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by means of the research project

**„Categorical or Dimensional? Differentiation of the  
Treatment Techniques in short-term and long-term  
Psychodynamic Psychotherapy and Psychoanalysis.”**

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## **1. General information**

### **1.1 Investigators**

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### **1.2 Research project**

#### **Working Title**

„Categorical or Dimensional? Differentiation of the Treatment Techniques in Short-Term and Long-term Psychodynamic Psychotherapy and Psychoanalysis.“

#### **Area of Expertise**

Psychotherapy Process Research

#### **Expected time frame**

Total time of the research intent: 12 months

Beginning of the project: November 2009

End of the project: November 2010

### 1.3 Scientific cooperation

This dissertation will include clinical data from two extensive archives: the German “Ulmer Textbank<sup>1</sup>” and the North American “Berkeley Psychotherapy Research Program Archive (Berkeley-Boston, USA)<sup>2</sup>”, which is now housed in the Department of Psychiatry at MGH and administered by the Massachusetts General Hospital Psychotherapy Research Program – Harvard Medical School. There, Dr. Stuart Ablon and Dr. Raymond A. Levy trained thoroughly the main researcher of this project for the application of the “Psychotherapy Process Q-Set” (Jones 2000), which is the essential evaluation method for the studied clinical data here.

Another sample of patients will come from the ongoing “Munich Attachment- and Effectiveness Project (MBWP)” (Prof. Dr. Mertens and Dr. S. Hörz) which is a joint effort between the Department of Psychology from the Ludwig-Maximilians-Universität and the “Academy for Psychoanalysis und Psychotherapy München e.V”.

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<sup>1</sup> This archive was developed in the context of the German Special Research Field 129 “Psychotherapy Processes” (founded by the German Research Association (DFG) and includes a unusual large number of psychoanalytic and psychotherapeutic material.

<sup>2</sup> This archive has been collected over a period of twenty-five years from the original home of the PQS method by Enrico Jones in Berkeley (USA). The archive is the most extensive collection – transcripts, audiotapes, and videotapes – of psychoanalyses, psychodynamic psychotherapies and cognitive behavioral psychotherapy in the Nord-American world. From this large material 18 to 20 treatments are complete psychoanalysis or psychodynamic psychotherapies. With the untimely passing of Dr. Enrico E. Jones, the archive has been transferred to a disciple of his, Dr. Stuart Ablon,

(3) Prof. Dr. Wolfgang Mertens and Dr. Susanne Hörtz

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## **Ethical safeguards**

The responsible Ethics Committees have accepted this project. The patient information in the material will be confidential according to the requirements of the original patient consent forms and the Massachusetts General Hospital Institutional Review Board, the “Ulmer Textbank” and the “Munich Attachment- and Effectiveness Project (MBWP)”.

## **2. Introduction**

### **2.1 Background and significance**

The present empirical research project will contribute with clinical data from psychoanalytic and psychodynamic practice for the understanding of theoretical constructs currently in use among the psychoanalytic field.

The impact of psychoanalysis seems to be vanishing; although as a treatment option it has always been for selected patients, a continuous decrease seems inevitable nowadays. Luckily, psychodynamic psychotherapy has been keeping psychoanalytic constructs alive. More than 50 years ago, Gill (1954) differentiated theoretically between psychoanalysis and the nowadays-called psychodynamic psychotherapy. Since then, several opinions have emerged about their differences and similarities, although all agree that psychodynamic psychotherapy follows psychoanalytic theory in trying “to make the unconscious conscious” (S. Freud 1917) and includes all theoretical and practical aspects that this implies. Yet, what does it include?

Several comparative outcome research studies have been done between different

psychotherapeutic treatments, summarized by Grawe et al. (1994). But in order to take a look at their differences (while having similar effects) one must dip into the therapeutic process. The broad concept of psychotherapeutic or psychoanalytic process includes a wide range of factors that seem difficult for professionals to define and agree on. Ablon & Jones (2005) defend “that if analysts are given a common vocabulary and a relatively theory free set of descriptors they can agree on what constitutes an ideal analytic process at least at the level of a single session (p. 563)”. One of the factors that constitute the therapeutic process is the range of therapeutic techniques used in each treatment. Different techniques are taught to therapist training in different therapy schools and consequently therapists attribute a different degree of confidence in the effect such techniques have for the process of improvement. The usage of specific therapeutic techniques and its frequency of application are part of the treatment methodology. Thus, in order to look deeper into the different therapeutic processes, it seems useful to study the techniques, therapeutic interventions and their interaction with the patient, setting etc.

The “Handbook of Psychotherapy and Behavior Change” (Lambert 2004) states that ‘therapist interventions or techniques’ are the formal and deliberate responses that therapists make to help resolve their patient’s personal difficulties, based on their expert understanding of the patient’s presentation and the recommendations of the treatment model they follow (pg 337). There we can also find the considerable amount of studies (that will be cited here) concerning therapeutic techniques and its correlation to therapeutic outcome done over the past 60 years.

Several authors (Smith & Grawe 2000; Ablon & Jones 1998 etc.) have studied the broader approach of the techniques as therapeutic strategies as they investigate the aims and steps taken by the therapist to achieve them. Research groups from a psychodynamic background like E. Jones at that time in Berkley, D. Kivlighan in Missouri and R. Sandell in Sweden, represent the trend towards studying therapist interventions at a more inclusive and meaningful level, although they have so far shown rather mixed results.

Nevertheless, more authors occupied themselves with a more specified investigation of therapeutic techniques like the therapists’ ‘questioning’ (Stiles & Shapiro, 1994; Russel, Bryant & Estrada, 1996 etc.), ‘reflection and feedback’ (Claiborn, Goodyear &

Horner, 2002 etc.), 'prescriptiveness, guidance and advice' (Hayes & Strauss 1998 etc.), 'support' and 'evocative exploration' (Gaston et al. 1998 etc.), 'experiential confrontation' (Schmidtchen, 2001 etc.), 'activating patients resources' (Dick 1999 etc.), 'therapist self-disclosure' (Barret & Berman 2001 etc.). From all investigated constructs in this domain we choose to elaborate on the psychodynamic method of 'interpretation'. The aim of interpretation is to make the patients aware of things that are currently outside their awareness (Gabbard 2009). Usually this requires the therapist to explain something that is "not clear" to the patients through, for example, connecting two ideas that were not linked by the patients. The interpretation technique continued to receive attention from several researchers (Hoeglend 1993, 1996b; Hoeglend et al. 1994; Norville, Sampson & Weiss 1996; Stiles & Shapiro 1994; etc) although certain interesting results relatively to its effect on outcome need to be clarified:

"On the one hand, it is important to note that 24 previous studies have found the use of 'interpretation in general' to be fairly consistently, and occasionally strongly, associated with positive therapeutic outcome. On the other hand, there is consistent evidence, cited in the review by Henry, Strupp, Schacht and Gaston (1994) and confirmed by recent studies, that the use of 'transference interpretations' specifically in brief psychotherapies is associated with negative therapeutic outcome and ought to be avoided. The use of transference interpretation was developed as a way of dealing with transference resistances in the context of long-term psychoanalytic treatment (Freud 1912a), and purposes a long-standing positive alliance. Whatever its value may be in that context, its use as a technique in brief psychotherapies probably should be abandoned...(p. 342)".

The excerpt shows the psychotherapeutic techniques' influence on the therapeutic process and how the influences' quality varies according to the treatment setting or orientation. This would possibly lead us to one of the important discussions of the presented project, namely the use of interpretation while comparing long-term psychodynamic psychotherapy with its short-term version.

Although we see that the impact of therapeutic techniques on outcome has been fairly studied, in psychoanalytic literature more attention has been given to ideal

conceptualizations of therapists' intervention. The result is that therapeutic techniques are well defined<sup>3</sup>. However, the extent to which and specific form they are practiced has not been sufficiently studied to satisfy empirical-analytical standards of research. Several reasons could have led to this research gap. An early example was Glover's survey conducted in 1940<sup>4</sup> (the results have been republished in Glover's textbook "The Technique of Psychoanalysis" (1955)). But it remained unclear to what extent the answers he received from analysts at that time about their behavior and techniques, corresponded to what was actually said and done (common problem found in the application of questionnaires).

Curiously the divergence between the ideal of a treatment orientation and their actual practice can be seen through the application of prototypes that represent the ideal conception of an analytic hour. Ablon and Jones (2005) based on the Psychotherapy Process Q-set (PQS) developed a prototype of an ideal psychoanalytic hour by asking experienced psychoanalysts<sup>5</sup>. The correlation of that prototype with actual psychoanalytic sessions showed a fairly high correlation ( $r = .58$ ), though not yet a so-called "perfect match" (perfect correlation). What would happen if we would only correlate those items that represent the analyst's techniques (since the PQS has 2/3 of other items representing other aspects of therapy like the patients behaviors and the interaction with the therapist)? Would we obtain a comparable correlation? Would it be higher or lower?

Another attempt in the past to study interactions based on the sequence of interventions and reactions failed because no consensus could be found within the discussion group concerning the evaluation of individual interventions (Ulm 1968). The diversity of meanings that one psychoanalytic comment can have does not seem reducible to a single evaluation. This raises the question of whether empirical research of psychoanalysts' techniques must fail because of this plurality, or if a

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<sup>3</sup> Within psychodynamic psychotherapy independently to preferred theoretical models, Gabbard (2009) names some fundamentals of technique: "therapeutic alliance, specific types of interventions (like interpretation, observation, confrontation, clarification, encouragement to elaborate, empathic validation, psycho educational intervention, advice and praise), transference, counter-transference, resistance, working-through and termination" (S.44).

<sup>4</sup> Glover E, Brierley M (Hrsg) (1940) An investigation of the technique of psycho-analysis. Baillière, Tindall & Cox, London

<sup>5</sup> For further information on the construction of the prototype please read Ablon & Jones (2005) pp. 5-8.

compromised solution can be found between clinical psychoanalytic standards and the scientific requirement of sufficient reliability.

In the last decades, the “categorical and dimensional” differentiation of techniques used in psychodynamic psychotherapies or psychoanalysis created substantial discussions. In the field of psychoanalysis there is still a preference for categorical differentiation between psychoanalysis and psychodynamic psychotherapy technique, which has not been scientifically determined on the basis of the empirical analysis of the practicing technique. This categorical differentiation of both therapy forms was politically motivated (similar to DSM-V vs. OPD, 2007 S.27/28), although several empirical findings encourage the establishment of a more dimensionally structured differentiation of therapy forms. Nowadays, the “Psychotherapy Process Q-set” method (Jones 2000) allows these differentiations to acquire a dimensional perspective; in other words, to obtain a quantifiable classification. We believe this method can help us to fill this research gap and clarify some of the possible differences or similarities in the usage of therapeutic techniques in different oriented therapy settings.

## **2.2 Introduction to the “Psychotherapy Process Q-set” and its Applications**

Work of the last twenty years has seen the completion of papers detailing the construction and use of the Q-sort measure, psychometric properties of the measure, including item reliability, inter-rater reliability and validity as well as the Q-set’s application to the intensive investigation of single cases (Jones and Windholz, 1990; Jones, Cumming & Pulos, 1993; Jones, Ghannam, Nigg & Dyer, 1993). The Psychotherapy Process Q-set (PQS) provides a clear language for the description and classification of therapy process. Since the Q-items are not closely bound to theoretical concepts, but rather to notions of therapy process, the influence of observers’ theoretical predilections on their descriptions of the nature of process is subdued within the flexible but stabilizing framework provided by the Q-set. The units of analysis reflected in the Q-items are conceptualized at clinically meaningful levels and anchored, as far as possible, to concrete behavioral and linguistic cues that can be identified in recordings of therapy hours. A coding manual (Jones, 2000) provides definitions for Q-items along with examples of their application, and specifies the

rules governing the use of inference in making Q-ratings.

The Q-method can subsume and describe multiple time frames. In contrast, almost all process rating scales rely on recordings of segments of therapy sessions of varying length, forcing judges to rate a dimension of presumed relevance on the basis of relatively brief impressions. Most often, these data are then aggregated without consideration for meaningful factors of timing and context. With the Q-technique, an entire hour (transcripts, audio- or video-taped), and not just a small segment, is the time frame rated, allowing a greater opportunity to capture events of importance. Although the Q-method is anchored in the therapy hour as a natural time frame for inquiry into process, successive hours, or groups of hours, can be rated, so that the temporal range used for descriptive purposes (given the basic unit of the treatment hour) is limited only by statistical or quantitative considerations. The Q-method is unusually flexible in terms of research designs and data analytic strategies, and can be used in group comparison designs, in which Q-ratings of groups of cases (or hours) selected on some dimension of interest are compared, as well as in idiographic (or N=1) designs.

The Psychotherapy Process Q-set addresses with considerable effectiveness many of the complexities encountered in the study of the therapy process. It has been constructed and piloted with care, has extremely sound psychometric properties, has very good reliability, and is supported by strong validity data (see Jones, Hall, & Parke, 1991). It is, in short, an effective process measure that has opened the way to a wide range of research possibilities.

### **Past research**

Over the last few years, several papers making empirical contributions to the understanding of the therapy process and outcome in psychotherapy have been completed using the Psychotherapy Process Q-set (PQS). The PQS allows for an empirical description of therapy process and the identification of the active ingredients that predict positive outcome. The PQS has been used to study psychoanalytic, cognitive-behavioral, interpersonal, client-centered, Gestalt, and rational-emotive therapies (Jones, Cumming & Horowitz, 1988; Jones & Pulos, 1993; Ablon & Jones, 1998). An initial study used a data archive at the University of

California, San Francisco (Jones, Cumming & Horowitz, 1988). The study examined the effects of specific factors, that is, carefully defined therapist actions and techniques, in the treatment of a sample of patients being treated for posttraumatic stress disorder (PTSD). Results demonstrated that specific factors were indeed predictive of treatment outcome, though usually in interaction with patient pre-treatment disturbance level. The characteristics of process that predicted successful outcome with less- and more-disturbed patients have paralleled the long-recognized distinction between 'expressive' and 'supportive' approaches. An intensive study of two of these treatments for PTSD, one successful and one unsuccessful, demonstrated the utility of the large Q-method for tracing themes in single case designs, and for testing the effectiveness of a particular model for the treatment of PTSD with more- and less-severely disturbed patients (Jones, Cumming, & Pulos, 1993).

In another study (Jones, Parke & Pulos, 1992), 30 patients representing a range of neurotic disorders were treated in a brief, 16-session psychodynamic psychotherapy in private practice settings. The sample demonstrated statistically significant change from pre- to post-treatment, and a majority of patients met at least one criterion for clinically significant change. The results confirm the importance of many technical features commonly considered essential for successful brief treatments, such as transference interpretations and a focus on the therapy relationship, interpretation of defenses, and the reformulation of patients' in-therapy behavior. A longitudinal view of the process data suggests that these treatments were characterized by what could be described as a gradual shift from focusing on external, reality-oriented explanations for personal difficulties to an emphasis on inner experience and the relationship with the therapist.

Single case studies of long-term psychodynamic psychotherapy are currently near completion by Tai Katzenstein and Raymond Levy, whose work is funded by the Fund for Psychoanalytic Research of the American Psychoanalytic Association.

### **Prototypes of Ideal Treatment Process**

Some of the most recent work with the PQS involves the development and implementation of empirical prototypes of ideal therapy process (Ablon & Jones, 1998, 2005; Pole, Connor a. Ablon, 2008) and the programmatic study of the process

and mechanisms of change in the NIMH Collaborative Study of Depression (Ablon & Jones, 1999). Prototype methodology presents an innovative methodology for assessing adherence to treatment process and identifying the active ingredients in the process of psychotherapy. The PQS is used to sample the opinion of expert therapists. Q-type factor analysis determines whether experts from different theoretical orientations have distinct views of ideal therapy process. Factor scores are used to determine prototypes. Correlations of the prototypes and observer Q-sorts of therapy sessions represent the degree to which an hour of therapy conforms to the prototypes. Thus, the prototypes provide a post-hoc method for measuring adherence to treatment approaches. The degree to which an hour of therapy adheres to a prototype can also be correlated with outcome to determine if those aspects of therapy process which should in theory promote patient change, are in fact responsible for predicting positive outcome. Expert senior psychoanalysts were surveyed to develop the prototype of ideal psychoanalytic process. It was determined empirically that the experts could agree on what constituted good analytic process – at least at the level of a single psychotherapeutic session. The prototype of analytic process was reliably distinguished from prototypes of other therapeutic modalities (e.g., cognitive-behavioral and interpersonal process).

Three archival samples of brief psychodynamic psychotherapy and cognitive-behavioral therapy were originally studied using prototypes of ideal psychodynamic and cognitive-behavioral therapy developed by experts using the PQS (Ablon & Jones, 1998). The prototypes were used to assess the extent to which three archived treatment samples of brief psychodynamic and cognitive-behavioral therapy conformed to the prototypes. A remarkable finding from this study was that observer Q-sorts were positively correlated with the cognitive-behavioral prototype in both psychodynamic treatment samples. The psychodynamic therapists applied a notable amount of cognitive-behavioral strategies in addition to psychodynamic strategies in the first psychodynamic sample and almost as much in the way of cognitive-behavioral strategies as they did psychodynamic strategies in the sample of psychodynamic treatments of posttraumatic stress disorder (PTSD). In contrast, in the archived cognitive-behavioral treatment sample, there was a high positive correlation of observer Q-sorts with the cognitive-behavioral prototype, but a negative correlation with the psychodynamic prototype. The cognitive-behavioral therapists

applied a good deal in the way of cognitive-behavioral techniques, but did not foster a psychodynamic process. The cognitive-behavioral treatments appeared to follow the cognitive-behavioral model closely. The psychodynamic treatments that were studied clearly included a more diverse set of interventions. Cognitive-behavioral techniques were, in a sense, a sub-sample of the techniques used by the psychodynamic therapists.

The degree to which the treatments adhered to the prototypes was measured quantitatively and correlated with outcome. The psychodynamic prototype constructed by experts was consistently significantly correlated with positive outcome in both psychodynamic and cognitive-behavioral therapy. The cognitive-behavioral prototype was not consistently significantly correlated with positive outcome in either type of therapy. The intriguing result that a psychodynamic process predicts positive outcome in cognitive-behavioral therapy was true despite the finding that psychodynamic strategies were not very prevalent in these cognitive-behavioral therapies. The correlations with the Q-prototypes indicate that on average, the therapists were rigidly applying cognitive-behavioral interventions and not psychodynamic interventions. When the therapists did use psychodynamic interventions in the session, it was these interventions that were correlated with positive outcome. These findings demonstrate the importance of studying the therapy process in addition to outcome. What is presumed by a cognitive-behavioral treatment may actually contain significant psychodynamic ingredients or vice versa, and these interventions may be among the active ingredients in the therapy process. This may help to explain why different forms of treatment have achieved such strikingly similar results in traditional outcome studies.

### **The Psychoanalytic Prototype**

The following description, which concerns the construction and development of a psychoanalytical prototype, will be based on two studies by its developers, Ablon & Jones (1998; 2005). This prototype was constructed with the help of a group of highly experienced psychoanalysts (N=11), all of whom had numerous years of clinical experience (M=28; SD=10.2). The great majority of them were active publishers in the field of psychoanalysis and therapists had been trained under their orientation. Each of the members of this group was asked to rate the 100 PQS-Items in a scale

from 1 to 9, according to their understanding of an ideal psychoanalytic session. In addition, each member was asked to designate relevant aspects of the psychoanalytic process, which were not mentioned by the 100 Items. The feedback revealed that this group of highly considered psychoanalysts agreed that no relevant domain was missing. This demonstrates that the selected items are representative enough for the conception of the expert panel (Ablon & Jones, 1998). The level of agreement (coefficient alpha reliabilities) for the items rated by the analysts was very high ( $\alpha = .94$ ). Thus, the prototype was created through Q-Factor analysis. A data matrix was prepared: the 11 expert-psychoanalysts represent the independent variables, whose ratings of the 100 PQS items were correlated. Ten experienced cognitive-behavioral therapists were also asked to assess an ideal therapy session in their therapeutic perspective. The level of agreement between cognitive-behavioral therapists was high as well ( $\alpha = .95$ ). The ratings of all 21 therapists (psychoanalysts and CB-therapists) have been submitted to a principal components factor analysis. With the Q-factor analysis a prototype for each of these two orientations could be defined. The analytic prototype corresponds to the Q-factors (or principal components), which have been extracted through correlation within the group of psychoanalysts. The factor analysis yielded two factors, which together explained 69.3% of the variation of correlation within the 21 therapists. The ratings of all 11 analysts were had primary loadings on factor 1 “psychoanalytic process”. In contrast, all cognitive behavioral therapists were held on factor 2 “cognitive-behavioral process”. The average value of the factor loadings for the psychoanalyst group was .79 (range .69 – .87) and for the cognitive-behavioral therapists was .82 (range .64 – .89). Later on, the results showed that the ratings of each psychoanalyst were consistent with the ratings of the other analysts of the group (for a detailed description of the prototypes of the psychoanalytic and cognitive-behavioral process, see Ablon & Jones 1998). After undertaking a similar construction process for the cognitive-behavioral prototype, Ablon and Jones demonstrated that the psychoanalytic prototype did not correlate with the ideal cognitive-behavioral prototype ( $r = .00$ ).

For the readers’ interest, the following table presents the 20 most characteristic Q-Items from the psychoanalytic prototype, that is going to be used in my dissertation.

**Table 1. Rank Ordering of the Q-Items by Factor Scores on Ideal Psychoanalytical Process**

Q-Item	Item description	Factor score
90	P's dreams or fantasies are discussed.	1.71
93	A is neutral.	1.57
36	A points out P's use of defensive maneuvers (e.g., undoing, denial).	1.53
100	A draws connections between the therapeutic relationship and other relationships.	1.47
6	A is sensitive to the P's feelings, attuned to P; empathic	1.46
67	A interprets warded-off or unconscious wishes, feelings, or ideas.	1.43
18	A conveys a sense of nonjudgmental acceptance.	1.38
32	P achieves a new understanding or insight.	1.32
98	The therapy relationship is a focus of discussion.	1.28
46	A communicates with P in a clear, coherent style.	1.24
50	A draws attention to feelings regarded by P as unacceptable (e.g. anger, envy, excitement).	1.17
11	Sexual feelings and experienced are discussed.	1.12
82	P's behavior during the hour is reformulated by A in a way not explicitly recognized previously.	1.12
35	Self-image is a focus of discussion.	1,11
91	Memories or reconstruction of infancy and childhood are topics of discussion.	1.08
92	P's feelings or perceptions are linked to situations or behavior of the past.	1.05
62	A identifies a recurrent theme in P's experience or conduct.	0.95
3	A's remarks are aimed to facilitating P's speech.	0.92
79	A comment on changes in P's mood or affect.	0.88
22	A focuses on Ps feelings of guilt.	0.87

*Note: Factor scores derived from expert psychodynamic therapists' (N= 11) ratings of the Psychotherapy Process Q-Sort (PQS). A= psychoanalyst; P= patient.*

### **3. Research Project**

Dissertation summary „Categorical or Dimensional? Differentiation of the Treatment Techniques in Psychodynamic Psychotherapy and Psychoanalysis.” (Advisor: Prof. Dr. Dr. Horst Kächele)

In the field of psychoanalysis there is still a preference for categorical differentiation between psychoanalysis and psychodynamic psychotherapy technique, which has not been scientifically determined on the basis of the empirical analysis of the practicing technique. Today, the Psychotherapy Process Q-sort (PQS) method allows this differentiation to acquire a dimensional perspective; in other words, to obtain a quantifiable classification.

The aim of this dissertation is to observe the active process variables of psychotherapy treatment in 15 psychoanalyses, 15 long-term psychodynamic psychotherapies and 30 brief psychodynamic psychotherapies. For each of the treatments, four therapy sessions will be selected and analyzed with the “Psychotherapy Q-sort (PQS)” (Jones, 2000). The rating of each session will be compared with the psychoanalytic prototype (according to Ablon & Jones, 1998) in order to empirically determine active process variables of the two treatments. This should lead to the identification of active ingredients of the therapeutic process, which these therapeutic orientations may or may not share. Similarities and differences between psychoanalysis and psychodynamic psychotherapy will be found and may lead to valuable results. Furthermore, the determination of the correlation between specific process variables in two treatment types and the treatment outcome may offer preliminary conclusions about the comparison of process variables among the two treatment groups. In addition, this study will allow us to assess whether there is congruence between the therapeutic process (in psychoanalysis and psychodynamic treatment) and that of the psychoanalytic prototype.

This dissertation will gather an exceptionally large database of material on this field, leading to heightened scientific discussion surrounding the delimitation of psychoanalysis and psychodynamic psychotherapy.

### **3.1 Research questions and hypotheses**

#### **Research questions**

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

In this study, the well-established Psychotherapy Process Q-Set (PQS) methodology will be applied. The PQS enables a detailed examination of the

psychotherapeutic process underlying these treatments; helps to characterize the applied techniques of all 30 treatments at 4 measuring points in the longer treatment samples and at 3 measuring points in the short-term psychodynamic psychotherapy sample. Additionally, the analytic prototype of an ideal psychoanalytic hour developed by Ablon & Jones (2005) will be applied to the already mentioned three treatment samples. The degree to which these treatments foster an analytic process as represented by the prototype will be measured quantitatively.

On an exploratory base, the study aims to compare PQS-items at the beginning of the treatments (measuring point 1 with the later points in time) and to seek differentiations that could be more significantly related with the variable time than with the setting or applied psychotherapeutic techniques.

## **Hypotheses**

Null Hypotheses: No differences in the usage of therapeutic techniques can be found between the three patient samples because there is more influence of patient, therapist or situational characteristics than from the actual therapy methodology.

Hypotheses 1: Differences between at least two of the three groups will be found:

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

Hypotheses 2: The “psychoanalytic prototype” will correlate higher with the therapy sessions from the psychoanalytic sample than the sessions from the two other psychodynamic samples.

## **3.2 Statistical analysis**

Dr. Dan Pokorny, Ph.D., is a mathematician, psychotherapy researcher, and

methodological consultant at Ulm University. His research interest includes process research, text analysis, “core conflictual relationship” themes, verbalized emotions, guided affective imagery, and exploratory statistical procedures. All statistical analyses of this research project will be conducted under his advice and supervision.

Firstly, it must be stated that the statistical analyses of our three research samples will mainly follow the procedures exemplified in the PQS literature (some presented in section 2.2). All statistical analysis will consider each sample, defined by different therapeutic schools as a whole, as well as the individual treatment processes integrated in each sample. The calculation of means and variances of the PQS items for each patient’s therapeutic process is planned to proceed with group-comparison strategies. Other statistical procedures may be included. The 4 different measuring points of the therapeutic process will be also taken into account and compared.

Specific attention will be given to the “PQS research tradition” that defends the importance of looking for repetitive interaction structures among the therapeutic processes. This is achieved through a statistical procedure, the exploratory factor analysis, which, for instance, may result in four clusters of items that can be interpreted as capturing interaction structures usually very important to the change process (Jones, 2000). This aims to distinguish interaction structures from the samples with differing theoretical orientation; possibly single cases will be picked out from these samples as explanatory examples.

The application of the prototypes will strictly follow the calculations done by Jones & Ablon (2005) for investigations of similarity between different therapy orientations. To understand which therapy process adheres more closely to the analytic prototype we will compare the full and component adherence scores using paired t-tests. These analyses will be accomplished with SPSS 17.

### 3.3 Methods

The chosen method for the data analysis of this research project is the “Psychotherapy Process Q-set (PQS)” developed by Enrico Jones (1985; 2000). The PQS Manual (2000) details instructions for Q-sorting, and provides the items, their definitions, and examples. The construction of the instrument, and reliability and validity data, as Jones et al. (1992) points out, are reported elsewhere (Jones et al., 1988; Jones, Krupnick, & Kesig, 1987). To illustrate the Psychotherapy Process Q-set (PQS) method we will mainly follow Jones et al. (1992) description:

The 100-item PQS provides a basic language for the description and classification of the therapy process. The Q-method requires judges to sort the 100 items into nine piles ranging on a continuum from least characteristic on the far left (category 1) to most characteristic on the far right (category 9). Q-items sorted into the middle pile (category 5) are characterized as neutral or irrelevant for the material being rated. Most items have specific instructions that provide examples of the distinction of between uncharacteristic and neutral ratings. For example, one item describes the therapist as “distant or aloof” when rated in the characteristic range. However, when rated in the uncharacteristic range, the item indicates that the therapist was “genuinely responsive or affectively involved” (the opposite of distant or aloof). Only if the item were irrelevant to the description of the hour would be placed in the neutral range (Ablon & Jones, 2002). The number of items to be sorted into each pile conforms to a normal distribution, which requires judges to make multiple evaluations among items, thus avoiding either positive or negative “halo effects.” Many process-rating scales employ small segments of therapy hours as units of measurement. In contrast, with the PQS the entire hour, not just a small segment, is the unit being described. This procedure permits judges to form hypotheses and study the material for confirmation or alternative conceptualizations over a number of interactions.

Psychometric Properties (Jones et al. 1992):

The Q-method has some unique psychometric properties. In most multi-item instruments there is considerable redundancy among the items, so they may be

grouped or summed into a smaller number of scales used to assess a more general construct. It is usually considered desirable that the redundancy among items, or factor structure of the instrument, be invariant across samples. In contrast, the PQS was constructed in a manner that insured minimum redundancy among its items; indeed, routine factor analyses of data sets typically yield 20 to 30 factors, that is, do not reflect invariant factor structure (Jones, Hall, & Parke, 1991). The interrelations that may emerge among the Q-items are meant to vary across forms of therapy, types of clients, or stages of therapy. The relatively large number of items in the Q-set increases the possibility of making a Type I error (accepting as true a relationship that is actually due to chance). While techniques exist for minimizing Type I errors (e.g., Davis & Gaito, 1984), they increase the probability of a Type II error (dismissing a true relationship as the result of chance). The danger of making Type II errors in the early stages of research is that results judged to be non-significant may not be investigated further. In contrast, Type I errors can be rectified because false positive results are unlikely to be replicated in subsequent research. The choice of risking a Type I error and minimizing the Type II error is consistent with a descriptive, discovery-oriented approach to process research (Greenberg, 1986). Despite the fact that the number of Q-items cannot be reduced by factor analysis, some items may be screened out if their placement is in the middle range of the Q-continuum and have little variability. Another strategy for data reduction is to select a subset of items based on their extreme placement.

### **The Application of the Prototype**

The procedure for the application of the prototype in this project will be guided by the procedure presented by Ablon & Jones (2005) in their work "On Analytic Process". The psychoanalytic Q-prototype will be employed to evaluate the brief and long-term psychodynamic psychotherapies and the psychoanalysis. The psychoanalyses will be previously rated with the PQS. A prototype adherence score will be calculated for each treatment session. The degree to which each treatment session adheres to the prototype in a given hour can be measured. The process variables that are present in each of the treatments can be observed. The correlation with the prototype will be then transformed into z-scores using Fisher  $r$  to  $z$  transformation. The z-scores

represent the degree to which an hour of psychodynamic psychotherapy or psychoanalysis is correlated with the analytic prototype. In this way, the z-score will demonstrate to what extent a psychodynamic psychotherapy or psychoanalysis is similar to the analytic prototype. The z-scores will also be correlated with the outcome in the archived treatment samples. This will determine whether those aspects of the therapy process, which in theory should promote patient change, are in fact responsible for predicting positive outcome.

### **3.3.1 Research sample**

Three sets of archived treatment samples will be used in this study:

- (1) Psychoanalysis;
- (2) Long-term Psychodynamic psychotherapies;
- (3) Brief psychodynamic psychotherapies.

(1) 15 audio-taped and transcribed psychoanalyses from Munich; (2) 15 videotaped longer-term, twice-weekly psychodynamic therapies from the Berkeley Psychotherapy Archive (Boston) with exception of 4 audio-taped treatments coming from the Ulmer Textbank Archive; and (3) one bigger sample of 30 brief psychodynamic psychotherapies collected by the Mount Zion group. Therapy sessions (audio- or videotaped) were randomized for each patient and rated with the PQS<sup>6</sup>. The Q-ratings were completed by psychologists and advanced doctoral students in clinical psychology trained in application of the Q-technique. So far the inter-rater reliability ranged from .68 to .90. For sample (1) and (2) four measuring times were to capture different points throughout the treatment process. The brief psychodynamic psychotherapy sample had already three measuring times defined (only three sessions through treatment were recorded), but those points are representative of the four measuring times from the longer treatment samples. The total of 60 patient's treatments required this data collection from the already mentioned different samples. Consequently the patient diagnoses were accessed differently from archive to archive, but all are documented. The majority of the

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<sup>6</sup> In case of the psychoanalytic sample (1) this process is not terminated.

patients were suffering of depression. Concerning the outcome data some is available, but the assessment instruments (e.g *Symptom-Checklist-90-Revised* (SCL-90-R; Derogatis et al., 1976; Franke, 1995); *Global Assessment of Functioning* (GAF; American Psychiatric Association, 2004) are not homogeneously administrated to enable process-outcome correlations. But some interpretations may be possible.

### **3.3.2 Measure**

The psychotherapy process measurement chosen to evaluate the psychoanalysis and psychodynamic psychotherapy treatments will be the already described method of Psychotherapy Process Q-Sort (Jones 2000).

### **Rating Process**

Verbatim transcripts, audio- and videotapes of therapeutic sessions of the “Jones Psychotherapy Archive” will be rated using the PQS Method. Two independent raters will rate the same material. A third rater will be added when sufficient reliability is not achieved (below .50 Pearson product-moment correlation coefficient).

## **4 Time Schedule and Cost Overview**

### **Time schedule**

Part 1 (6 months):

- Accomplishment of all the PQS Ratings;
- Data entry and Organization of process measurement (PQS)
- Theoretical preparation considering the psychotherapeutic process research and specificities of the therapeutic orientations (psychoanalysis and psychodynamic psychotherapy);

Part 2 (6 months):

- Data analysis
- Interpretation of results
- Written composition of results of the project (Dissertation)

### **Cost overview**

The present research project is part of a dissertation, which has a non-funded, neither paid PhD student position at University Ulm. As a consequence the costs of this project will only concern the living and work expenses of one researcher, the student Carolina Seybert. The Department of Psychosomatic Medicine and Psychotherapy will support working material and most literary acquisitions. Possibly money for data analysis will be required. IPA funded money for data collection in Boston.

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