

FURTHER RESEARCH ON THE PSYCHOANALYTIC PROCESS*

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INTRODUCTION: THE THEORETICAL BACKGROUND OF THE RESEARCH

Joseph Weiss, M.D.

Our research group is very pleased with the opportunity to present our research to this distinguished forum. It is, we believe, appropriate that we present it here, since, as will be seen, it supports a cognitive psychoanalytic theory such as George S. Klein was developing.

I would like to mention two San Francisco colleagues who have been especially helpful to us. The first is Dr. Emanuel Windholz, who both inspired us with his ideas about the application of ego psychology to the understanding of the therapeutic process and encouraged us to do research as a group. The second is Dr. Robert Wallerstein, who, by his own example, has strongly contributed to an atmosphere conducive to empirical study, and who, in addition, has been a valued consultant.

We plan today to present a number of different but closely related research projects. They are all concerned with processes which are central to the psychoanalytic theory of therapy, and which are frequently observed by the analyst in his daily work.

For example, our research is about such processes as the acquisition of insight, the formation of the transference neurosis, and the analytic patient's reactions to the frustrations in the transference, of those impulses which the patient is pulling unconsciously for the analyst to gratify.

Some of our findings may be surprising. For example, we found that a woman patient, during the first 100 sessions of her analysis, acquired considerable insight, on her own--that is, without analytic interpretation. During these sessions she gained more and more insight into her unconscious belief in her omnipotence and into other mental contents which at the beginning of her analysis she had been warding off, and she applied this insight constructively to the understanding of her difficulties. Moreover, while acquiring this insight, she became more direct in disagreeing both with the analyst and others, and also in expressing love. Indeed, she became able for the first time in her life to have orgasms during intercourse. In addition, she did not, during these 100 sessions, become more tense than at the beginning. She maintained approximately the same degree of tension that she had at first. Moreover, she became, according to our measures, considerably less driven; that is, she became considerably more in control and less obsessive.

In another study we found that when this same patient pulled for the analyst to satisfy certain of her infantile impulses and the analyst did not do so, she became, not more tense, but more relaxed.

In still another study, which was of a man with a severe obsessive compulsive neurosis, we found that he was, according to our measures, somewhat more relaxed at the height of the transference neurosis than he had been during the first 100 sessions of his analysis.

In order to indicate how these and other findings may bear on psychoanalytic theory, I shall now present a broad view of psychoanalytic theory, in particular the psychoanalytic theory of unconscious mental functioning. I shall approach this presentation historically.

The most profound changes in psychoanalytic concepts about unconscious mental functioning occurred with the development of ego psychology. Indeed, with ego psychology psychoanalysis acquired a number of new ideas about the nature of unconscious functioning.

Let us look broadly at the theory of unconscious mental functioning which Freud developed before ego psychology and which he presented in the Interpretation of Dreams, the Papers on Technique, and the Papers on Metapsychology. Then let us examine the new ideas which, with ego psychology, Freud added to his earlier conceptions of unconscious mental functioning.

The theory of unconscious mental functioning which was developed before ego psychology and which may be called the traditional theory is based, more or less, on what may be called the automatic functioning paradigm. Freud, in developing this paradigm, was inspired by the example of physics. Physicists had conceived of the material world as a vast machine which runs automatically. Moreover, they had, by starting with a few simple assumptions about the material elements and the laws governing their behaviors and interactions, derived many of the phenomena of the physical world.

Freud, in following the example of physics, conceived of the mind as a machine which runs automatically. Freud hoped that, by beginning with a few simple assumptions about the basic psychic elements and the laws governing their behaviors and interactions, he could derive many of the phenomena of the mental world. And, of course, as we all know, he was quite successful in his endeavor.

The basic elements which Freud postulated are psychic forces. The law which he assumed automatically governs their behaviors and interactions is the pleasure principle. According to this principle, psychic forces are always seeking discharge. Moreover, they are, in their interactions, dynamic; that is, they are additive much as are certain forces in the physical world.

In the traditional theory the major unconscious motives are impulses. These are shaped from instinct by infantile gratifications, and they continue after early childhood automatically to seek the gratifications they found then. Moreover, they seek immediate gratification, as opposed to such gratification as may be attained by the realization of long-term goals.

What new ideas, then, did Freud, by his ego psychology, add to these traditional views?

In Beyond the Pleasure Principle Freud modified the traditional theory by limiting the sway of the pleasure principle and by introducing an unconscious motivation which is not aimed at the direct and immediate attainment of pleasure. He pointed out that a person may unconsciously try to repeat not only pleasurable infantile experiences but infantile, or even

adult, experiences which are painful and traumatic. Freud offered various explanations for a person's unconsciously repeating traumatic experiences, including the idea that he may, in doing so, be motivated unconsciously by the wish to master these experiences.

Then in The Ego and the Id, Freud modified the idea of unconscious automatic functioning. He stated that much of the ego may be unconscious and so implied that a number of processes which are not automatic and which earlier were thought to take place consciously, but not unconsciously, may also take place unconsciously. For example, Freud stated explicitly in The Ego and the Id that the ego may exert control unconsciously, in that it may unconsciously regulate its various parts.

Freud also in The Ego and the Id modified the earlier idea that impulses seek immediate gratification. He suggested that a person may, by unconscious identifications, develop long-term unconscious goals. A person, Freud suggested, may, by identifying unconsciously with a lost love object, develop the wish unconsciously to attain certain attributes, positions, or abilities such as those which the lost love object had attained. Thus he may develop unconscious goals which he may reach only over a considerable period of time.

Freud in The Ego and the Id further changed the traditional view of unconscious motivation by indicating that a considerable part of the unconscious mind is taken up by the superego, and thus that a person may unconsciously do things which are opposed to the attainment of infantile gratifications. Indeed, a person may unconsciously even carry out certain acts of self-punishment.

In Inhibitions, Symptoms and Anxiety Freud modified even further his old idea that unconscious functioning is automatic. He stated explicitly that a person may think unconsciously much as he thinks consciously. A person, Freud stated, may think unconsciously about an emerging impulse, anticipate that his expressing it would be dangerous, and then bring about its repression. The person, moreover, in anticipating that his expressing a particular unconscious impulse would be dangerous, may be guided by certain unconscious ideas. For example, a person who anticipates that his expressing his sexuality would be dangerous, may be guided by the unconscious theory that were he to express it, he would be castrated.

From the above, it is evident that in Inhibitions, Symptoms and Anxiety Freud postulated an important capacity unconsciously to exert control; namely, the capacity unconsciously to bring about repression. Moreover, he pointed to the importance of a person's unconscious beliefs or theories--as, for example, a person's unconscious theory, that if he expressed his sexuality he would be castrated. By indicating that a person may be guided by unconscious beliefs, Freud laid the foundation for a cognitive view of unconscious behavior.

I shall briefly repeat some of the ideas which ego psychology added to the traditional concepts of unconscious motivations:

Ego psychology suggested a new unconscious motive--the unconscious wish for mastery. It pointed to the importance of unconscious guilt and the unconscious need for punishment. It pointed to the importance of unconscious identifications and, with these, unconscious long-term goals. It indicated

the capacity for unconscious thinking and anticipation. It indicated the capacity unconsciously to exert control. Indeed, it indicated the capacity to exert control unconsciously in accordance with unconscious thoughts, anticipations, theories, and ideas. Finally, it indicated that a person's unconscious ideas may be, not only pleasant fantasies which he would wish to retain, but unpleasant ideas, such as the idea that he would be castrated, which presumably he would wish to change.

According to the new ideas of ego psychology, a person may do many of the same kinds of things unconsciously that he may do consciously. He may, in contrast to the concepts of the traditional theory, seek long-term goals, be guided by unconscious beliefs or theories, and make use unconsciously of his higher mental functions in the regulation of behavior. While the traditional theory may be said to be based on the automatic functioning paradigm, ego psychology may be said to have added, or at least pointed to, a higher mental functioning paradigm.

The higher mental functioning paradigm which Freud began to develop in his ego psychology has, of course, been carried further by other analysts. I shall mention merely a few examples:

The idea that the ego may exert control unconsciously and for its own purposes has been developed by Kris in his discussion of regression in the service of the ego, in, say, the production of art. It has been developed, too, by Kris, in his idea that the ego plays a major role unconsciously in the recovery of memories which it brings forth, not mainly for gratification, but in order to extend its mastery over unconscious mental life.

The higher mental functioning paradigm has been developed by Rangell in a series of papers on the decision-making function of the ego. He has elaborated on Freud's ideas about the capacity of the ego unconsciously to think, anticipate, and in various ways make use of its higher mental functions in the regulation of behavior.

The higher mental functioning paradigm has been developed by Sandler. He has extended Freud's idea that a person may unconsciously bring about the repression of an impulse which he unconsciously assumes would endanger him, by adding that a person may unconsciously lift the repression of an impulse which he unconsciously anticipates he may safely experience.

The higher mental functioning paradigm has been elaborated by Lowenstein who has developed a suggestion of Freud's that a person may do analytic work unconsciously. Lowenstein has suggested that a person may work unconsciously by using the analyst as an autonomous auxiliary ego, which, of course, a person could do only by making use unconsciously of his higher mental functions.

The idea that a patient may do unconscious work has also been developed by Rangell, who has offered another way by which a person may do such work; namely, by unconsciously testing the analyst.

Finally, the higher mental functioning paradigm has been developed by George S. Klein, who has evolved the cognitive position which Freud implied in his discussion of castration anxiety. For Freud's discussion of castration anxiety, as I have already pointed out, implies that a person may unconsciously regulate his behavior in accordance with a belief or a theory.

The concepts of ego psychology and the higher mental functioning paradigm upon which they are based have affected the thinking and practice of different analysts in different ways.

Some analysts have rejected the new ideas, both in theory and in practice. A good example is Waelder, who believes that ideas about unconscious thinking and anticipating are teleological and hence unscientific. Other analysts reject concepts about unconscious thinking and anticipating on the related grounds that these concepts are unscientific in that they imply a homunculus. Analysts who, on such grounds believe it unscientific to assume unconscious thinking and anticipating, are upholding the premises of the traditional theory. According to these premises, unconscious forces are the basic psychic elements; that is, they are the basic determiners of behavior, whereas thoughts and anticipations are epiphenomena derived from these forces and thus are not independent factors in the determination of behavior. The idea that decisions are epiphenomena was suggested in a traditional formulation. This formulation is that the ego is to the id like a weak rider, who believes that he is guiding his horse but is in fact simply going where his horse is taking him.

The traditional view that unconscious forces, as opposed to ideas and decisions, are the true determiners of behavior is, in our view, arbitrary. Gallanter, Miller, and Pribriam have argued that all psychological processes, whether simple or complex, conscious or unconscious, are necessarily based on plans and hence on decisions. Indeed, a theory in which decisions are a fundamental determinant of behavior is no less scientific than one in which forces are fundamental.

While some analysts reject ego psychology both in theory and in practice, others, though accepting it in theory, continue in their work to think of the patient's unconscious behavior as regulated automatically by the pleasure principle. Another group of analysts, while rejecting the ideas of ego psychology in theory, use them implicitly in their clinical discussions.

Some analysts consider the two paradigms completely compatible. Rappaport, for example, has devised a model which includes automatic functioning at the lower levels of the mental hierarchy and higher mental functioning in the superficial layers. Other analysts, including George S. Klein, question the compatibility of the two paradigms. Yet most analysts, including those who are uncertain of the compatibility of the two paradigms, accept both sets of ideas, and apply both in theory and in practice. Freud, of course, used both sets in his own thinking. To use both sets offers flexibility, and it avoids premature closure and systematization in a young and developing field.

Indeed, even if the two paradigms do not, at our present level of theorizing, seem completely compatible, their dual use may, nonetheless, be justified. For, from some higher level of conceptual synthesis which we have not yet attained, the unconscious mind may be basically both a decision-making apparatus and an apparatus which functions automatically in accordance with the pleasure principle.

I am reminded of Winston Churchill's resolution of the problem of free-will versus determinism, which he described in his book My Early Years. He resolved it by an analogy with a feather which looks purple when viewed from one direction and green when viewed from another.

The various groups of analysts, to which I have just referred, may perhaps be placed along a spectrum. At one end are analysts who rely mainly on ideas based on unconscious automatic functioning; in the middle are a majority of analysts, who make use of ideas which imply both automatic functioning and regulation by higher mental processes; and, at the other end are a few analysts who, in their thinking and in their work, rely mainly on concepts implying regulation by higher mental functions. We may call the set of hypotheses used by the first group "A"; those used by the second group, "A-B"; and those used by the third group, "B".

In our view each set is conceivable. Moreover, we believe that the question, "Which set is superior?", is ultimately an empirical question and thus one which may be tested informally in clinical work and, in addition, by formal research techniques. It is to test these three sets of hypotheses that we developed and carried out our research.

The testing of the sets of hypotheses A, A-B, and B has been a difficult process. Each set of hypotheses is very powerful and can account for a great deal of clinical phenomena. Indeed, it was a difficult task for us merely to figure out which findings one set of hypotheses could explain more simply, directly, and convincingly than the others. In determining the kinds of data which would support one set of hypotheses over another, one must reason from theory and, in doing so, indicate the relationship of the findings to the theory. Indeed, in a field as complex theoretically as psychoanalysis, the way a group of findings bears on theory is not necessarily immediately evident.

I would like, before illustrating the relations between findings and theory, to indicate the theoretical preferences of our group. It is for the B hypotheses. In our thinking about the therapeutic process, we make considerable use of concepts which imply unconscious regulation by higher mental functions, and little use of concepts which imply automatic regulation. Thus we subscribe to the belief, that in order to understand the therapeutic process, one must assume that the analytic patient thinks and anticipates unconsciously, and that he regulates much of his behavior unconsciously in accordance with thoughts and anticipations based on unconscious beliefs.

Various analysts have come, in different ways, to recognize that unconscious behavior may be regulated, unconsciously, by thoughts and anticipations. I shall briefly indicate how I became convinced of the unconscious regulation of behavior, because, in doing so, I hope to stimulate your intuitions about such regulation.

My interest in the question of unconscious control by higher mental functions was stimulated by the phenomenon of crying at the happy ending, a typical example of which is as follows:

A person who was watching a movie about a love story experienced little or no emotion when the lovers quarreled and left each other. He was deeply moved, however, when, at the happy ending, they resolved their difficulties. He became happy and, while remaining so, experienced a brief but not unpleasant sense of sadness and, for a moment, wept.

I explained the moviegoer's paradoxical behavior by assuming that he had become sad, before the happy ending, when the lovers had quarreled and left each other. However, he had felt endangered by his sadness then; and so repressed it. Later, at the happy ending, when the lovers had resolved their difficulties, he stopped being endangered by the sadness and so could safely experience it. Since he no longer needed to repress it, he lifted the repressions opposed to its emergence and brought it forth. He did not make it conscious primarily for gratification. Indeed, since the experience of sadness is not, in itself, pleasurable, the coming forth of sadness is a process of the kind which induced Freud (in Beyond the Pleasure Principle) to modify his earlier view of the omnipotence of the pleasure principle in unconscious mental life. The moviegoer, then, made the sadness conscious, not to gratify it, but to resolve his conflict with it and thus to master it and to gain relief from the effort he had been making to keep it repressed.

In my explanation of the moviegoer's weeping, I leaned heavily on two of Freud's theories; namely, his theory of wit as presented in Wit and the Unconscious (1905) and his theory of repression as developed in Inhibitions, Symptoms and Anxiety (1927).

From Freud's explanation of the everyday phenomenon of laughing at a witicism, I adapted the general outline of my explanation of the moviegoer's weeping at a happy ending. I took from Freud's explanation the idea that a person may, as part of an everyday experience, become conscious of a mental content which previously had been repressed. I modified Freud's explanation, however, to include the idea of unconscious control by the ego: I assumed that the moviegoer's repression gave way, not because it was lifted automatically, but because the moviegoer lifted it. I assumed that the moviegoer unconsciously anticipated that since the lovers had resolved their quarrel, he would not be threatened by his sadness about it (which being repressed had not yet been dissipated) and so decided to make his sadness conscious.

In my assumption that the moviegoer unconsciously controlled the lifting of the repression, I relied on the theory of repression which Freud introduced in Inhibitions, Symptoms and Anxiety. I simply extended Freud's theory of repression, as does Sandler, to assume that if a person may bring about the repression of an affect or impulse which he unconsciously decides is dangerous, he may permit the emergence of an affect or impulse which he unconsciously decides he may safely experience.

The phenomenon of crying at the happy ending was for me a vivid and concrete illustration of the pertinence, to the understanding of behavior, of certain concepts in ego psychology.

The differences between the traditional theory (hypotheses A) and the theory which I used to explain crying at the happy ending (hypotheses A-B or B) were brought home to me by the realization that the A hypotheses--that is, the hypotheses of the traditional theory--cannot offer a convincing explanation of crying at the happy ending. The traditional theory does not endow a person with the capacity to lift his repressions and so must explain the emergence of the repressed sadness by assuming that it comes forth by breaking through the defenses opposed to its emergence. It may break through only if it is intensified relative to the defenses; either the sadness

becomes stronger or the defenses weaker. Yet the traditional theory is unable convincingly to explain either a weakening of the defenses or an intensification of the sadness. Nor can it explain why one or both of these things should take place just at the moment the moviegoer becomes happy.

Moreover, if the traditional theory were able to explain the coming forth of the sadness as a result of a breakthrough, its explanation would still not fit the moviegoer's experience. For were the sadness to emerge by breaking through the repressions opposed to its emergence, it should, before, during, or even after its emergence, be in conflict with these repressions. The moviegoer should feel tense or anxious before and during the coming forth of the sadness, and he should, after it comes forth, become conscious of his conflict with it. Yet the moviegoer is at no time either anxious about his sadness or in conflict with it.

The traditional theory could attempt to explain the moviegoer's sadness in another way, which also is unconvincing. It could attempt to account for it by assuming that the moviegoer becomes so guilty unconsciously about his happiness that he becomes sad in order to undo it. This explanation, however, is unsatisfactory because it does not draw a connection between the sadness at the happy ending and the sadness which the moviegoer is tempted to feel earlier; nor does it account for the fact that the moviegoer, at the happy ending, is neither guilty nor depressed.

The crying at the happy ending phenomenon suggested a hypothesis about the analytic patient which I tested by studying process notes. It is that the analytic patient, like the moviegoer, may wait until he is able safely to bring forth a mental content which he has kept repressed, then bring it forth in order to master it.

For example, a certain analytic patient became aware of a sexual fantasy of being beaten by the analyst only after she had assured herself that she comfortably could say "no" to him. She had been afraid earlier to bring this fantasy to consciousness, for fear that, in experiencing it, she would act on it. That is, she had been afraid that she would submit to the analyst and be dominated by him. She could not trust the analyst not to dominate her, nor could she trust her capacity to extricate herself from his domination. However, after she had become able comfortably to disagree with the analyst, she calmly, without anxiety, and unaided by interpretation, brought her beating fantasy to consciousness.

I shall close this discussion with an example of our research which illustrates how our findings bear on theory, and indeed support either hypotheses A-B or B, over hypotheses A. My argument, as will be seen, follows the argument I gave for the superiority either of the A-B or the B hypotheses in explaining crying at the happy ending.

My example, which will be presented very briefly now, will be taken up in some detail later this morning. It is about the behavior of the analytic patient who acquired considerable insight, on her own, during the first 100 sessions of her analysis. During these sessions, the patient, as you may recall, did the following things:

She gained more and more insight into her unconscious belief in her omnipotence and into certain previously ward-off impulses, affects, and

ideas. She used these insights constructively. She became more direct in her expressions of aggression and of love, and became for the first time orgasmic. She did these things without benefit of interpretation, and while doing them, she became no more anxious than earlier, and indeed more in control of herself than she had been. Finally, while bringing unconscious mental contents to consciousness, the patient was not constricted, but experienced things more vividly and with more insight than usual.

The automatic functioning paradigm of the traditional theory (hypotheses A) is not able, simply and directly, to explain these findings. It assumes that a person is unable to lift his defenses, and thus that if unconscious mental contents come forth without their being interpreted, they have done so in one of the two following ways: They have emerged because they have exerted pressure to consciousness and so broken through the patient's defenses; or they have emerged because they have exerted such pressure, and so came forth as part of compromise formations.

If the contents emerged by breaking through the patient's defenses, the patient should have felt anxious about them and less in control of herself. If they emerged as part of compromise formations, they emerged while being defended against. Therefore, the patient may not have felt anxious about them; however, she should not, while bringing them forth, have been unconstricted, and she should not have experienced things more vividly than usual. Nor should she have used them constructively to advance the cause of her therapy.

The higher mental functioning paradigm (hypotheses A-B or B), however, does explain these findings simply and directly. It assumes that, as Sandler has argued, a patient may keep unconscious mental contents warded-off until he unconsciously decides that he may safely experience them. Then he may lift his defenses and bring them forth. According to hypotheses A-B or B, our patient waited until she was not anxious about the contents which she had warded-off and brought them forth. Since she had overcome her anxiety before bringing them forth, she could keep them in consciousness without anxiety, and use them to advance the cause of her therapy. She could experience things vividly. Moreover, she could, while bringing the contents forth, feel more in control of herself than previously.

According to my argument then, either hypotheses A-B or B explains our data better than hypotheses A. Moreover, hypotheses B explains our data as well as hypotheses A-B, for in my explanation of the data I did not rely on any of the A hypotheses.

TESTING THE HYPOTHESES

Hal Sampson, Ph.D.

As a preface to Dr. Gassner's presentation, I should like to take up certain broad considerations in testing the explanatory power of the higher mental processes hypotheses which Dr. Weiss has described.

I should like to distinguish between two somewhat different questions we have posed in testing the higher mental processes hypotheses:

- (1) The first is: Do these hypotheses predict correctly how things hang together in nature? That is, do these hypotheses specify comprehensive, orderly relationships which may be observed repeatedly in nature? If so, the hypotheses are powerful in their own right, whatever their exact relationship to other psychoanalytic hypotheses. And regardless, I might add, of whether or not they are already familiar hypotheses or are novel, or for that matter, plausible seeming or implausible.
- (2) The second question is: Do these hypotheses predict different observations in some specifiable situation(s) than would be predicted in the same situation(s) by other psychoanalytic hypotheses? If so, we can be assured that the hypotheses are truly different from each other, and not simply two equivalent ways of looking at the same phenomenon, or two versions of the same idea in different language. Moreover, if one set of hypotheses fits the data better than the other, we have learned something about the relative merits of the competing sets of hypotheses.

This second question poses especially difficult conceptual problems for research. These problems are inherent in the state of the field. A key difficulty was mentioned earlier by Dr. Weiss. In order to compare competing sets of hypotheses, we have to reason closely from theory to observation, and to discover where two theories may imply different observations. There are relatively few precedents in our field for doing this,* and naturally there is no pre-existing consensus in our field about what observations are implied by the three sets of hypotheses (A, B, and A-B) described by Dr. Weiss. It is for this very reason that we are going to such lengths today to begin our research presentations by spelling out for you the logic by which we have related differing sets of hypotheses to observations.

*One precedent is that of Freud in the opening sections of Beyond the Pleasure Principle. In these sections he goes back and forth between theories and observations, arguing that certain observations pose difficulties for his own earlier theory, which had accounted for certain repetitions in dreams, play, and the transference in terms of the pleasure principle.

Our general approach in testing competing hypotheses is to specify the different patterns of observations which should occur in a given type of situation if one or another hypothesis is true. We then attempt to determine by reliable, objective procedures which pattern of observation does obtain in that situation. Sometimes--as you will hear this afternoon--a natural experiment offers some sharp contrast between hypotheses.

However, it is often true that any one observation, or even a pattern of observations, may be explained fairly well by alternative sets of hypotheses. For this reason, we have found it useful to test out alternative explanations against a whole network of findings. This enables us to eliminate many plausible but merely ad hoc explanations, as well as to study closely whether one or another of the broad sets of hypotheses described by Dr. Weiss affords a better explanation for the whole network of findings. Dr. Gassner's presentation will illustrate this approach.

In addition, Dr. Gassner's presentation will give some detail on what changes took place in the patient studied during the first 100 hours of her analysis. This afternoon's research presentation, by Dr. Caston, will cast some light on how these changes took place.

RESEARCH DESCRIBING THE THERAPEUTIC PROCESS
DURING THE FIRST 100 TREATMENT HOURS

Suzanne Gassner, Ph.D.

The purpose of this presentation is to lay out in greater detail the findings which Dr. Weiss summarized in his opening statement and to describe to you the methods by which these findings were obtained. These findings are:

- (1) That the patient becomes conscious of previously unconscious ideas often without conflict, and keeps these ideas in consciousness, experiencing them emotionally, and integrating them within her personality.
- (2) That she develops insights, especially into previously unconscious omnipotent ideas; that is, ideas that she can magically harm others by her thoughts or actions.
- (3) That she becomes more direct in her expression of aggression and love, and develops an increased ability to experience sexual pleasure.
- (4) That all of the above-mentioned changes take place largely without interpretation.
- (5) And that while these changes are taking place, the patient is becoming less driven, and more in control.

As Dr. Weiss has pointed out, this network of findings is most easily explained by a theory in which patients keep mental contents warded off until they unconsciously decide that they may safely be experienced, and then, when they experience it as safe to do so, they may lift their defenses and bring them forth. Since patients may wait until they are no longer endangered by a particular content before bringing it forth, warded-off contents may emerge without anxiety, and then be kept in consciousness without anxiety, experienced vividly, and used progressively. Moreover, patients may, while bringing forth warded-off contents, feel more, rather than less, in control of themselves.

I do not wish to focus further on the theoretical issues at this point, but rather to summarize for you the major methods and findings.

I shall begin with a brief description of the case:

The patient, whom we shall refer to as Mrs. C., was successfully analyzed during the 1960's. Mrs. C. was a professional woman in her late twenties who had been married for several years at the time that she entered analysis. She was the second of four children, with a sister two years older, a sister three years younger, and a brother six years younger. She came from a very conservative Protestant New England family. Her mother was a social worker during the

patient's childhood, who later devoted herself to civic causes. Her father, like her husband, is a successful business man. The patient grew up in a comfortable suburb, attended public schools through high school, and then went to a fashionable woman's college. She earned a master's degree in teaching from a prominent Eastern university and had been employed for several years at a private elementary school, at the time that she sought treatment.

During the intake interviews,* the patient stated that she sought help primarily because her husband, who had been in analysis for two years, had strongly urged her to do so, and her husband's analyst had supported the idea.

Her major presenting problem was her inability to enjoy and reluctance to have sexual relations with her husband. In addition, the patient described a fear of simply being a non-entity, of existing as a maid to her husband, and of not occupying an equal position in the relationship. She also complained of feeling chronically tense, self-critical, overly anxious, and unable to relax and interact comfortably with other people. At work she felt driven by a strong sense of obligation and duty. She also felt more distant from co-workers than she thought she should be.

In attempting to explain her sexual inhibitions to the in-take worker, she mentioned that her family was controlled, unemotional, and unaffectionate. Mrs. C. felt she had deeply internalized her father's disapproval of sensuality. She characterized him as a stern, ascetic tyrant who rarely showed her any physical affection, but who often punished her in violent outbursts of emotion.

The patient described herself to be much like her mother--efficient, overly organized, and afraid to show emotion. Like her mother, she felt unable to relax and enjoy herself. The patient expressed long-standing resentment toward her mother for not having protected her from her father's rage.

The patient remembered an incident from her childhood where her older sister hit her in the stomach. She protested to her then pregnant mother, who seemed uninterested. The patient reacted by punching her mother in the stomach even harder than her sister had hit her. Her mother, in a typical fashion, made no effort to defend herself or to discipline the patient. Doubled over in pain, she simply went to her room to lie down. When her father came home, he had one of his characteristic temper outbursts. He beat the patient severely, making her feel that he might even want to kill her, and threw her into a closet and shut the door.

*Jerry Lenzer summarized all the intake material, and some parts of this case presentation are taken from his summary.

The patient believed her fear of sexual intercourse largely stemmed from an incident that occurred when she was nine years old. She had been playing with her brother and accidentally fell on a long stick, sustaining an injury to her genital area which necessitated stitches in the perineum. Many years later, during her first mother-daughter talk about sexuality, her mother warned her that, in addition to the danger of pregnancy, intercourse might be particularly painful because of the injury. Her mother told her that she might have been stitched up too tightly, and therefore an operation might be required before she could have intercourse. Although during the pre-marital examination the doctor assured her that this was not the case, the patient thought the effects of the injury were a major factor behind her fear of intercourse.

Mrs. C.'s childhood and adolescence were generally characterized as lonely years. Between the ages of five and eight, the patient knew that she had recurrent nightmares of something happening to her mother. Throughout her childhood she went to a friend's mother to confide problems and receive affection. An early childhood memory of the patient was of using a wooden object in her play which represented a penis. Throughout childhood she wished she had a penis. During high school the patient had one close female friend, but on the whole she considered her dates and friends to be uninteresting and inferior compared to those of her older sister. The patient always felt like an outsider to her family, and currently lives some distance from the rest of her family.

Mrs. C. had been diagnosed by the psychiatrist who referred her for analysis as a neurotic woman who was suffering from obsessive-compulsive difficulties.

A highly experienced analyst treated Mrs. C. He was located in a distant city, and had no knowledge of our research group's hypotheses at the time that he conducted the analysis. With the consent of the patient, the entire analysis was tape-recorded for research purposes. In addition, the analyst wrote detailed process notes during the sessions. The first 100 hours of the analysis have been transcribed, and these studies, to be presented this morning, made use of both the verbatim transcripts and the process notes from this same period.

Two training analysts who were working independently from our research group agreed to read the first 100 hours of the process notes and to describe their observations. These analysts were not informed about our group's hypotheses. They concluded that there was clinical evidence of true improvement taking place during this period of treatment. They observed that Mrs. C. became considerably more relaxed, acquired an increased ability to enjoy her work and be effective at it, that she came to enjoy sex more, and was generally happier in her marriage. They also felt that she was bringing out important material on her own.

I am now going to summarize the five research findings to which I referred at the beginning of this presentation. The studies which I am going to describe were conducted by various members of our research group, many of whom are here

today. During our discussion period they will be available to answer those questions you have concerning the details of our research methods and findings.

The first set of studies I am going to describe investigated how well the automatic functioning paradigm and the higher mental functioning paradigm could each account for observations about how warded-off contents emerged in the course of the first 100 hours of Mrs. C.'s psychoanalysis. In Freud's original formulations, warded-off contents emerge in two general ways: They can become conscious through the assistance provided by the analyst's interpretations; or by breaking through to consciousness due to some increase in their strength relative to the strength of the defenses against them. In the latter case, if there is little or no disguise, the patient will be in conflict with the emerging ideas, and will attempt to invoke additional defenses to eliminate the conflict. If the emerging ideas are successfully defended against, the patient will not experience conflict. But in these instances the patient should not be able to put them to constructive use. The combination of observations about the emergence of warded-off contents that would be unanticipated, based on Freud's original formulations, would be that a patient is able first, to bring forth previously warded-off contents without benefit of interpretations from the therapist; second, report these contents without experiencing anxiety, coming into conflict with them, or trying to ward them off; and third, maintain conscious control over these contents.

In order to study the conditions under which warded-off contents emerge in analysis, we needed a method for identifying them, that would not make use of clues about whether their emergence was accompanied by conflict, and yet would meet the psychoanalytic criteria that the contents had been previously unacceptable to the patient and consequently warded-off by defenses.

A novel method for identifying previously warded-off contents was first devised by Professor Leonard Horowitz of Stanford University,* and I applied a modified version of this method to the case of Mrs. C. The major procedural steps in the present study were as follows:

All new ideas that emerged in hours 41-100 which were not expressed during hours 41-100 were identified. Two judges worked with the process notes of the first 100 hours to make this determination. Over 500 such statements were identified and these statements were organized according to their thematic contents. One hundred statements were randomly selected, with the constraint that the thematic contents of these statements were in direct proportion to the total number of statements found in each thematic category.

The 100 selected statements, as well as the process notes of the first 10 treatment hours, were presented to 19 judges who were highly experienced clinicians. Their instructions read: "These statements come from hours 41-100; they appeared for the first time during those hours. Please read each statement. We want to know whether you think that the content had been warded-off earlier. Use your clinical intuition to make this judgment, applying whatever criteria would lead you to call a content warded-off. As one possible criterion, you might want to ask whether that content would have been acceptable to the patient during the first 10 hours of treatment. Other criteria may also occur to you. Feel free to apply whatever criteria seem pertinent."

*Horowitz, L. M.; Sampson, H.; Siegelman, E. Y.; Wolfson, A. W.; and Weiss, Jos. On the identification of warded-off mental contents. J. Abnormal Psychology, 1975, 84: 545-558.

Judges were asked to rate the 100 statements on a five-point scale that indicated the degree of confidence that they had that a content had been previously ward-off. A rating of "5" indicated a strong belief that a content had been previously ward-off; a rating of "1" indicated a strong belief that the content had not been previously ward-off.

The split-half reliability coefficient for the 100 statements studied was calculated by correlating the mean values of one randomly selected group of 9 judges' ratings with those of another group of 10 judges: The reliability coefficient was found to be .90. This analysis demonstrated that clinicians showed considerable agreement about which statements had been previously ward-off.

Thirteen of the 100 statements received a mean scale value of "4" or higher, and these statements comprise the items which we refer to as the Highly Warded-Off (HWO) statements. We conducted an additional study of the judges' ratings and obtained further evidence of the validity of their ratings. This procedure enabled us to identify 13 previously ward-off contents which had not been selected on the basis of any particular psychoanalytic theory. (This study can be described in the discussion period, should it be of interest to you.)

We then studied these 13 statements to determine whether they had been interpreted to the patient earlier in the treatment, to assess the patient's level of anxiety when these statements emerged, and to see whether they were subsequently defended against or used therapeutically.

Two members of our research group, Drs. Marla Isaacs and Carol Drucker independently catalogued all of the analyst's interventions. Drawing upon their work, we were able to look at each of the analyst's interventions to see if there was anything he had said prior to the hour in which the ward-off content emerged, that in any way related to the ideas expressed in the patient's previously ward-off contents. We found that there was one interpretation made by the analyst that related to one of the previously ward-off ideas which the patient had subsequently expressed. Twelve of the 13 statements emerged without any prior interpretation by the analyst.

We then studied these 12 statements to assess whether there was an increase in anxiety when they emerged. Dr. Suzanne Brumer of our research group applied three techniques for rating the patient's anxiety at any given moment in the treatment. The three techniques are: Mahl's Speech Disturbance Ratio, the Gottschalk-Gleser content analysis scale, and clinical ratings of anxiety level.

Interrater reliability was high for all three anxiety measures. For all three methods used, there was no evidence that the patient was any more anxious when previously ward-off contents were emerging (or during the five minutes that preceded their emergence), than at randomly selected times during the analysis. (See Figures 1, 2, and 3). It is particularly noteworthy that in the analysis of data based on Mahl's Speech Disturbance technique, it was found that randomly selected patient statements were accompanied by considerably more anxiety than were previously ward-off statements. The difference was statistically significant at the .025 level.

In order to find out whether the patient was defensive in relation to the previously ward-off contents, we applied the Experiencing Scale to

warded-off statements, as well as to randomly selected statements. The Experiencing Scale assesses the degree to which a patient focuses on his ongoing flow of changing feelings as they occur during psychotherapy, and how he reflects about these feelings and puts such observations to use for problem-solving purposes. Luborsky and Spence have described the scale as measuring a lack of resistance. Previously warding-off contents were rated significantly higher on the Experiencing Scale than were randomly selected statements. (See Figure 4.) This means that the patient was actually more involved with reflecting on the feelings she associated with the warding-off contents than with the randomly selected contents chosen from her psychoanalysis. This data suggests that the patient was particularly involved in the analytic process at just the times when she was doing the progressive therapeutic work of allowing previously warding-off contents into consciousness.

We know of no way that the automatic functioning paradigm can explain this combination of findings. These findings do seem to support the idea that the patient has the capacity to lift her defenses, and that the ego plays a central role in the recovery of warding-off mental contents.

It should be pointed out that these findings interest us because they may throw some light on the question of how the mind works. This study was not designed to test the merits of one or another theory of therapy. We all recognize not only that interpretations are important, but that at times they can be crucial for analytic work to occur. Likewise, we recognize that sometimes patients may be anxious when warding-off contents emerge. Nonetheless, in contrast to ideas often found in the literature, our findings point to the conclusion that warding-off contents can emerge without anxiety and that oftentimes interpretations are not required before something warding-off can be expressed.

Our second set of studies investigated the emergence of a particular set of new ideas: those having to do with Mrs. C.'s beliefs about her own omnipotence. Based on the process notes of the first 10 hours, our research group had concluded that Mrs. C. not only had considerable difficulty with fighting with others, but that, in order for her to make significant gains, she would need to acquire insight into the reasons that fighting, criticizing, blaming, etc. were so troublesome to her. It was further hypothesized that her conflicts in this area were the result of her omnipotence fantasies about her power to hurt others. For these purposes, omnipotence is defined as the patient's unconscious and unrealistic appraisal of the power her thoughts and actions have to affect others. It is important to note that this concept of omnipotence contrasts with the concept of omnipotence as being a wish or impulse to be all powerful and push people around.

Dr. Cynthia Johnson Shilkret of our research group developed a case-specific omnipotence scale on the basis of a clinical inductive study of the process notes of the first 100 hours of the patient's analysis. Based on a thorough reading of these process notes, Dr. Shilkret identified five different levels of the patient's own insight into these problems. Dr. Shilkret's approach was to identify all of Mrs. C.'s expressions of omnipotence and then to order them sequentially. I will briefly describe her scale to you:

At the lowest levels of the omnipotence scale, the patient displays little or no recognition of either omnipotent fantasies or feelings; or

awareness that she is troubled by these issues. For instance, at Stage 1 the patient expresses the general idea that she is in some way bad, harmful, or unable to be good, without qualification. The patient feels that she is weak, helpless, impotent, or unable to exert control in interpersonal situations, so that she cannot do things she wants to, or feels compelled to do things that she does not want to. She does not consciously experience guilt because she doesn't feel responsible or in control of her thoughts or actions.

At Stage 2, the patient still feels unable to exert control, but she recognizes a vague sense of guilt and/or responsibility for others that she cannot account for or knows is unreasonable. Her insight at this stage is that she feels guilty for "something" but she is unaware of the omnipotent thoughts that are causing the guilt.

At Stage 3, the patient makes her concerns explicit--that she feels responsible, guilty, or blameworthy because of her thoughts or actions. The patient now feels that she can control others and is bothered that she can harm others by this control. She now has insight into the cause of her feelings of excessive responsibility (i.e., her idea that she can control and thus harm people).

At Stage 4, the patient feels she can control others without being bothered by that feeling. She feels powerful without feeling guilty. She may even enjoy feeling powerful, strong, or controlling.

At Stage 5, the patient is engaged in an attempt to assess realistically the extent of her ability to control others. As part of this assessment, she may distinguish between her thoughts and her actions, or she may attempt to anticipate the realistic consequences of her actions, even if this assessment is difficult to make.

Once the scale was developed, six judges were asked to read through the 100 hours and select any item that might pertain to the scale. Since the intent of the scale was to measure Mrs. C.'s insights into her omnipotence, the judges were instructed not to use clinical inferences or behavioral observations, but only the explicit content of her conscious thoughts. Following this selection of items, two experienced clinicians read through the statements to determine if they adhered to the criteria. Based on these two procedures, 131 items were identified. These items were presented to three judges to rate on the omnipotence scale, and the average interrater reliability was .72. Each item was given the rating which two or more judges agreed upon. It was found that the mean ratings for 10 hour blocks showed a statistically significant change across the 100 hours, providing evidence for the patient's increasing insight into her problems of omnipotence. (See Figure 5.) This study suggests that increases in Mrs. C.'s capacity to blame, criticize, and fight with others was accompanied by her acquisition of genuine insights into her problems with omnipotence.

Dr. Shilkret was able to trace how the patient began to develop insight into a very central conflict; namely, her fears of hurting people, and her conflicts about having power or strength of any kind. Drs. Isaacs and Drucker, building on Dr. Shilkret's study, set out to investigate whether Mrs. C. gained these insights into her conflicts because they were interpreted to her, or whether they were acquired without interpretation.

They proceeded by adapting Dr. Shilkret's five-stage omnipotence scale to investigate the analyst's interpretations into this same area of conflict. I will define a few points on this scale just to give you some idea about how the analyst's interpretations were catalogued:

At Stage 1, the analyst interprets that the patient is feeling weak, helpless, or unable to exert control in interpersonal situations. He may interpret that she cannot do things that she wants to do, or feels compelled to do things that she does not want to do in relation to other people. At Stage 3, the analyst points to the patient's feeling that she can control others and that she feels bothered by that feeling. At Stage 5, the analyst points out the realistic extent of the patient's ability to control others.

In the first 100 hours of the analysis of Mrs. C., 153 of the analyst's interventions were found to be interpretations. The other interventions which were not included in this study included direct questions, one word responses, business matters, etc. Two judges familiar with the case read the 153 interventions with instructions to select any statements which in any way alluded to the patient's conflicts over omnipotence. A final sample of 21 analyst interventions was identified which were given ratings of 1 through 4. The overall interrater reliability was .82.

It was found that the patient reached each of the five levels of insight prior to the analyst's making an interpretation at the same level. There was also evidence that when the analyst's interpretations were at the same level as those of the patient, that these interpretations facilitated and accelerated the patient's progress, even though the interventions came after the patient had first reached that level of insight on her own.

The unconscious automatic mental functioning paradigm and the unconscious higher mental functioning paradigm would be likely to account for these findings in different ways. Since the patient's ideas about omnipotence emerged regularly without interpretation, the traditional theory might view the patient's expressions of omnipotence as the result of the analyst frustrating her impulses to be omnipotent. The higher mental functioning explanation would be that the patient's ideas about omnipotence represented a pathogenic belief from which she wanted to free herself. As the patient learned that she was not hurting the analyst with her thoughts and actions, she became relieved, and felt safer to express these ideas for purposes of mastery.

Our third set of studies demonstrated that during the first 100 treatment hours, Mrs. C. acquired an increasing capacity to fight and to be close. In a few moments I shall describe our method and some of the details of the findings. But first, it should be pointed out that these observed changes in the patient, could in and of themselves be accounted for by each of the psychoanalytic paradigms which Dr. Weiss described in his presentation:

The automatic functioning paradigm would explain these findings in terms of a mobilization of conflict, stimulated by the analyst's interpretive work and the frustration of the patient's unconscious libidinal wishes. In contrast, according to the higher mental functioning paradigm, these changes could be understood as following from the patient's unconscious sense of increased safety with the analyst.

It is only after we consider this study in combination with our other studies, including those which look at how driven or relaxed the patient is becoming during these 100 hours, that we can distinguish how well the two paradigms account for the combination of observations.

The third sets of studies was conducted by several members of our research group, and the project was led by Dr. Leonard Horowitz. Three clinicians read the process notes of the first 100 hours and looked for all instances of fighting behaviors; that is, all instances in which the patient blamed, criticized, disagreed with, or opposed another person. 190 such instances were identified.

These 190 passages were presented to a panel of four clinicians who had no other information about the case. The passages were presented in random order to each judge. The judges applied a four-point rating scale to assess how directly the patient was able to blame, criticize, disagree, or oppose. If the blame or criticism was only implied, the scale value was at "1"; if the blame or criticism was expressed and then undone, the rating was "2"; if the blame or criticism of one person was expressed directly to someone other than the individual for whom it was intended, the rating was "3"; and a direct confrontation of someone was rated "4". An additional .5 was added to the scale value if the event occurred in the present tense, and thus the range of possible ratings was from 1 to 4.5.

A comparable procedure was used to identify all passages describing behavior that expressed closeness or intimacy. There were 106 instances where confiding, cooperating, and loving were expressed. A corresponding 4 point rating scale was devised for these closeness items.

It was found that both sets of passages were very reliably rated. The mean ratings for each 10-hour block were computed; and for both the fighting and the closeness measures, the change across hours revealed the type of growth usually associated with a learning curve. (See Figure 6.)

It should be noted that there were 18 patient statements which were classified in the closeness category which directly referred to the patient's sexual behavior. These were studied separately, since they referred to her presenting complaint of sexual frigidity. For this sub-category of closeness behaviors there was also a statistically significant change in the patient's capacity to directly describe her experiences with sexual intercourse.

A study is currently being conducted by Drs. Ransohoff and Curtis to replicate this research on actual transcripts of Mrs. C.'s analysis. They have demonstrated that Mrs. C. became more explicit and direct in her expression of fighting behaviors; and they are currently studying the changes in her expression of closeness behaviors.

We were interested to learn whether the patient's changes during the first 100 hours in the directness with which she was able to express fighting and closeness might be attributable to some influence on the analyst's part. Drs. Rosenberg and Campbell investigated this question. I won't describe their methods now, but will only mention that their study demonstrated that there was no evidence that the analyst directly influenced the patient to engage in fighting or closeness behaviors. Although Rosenberg and Campbell

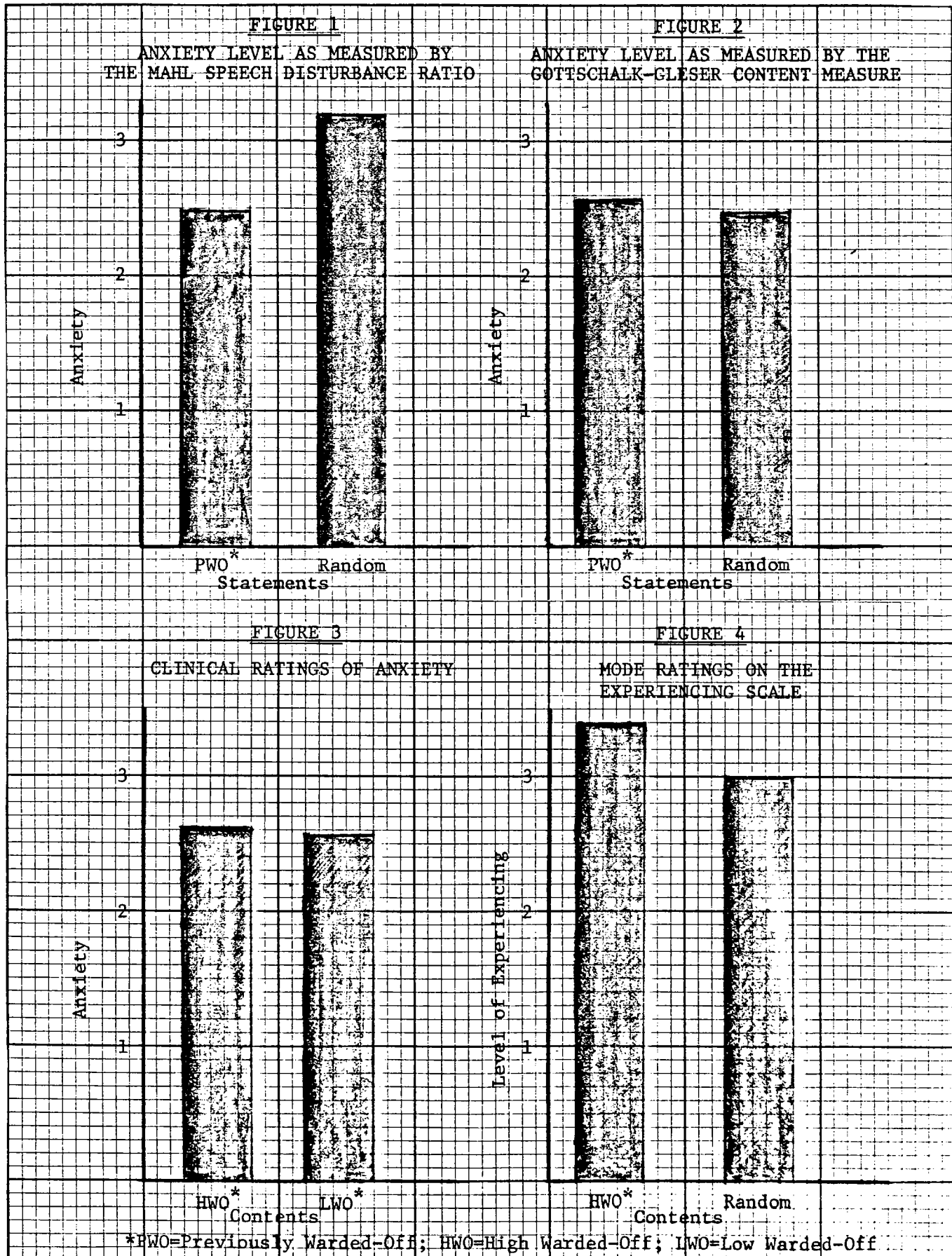
did find that a higher proportion of the analyst's interventions focused on aspects of fighting, rather than on closeness, there is no evidence that the patient's increasing ability to express both fighting and closeness was a response to the analyst's overt suggestions.

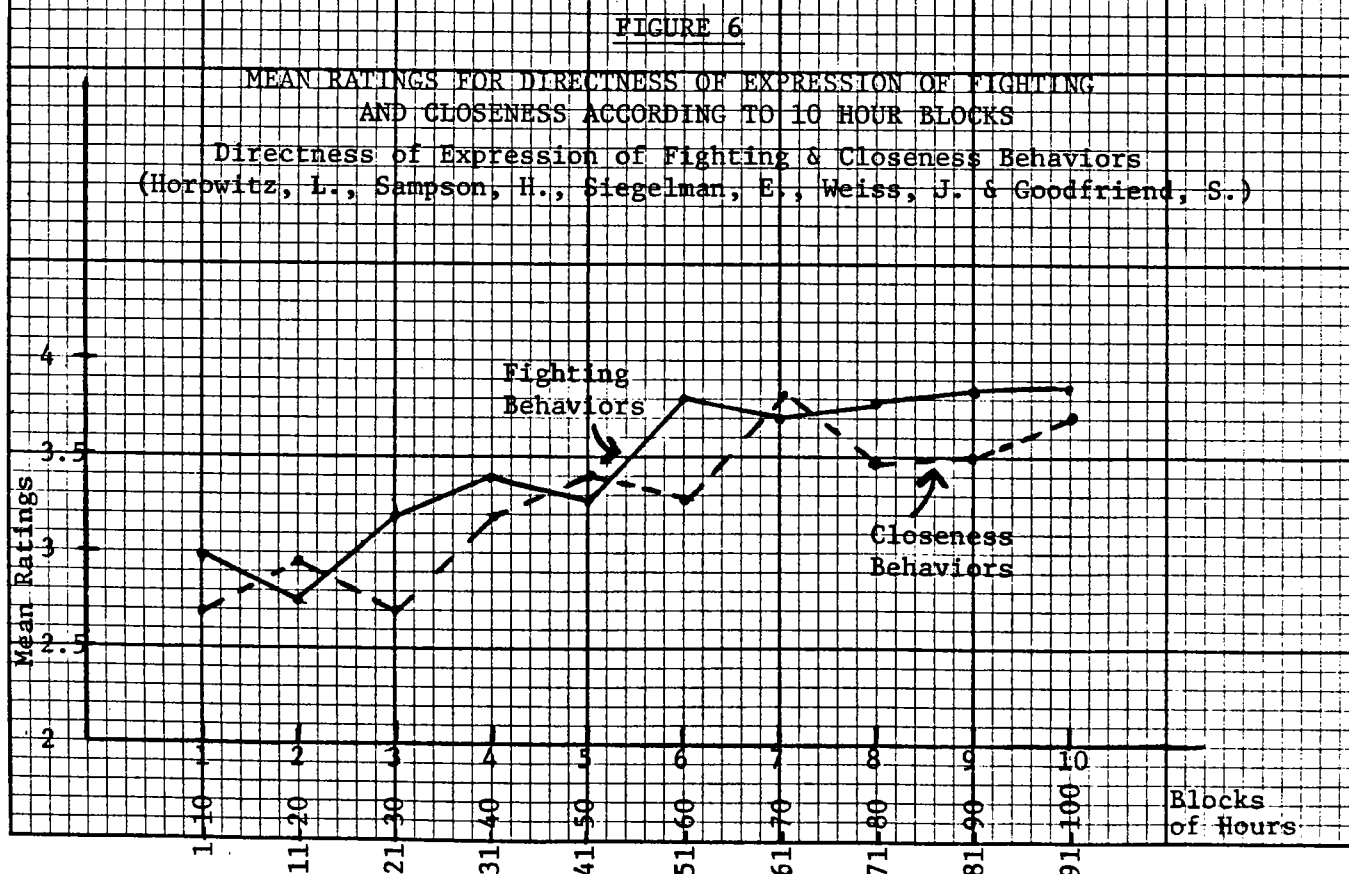
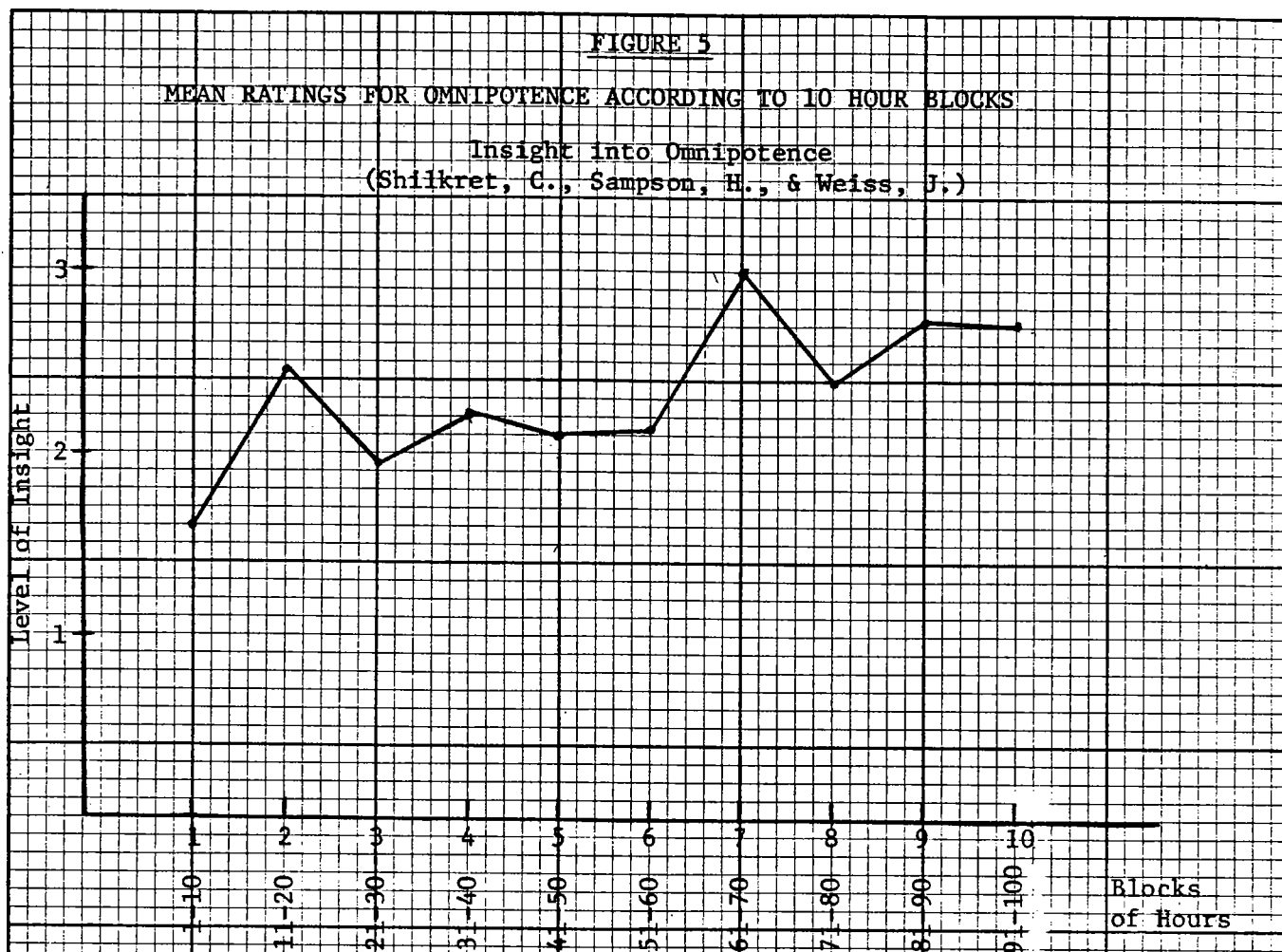
In order to distinguish the automatic functioning paradigm from the higher mental functioning hypothesis, research was done which investigated whether the patient was becoming more or less anxious and driven during the course of the first 100 treatment hours, while she was progressing in the ways that have been described so far. Dr. Lisby Mayer, working with others from our group, developed a new measure, called the Freedom-Beleaguerment Scale, to assess the patient's level of relaxation over time. Her group found that the patient seemed to maintain a constant level of tension during the first 100 hours. (See Figure 7.)

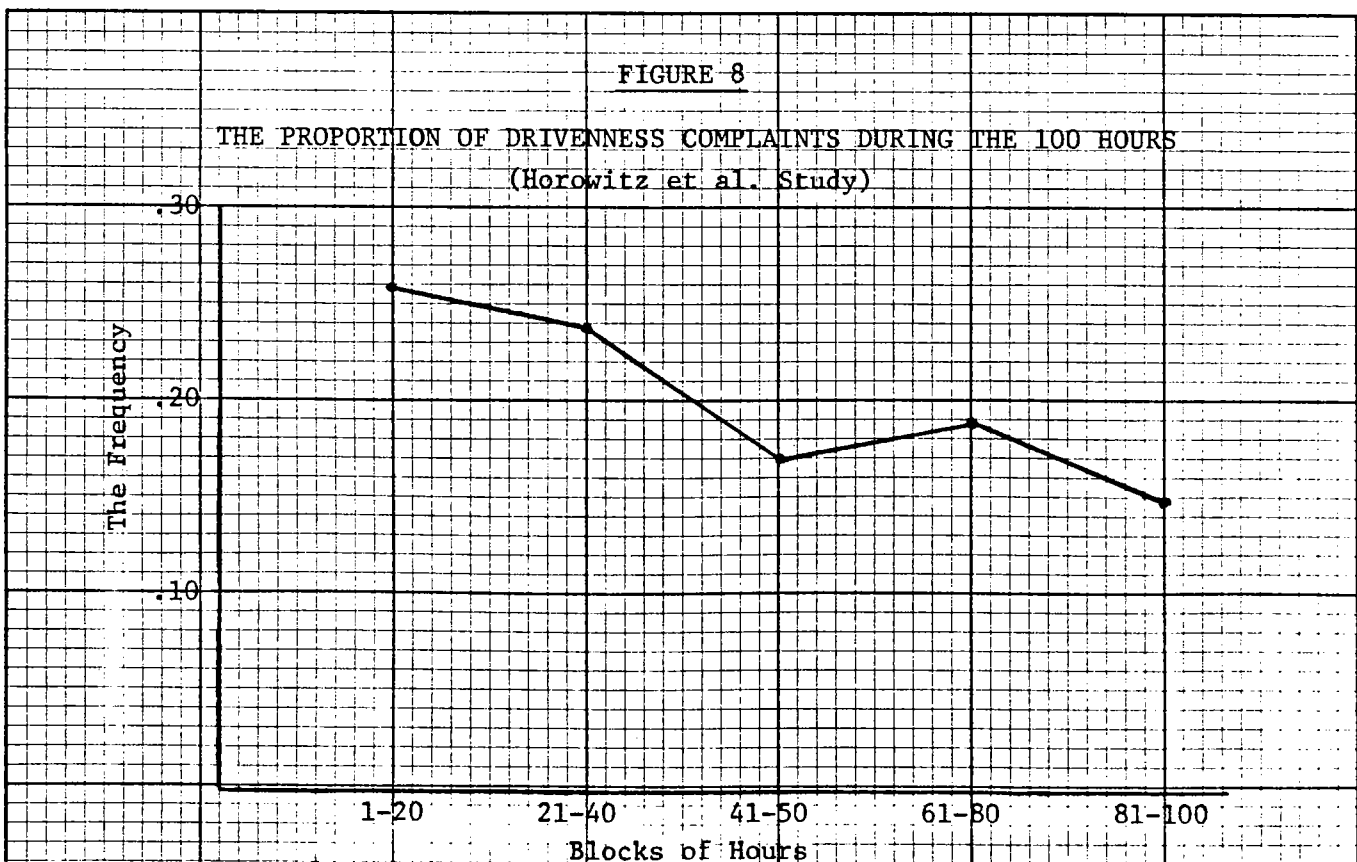
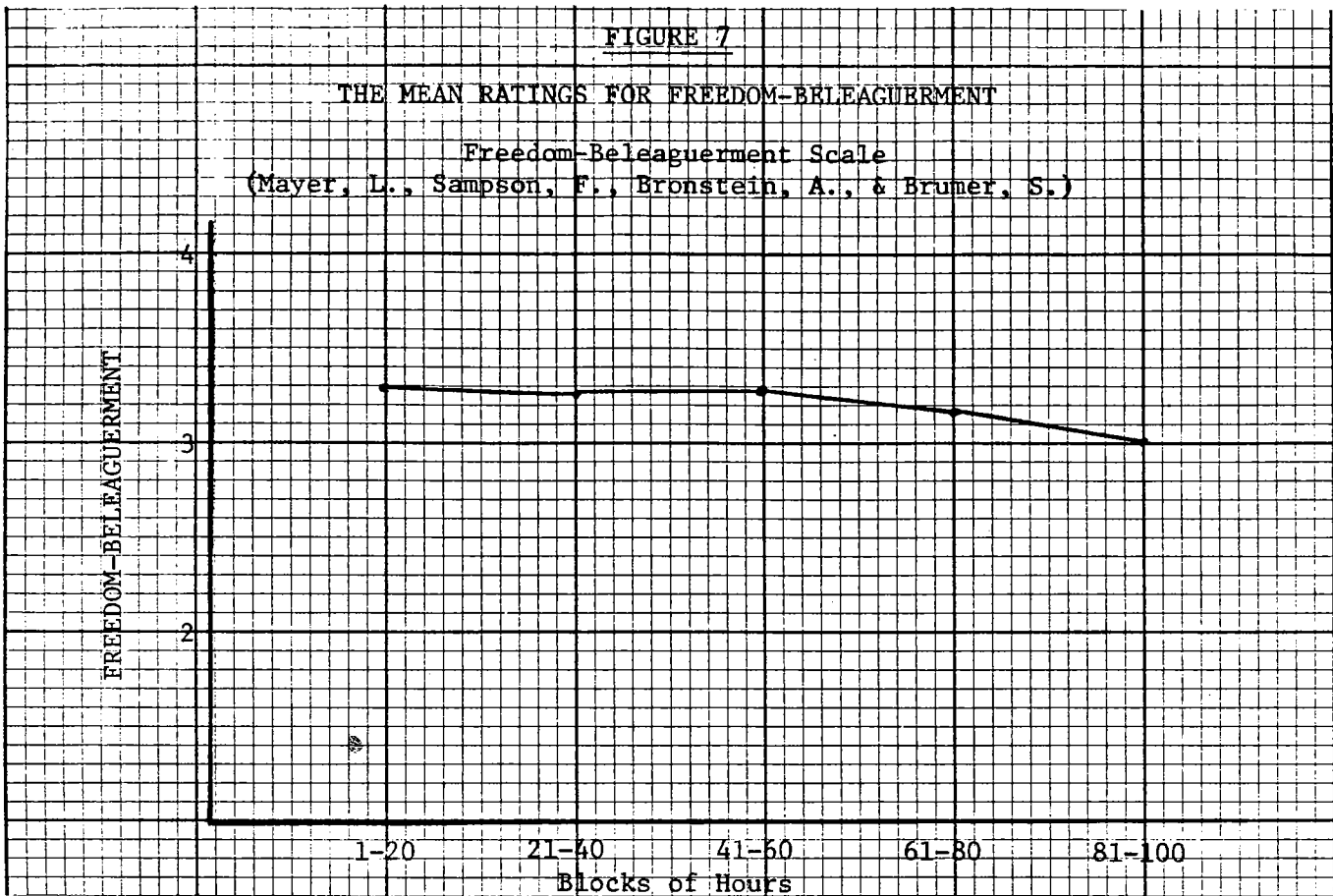
In order to study how driven the patient was becoming, Dr. Horowitz, working with others from the research group, identified all instances in the process notes where the patient expressed compulsions or inhibitions having to do with closeness and fighting. These complaints were typically expressed in terms such as "I have to" or "I can't". 351 such complaints were identified, amongst which were 60 statements referring to fighting and 56 statements referring to closeness. A statistically significant decrease was found in the patient's expressions of driven behavior, over the course of the first 100 hours. (See Figure 8.) Dr. Frances Sampson has verified this finding, working from transcripts; and has also studied the continued decrease in drivenness as observed in the process notes from a later period in the psychoanalysis.

This combination of findings can readily be explained by the higher mental functioning paradigm. During the first 100 hours, warded-off contents emerged without anxiety or prior interpretation. The results from the Experiencing Scale showed that the patient made constructive use of these previously warded-off contents. The lack of anxiety while the previously warded-off contents were first being expressed suggests that their emergence was not pressured. Just as I showed that warded-off contents emerged without interpretation or anxiety and were not defended against, Dr. Shilkret, in combination with Dr. Horowitz and others, demonstrated that while new omnipotent ideas were emerging during the first 100 hours, the patient was becoming less driven. These ideas, too, came forth without prior interpretation. Additional evidence that the patient was using her insights into omnipotence constructively may be that the patient became more direct in expressing her ideas and feelings concerning fighting, blaming, criticizing, and opposing others. Likewise, she became less obsessive about closeness in general, including sexual intercourse in particular. Whereas it is difficult to see how this combination of findings can be parsimoniously accounted for as the result of an interplay of instinctual and defensive forces that have been mobilized by the analytic process, these findings can be readily accounted for by the higher mental functioning paradigm.

A STUDY OF HOW WARDED-OFF CONTENTS EMERGE IN TREATMENT
(Gassner, S.; Sampson, H.; Weiss, Jos.; & Brumer, S.)







A PATIENT'S UNCONSCIOUS WORK

Hal Sampson, Ph.D.

This afternoon Dr. Joseph Caston will present another area of our research. Like the research presented this morning, the work he will report is designed to cast light on certain basic questions in the psychoanalytic theory of therapy. His report will focus on how a patient may work unconsciously to overcome his problems, and on how the analyst's interpretations and other activities may facilitate the patient's work.

The key hypotheses we are testing are based on what Dr. Weiss described this morning as a higher mental processes paradigm; that is, these hypotheses explain a patient's behavior in terms of his unconscious beliefs, decisions, and plans. Dr. Weiss referred to these as Type B hypotheses, and contrasted them to the hypotheses contained in or implied by Freud's early theory of the mind and of therapy. This early theory explained much of a person's behavior in terms of a dynamic-economic interaction of forces--that is, in terms of a shifting dynamic equilibrium between impulses and defenses. Weiss characterized the early theory as an automatic functioning paradigm, and designated its hypotheses as Type A hypotheses. He noted that some analysts today rely primarily on Type A hypotheses, that many use both Type A and Type B hypotheses, and that we have set out to test the explanatory power of Type B hypotheses taken by themselves.

I would like to introduce this afternoon the Type B concepts--the higher mental processes concepts--we are using to explain a patient's unconscious work in analysis. I hope to show that these concepts (1) make some sense intuitively and are supported by some informal clinical evidence; (2) are derived from ego psychology, and constitute a theoretical framework which is coherent and psychoanalytic; and (3) that these concepts are amenable to formal research--i.e. lead to testable propositions.

In introducing the key concepts related to Dr. Caston's presentation--concepts which concern a patient's unconscious testing of the analyst, and a patient's unconscious planning to work to overcome unconscious, infantile, pathological beliefs--I will first recapitulate a part of Dr. Weiss's presentation, and then proceed a little further along the path he followed.

Dr. Weiss described first the paradoxical phenomenon of a person crying not when he is sad, but rather at "the happy ending." Weiss showed that the familiar phenomenon of crying at the happy ending is not easily explained by Type A hypotheses alone; i.e. by hypotheses involving a dynamic-economic interaction of impulses and defenses. However, crying at the happy ending, including all of the observations associated with it, is readily explained by concepts which assume:

- (1) That a person has a capacity to lift his defenses and to experience a warded-off mental trend, such as defended against sadness.
- (2) That he is likely to do so when he decides unconsciously that it is safe for him to experience the content.

- (3) That he may experience the content not in order to gratify it, but rather to resolve his conflict with it.

Weiss then described his early studies of the process notes of a number of analyses. He observed in these studies that new themes--often consisting of important unconscious ideas or fantasies--may sometimes become conscious without interpretation, yet without much anxiety or conflict. Moreover, the patient frequently did not isolate this new content or otherwise defend against it. Instead, the patient frequently linked the new content to other material, recalled new memories related to the content, and worked analytically to resolve his conflict with the content. Weiss gave the example of an unconscious beating fantasy which became conscious without interpretation just when conditions in the analysis made it safe for the patient to experience it. This example is a variant of the crying-at-the-happy-ending phenomenon, and it is most readily explained by the same set of hypotheses or assumptions I laid out a moment ago.

In studying such sequences in process notes, Weiss took a small additional step. He added to the idea that a patient may unconsciously decide to experience an unconscious content when an opportunity arises which makes it safe for him to do so, the further hypothesis that a patient actually works unconsciously to bring about these conditions. Once this hypothesis was considered, there was a great deal of informal evidence that indeed patients often seem to proceed planfully, albeit unconsciously, to create just those conditions which will make it safe for them to experience unconscious ideas, beliefs, wishes, and fantasies.

Weiss was helped to this new step not only by his observations, but also by many concepts available in contemporary ego psychology. For example, Löewenstein's concept that a patient may use the analyst as an autonomous auxiliary ego to assist the patient in overcoming distortions brought about by his transferences and defenses, implies that a patient works unconsciously to resolve his unconscious conflicts. Such a concept is also implied by the idea of unconscious testing of the analyst, and this idea is used in contemporary psychoanalytic writing about therapy, e.g. by Rangell and Dewald, among others.

Indeed, our own informal clinical studies have suggested that such unconscious testing is one of the main methods a patient uses to work unconsciously to resolve unconscious conflicts.

Let me give a brief example of what we refer to as an unconscious test:

The patient, a young professional woman, seemed anxious during the early part of one session. She then asked the analyst if he could give her an extra appointment to make up for an hour which fell on a holiday. The analyst declined to do so. After a momentary sigh of protest, the patient seemed much calmer. She began to talk of new material: She is often afraid that men she dates will become too involved with her and give her special favors. She recalled a new memory of her father's overinvolvement with her. She felt her father had been seductive. She became aware that she was concerned that the analyst might be seductive. In subsequent hours, she continued to analyze this material, becoming conscious of her own love for her father and her own sexual interest in the analyst.

This kind of sequence is, we believe, a very familiar one in psychoanalytic practice. It is in fact similar to the example used by Freud in his paper on Transference Love, in which he said that if the analyst is "proof against every temptation...the patient will then feel safe enough to allow all her preconditions for loving, all the phantasies springing from her sexual desires, all the detailed characteristics of her state of being in love, to come to light; and from these she will herself open the way to the infantile roots of her love". *Italics mine.* (Freud, 1915, SE 12, p. 166).

We believe this sequence is most simply and most comprehensively explained by the concept of unconscious testing. The young woman in the example cited unconsciously feared that the analyst, like her father, would be overattached to her and seductive. If this danger were confirmed, she could not bring forth safely her sexual conflicts, and work to resolve them. She unconsciously planned and carried out a trial action--a request for a special favor--to test whether her unconscious fears were justified. When the analyst disconfirmed her unconscious fear by declining her request, she became more calm, and brought her fears to consciousness and worked on their historical roots and their presence in the transference.

This type of sequence cannot be readily explained, in its entirety, by Type A hypotheses. We do not think it can be explained adequately by any hypotheses which do not assume the patient's behavior is regulated by higher mental processes. If the patient's demand for love is an imperious transference wish (perhaps serving as a resistance as in Freud's paper on Transference Love), the analyst's declination is a frustration of the patient's longings, and should intensify her unconscious conflict with these repressed longings. If the intensified longings become conscious nonetheless because of their intensification, she would feel anxious and conflicted if the emergence was relatively undisguised. If, in contrast, the emergence of the transference longing was more disguised, the repressed wish would appear in some kind of compromise formation--i.e. it would be in some way conscious but defended against, and the patient would not continue to work with the material progressively without interpretive help.

I should now like to trace some of the building blocks in psychoanalytic theory for the concept of unconscious testing, as we are using this concept. I've noted Freud's observation in his 1915 paper on Transference Love. Since Freud's theory at that time conceptualized such behavior as due to the mobilization of transferences and resistances outside of the patient's control, Freud did not assimilate this observation to the theoretical framework we are now considering.

However, two important theoretical building blocks are suggested by another of Freud's early concepts; namely, that of castration anxiety. This concept implies the following two ideas:

- (1) The first is the idea that a patient's neurotic symptoms may derive from an unconscious infantile belief. A patient's sexual symptoms, and his inhibitions in competition may, for example, be based on his unconscious belief that if he were to be sexual toward women and rivalrous toward men, he would be castrated.

- (2) Second, since a patient's unconscious belief that he may be castrated is--in contrast to pleasurable unconscious sexual fantasies--unpleasant and distressing to him, it is plausible to assume that he would wish to disconfirm the unconscious belief if it were possible for him to do so.

The concept of castration anxiety played an important part in the theoretical revisions Freud introduced in 1926. In his 1926 theory, the two basic ideas I have just mentioned are cast in a more general form. In Inhibitions, Symptoms and Anxiety, Freud made clear that a patient's defenses and his neurotic symptoms are based on unconscious convictions of danger derived from infantile traumas. It is again evident that a patient would wish to overcome these distressing unconscious ideas if he could do so.

It is a small step from these two ideas to the idea that a patient may test unconsciously his infantile pathological beliefs in his relationship to the analyst. In testing such unconscious beliefs in relation to the analyst, the patient carries out unconsciously a trial action which invites the analyst to respond in ways which either confirm or disconfirm the belief. Naturally, the patient will hope that the analyst's response will disconfirm his unconscious fear--he is not likely to wish, for example, that the analyst will confirm the unconscious belief that he will be castrated if he is sexual.

In brief, then, three closely related ideas are intrinsic to the concept of unconscious testing:

- (1) The centrality for defense and neurosis of unconscious, infantile convictions of danger (Freud 1926);
- (2) The assumption that the patient would wish to overcome these unpleasant unconscious beliefs; and
- (3) The assumption that the patient has a capacity to disconfirm these infantile beliefs in favorable circumstances, such as in analysis, by unconsciously testing these beliefs in relationship to another person.

The concept of testing is also based on the fundamental psychoanalytic concept of reality testing. In reality testing a person distinguishes a percept originating from within from a percept originating in the external world, and he may make this distinction on the basis of an action. In our usage, a person distinguishes between a danger situation originating from within and based on an infantile trauma, from a danger situation present in the external world. And a person may make this distinction on the basis of a trial action.

Somewhat similar ideas of testing have been used explicitly by a number of other contemporary analysts such as Rangell and Dewald. Very similar ideas are used implicitly in the clinical work of yet other analysts.

Because a higher mental processes paradigm--as illustrated by the concept of unconscious testing--is not easily assimilated to intuitions based on the traditional theory, we have found that some analysts view testing as a relatively superficial activity which may take place occasionally in the opening phase of the work, or, later, as a kind of unconscious manipulation.

Such analysts assume that behavior based on unconscious higher mental processes is necessarily superficial, for they assume that truly important processes are regulated outside of the patient's control by an interaction of instinctual and defensive forces.

We understand this conviction, but we do not believe it to be true. We believe that unconscious testing is a central activity of a patient, and that it takes place throughout an analysis. It is not a superficial or manipulative activity for a patient, for it concerns confirmation or disconfirmation of that patient's unconscious beliefs about infantile situations of danger, those very beliefs which initially caused the patient to institute defenses, to remain unaware of his infantile wishes, to develop inhibitions and symptoms, and to renounce important goals. There is scarcely anything which could be deeper, or more important.

I should now like to take another step by noting that this concept of testing implies that a patient has a capacity for unconscious planning, for testing is a complex trial action which must be carried out according to a plan. Moreover, this unconscious plan has the purpose of disconfirming an unconscious infantile conviction of danger.

As Weiss noted this morning, The Ego and the Id implies strongly a broader idea of unconscious planning, and of unconscious working toward long-term goals. In The Ego and the Id, Freud describes relatively complex unconscious motives. These motives arise from identification with lost love objects. Such motives--as, for example, the wish to reach life goals similar to those attained by the lost love object--imply unconscious planning. To fulfill such motives requires unconscious work in accordance with unconscious long-term goals. Freud's ideas in The Ego and the Id form the basis for many related concepts in ego psychology, such as Kris' discussion of unconscious life plans, and Erikson's concept of identity. Erikson's concept assumes that unconscious impulses, defenses, identifications, values, and so forth are integrated into broad motivational systems, and that a person unconsciously plans and directs his life in accordance with these broad goals. Our own concept of unconscious plans, and how it applies to the analytic process, will be described in some detail by Dr. Caston.

In concluding my introduction to Dr. Caston's report, I want to comment briefly and in a broad way on how such higher mental process concepts as "unconscious decision" or "unconscious plan" or "unconscious testing" are amenable to formal research.

First of all, it should be noted that there is no a priori theoretical or philosophical basis for considering an inferred "unconscious decision", for example, as less basic or real than an inferred "instinctual impulse" or "defense". Both are constructions inferred from a person's thoughts, fantasies, affects, and actions. Moreover, neither type of explanation is ordinarily tautological. When we say that a person did "X" because he decided or planned to do so, or that a person did "X" because he had an impulse which was expressed by "X", we do risk a tautology; but in fact neither explanation is ordinarily tautological, for both kinds of concepts achieve explanatory power through their capacity to order a multiplicity of different phenomena and events in terms of a few fundamental premises and laws. Let us examine certain broad empirical implications of the two kinds of explanations.

In the traditional theory, fundamental explanations are sought in the lawful dynamic-economic interaction of basic forces; namely, impulses and defenses. Thus, in a clinical situation, attention is directed toward factors which account for shifts in dynamic equilibria: for example, frustrations which may intensify the strength of unconscious drives, or substitute gratifications which may weaken the intensity of unconscious drives and "dilute" the transference, or attention is turned toward factors which may strengthen or weaken the force of resistances, such as confrontations of these resistances or interpretations of these resistances, or to interpretations or other distortions of the material. In short, the traditional theory provides a coherent network of ideas to account for clinical phenomena.

In the higher mental processes paradigm we are testing, fundamental explanations are sought in a person's unconscious decisions. Thus, in a clinical situation, attention is directed toward factors which may influence a patient's decision to maintain his defenses, or to lift them and allow unconscious contents to be expressed prominently in his behavior, or to be experienced consciously. What are these factors? There are a number of factors which may influence a patient's decision, but considerations of anticipated danger or of safety are usually paramount.

Our hypotheses thus direct the attention of clinician and research investigator alike to those factors in the behavior of the patient or of the analyst which are likely to increase or decrease unconscious feelings of danger or safety for the particular patient.

We have used precisely this logic to make a number of specific and testable predictions--for example, about how an analyst's response to a patient's test will influence the patient's subsequent productions, or about how a patient will react to an analyst's interpretations. In both instances, we predict on the basis of whether the analyst's activity will be experienced as increasing or decreasing the patient's unconscious judgment of danger.

My overall point is that neither the automatic functioning paradigm of the traditional theory, nor a higher mental processes paradigm, have a priori claims to being more fundamental; that neither kind of explanation need be tautological; that both types of explanations assume determinism; and that both can lead to potentially testable propositions. Further, they point to different sets of factors which will influence the course of events, and they sometimes lead to different predictions in the same situation. In such instances, the explanations may be tested against each other.

Dr. Caston's report will show that clinicians familiar with our concepts can identify, with high interjudge reliability, a patient's major tests, and with equally high reliability can identify whether the analyst's response passes or fails that test. Moreover, clinicians can infer reliably from case material a patient's unconscious plan, including his unconscious goals and the means he will use in analysis in attempting to achieve these goals. Finally, Dr. Caston's report will show that these concepts have at least a certain degree of predictive power, and that, in fact, in one study, all of our predictions were supported by the findings, while predictions based on an automatic functioning paradigm were contradicted by the findings. He will also report some preliminary findings in another study--findings which we did not anticipate. Such unanticipated findings are almost (but not quite) as appealing to us as research scientists as those results which confirm our prior clinical convictions!

I. PLAN DIAGNOSIS RELIABILITY

II. STUDIES ON THE EFFECTS OF INTERVENTIONS

Joseph Caston, M.D.

This afternoon I should like to present four studies: one on the reliability of the diagnosis of the unconscious plan, and three on analytic interventions.

The several studies presented by Dr. Gassner this morning have provided evidence that the process of improvement in an analytic case conforms to the predictions of the higher mental functioning paradigm. This theory postulates that in each patient a case-specific unconscious plan exists with respect to inadequately mastered areas of the patient's personality.

The basic process in therapeutic change is conceptualized here as the de jeopardization of what the ego has erroneously regarded as dangerous. In essence, beneficial change in a previously unmastered area follows a series of re-appraisals by the ego that relevant safety obtains, and conversely, either no therapeutic change, or a pathologically regressive change, follows appraisals of continuing or increased relevant danger.

You will note that in several of the Mrs. C. studies presented today, the patient acquired certain significant insights without the benefit of the analyst's interpretations which were specific to those areas. This does not mean that interpretive work by the analyst is unnecessary, but that it is not the only route through which such beneficial effects are achieved. One may, for instance, invoke the presence of general factors which may have facilitated her increasing mastery of problem areas, e.g. factors such as the regularity of the analytic setting, the analyst's overall neutrality, the safe opportunity to regress and explore, his amplification of her insights, etc.

In studies which I will now present, we were interested in the specific and immediate influence on the appraisal process by an important external variable: the analyst's interventions. From the perspective of the higher mental functioning paradigm and the concept of the unconscious plan, we would predict that those interventions which facilitate the plan will produce beneficial effects in the patient's immediate responses.

Reliability of the Diagnosis of the Unconscious Plan

A plan diagnosis is a complex psychoanalytic formulation which delineates: the unmastered problem areas for which the patient consciously or unconsciously shows a high priority for mastery; what dangers characterize these arrangements; and what operations are being utilized or are likely to be utilized to alter these arrangements in the service of mastery.

It is an a priori task for research using measures based on such a case-specific variable as the unconscious plan to determine the reliability of the plan diagnosis in each case. Here we required judges to make clinical ratings on the first five hours of process notes.

The difficulty of achieving consensus in complex psychoanalytic formulations are familiar to you, especially as laid out in a paper on this problem by Philip Seitz some years ago. I developed a methodology, which, when applied to determining the reliability of the diagnosis of the unconscious plan, successfully overcame the consensus problem. The form of this methodology would be applicable, I believe, to any area of psychoanalytic formulation, but you will see that here it restricts itself to the terms and foci of the concept of the unconscious plan.

First: I dissected the concept of unconscious plan into several simpler clinical rubrics, so that the reliability of the clinical judgments required for each rubric could be determined separately. In contrast, a summary statement of Mrs. C.'s plan could be put as follows: the patient wishes to be able to be stubborn, separate, and aggressive without guilt so that she can be more comfortable being close. This statement does not disclose the steps in clinical judgments, each guided by theory, of which it is a resultant. The following rubrics, which I will define in a moment, comprise what must be clinically noticed and assessed in order to arrive at a notion of the unconscious plan: (1) immediate and eventual goals; (2) obstructions to the goals; (3) tests by the patient and their relative power to generate relevant information from the analyst's responses; (4) the relative compatibility of analytic interventions with what is to be mastered; (5) outcome criteria for patient's productions following analyst's interventions; (6) the means. The clinical tasks for the assessment of these dimensions were operationalized with definitions, directions, and examples in a manual, for the use of clinician-judges who had already had clinical experience and training in the application of the higher mental functioning paradigm.

What were the clinical tasks under each rubric for the judges? This brings us to the second methodological step. To have allowed the judges to freely describe their assessments of the process materials under each rubric, might have left us with idiosyncratic, difficult-to-compare formulations. Instead, a large array of possible clinical propositions, relevant to the first five hours of process notes, were provided under each rubric. These had been selected and constructed by a prior group of clinicians, whose task it was to discern the fullest array of relevant possibilities.

Each judge, blind to the others, then individually developed hierarchies (via rating scales) for propositions under each rubric; each judge used the same standard array of items. Hence, each judge generated a profile of high- and low-rated clusters of items under each rubric; and whenever extensive similarities of profiles between judges obtained, statistically reliable agreement could be demonstrated. It was thus also possible to avoid the contamination that occurs in consensual group review processes of diagnosis and formulation.

I will now present brief definitions of the rubrics and give examples of the propositions that were rated in each category.

(1) The goal or goals is represented by some significant behavior, attitude, affect, memory, mood state, objective within an interpersonal relation, or a group of such, which the patient wishes to enjoy, employ, achieve, renounce at will, or render innocuous, but at present is unable to do so.

These fall within the realistic repertoire of achievable human activities and states, and usually represents a developmentally higher achievement than the current state of events. These can be characterized either in a general abstract way, e.g. "the capacity to bear and express sadness", or in a concrete, highly specified way, e.g. "to mourn father's death".

The recognition of goals depends on the application of both a clinical and common sense and a dynamic formulational approach. Commonly, goals may be represented by conventional desires (e.g. the wish to not be afraid of girls), developmental goals (e.g. the wish to not be so dependent), or situationally specific goals, such as the need to master a past trauma, or the wish to overcome crippling inhibitions or symptoms.

Finally, it is necessary to distinguish between immediate and eventual goals. The immediate goal, or goals, will predominate in the material as a focus of work toward mastery, if not in a cognitive way, then always by "testing" activity (see below). Patients will differ most in the immediate goals which manifest themselves at any point in the therapy. Other goals may be apparent in the material which are less predominant, and do not discernibly form a frequent focus of "testing" activity. These are eventual goals, which may later come to be mastered, and form a larger potential list. Missing from this list will be areas already mastered by the patient; even so, patients may be more similar with regard to this larger set of unattained eventual goals than they are with respect to the immediate goals.

There were 33 items representing the immediate goal category in the rating task materials for both Mrs. C. and for a pilot case. These were expressed as concrete clinical propositions regarding possible and immediate priorities for previously unmastered goals which the patient may want to attain. Examples from the Mrs. C. protocol demonstrate their form:

To acknowledge her sense of being physically defective.
To confront her sexual attraction to her father.
To criticize the analyst.

In the Mrs. C. case judges were required to rate the propositions in a forced Q-sort over nine points, ranging from "extremely high degree of importance or priority..." to "no importance or priority as an immediate goal".

Eventual Goals: In this task, the judge carried out the same procedure with the same items as for immediate goals, except that he now considered which goals would attain prominence later in treatment.

(2) Obstructions represent the present or anticipated state of events which makes the person regard a goal as dangerous at the outset. Frequently we will be able to see what defense is used, usually continuously and flexibly, to side-step the dangerous consequences of pursuing the goal. Familiar

obstructions, which vary in a case-specific way, include guilt over omnipotence, vulnerability to injured self-esteem, confirmation of inadequacy, fear of retaliatory castration, fear of repetition of a previous trauma, shame, fear or loss of control (e.g. as with sadness, or as with rage)...etc.

Examples from the Mrs. C. case include:

- Defensive need to make men impotent.
- Fear of criticism because of narcissistic injury.
- Guilt about omnipotent fantasies of power over the analyst.
- Defensive need to submit to the analyst.

There were 22 such items in the pilot case and 20 such items in Mrs. C.'s case. The judge indicated on a nine-point scale the degree to which he inferred an obstruction to be consciously or unconsciously operative.

(3) Tests are the actual presentations by the patient which have the unconscious or conscious purpose of confirming or disconfirming the present appraisal of the case-specific immediate goal as dangerous. In a test, either side of a dilemma may present itself, i.e. there will either appear to be a retreat from, or advance towards, the immediate goal. If the immediate goal is to master boastfulness, for instance, the patient may present himself as unnecessarily modest (i.e. a retreat) or, on the other hand, display a virtuosity at some idea or behavior (an advance). Either is a test to gather information as to how safe it is, currently, to boast. The test may be carried out on the patient himself (e.g. a patient may follow a line of thought to see if he can scare himself with it, or pursue a regressive path to see if he can reverse it), on the world (e.g. it might constitute a primary process "punishment" if some miserable course of events ensues), or on the therapist.

(4) The therapist either facilitates or hinders mastery with respect to the immediate goal, in a test situation, by the witting or unwitting support or attack by his intervention, or lack of intervention, as perceived by the patient. Acquaintance with the obstructions, dangers, and means, should enable one to predict what therapist behaviors will facilitate or hinder.

From the foregoing considerations, what would constitute a powerful test, and what a weak test by the patient? A powerful test is one with a likelihood of generating clarifying responses from the therapist regarding the relative danger or safety of the immediate goal (means).

Judges were asked to rate the power of the patient's tests and the plan compatibility of the analyst's interventions on nine-point scales. Specific reference points were designated in chronological sequence in the process materials, and both types of items were intermixed according to their actual occurrence. In addition to actual instances of tests and interventions, possible hypothetical instances were also used, with the following form: "At point 'X', what if the patient or analyst had instead said 'Y'?"

Examples from the Mrs. C. case which refer to given points in the material are as follows:

Actual instance, intervention: "After patient asks if she should force herself to say things, even if she is not ready, analyst responds by asking patient if she remembers the rule."

Hypothetical instance, intervention: "In reference to the (item above), what if analyst had instead said, 'you are implying you need me to tell you what to do'."

Actual instance, test: Patient's question about the people in the front office leaving and how would the analyst know that she was there.

Hypothetical instance, test: Patient refers to having been late last session and asks what she should do.

In the pilot case there were 11 test items and 19 intervention items. In the case of Mrs. C. there were 21 test items and 18 intervention items.

(5) Test outcomes. If the tests are passed, the patient will show specific advance toward the goal behaviors by further derivative or direct manifestations of the goal behaviors, but in an increasingly flexible, bold, relaxed manner; or general advance by a relevant insightful expansion of material, or emergence of previously warded-off contents or behaviors, or appearance of generally bold, exploratory, or self-confronting behaviors. A retreat may, accordingly, be characterized in opposite ways.

In this instance, the measures are not necessarily patient-specific with respect to the plan; it is important to recognize their general manifestations when diagnosing the plan. Our plan reliability judges did not do this particular task, but other judges in the intervention studies obtain reliabilities of .83 on the process notes and .65 for the verbatim transcripts for scales of Insight or Boldness (self-confrontation) in the patient's productions.

(6) Means represent routes and steps which permit increments of behavior change toward the goal. Essentially, every means is an immediate goal, which is on the track to a specific later one. For instance, a person may have to master boastfulness preparatory to the later confrontation with the painful unconscious fantasy of puniness. All immediate goals designate the content aspect of the means. The formal aspect is indicated by how the task of mastery is effected.

Judges were required to identify only the content aspect of the means. This task differed from the others in that no ratings were established. Each judge was required to choose one out of five summary descriptions of the content aspect of the means, based on his review of his ratings of immediate goals. The five choices for Mrs. C. are given below:

- (1) The patient wishes to be able to confront the sources of her envy and jealousy without shame so that she can feel less compelled toward self-defeating competitiveness.
- (2) The patient wishes to be able to attenuate her unrealistic perfectionism without anxiety so that she can be more able to be satisfied with herself.
- (3) The patient wishes to be able to be stubborn, separate, and aggressive without guilt so that she can be more comfortable being close.
- (4) The patient wishes to be able to bring forth and explore her unconscious homosexuality without anxiety so that she can more freely enjoy a heterosexual relationship.
- (5) The patient wishes to be able to master her feelings of being messy and defective without anxiety so that she does not always have to maintain tight control of herself.

Four judges previously unacquainted with the Mrs. C. or the pilot case were utilized. Reliabilities were remarkably high for diagnostic and formulational studies, ranging from .69 to .92 (see Table I). All judges in each case chose the correct "means" statement.

We have now demonstrated in these two cases, that plan diagnosis can be reliably made, demonstrating that it is a teachable concept. One reason for the high reliability may lie in the fact that some of the plan rubrics, such as "immediate goal" are relatively easy to discern, when concretely expressed, compared to other "experience-par" attributes. Another source of increased reliability may lie in narrowing the clinical task, through parsing complex formulations into simpler subjects. I believe that the strength of the method lies in allowing the overlap of clinicians' agreements to be captured by a correlational approach, when a standard array of clinical propositions is employed.

The Pilot Study on the Immediate Effects of Interventions

In the light of the higher mental processes paradigm and the concept of the unconscious plan, we hypothesized that those interventions which facilitate the plan would tend to produce observable, beneficial effects in patient responses. This approach assumes that the plan-compatibility of the intervention is an important, indeed, central determinant of such effects, though not an exclusive source. It is one which has heretofore never been systematically studied.

The scope of likely beneficial factors in interventions and interpretations which clinician-theorists have long believed pertinent is rather large. Such factors have included various aspects of psychoanalytic interpretiveness such as: the moderateness of the depth of interpretation, completeness and accuracy, causal or linkage-making explanatoriness, transference-centeredness, and resistance-centeredness; other aspects have included the timing, dose, tact, and economy of interpretations, and also the degree of the concurrent presence of such dimensions as the analyst's neutrality, and the adequacy of the working alliance.

Now, were a sophisticated psychoanalytic observer who is otherwise unacquainted with the concept of unconscious plans to observe sequences of what we would identify as plan-compatible versus plan-incompatible interventions, he would likely characterize their guiding principle as one of "therapeutic tact". The study of the effects of the plan-compatibility of interventions might be thus regarded as a systematization of therapeutic tact, but it is one which is informed by a careful, theory-based diagnostic assessment by which we arrive at the unconscious plan.

In judging the plan compatibility of interventions, it is the patient's perception, not necessarily conscious, of the relative safety or danger of the interventions which is crucial, as opposed to any "objective" or intended character of the interventions. In each instance, the pertinent question is: In this patient's present frame of mind, and in the light of his particular unconscious plan, how does he perceive what the analyst is now saying and how is he saying it?

In a pilot study which I carried out on material from the process notes of Mrs. C., four rating scales were used:

- (1) Plan-Compatibility: by which the analyst's interventions were judged in terms of their facilitation versus hindrance of the unconscious plan.
- (2) Boldness: used to rate the degree to which the patient develops a deepening exploration of significant personal issues with boldness, ease, and interest.
- (3) Insight: used to rate the degree to which the patient develops insight into himself and his problems.
- (4) Cognitive Enlightenment: by which the analyst's utterances are rated by the extent to which they carry material which stimulate or aid the development of the patient's insight; the interventions are judged in the light of the immediately preceding productions by the patient; how far beyond the patient material the intervention reaches is one consideration in the assessment.

In view of the demonstrated immediate effects of interpretation reported in clinical literature and especially in three experimental studies (Speisman; Garduke and Haggard; Colby) on psychoanalytic interventions, it was deemed useful to join a preliminary investigation of this aspect with the main hypothesis under study.

The model fragment used in constructing items was built around a target intervention, preceded by a segment of patient speech (the context segment) which itself included the preceding analyst's intervention (which was used to provide a clearer impression of the context). The target intervention was succeeded by a segment of patient speech (the effect segment). Segments of patient speeches had to fall within a given size range (7-26, mean = 13 lines) without interruption by other analyst interventions. Fifteen fragments conforming to these restrictions were randomly selected from the first 100 sessions.

Four clinicians acquainted with the case read the analyst's interventions and the preceding context, but were blind to the effect segment. In addition to the Plan Compatibility scale, judges used a manual describing the unconscious plan for the case in rating the interventions. Four other judges blind to the intervention rated the patient's effect segment, in the light of the context segment, for the degree of Boldness and Insight. In this study both Boldness and Insight were so highly correlated, they were combined. A separate group of judges also rated the preceding patient context segment alone for a "baseline rating" of Boldness and Insight (also combined).

The results are shown in Table II. The degree of Plan-Compatibility of the interventions significantly predicted the degree of Boldness and Insight in the patient effect segment at $+0.48$ (Spearman correlation). The baseline Boldness/Insight rating of the context segment also predicted the effect segment's Boldness/Insight rating at $+0.5$; Plan-Compatibility ratings of the interventions and baseline Boldness/Insight ratings of the context correlated at near-zero; this suggested two independent sources of variance at the dependent variable. These results were striking, and together account for 50% of the variance.

It will be noted that while correlations of the Cognitive Enlightenment with Boldness/Insight Effects and Plan-Compatibility were not significant, they yielded positive correlations of low order that were interesting and suggestive.

The main hypothesis had been upheld. This pilot work stimulated two different studies on interventions utilizing the transcripts of the tapes of the first 100 hours. George Silberschatz carried out a study presented at this forum last year, which compared competing traditional "A" model vs. higher mental functioning paradigm predictions in the patient-analyst interactions of a "testing" or "transference-frustration" nature. In collaboration with Riese Goldman and Mary Margaret McClure, I carried out a complex replication of the original pilot on the taped transcripts.

The Silberschatz Study: A Comparison of Competing Hypotheses

I will briefly summarize George Silberschatz' findings and later return to certain implications it holds for the general study of interventions. In a very elegant study of competing hypotheses, Silberschatz compared the predictions of a traditionally psychoanalytic, "pure" "A" model hypothesis with that of the higher mental processes paradigm, or "B" model, regarding effects on the patient, of interactions in which the patient appears to be pulling for some gratification in conjunction with given analyst-responses.

According to the traditional, or "A" model, when a patient pulls for a response and the analyst does not satisfy it, the patient is unconsciously frustrated. The patient's unconscious transference wish is thereby intensified and may "thrust forward into consciousness" (Freud, 1912). Freud argued that such frustrated transference wishes are one of the key "driving forces" in therapy, a viewpoint which has been continued by many clinician-theorists.

In contrast, the "B" model views the patient as pulling for a response from the analyst in order to unconsciously test the analyst with respect to

what needs to be mastered, in terms of his unconscious plan; if the analyst passes the test, what has unconsciously been regarded as dangerous may seem safer, and new behaviors, memories, or previously warded-off feelings or contents may emerge. If he fails the test, no defenses are lifted in view of the increased or continued danger which is implied.

To summarize, the "B" model viewpoint regards the interactions in question as tests by the patient which the analyst passed or failed; the "A" model viewpoint regards the interaction as transference expressions which are either frustrated or gratified. Instances were sought in which the two theories would predict oppositely, since in many instances they might view an interaction in parallel fashion. Since the "A" model would predict distress and upset by a transference-frustration by the analyst, interactions which constituted both passed-test and frustration-of-transference-wish types of analyst-responses were sought.

Nine raters read through the verbatim transcripts of the first 100 hours and selected 87 instances of "transference pulls" by the patient for the analyst to respond in particular ways. Two independent groups of psychoanalytic judges read a description of the patient and historical data; five "A" model judges, all classically trained psychoanalysts, and four "B" model psychoanalytic judges, trained in the higher mental processes paradigm, rated how good the patient's "pull" was. The "A" judges also rated the neutrality of the analyst's responses; the "B" judges rated the degree to which the analyst passed the tests. The reliabilities for the mean judgments run from .74 to .86 (see Table III).

The "B" hypothesis judges selected from the general pool of 87 "pull" interactions those which were "Key" for the unconscious plan of Mrs. C. The "A" hypothesis judges selected "Key" frustrations which conformed to a penis envy formulation of the case. Key Test reliability for three raters was $r = .82$. Key Frustration reliability for three raters was $r = .66$. In all, 34 Key Tests and Key Frustrations items overlapped, and correlated on these ratings at $+ .81$ ($p < .001$). Measures of the patient's productions before and after the analyst's intervention from the tapescripts were made for the Experiencing scale, the Boldness scale, a Relaxation measure, and multiple affect measures based on a content analysis as developed by Hartvig Dahl (reliabilities shown in Table IV).

The effects of pre-intervention patient segments on the measures of post-intervention segments were statistically removed. The results are shown in Table V. Significant positive correlations were obtained for the degree to which the analytic interventions passed the test, with Boldness, Relaxation, and "Love" affect measures, and a significant negative correlation with the anxiety measure. The results are given in Table IV, and one can see that the data upholds the "B" hypothesis, rather than the "A" hypothesis, in this rigorous empirical comparison.

The Replication Study on the Immediate Effects of Interventions

My co-investigators, Drs. Goldman and McClure, and I, carried out a replication study of the pilot study on the immediate effects of interventions on the taped transcripts. Pilot findings had shown a significant tendency for bold, insightful, self-confrontative patient productions to follow plan-compatible interventions, or to continue the baseline trend of boldness

and insightfulness in the patient's production preceding the intervention; together these two factors accounted for 50% of the variance. A strong hint was also present that the degree of insight delivered by the analyst's intervention played a role in these effects. We were also interested in the role of "test power", the degree to which a patient, through testing the analyst, can present a situation which can potentially clarify his responses regarding the safety or danger of the "immediate goal" in the unconscious plan.

Our approach had been guided by certain assumptions about how interventions and the ego's appraisal system works, for instance: that it is as if the appraisal of safety and danger relative to the unconscious plan is always operative, with every intervention brought under scrutiny, even if other factors influence and confound the process; that on the average, interventions will show orderly effects on patient productions, and that these effects are of a general nature, not merely specific to the unconscious plan; and that the judge who rates the compatibility of an analyst's intervention with the unconscious plan, does so empathically with respect to the patient's likely perceptions of the analyst's behavior, and hence makes rough approximate judgments similar to, or, if you will, homologous with the operation of the ego's appraisal system.

The Silbserschatz study, although developed to compare the predictions of two different theories, had also confirmed the pilot study's findings that there are measurable and predictable immediate effects of interventions, using taped transcripts. However, it did so within a narrow realm of events; namely, in those interactions which contained "key tests," i.e. those where the patient's productions had shown a high degree of test power. In other words, he was able to show that the plan compatibility of interventions predicted significant positive correlations with the effects when the patient powerfully tested the analyst. He could not show this with non-key test situations.

In my pilot study and our present replication of it, we proceeded on the initial assumption that all interventions would be appraised by the ego, regardless of whether the patient was posing a powerful test or not. But was test power a determinant of the immediate effect of interventions, perhaps through maximization of other such interaction with the plan-compatibility of the interventions? In the replication study, a measure of the test power of the context segment, i.e. the pre-intervention patient segment, was included, in which the judges were blind to the intervention and to the patient effect segments.

We were also interested as to the role played by the insight delivered by the analyst to the patient. In particular, did an interaction exist between the plan-compatibility of an intervention and the degree of insight it delivered, with respect to immediate effects on the patient's productiveness? I will point out that this measure of general insight delivered by the analyst, called here "cognitive enlightenment", is very different from plan-compatibility; it does not depend on what the plan is. It represents a spectrum of general insights ranging from low levels of information, to higher degrees of "spotlighting" of areas for further exploration, to naming what is likely to be ward-offed, to deep causal constructions; the scale also takes into consideration how much the interpretation moves beyond a paraphrase of what

the patient has just communicated. For example, while a highly enlightening intervention might be compatible with the plan, it is possible for the analyst's grunt of acknowledgement to the patient's material which is relevant to the plan (e.g. her criticizing activity) to receive a high plan compatibility rating, albeit with a very low cognitive enlightenment score. Indeed, the analyst's grunt yields information important to the ego's appraisal process, but not in a traditional interpretive format.

From the entire 800 analyst's interventions in the first 100 hours of taped transcripts, all interventions were selected which conformed to the following: a single analyst's intervention, flanked before and after by patient speech segments of a certain size range (20-35 lines) which did not have embedded silences greater than one minute duration; 81 fragments conformed to this model. Two separate groups of (3 and 4) judges for Boldness and Insight, blind to the interventions, determined ratings for both context and effect segments, which had been randomized and unlabelled as to location. Afterwards, the same judges then carried out a second determination based on these Boldness and Insight scales, called "Boldness Shift" and "Insight Shift". They were provided with the actual pairs of context and effect segments, without the intervention, and asked to rate to what degree the second, or effect, segment had changed along the Boldness or Insight dimension relative to the first segment, and in which direction. Some pilot work had suggested that this second clinical "shift" comparison was an especially sensitive measure. Thus we were provided with four effect measures: Boldness Effect, Insight Effect, Boldness Shift, and Insight Shift. There were 2 and 4 judges each for cognitive enlightenment and plan compatibility, respectively, who examined only context and intervention. There were 3 judges for test power who examined the context only. (Reliabilities of mean ratings of judge groups ran between +.6 to +.7, shown in Table VI.)

Results revealed that the baseline level of boldness and insight (the pre-intervention patient segment) predicted the effect level of boldness and insight, as in the pilot study (+.3 to +.5).

In a multiple regression procedure, we removed the contribution of baseline boldness and insight from the variance of boldness and insight in the post-intervention "effect" segments. The results are shown in Table VII. The correlation of plan compatibility of analytic interventions with these residualized gain scores for both boldness and insight effects and for insight shift and boldness shift scores was not significant. Thus, the main hypothesis was not confirmed in a replication on the tape transcripts. There was, however, a significant interaction between plan-compatibility and cognitive enlightenment which correlated at +.24 with residualized boldness effect ($p < .05$).

In contrast, cognitive enlightenment correlated significantly at +.31 ($p < .005$) with residualized insight effect and +.28 ($p < .01$) with insight shift (see Table VIII). This was true whether the contribution of plan compatibility was removed or not. An unexpected relationship was the following: The test power ratings of the patient's context segment correlated significantly with the cognitive enlightenment ratings of the analytic intervention, but not with plan compatibility or with effect scores. This suggests that when the patient tested more relevantly in terms of the unconscious plan, the analyst tended to respond with increased general interpretiveness; secondly, when the analyst was more generally interpretive, the patient tended to respond with greater immediate insight.

Then, in a procedure roughly similar to selecting only Key Test interactions, we took all items, 27 in all, which contained the highest third of test power ratings for context segments, and re-ran the correlations. The results are shown in Table IX. Strikingly, cognitive enlightenment now correlated +.54 with Insight Shift. Plan-compatibility yielded no significant correlations with effect scores.

In this study a predictor variable, cognitive enlightenment, accounted for 9% of the variance of insight effects in patient productions in a random population of interactions, yet jumped to 29% when we narrowed the realm to instances when the patient was testing powerfully. Likewise, Silberschatz found the degree of passing tests, or plan-compatibility, predicted effects significantly in patient productions when he narrowed the realm to Key Tests (16% of the variance). In re-examining the pilot study on the process notes, to see why my original results should have been so impressive, I believe I found a similar process. Almost all the context segments in the pilot study rate fairly high in terms of test power. Why? I think, in retrospect, the selection procedure for the pilot inadvertently pulled for it. In order to create adequate contexts for judges, each context in that study was required to begin with an analyst intervention, followed by a patient production of about 13 lines, followed by the target intervention, then the patient effect segment. Such interchanges, with brief patient speech between two analytic interventions, show a high yield of testing (or transference-active) patient responses.

Are we then forced to revise our view of the ego's appraisal activity as one which is not constantly fully vigilant, but rather one which operates predictively when it is sufficiently alerted, either by the patient initiating a salient test, or if the ensuing interaction with the analyst "heats up" into a salient and plan-relevant test situation? It seems to be the case, at least, that the patient's testing activity appears to drive a lot of noise out of the system.

Plan compatibility as a determinant of immediate effects in patient productions has made a showing only in the pilot study and in Silberschatz's study, and as part of a significant interaction with cognitive enlightenment. The lack of results in the replication study for this variable is not so much a problem for our hypotheses, as is the very clear, and independent, role of the cognitive enlightenment variable. We do note that its predictive power is tied to the patient's testing in terms of the unconscious plan, and can provide some theoretical argument for it: i.e. the patient takes the analyst's increased general interpretiveness, when she puts forth a powerful test, as a safety-rendering response to it. But other explanations are equally possible. Silberschatz showed that Key Tests correlated with Key Frustrations (of the transference) at .81, and thus some classical transference-responsive mode of action of insight may be invoked.

We are once again at a point of comparison of two theories, but at a different place: In the Silberschatz study it was the nature of the outcome of interventions which was at issue. In the present case, we ask, what is the mode of action of analytic insight, and just how does the ego's appraisal system which receives it, work?

PLAN DIAGNOSIS RELIABILITY STUDY

TABLE I

Split-half Reliabilities for the Average Ratings of Four Judges

	Case	Number of Items	Reliability Coefficient (Spearman-Brown Prediction)
Immediate Goals	Pilot	33	.87
	Mrs. C.	33	.89
Eventual Goals	Pilot	33	.72
	Mrs. C.	33	.69
Obstructions	Pilot	22	.91
	Mrs. C.	20	.14
	Mrs. C. (2 Judges)	20	.80*
Test Power	Pilot	11	.85
	Mrs. C.	21	.76
Plan Compatibility of Interventions	Pilot	19	.92
	Mrs. C.	18	.92
Means	Pilot	5	(Multiple choice chosen correctly by 4 judges)
	Mrs. C.	5	(Multiple choice chosen correctly by 4 judges)

* On this item reliability was attained for only two of the judges.

PILOT STUDY ON THE IMMEDIATE EFFECTS
OF INTERVENTIONS

TABLE II

	<u>B/I-PRE</u>	<u>B/I-POST</u>	<u>PC-INT</u>	<u>CE-INT</u>
Boldness/Insight (Patient Pre-intervention Segment) (B/I-PRE)		+.50*	.07	
Boldness/Insight (Patient Post-intervention Segment) (B/I-POST)			+.48*	+.24
Plan-Compatibility of Analyst's Intervention (PC-INT)				+.384
Cognitive Enlightenment of Analyst's Intervention (CE-INT)				

(N = 15 interventions)

* = $p < .05$

TABLE III
RELIABILITIES FOR THE PATIENT
AND ANALYST SCALES
(Silberschatz)

<u>Rating Scale</u>	<u>Number of Judges</u>	<u>r₁₁</u>	<u>r_{kk}</u>
FT Patient Scale *	5	.54	.86
FT Analyst Scale *	5	.35	.74
CM Patient Scale **	4	.42	.75
CM Analyst Scale **	4	.47	.78

* "A" judges
** "B" judges

TABLE IV
RELIABILITIES FOR EXPERIENCING, BOLDNESS,
AND RELAXATION RATINGS
(Silberschatz)

<u>Rating Scale</u>	<u>Number of Judges</u>	<u>r₁₁</u>	<u>r_{kk}</u>
Experiencing Scale: Mode	4	.55	.83
Experiencing Scale: Peak	4	.58	.84
Experiencing Scale: Mode + Peak	4	.64	.88
Boldness	2	.47	.64
Relaxation	3	.45	.72

TABLE V

CORRELATIONS BETWEEN RATINGS OF THE THERAPIST'S BEHAVIOR
(PASSED OR FAILED TEST) AND CHANGES IN THE
PATIENT MEASURES FOR SEGMENTS IDENTIFIED AS BOTH
KEY FRUSTRATIONS AND KEY TESTS (N = 34)
(Silberschatz)

	Results Obtained
Experiencing	+ .23
Boldness	+ .41 *
Relaxation	+ .35 *
Love	+ .36 *
Surprise	+ .07
Satisfaction	+ .15
Enthusiasm	+ .08
Anger	- .07
Fear	- .31
Depression	+ .14
Anxiety	- .34 *

* $p < .05$,
two-tailed test

TAPED TRANSCRIPT REPLICATION STUDY
OF THE IMMEDIATE EFFECTS OF INTERVENTIONS

TABLE VI

Reliabilities for Patient Production and Analyst Intervention Scales

<u>Variable</u>	<u>Number of Judges</u>	<u>Alpha Coefficient</u>	<u>Symbol</u>
Boldness Context	3	.70	BC
Insight Context	4	.67	IC
Boldness Effect	3	.66	BE
Insight Effect	4	.64	IE
Boldness Shift	3	.65	BS
Insight Shift	4	.65	IS
Test Power	3	.60	TP
Plan Compatibility	4	.64	PC
Cognitive Enlightenment	2	.69	CE

N = 81 Items

Plan Compatibility and Cognitive Enlightenment are
analyst intervention scales; all others are patient
scales.

"Context" means pre-intervention segment only;
Test Power is also a measure of the context.

"Effect" means post-intervention segment only;
"Shift" is a measure carried out by clinical comparison
of context and effect segments.

TAPED TRANSCRIPT REPLICATION STUDY
ON THE IMMEDIATE EFFECTS OF INTERVENTIONS

TABLE VII
CORRELATIONS (N = 81 ITEMS)

	IC	BE	IE	BS	IS	TP	PC	CE
Boldness Context	.53##	.48##	.33#	-.2	-.05	-.01	.07	-.2
Insight Context		.35##	.31***	-.07	-.08	.22	-.17	-.03
Boldness Effect			.49##	.31	.33#	.07	-.03	.08
Insight Effect				.17	.60##	.13	-.03	.24*
Boldness Shift					.40##	.12	.03	.18
Insight Shift						.12	.06	.28**
Test Power							.03	.28**
Plan Compatibility								.08
Cognitive Enlightenment								

TABLE VIII

	RI	PC	CE	NPC	NCE
RB	.39##	-.04	.19	-.04	.19
RI			.31***	.04	.28**
Boldness Shift				.10	.13
Insight Shift				.13	.24*

RI = Insight effect residualized for
Boldness Context and Insight Context

RB = Boldness effect residualized for
Boldness Context and Insight Context

NPC = Plan Compatibility residualized for
Cognitive Enlightenment

NCE = Cognitive Enlightenment residualized
for Plan Compatibility

* p < .03
** p < .01
*** p < .005
p < .003
p < .001

TAPED TRANSCRIPT REPLICATION STUDY
ON THE IMMEDIATE EFFECTS OF INTERVENTIONS

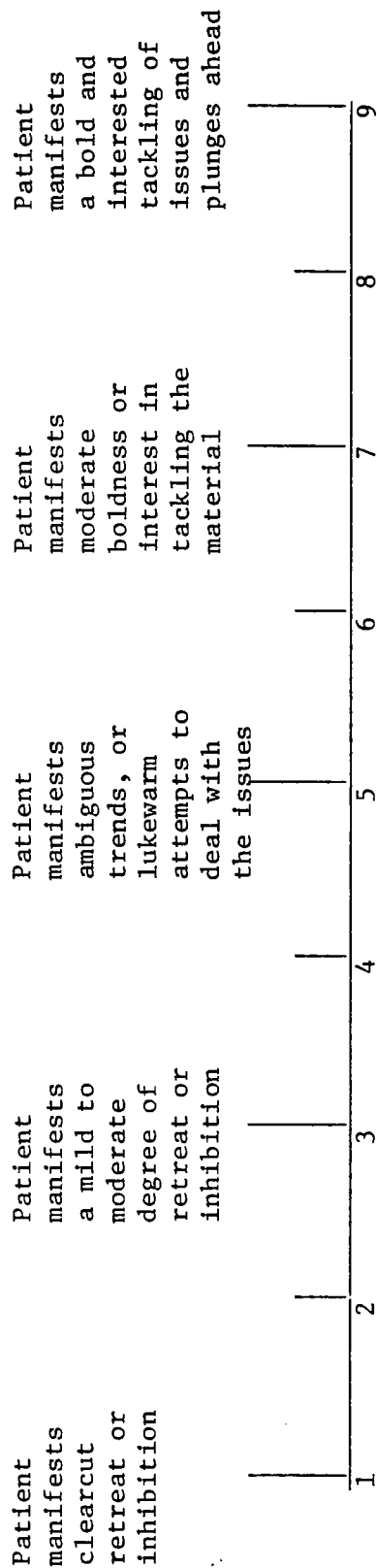
TABLE IX

CORRELATIONS FOR HIGHEST ONE-THIRD
OF TEST-POWER INTERACTIONS (N = 27)

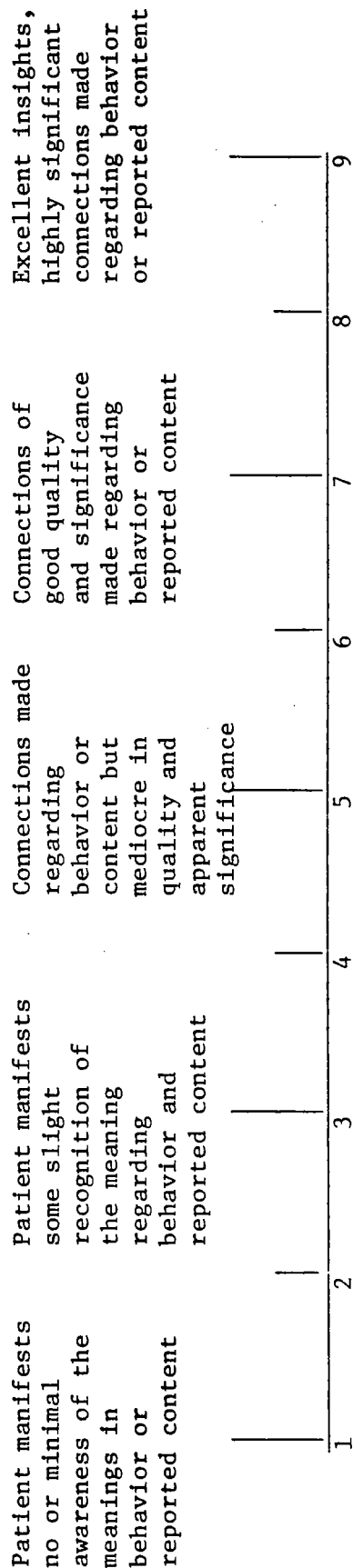
	IC	BE	IE	BS	IS	PC	CE
Boldness Context	.44 [*]	.51 ^{***}	.43 [*]	-.27	.08	.21	-.18
Insight Context		.21	.36	-.06	-.02	-.44 [*]	-.13
Boldness Effect			.66 ^{##}	.27	.60 ^{##}	.12	.31
Insight Effect				.19	.64 ^{##}	-.21	.27
Boldness Shift					.46 ^{**}	-.02	.27
Insight Shift						.15	.54 [#]
Plan Compatibility							.07

* p < .03
** p < .02
*** p < .006
p < .004
p < .001

BOLDNESS SCALE

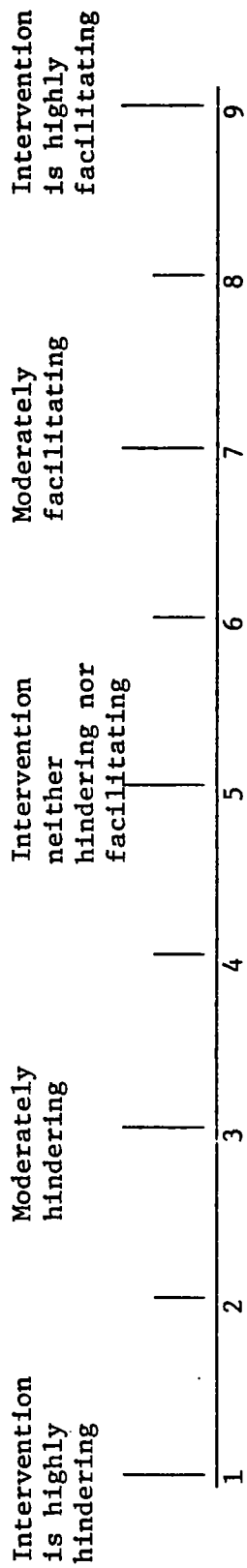


INSIGHT SCALE



Joseph Caston, M.D.
 April 28, 1980

INTERVENTION SCALE
 PLAN COMPATIBILITY



RATING THE SHIFT IN
INSIGHT AFTER AN INTERVENTION

After you have made judgments of single segments using the Insight Scale, you will be shown how the items pair up in terms of preceding, or "context" segments, and succeeding, or "effect" segments, with respect to the analyst's interventions. Using the first of each pair as an anchoring context, make a global judgment in terms of how much the patient has shifted ahead or back in his level of insight in the segment which follows the intervention.

SHIFT SCALE (INSIGHT)

- +3 Notable increase
- +2 Moderate increase
- +1 Small increase
- 0 No change
- 1 Small decrease
- 2 Moderate decrease
- 3 Notable decrease

SCALE FOR THE DELIVERY
OF COGNITIVE ENLIGHTENMENT
OF PSYCHOTHERAPEUTIC INTERVENTIONS

This scale categorizes the therapist's utterances by the extent to which they carry material helpful to the development of the patient's insight. The range extends from comments of low or extra-therapeutic content to deep interpretations. The rationale behind the scale assumes that the directing beacon of the therapist--even when he makes no proposition, but merely says something like, "Notice this"--generates associations and attempts at new organization on the part of the patient. Such assertions have enlightenment value without necessarily delineating the final gestalt. This scale, therefore, may be viewed as a spectrum of the naming of what is relatively not available to the patient.

The interventions are judged in the light of the immediately preceding production by the patient. How far beyond the patient's material the cognitive content of the intervention reaches, is, of course, one consideration in the assessment. At the same time, since the therapy hour is a time of fresh and ever-shifting warding-off activities in the patient's mind, even a therapist's statement which is a mere direct paraphrase of what the patient said may have enlightenment impact; rather than being experienced as "nothing new," it may be received, utilized, and assimilated in the development of further integrations and insights.

<u>LEVEL</u>	<u>CATEGORY</u>	<u>EXAMPLE</u>
1	EXTRA-THERAPEUTIC OR LOW CONTENT-CONTAINING ASSERTION (i.e., a comment not part of, or contributing minimally to, the exploration in the therapy)	(1) "I have a schedule change." (2) "Sorry, I have to answer the phone." (3) "Oh, yes, yes."
1	REQUEST FOR MATERIAL ALREADY RECENTLY VERBALIZED	(1) "Huh? What?" (2) "Would you repeat that please, I didn't catch all of it."
2	REQUEST FOR MATERIAL NOT RECENTLY VERBALIZED, BUT WHICH IS NOT LIKELY TO HAVE BEEN WITHHELD OR WARDED-OFF	(1) "At what age did that happen?" (2) "Which girl did you mean?" (3) "And what was the name of the book?"
3	REQUEST FOR ASSOCIATIONS TO SPECIFIC MATERIAL (i.e., rather than free associations)	(1) "What comes to mind when you think about that incident?" (2) "And what about boys wearing bell- bottoms?"

<u>LEVEL</u>	<u>CATEGORY</u>	<u>EXAMPLE</u>
3	ECHOING PARAPHRASE OR ASSERTION (i.e., therapist repeats or paraphrases closely a part or all of what patient has just said)	(1) <u>Paraphrase A</u> PATIENT: "It's not that I'm not thinking of anything, it's that sometimes it doesn't seem so important to me, or to you maybe, and that it won't lead to anything, and so I don't talk about it." THERAPIST: "So you won't talk about it because you think it won't lead to anything..."
		(2) <u>Paraphrase B</u> PATIENT: "And if I ever do have a son, I think I probably wouldn't let him have the gun to play with, I'd probably just bully him and make him docile like his sisters." THERAPIST: "You'd take away, not let him have his gun to play with."
3	ASSERTION OF SIGNIFICANCE (i.e., of some area or material, without specifying in that way)	(1) "That's a striking way to put that." (2) "You've mentioned that three times today."
4	REQUEST FOR MATERIAL LIKELY TO HAVE BEEN WITHHELD OR WARDED-OFF	(1) "Maybe when you said 'sexual organs' you were really thinking of the street word?" (2) "Did this business about the garbage remind you of what you said about mother yesterday?" (3) "Perhaps you felt excited when he said that to you?"
4	NAMING OR FOCUSING ASSERTION ON PARAPHRASE (OR SAME DISGUISED AS A REQUEST) ESPECIALLY FOR MATERIAL WITHHELD, WWARDED-OFF, OR NOT NOTICED (i.e., inference very near to the available verbal or non- verbal source. Pointing out affects and defenses are appropriate here. For focused paraphrase, the therapist makes heightened clarification of his re-verbalization.)	(1) "You're guilty about this." (2) "You seem hesitant." (3) "Why are you chuckling when you said you were disappointed?" (4) "You're leaving out that the same is true of your father." (5) <u>Paraphrase A</u> PATIENT: "It's not that I'm not thinking of anything, it's that sometimes it doesn't seem so important to me, or to you maybe, and that it won't lead to anything, and so I don't talk about it." THERAPIST: "So, essentially, you're editing." Or, THERAPIST: "Making omissions so as to always seem pertinent."

<u>LEVEL</u>	<u>CATEGORY</u>	<u>EXAMPLE</u>
		(continued)
		(6) <u>Paraphrase B</u> PATIENT: "And if ever I do have a son, I think I probably wouldn't let him have the gun to play with; I'd probably just bully him and make him docile like his sisters." THERAPIST: "Not wanting your boy to have the equipment his sisters can't have."
5	ENLARGING PARAPHRASE OR ASSERTION (OR SAME DISGUISED AS A REQUEST) (Here, while the inference is still moderately near to the manifest source, it carries the implications in the deriva- tives a step beyond, adding something novel or revelatory in content or organization.)	(1) <u>Paraphrase A</u> PATIENT: "It's not that I'm thinking of anything, it's that...(etc., as in previous Paraphrase A patient quote)." THERAPIST: "Leaving me to admire your best products." (2) <u>Paraphrase B</u> PATIENT: "And if I ever do have a son...(etc., as in previous Paraphrase B patient quote)." THERAPIST: "Making men equal with you by making them like your concept of women, who don't have any powerful equipment."
6	DEEPLY INTERPRETATIVE PARAPHRASE OR ASSERTION (OR SAME DISGUISED AS A REQUEST) (Here, the symbolic trans- formation or new organization spelled out in the inference is at a greater distance from the manifest source.)	(1) <u>Paraphrase A</u> PATIENT: "It's not that I'm not thinking of anything, it's that...(etc., as in previous Paraphrase A patient quote)." THERAPIST: "So mother can beam admiringly into your potty and say, 'good job'. " (2) <u>Paraphrase B</u> PATIENT: "And if I ever do have a son...(etc., as in previous Paraphrase B patient quote)." THERAPIST: "To castrate him to make him like what you believe girls are."

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- Gassner, S.; Sampson, H.; Weiss, Jos.; and Brumer, S. The Emergence of Warded-Off Contents. Submitted for publication, 1980.
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- Rosenberg, S.; Silberschatz, G.; Sampson, H.; and Weiss, Jos. Plan Attainment Scaling: An Individualized Psychodynamic Outcome Measure. Submitted for publication, 1980. (Presented to Society for Psychotherapy Research, June 1980.)
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- Sampson, H. A critique of certain traditional concepts in the psychoanalytic theory of therapy. Bull. Menninger Clinic, May 1976, 40: 255-262.
- Sampson, H., and Weiss, Jos. "Research on the Psychoanalytic Process: An Overview." Bulletin #2, March 1977. The Psychotherapy Research Group, Department of Psychiatry, Mount Zion Hospital and Medical Center. (Based on a paper submitted to the Fund for Psychoanalytic Research of the American Psychoanalytic Association.)
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_____. A New Psychoanalytic Theory of Therapy and Technique. Manuscript in preparation, 1979.

Weiss, Jos.; Sampson, H.; Caston, J.; Silberschatz, G.; and Gassner, S. "Research on the Psychoanalytic Process." Bulletin #3, December 1977. The Psychotherapy Research Group, Department of Psychiatry, Mount Zion Hospital and Medical Center. (Based on the presentations to the 1977 Series of Seminars on October 11 and November 8, 1977, Langley Porter Institute, Psychotherapy Evaluation and Study Center.)

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Wolfson, A., and Sampson, H. A comparison of process-notes and tape-recordings: Implications for therapy research. Archives of General Psychiatry, May 1976, 33: 558-563.