off, and thus does not express it. Then, when the lovers are reunited, he no longer has a need to ward off his sadness about their separation, so that he lifts his defenses and brings the sadness forth. He brings it forth in order to master it and thus to resolve his conflict with it.

This explanation assumes that the sadness comes forth because the moviegoer brings it forth and not because, as the traditional theory assumes, the sadness breaks through the patient's defenses to consciousness. It assumes, too, that the moviegoer controls the coming forth of the sadness, bringing it forth when he unconsciously realizes that he could safely experience it.

The traditional theory is hard put to explain the phenomena of crying at the happy ending. It assumes, of course, that the sadness breaks through the patient's defenses to consciousness. Since it does not acknowledge that the patient could lift his defenses, it has no other way of explaining the sudden emergence of an unconscious mental content which has not been interpreted.

The traditional theory does not give a good explanation about why the sadness breaks through just when the moviegoer becomes relieved and happy. In order to explain this, in its own terms, the traditional theory should show that the sadness was intensified, or that the defenses opposing it gave way, and it should link these events to the moviegoer's sudden happiness. This it does not do, for the moviegoer's sudden happiness would neither intensify his sadness, nor weaken the defenses opposed to it.

The traditional theory also fails to account for the moviegoer's not feeling anxious and upset as he experiences the sadness. For, if the sadness had become conscious because it had become so strong in relation to the defenses, that it had broken through them to consciousness, the moviegoer would have become anxious about the sadness and would develop a conflict with it.

This brings us to the second topic of my paper; that is, the evidence for our theory, in particular, for two of its central tenets. These are that the patient generally exerts control over his unconscious mental life and that he is powerfully motivated to gain mastery over the mental contents which he has warded off by defenses.

To find such evidence, we must do two things: We must find in patients certain behavior patterns which our theory could explain, but which the traditional theory could not. We must then study patients carefully, by clinical methods, by research methods, or by both of these, to determine whether or not they demonstrate these behavior patterns.

We have not discovered any behavior patterns which the traditional theory could explain, but which our theory could not explain. However, we have found a number of patterns which our theory could explain, but which the traditional theory could not. I will take up just two such patterns. Then Hal Sampson will describe the research methods we have used and are using to determine whether or not patients demonstrate these patterns.

The first pattern emphasizes the patient's ability to bring forth a powerful mental content, on his own, unaided by the analyst.

It is the patient's becoming conscious of a previously warded-off mental content on his own, unaided by the analyst, his not feeling much anxiety about this content, his keeping this content in mind without a great deal of conflict about it, and his proceeding to master it.

An example of this pattern is a patient becoming aware, say, of a powerful homosexual impulse which had not been interpreted, his not feeling anxious about this impulse, his keeping it in consciousness without feeling much anxiety about it, and his using his knowledge of it appropriately, to understand more about his relationship to the analyst and to the objects of his past and present life.

Our theory could readily explain this pattern because it assumes that the patient could control the coming forth of the homosexual impulse. He could keep it unconscious until he had overcome most of his anxiety about it, and then bring it forth in order to master it.

If he were to keep the homosexual impulse unconscious until he had overcome his anxiety about it, he would not, after bringing it forth, necessarily experience much anxiety about it, and he would be able to master it, on his own, unaided by the analyst.

The traditional theory, however, could not explain this pattern. Since it assumes that the patient could not lift his defenses, it could explain the sudden emergence of the homosexual impulse in only one way--by the idea that the impulse broke through the patient's defenses to consciousness. Were this to happen, however, the patient would be very upset about the homosexual impulse, and he would develop an intense conflict with it. He would struggle to repress it and would not proceed calmly and without anxiety to master it.

Let me now turn to the second pattern. It is more elaborate than the first, and it includes an instance of the first.

Its main point is that the patient is unconsciously pleased, not frustrated, when the analyst does not attempt to satisfy an unconscious transference which the patient is pulling for him to satisfy.

Here is the pattern: The patient pulls unconsciously for the analyst to gratify the transference. The analyst does not gratify it. The patient then is unconsciously pleased with the analyst, though he would not be likely to acknowledge this. He becomes more optimistic than before and more confident that the analysis will help him. He tackles problems which before he had been afraid to tackle. He then becomes conscious of the transference which he had pulled for the analyst to gratify. He is not particularly anxious about it, he keeps it in consciousness, and he proceeds to master it.

Let me present an example of this pattern:

A patient is unconsciously sexually seductive toward the analyst. He pulls unconsciously for the analyst to admire him, to give him extra appointments, and to show special interest in his sexual fantasies. Each time the analyst does not accede to such a pull, the patient becomes less anxious and more confident. Then, on one occasion, after the analyst does not attempt to gratify the patient's homosexual impulses, the patient becomes conscious of his homosexual interest in the analyst. He is not, however, anxious about his homosexual feelings. He keeps them in consciousness without coming into conflict with them, and proceeds to master them.

Our theory could readily explain this sequence of events as follows:

The patient would like to bring forth his warded off homosexual interest in the analyst in order to master it. However, he hesitates to bring it forth, fearing that the analyst would attempt to satisfy it and thereby endanger him. For the patient knows that his unconscious control of his homosexuality is weak, so that he would be in danger of losing his control over it if the analyst were to behave sexually toward him.

Since the patient realizes that he could safely become aware of his homosexual interest in the analyst, only if he knows that the analyst would not be seduced by it, he decides to test the analyst in order to find out how the analyst would behave if he were to express this interest. He tests the analyst by pulling for him to satisfy the homosexual transference, thereby tempting the analyst to do the very thing which the patient would find threatening.

The patient infers from the analyst's not acceding to his pulls, that the analyst would not behave sexually to him. The patient, therefore, gains confidence in the analyst and becomes more hopeful that the analysis will help him. He becomes less afraid of the homosexual transference, and he brings it forth. Since he has overcome much of his anxiety about expressing it before bringing it forth, he is not especially anxious about it after making it conscious. He keeps it in consciousness without coming into serious conflict with it, and puts it under conscious control, unaided by interpretation.

The traditional theory could not explain this pattern. It could explain the patient's becoming conscious of the transference by the idea that the transference is frustrated by the analyst so that it becomes intensified and breaks through the patient's defenses. However, if this were to happen, the patient would be in considerable conflict before the homosexuality came forth, rather than optimistic and confident. And he would be anxious while the homosexual feelings were becoming conscious and after they had become conscious. He would struggle to ward them off and would not proceed calmly to master them.

I have outlined, then, two patterns which, if verified in the behavior of patients, would support our theory over the traditional theory. Hal Sampson will now tell what we have done, are doing, and will do, to verify these and similar patterns.

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Harold Sampson, Ph.D.

PART III

AN OVERVIEW OF THE CURRENT RESEARCH

I am going to describe in broad outline several of our current studies. Most of these studies are not yet completed, and I shall not emphasize findings. My purpose, rather, is to give you an overall impression of what we are doing, and of how it hangs together.

Our general method is to study by objective and replicable means those patterns of behavior in a treatment case which may provide evidence to support or to challenge the theories we are investigating. Our formal research has been carried out on three cases to date. My presentation today will cover several studies on one of these cases, which I shall refer to as the case of Mrs. C. In preparation for my exposition of the studies I shall mention the source and nature of the data, and then describe Mrs. C. briefly.

The patient was seen for psychoanalysis during the 1960's in a distant city. The analyst was highly experienced. He was not familiar with our views about the therapeutic process.

The analysis was audio-recorded in its entirety with the consent of the patient. In spite of the potential problems which may be introduced by recording, a panel of experts in that distant city concluded that the treatment fulfilled the criteria for an analytic process.

In addition to the recording, the analyst took detailed notes during each session. These notes describe the content of the hour, and include almost no commentary or clinical inference. We have compared the analyst's notes for several sessions with the corresponding verbatim transcripts. The notes are accurate. In some of our research in this case, we have worked from the analyst's notes, and then verified results with the verbatim transcripts. In other of these studies, we have worked directly from the transcripts.

The studies I shall describe are all based on the first 100 sessions of this analysis.

Now for a brief description of Mrs. C. At the beginning of treatment, Mrs. C. was a professional woman in her late 20's who had been married for about two years. Her father was a professional man, her mother a housewife. She had an older sister and a younger brother.

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Mrs. C. came to treatment with complaints of sexual frigidity, and of feelings of constriction, joylessness, and self-dissatisfaction. She felt beleaguered and in emotional turmoil in any situation--not only sexual intercourse--which called for some degree of closeness. She was often conscious of ambivalent feelings. The psychiatrist who referred her for analysis diagnosed her as suffering from obsessive-compulsive problems.

Our initial research on this case was a prediction study which is of interest in its own right, offers a partial test of theory, and provides the background for the studies to be outlined subsequently.

Let me begin with the theoretical issue in the prediction study:

We have hypothesized that warded-off mental contents--i.e., prohibited ideas, memories, fantasies, feelings--ordinarily appear during treatment when a patient decides to bring them forth, and that he will not decide to do so unless he judges he can do so safely. Therefore, if we knew that a warded-off content had at some later time become conscious, we would assume that at an earlier time some change had taken place which made if safe for the patient to experience that content. In contrast, the traditional theory assumes that a warded-off mental content can come forth without interpretation only because of the dynamic interaction of impulses and defenses; i.e., because the content has been intensified and has forced its way into consiousness.

Now let us turn to the study itself:

We asked two analysts working independently of our team to review the notes of the 100 sessions, and to specify the most important new theme, formerly warded-off, which came forth late in the series of sessions. They specified to us that the patient became generally freer and more relaxed in the latter part of the 100 sessions, and that she began to experience orgasms with pleasurable sexual feelings which she had had to ward off earlier.

We then studied the notes of the first 10 sessions with the aim of predicting just what changes would have to take place, according to our theory, for the patient to be able to tolerate these sexual feelings which earlier had been unacceptable to her. For us, this meant figuring out what changes would enable Mrs. C. to decide that it would be safe to experience these feelings. We also specified, in accord with our theory, Mrs. C.'s plan for working in therapy so as to be able to achieve this feeling of safety; and how the analyst's interventions would facilitate or hinder her efforts to carry out this plan.

We constructed the following picture of the case from our study of the first 10 hours:

Mrs. C. was very inhibited. We inferred that her immediate difficulties were caused by unconscious guilt based on omnipotent fantasies that if she asserted herself with other people she would hurt them seriously. Because of this guilt, she was in danger of submitting in a close relationship, and of allowing herself to be criticized, put down, humiliated, and dominated. In order to avoid these dangers, she had to avoid feelings of closeness, including feelings of sexual closeness and responsiveness.

We also inferred that Mrs. C. had developed an unconscious plan to reduce her fears about hurting others, and her guilt. We inferred that she would attempt

to test the analyst to see whether he was hurt when she disagreed with him, criticized him, and found fault with him. More generally, we inferred that she would work in various ways to develop the capacity to fight with others in addition to the analyst; and that when she developed this capacity, she would then feel safe enough to risk feelings of closeness, including feelings of sexual pleasure with her husband. She would feel safe enough to experience sexual pleasure with him, if she could feel able to fight back if he should attempt to exploit her guilt in order to make her submit.

Our specific prediction--based on our picture of the case, and our theory--was this:

Mrs. C. would develop the capacity to fight with others--i.e., to disagree with them, criticize them, and blame them--before she felt able to be close to them, and to tolerate the previously warded-off sexual feelings which we had been told she did come to tolerate.

Let me summarize how we tested this prediction:

Professor Leonard Horowitz of Stanford, who was at that time a member of our research group, devised a reliable procedure for identifying all instances within the notes of the first 100 hours in which the patient blamed, criticized, or disagreed with others. These instances were typed on cards, and sorted by independent judges on a scale of the explicitness and directness with which the behavior was expressed. Then, the mean rating on this scale was calculated for blocs of 10 sessions each, and a graph was prepared. It went something like this (blackboard). The graph (figure 1) shows that Mrs. C. became increasingly more direct and overt in her expressions of fighting during the 100 hours.

Professor Horowitz applied a parallel procedure to behaviors expressing closeness and cooperation. The resulting graph went something like this (blackboard). Both fighting and closeness became overt together over the 100 hours.

Professor Horowitz then examined more closely the relationship between changes in "fighting" and changes in "closeness". He found that there were instances in which fighting went up sharply in once bloc of 10 hours, and in each case, closeness went up distinctly in the next bloc of 10 hours. There were also three instances in which fighting dropped in a given bloc of hours; and in each case, closeness dropped in the subsequent bloc of hours. This suggests that changes in fighting did indeed facilitate changes in closeness, exactly as we had predicted.

The success of this prediction is of some interest in its own right. We have carried out a study in another distant city to see if other analysts, provided with the same data as we had, but operating from a differing theory, would make the same prediction as we did. Although our analysis of the data from this study is incomplete, the evidence is clear that not one of the 23 analysts made the same prediction as ours. This substudy is being carried out by a team led by Dr. Abby Wolfson.

The results of the prediction study are consistent with our expectations, but they may also be explained by certain alternative concepts of traditional psychoanalytic theory. One alternative explanation may be called the mobilization hypothesis. According to this hypothesis, fighting and closeness have both become more overt and direct because the treatment has mobilized the patient's sexual and aggressive impulses. They have become intensified outside

of the patient's control. If the mobilization hypothesis is true, then the patient should behave in an increasingly driven and compulsive way, and she should feel increasingly tense and besieged, as aggressive and sexual tendencies become more prominent in her behavior. In contrast, we assume that the patient is expressing these tendencies under her own control, and therefore she should be behaving in a less driven and compulsive way, and should feel less tense and besieged, as the two tendencies become prominent in her behavior. You may recall that the two independent analysts who identified the warded-off content as feelings of sexual pleasure did describe Mrs. C. as becoming generally more relaxed. This is our clinical impression too. A research team directed by Dr. Elizabeth Mayer is developing an objective method to determine whether this is so, and thereby help determine whether the evidence best fits our view or the mobilization hypothesis.

Let us assume for the moment that both fighting and closeness are becoming more overt, as Professor Horowitz found, and that at the same time the patient is becoming more relaxed, as we anticipate that we shall be able to demonstrate objectively. If so, is this a genuine analytic change--a change based for example on significant new insight--or is it only a change in behavior such as might result from a transient "honeymoon" at the beginning of treatment, or which might result from the therapist's reinforcing certain behaviors, such as Mrs. C.'s assertiveness.

As our first important step in addressing these questions, we sought to find out whether the patient was developing insight into the conflicts which were responsible for her difficulties. As I pointed out earlier, Mrs. C.'s inability to fight with others was based on omnipotent fantasies; she was unconsciously afraid of how much she would hurt other people. Therefore, we decided to investigate whether she was gaining insight into her conflicts about omnipotence, and about hurting others as she was becoming more overtly aggressive in her behavior.

Dr. Cynthia Johnson then devised a rating scale to assess how much insight the patient had into her conflicts about omnipotence. At a relatively low level of insight, for example, Mrs. C. was only aware of vague feelings of irrational responsibility for other people, but did not know why she felt that way. At a higher stage of insight she became aware of fears of hurting the other person; and at a still higher stage of insight she began to differentiate between thoughts and actions and to assess the realistic consequences of her actions.

Dr. Johnson's preliminary findings are that the patient develops progressively increasing insight into her conflicts about omnipotence during the first 100 sessions. These findings have not yet been verified by independent judges, but we expect verification to be successful.

Thus, Mrs. C. is both fighting more overtly, and becoming closer to others, and these changes do not seem to be due to a mobilization of her conflicts, nor do they seem explicable as merely a behavior change, for she is simultaneously gaining insight into formerly unconscious conflicts.

Now this raises another interesting question: has she gained insight into her unconscious conflict because the analyst has interpreted this conflict to her, or has she gained this insight without benefit of such interpretation? We assume, as does the traditional theory, that interpretation may help a patient to become conscious of and to gain insight into an unconscious conflict.

We differ from the traditional theory, however, in assuming that a patient may in some instances be able to make a conflict conscious and gain insight into it without benefit of interpretation, for we assume that a patient's primary unconscious motivation is to master his conflicts, and that he is able to decide to lift his defenses against an unconscious content if he considers it safe to do so, with or without interpretation.

Now let us see what did happen in this particular instance.

Drs. Isaacs and Drucker examined the verbatim transcripts of the 100 sessions, and noted every intervention made by the analyst. They found 24 interventions which directly communicated information about the patient's conflicts about omnipotence. These interventions could be scored in a way that was directly analogous to the insight scale, i.e., instead of scoring the patient's remark for stage of insight, the analyst's intervention could be scored on the same scale for the stage of insight he was communicating. For example, the following statement by Mrs. C. would be scored as stage 2 on the insight scale--"I feel responsible for my assistant's problem even though I had nothing to do with it". If the analyst made that statement to the patient--had told her that she felt responsible for her assistant's problem even though she did not see that she had anything to do with it--that would have been scored as stage 2 on the scale applied to the analyst's interventions. After this was done for all 24 interventions, we could see whether the analyst communicated to the patient information about her conflicts before or after she had expressed that level of insight into the problem. We found that the patient reached each new stage of insight into her conflicts about omnipotence before the analyst made any interpretations at that stage.

Next, we wanted to examine in a more detailed, microscopic way how specific mental contents, which are independently judged to have been previously warded-off, emerge during the course of treatment. Is it true that such contents may emerge without previous interpretation? If so, is it because of their thrust--have they pushed forth because the treatment has intensified them or revived them outside of the patient's control? If instead, as we propose, a patient exercises control over such contents and decides to bring them forth in order to master them, then we may anticipate instances in which: 1) a previously warded-off content appears in the patient's productions without benefit of prior interpretation; 2) that the patient does not show evidence of being anxious about the content, or of coming into conflict with it; 3) that he uses the content to advance the therapy--i.e., he integrates the content into his mental life and gains further control over it.

We have made this observation clinically in many cases. We believe this observation is not generally made and noted because it is incompatible with most people's intuitions, which are based on the concept that powerful warded-off thoughts and feelings push their way into awareness. Thus, if a new content appears without interpretation, and without distress or conflict, it may not be noticed by the therapist as new, or it may be judged as new but as not previously unconscious. In order to overcome this circularity, a method was devised--which has been described in a publication by Professor Leonard Horowitz and others--to identify warded-off contents independently of the context in which they emerged. The method was this: psychoanalytic clinicians read notes of early sessions, and then judged whether contents which emerged much later in the treatment were warded-off at the earlier time. This study was done on another case, that of Mr. B. Dr. Gassner is now carrying it out on the case of Mrs. C. Dr. Gassner will then investigate whether unconscious contents may emerge in the way which our theory leads us to anticipate. We believe Dr. Gassner's findings will be of considerable theoretical

interest.

These are illustrative of the kinds of studies we are undertaking in order to make objective observations which can clarify and test alternative theories about how therapy works.

Dr. Caston will now present in detail yet another of our studies of Mrs. C.

/jw

Table 1

The Rating Categories and Examples

Type D Behavior

OBSERVED D BEHAVIOR		EXAMPLE
I.	Implied blame, criticism, disagreement	(Hour 4) It is very hard for her to suddenly be stopped when I call the time. When she gets to talking, her feelings well up and it is hard for her to get them under control. She feels somewhat upset.
II.	Blame, criticism, disagreement, and then immediate undoing	(Hour 41) Next her thoughts turned to the principal at school, and the essence of this was that he wanted the kids to be reading at an earlier stage. She thinks she disagrees with him on this, but then, maybe she's wrong.
III.	Blame, criticism, disagreement of a third person	(Hour 77) On Saturday her brother's friends had a girlfriend and he wanted to stay over with them, but her mother had answered no. She said she didn't have time to make the arrangements. Patient was very upset by this; she thought her mother should have been able to do it, and it led her to raise many questions about her mother's priorities.
IV.	Direct confrontation of someone	(Hour 99) She wanted sympathy from Bill, and his response was to want to have intercourse. Then she made up her mind that she simply wasn't going to and didn't.

Table 2

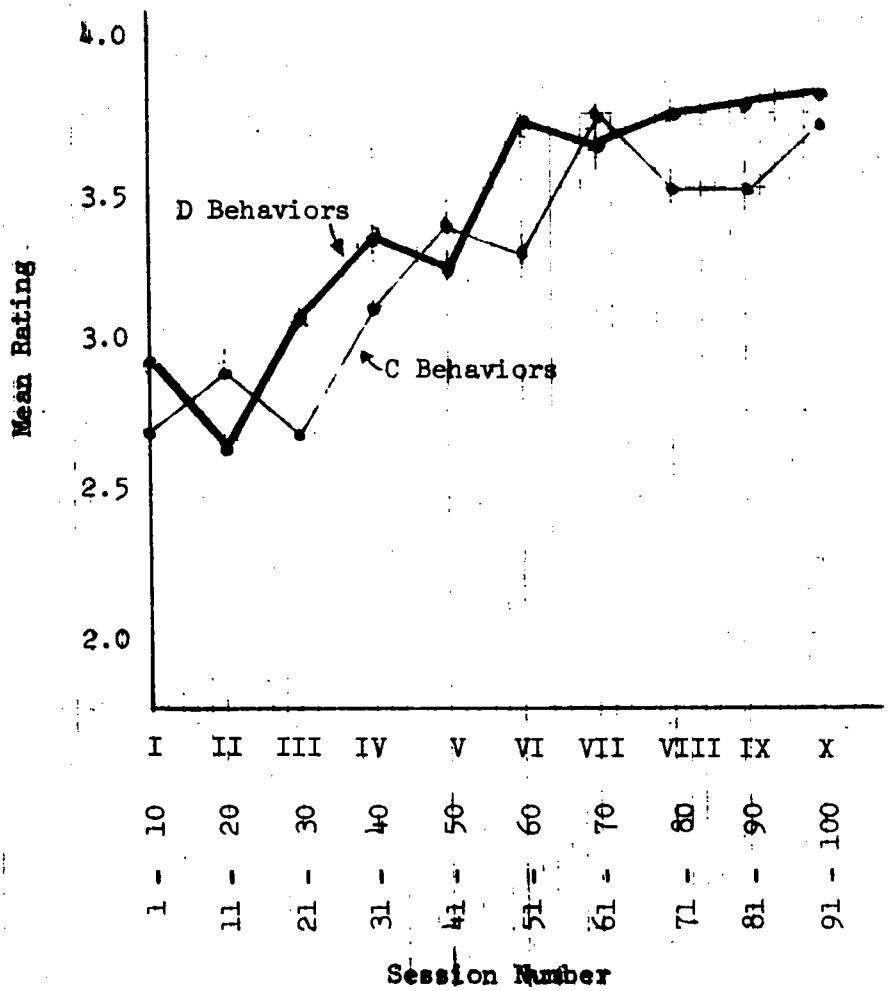
The Rating Categories and Examples

Type C Behavior

OBSERVED C BEHAVIOR	EXAMPLE
I. Implied feeling of closeness but confused, unclear, or dysphoric	(Hour 2) She was also troubled with not getting any reactions from me. No interaction. She was afraid that maybe she needed approval.
II. Feeling close or affectionate with immediate undoing	(Hour 6) She referred to a woman that she had to dinner and how nice and free this woman was and yet how she felt compelled to think of something critical.
III. Affection, admiration, or closeness told to a third person	(Hour 59) This week she felt closer to Bill than she ever has, and she said there were times when she really wanted intercourse.
IV. Direct expression of affection, admiration, or closeness	(Hour 94) When Bill came home last night she was happy that he was home and she said so.

Figure 1

Mean Rating of Passages in Each Block of Hours



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PART IV

THE IMMEDIATE EFFECTS OF ANALYTIC INTERVENTIONS

A PILOT STUDY

The immediate effects of analytic interventions on the progress of an analysis were studied in the light of a recent theory and related findings which ascribe a central role to mastery in the therapeutic process (Weiss, Sampson, et al). Clinical experience as well as quantified approaches (Horowitz, et al) indicates that the course and pace of analytic progress along a given line are not smooth, but are characterized by erratic accelerations and decelerations, despite the general "upward" trend, i.e. improvement. We may hypothesize that these short range "fits, starts, and slumps" in the therapy might be governed by 1) what is happening within the patient, e.g. based on his own newly-won integrations, he may surge forward; 2) extra-analytic events (e.g. humiliations, betrayals, achievements) which may have meanings which contribute to a powerful degree of influence; 3) and analytic interventions, including interpretations. We hypothesized that interventions which are judged as facilitative to the mastery of certain case-specific defensive behaviours (conceptualized as clinically identifiable unconscious goal and plan in the patient) will facilitate both the case-specific, and the general aspects of analytic progress, work, and elaboration.

METHOD

It became clear in the course of this work that the role of interventions could not be adequately studied apart from the immediate context in which they appear, nor could the possible effect of this context on ensuing productiveness in the analysand be ignored. The pilot study was carried out on carefully detailed process notes from the first hundred hours of an analysis conducted in a different geographic locale by an analyst blind to the theory and methods of this experiment. The model data fragment contained the 1) "target" intervention by the analyst, 2) the immediately preceding context, and 3) the immediately succeeding patient production. The "context" included the patient production immediately antecedent to the target intervention, as well as the analyst's intervention just preceding this antecedent patient production. For the purposes of this pilot, only data fragments were used which limited the size of both preceding and succeeding patient productions to a paragraph of patient speech (as reported in the process notes) and the body of each patient production uninterrupted by analyst's interventions. Fifteen data fragments were randomly obtained which fulfilled this size restriction criterion.

A correlational study was carried out, to test the hypothesis that the degree to which interventions facilitate or hinder the "unconscious plan" correlates positively with the degree to which the patient in his immediate response will boldly confront and explore non-trivial issues and make insightful connections. Thus the general, rather than case-specific, effect in the productiveness of the patients' immediate response following the target intervention was the focus of the present investigation. Separate groups of judges made their determinations blind to each other's ratings.

The Plan-Compatibility Scale. Judges rated each target intervention on a 5-point scale according to whether it hindered or facilitated the unconscious plan specific to this case. The unconscious plan had been formulated by the research group (excluding the present author) from the process notes of the first ten hours of the case. In their syllabus, judges were given a brief overview of the unconscious plan, its dynamics, and what kind of interventional behaviour by the analyst would promote or hinder it. In essence, the plan was that before the patient could master closeness and intimacy and related behaviours, she had first to master a different tendency, i.e. oppositionalness, in order to adequately manage her excessive sense of vulnerability and guilt. The judge read the context preceding the target intervention, to help establish whether at that point in time, for that patient in that frame of mind, the character and content of the target intervention made the tendency to oppose a safer or more dangerous prospect. For the average score of six judges, a reliability (Spearman-Brown prophecy) of +0.65 was established.

The Boldness-Insight Scale. Judges rated patient productions immediately succeeding each target intervention for the degree to which the patient appeared to be confronting or elaborating non-trivial material (or affect-states, attitudes, etc.), and also for the degree to which she evidenced awareness of meanings in her behaviour or reported content, or made significant connections. (See accompanying chart for these two 5-point scales, which correlate +.93 with each other.) A combined Boldness-Insight measure has a reliability of +.83 for the average ratings of four judges. For reasons to be explained, a third set of judges also used the Boldness-Insight scales to rate the (antecedent) patient production from the "context".

FINDINGS

Plan-compatibility of the target interventions correlated significantly with the general Boldness-Insightfulness measure of the patient's responses immediately following the intervention ($r=+.484$, $p<.05$, accounting for 23% of the variance). Thus, the main hypothesis was borne out, but it was essential to know whether the context prior to the intervention, i.e. the "baseline" degree of the patient's boldness and insightfulness prior to the intervention, also contributed an effect. Boldness-Insightfulness of the context (antecedent patient's production) and the Boldness-Insightfulness of the succeeding patient production correlated significantly at +0.504, $p<.05$, accounting for 25% of the variance. Was this due to a confounding or halo effect relating to the fact that judges rating the interventions had had available the context as an aid to their determinations?

Plan-compatibility of the interventions was correlated against the Boldness-Insightfulness of the context, i.e. the antecedent patient statement,

and an $r = -0.07$ was obtained, i.e. a virtually zero correlation, signifying independent effects of these two antecedent variables on the patient's immediate response.

IMPLICATIONS

These pilot findings suggest that at least two independent factors converge to produce the effect on the patient's immediate progressive activity in the therapy: where the patient starts from, i.e. the baseline state with regard to bold and insightful activity, and to what degree the analyst's intervention maintains a facilitative posture toward the patient's unconscious plan. Together they appear to account for half the variance in this prediction. Does delivery of cognitive enlightenment by interventions account for the rest of the variance? Does insight delivery operate as an independent factor or only in interaction with context and plan-compatibility variables?

These and future researches promise to bring order and systematization to such issues as therapeutic tact, timing and dose of interpretations.

"BOLDNESS" SCALE

1	2	3	4	5
Patient manifests clearcut anxious retreat or inhibition, or clearcut dissatisfaction about her handling of the material	Patient manifests a mild to moderate degree of anxious retreat or inhibition, or shows some indication of dissatisfaction about her own handling of the material	Patient manifests ambiguous trends, or lukewarm attempts to deal with the issues	Patient manifests moderate boldness or interest in tackling the material	Patient manifests a bold or interested tackling of issues, or plunges ahead even if material is painful or distressing

"INSIGHT" SCALE

1	2	3	4	5
Patient manifests no or minimal awareness of the meanings in her behaviour or reported content	Patient manifests some slight recognition of the meaning regarding behaviour and reported content	Connections made regarding behaviour or content but mediocre in quality and apparent significance	Connections of good quality and significance made regarding behaviour or reported content	Excellent insights, highly significant connections made regarding behaviour or reported content