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Running head: ALLIANCE EVOLUTIONS IN STDP

Alliance Evolutions over the Course of Short-Term Dynamic Psychotherapy (STDP):

A Case Study

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Abstract

Alliance evolutions, *i.e.*, ruptures and resolutions over the course of psychotherapy, have shown to be an important descriptive feature in different forms of psychotherapy, and in particular in psychodynamic psychotherapy. This case study of a client presenting elements of adjustment disorder undergoing short-term dynamic psychotherapy is drawn from a systematic naturalistic study and aims at illustrating, on a session-by-session-level, the processes of alliance ruptures and resolutions, by comparing both the client's and the therapist's perspectives. Two episodes of alliance evolution are more fully studied, in relation to the evolution of transference, as well as the client's defensive functioning and core conflictual theme. These concepts are measured by means of valid, reliable observer-rater methods, based on session transcripts: Defense Mechanisms Rating Scales (DMRS; Perry, 1990) for defensive functioning and Core Conflictual Relationship Theme (CCRT; Luborsky, & Crits-Christoph, 1990) for the conflicts. Alliance is measured after each session using the Helping Alliance questionnaire (HAQ-II). Results indicate that these episodes of alliance ruptures and resolutions may be understood as key moments of the whole therapeutic process reflecting the client's main relationship stakes. Illustrations are provided based on the client's in-session processes and related to the alliance development over the course of the entire therapy.

Key-Words: Case Study; Alliance; Transference; Defense Mechanisms; Psychodynamic Psychotherapy

Alliance Evolutions over the Course of Short-Term Dynamic Psychotherapy (STDP) : A Case Study

Therapeutic alliance has been shown to be related to psychotherapy outcome (Martin, Garske & Davis, 2000). Several authors have suggested that alliance should not merely be measured at one point in time, but rather be understood in its changes over the course of the entire treatment (e.g., Castonguay, Constantino, & Grosse Holtforth, 2006). Empirically, recent studies have shown the relevance of alliance evolution as being related to outcome (de Roten, Fischer, Drapeau, Beretta, Kramer, Favre, & Despland, 2004; Kivlighan, & Shaugnessy, 2000; Kramer, de Roten, Beretta, Michel, & Despland, 2008; Kramer, de Roten, Beretta, Michel, & Despland, 2009). The afore-mentioned studies use formalizing procedures enabling the representation of either (1) general growth tendencies of alliance over the course of psychotherapy or (2) alliance patterns as groupings of clients presenting similar alliance evolution over the course of psychotherapy. Both methods are based on the principles of regression, focusing on the mean evolution and neglecting the session-by-session momentary fluctuations of alliance. As suggested by Safran and Muran (2000) and shown by Stiles, Glick, Osatuke, Hardy, Shapiro, Agnew-Davies, Rees and Barkham (2004), the shape of alliance evolution may be characterized by local (session-by-session) V-shapes, generally interpreted as alliance ruptures and resolutions; the latter may be related to outcome.

Alliance ruptures/resolutions and transference

According to Safran (1993) the moment of alliance rupture is understood as a “window into core themes” of the client (p. 13). It may be postulated that at the moment of alliance rupture, the clients and therapists enact the vicious circle which corresponds to the client’s core conflictual relationship theme (Luborsky & Crits-Christoph, 1990). For instance, an alliance rupture may be the result of a therapist intervention aiming at pushing a withdrawn client to self-disclosure (Safran, 1993). From the perspective of psychoanalytic theory, such

interactional dynamics may be paralleled to the transference-countertransference dynamics in psychotherapy. Negative affect in the therapist is provoked by the enactment of the core conflictual relationship theme in the therapeutic relationship. Alliance ruptures therefore have an important diagnostic function in the reconstruction of the client's conflicts. Alliance resolution phases follow the moments of ruptures in positive therapeutic processes (Safran, 1993). They are characterized by what Alexander and French (1946) have called the corrective emotional experience. The latter concept describes the therapeutic attitude facing the alliance rupture. Clinical illustrations of these processes may be found in de Roten, Michel and Peter (2007).

The role of the client's psychodynamic characteristics

Defense mechanisms, reflecting the person's structural functioning, are key-concepts in psychodynamic formulation and treatment. They are postulated to change over the course of dynamic psychotherapy, as shown by Perry (2001). A client's defenses change throughout psychotherapy along the hierarchy of adaptiveness, from immature defenses to neurotic and mature defenses at the end of treatment. A recent study showed a medium effect size for change in the client's defensive functioning over the course of Short-Term Dynamic Psychotherapy (STDP; Kramer, Despland, Michel, & de Roten, 2010). Defensive functioning may also be related to the individual's intra-psychic conflicts (Luborsky, & Crits-Christoph, 1990; de Roten, Drapeau, Stigler, & Despland, 2004).

The aim of the current single case study is to present a possible articulation between clinical material and research-informed assessment over time, in particular around the notion of evolution of the therapeutic alliance. This single case study is greatly inspired by the pragmatic paradigm (Fishman, 1999) which tends to bridge the gap between opposing movements, *i.e.*, the positivistic approach versus the hermeneutic approach to the clinical phenomenon. The present single case study is based on the session-by-session monitoring of

alliance as measured by a self-report questionnaire, in that it aims at identifying alliance ruptures and resolutions. These episodes are related to the clinical evolution of the case – the underlying psychological meaning of the alliance ruptures and resolutions - as well as psychodynamic characteristics, *i.e.*, defense mechanisms, the core conflictual relationship theme and transference issues.

Method

The Client

Julia is a PhD student who has come to see us because she has been suffering from bouts of weeping and diffuse anxiety for several weeks, and this is stopping her from getting on with her work. She presents with a depressed way of thinking and various somatizations. This symptomatology appeared when Julia was coming to the end of her doctoral thesis and would have to start thinking about her professional career. In addition, she was not very happy about having two thesis supervisors as she felt that there was a certain tension between them. One is ambitious and a good researcher and the other gives priority to his family. She finds this situation confusing and it is paralyzing her.

Julia is the youngest of three children; both her parents went to university. Her parents married young while still at university. Her childhood was marked by several house moves to different language zones, due to her father's university career. Her mother gave up her career to follow her husband. « My mother sacrificed her career for that of her husband» were her exact words.

Julia remembers a particularly difficult moment in her early teenage years when the family moved. When she was 18, her parents separated. Julia chose to finish her schooling alone. She came back to her hometown to round off her studies and start on a thesis. The return was not easy in the beginning and Julia went through “a period of depression” because she had trouble in re-adapting.

An important element is that Julia has been in an intimate relationship for five years now and is beginning to see it as a long-term commitment. Her boyfriend would agree to go abroad with her if her professional plans required such a move. The question of having children is a cause of distress: “It’s impossible to be a PhD student and pregnant !”

Julia is in a crisis when she consults - at a crossroads both professionally and existentially. The difficulty she has in making a choice seems to relate to her parents’ contrasting lifestyle. She realizes she is embarking on the same path as her father and feels a certain rivalry yet also seeks to please him by following in his footsteps. But how can she conciliate her career with her life as a woman reflecting the image of her mother and the sacrifices her mother had to make? Her internal conflictuality becomes reality in her discomfort regarding her two thesis supervisors on whom she projects.

We need to note that this client did not present any psychiatric diagnosis nor had clinically significant symptoms (as reported on SCL-90) at intake, discharge and follow-up.

The client explicitly agreed with the use of the data related to her psychotherapy for research.

The Therapist

The therapist is an expert in psychoanalytic psychotherapy and psychoanalysis. In this particular context, he offers specific short-term dynamic psychotherapy for university students (Gilliéron, 1997; Michel & Despland, 2006), in particular within the context of a naturalistic study focusing on psychodynamic psychotherapy of adjustment disorder (Kramer et al., 2010).

The research team

The research team was composed by the therapist and two senior researchers in psychotherapy (co-authors). All members of the team have expertise in methodological

issues, two are psychologists (PhD), one is a MD. The use of the therapist as a member of the research team is described under Procedure.

Goals and context of treatment

The aim of the psychotherapy is to enable the client to become aware of and work through this crisis hypothesis. This will serve as the focus for the beginning of psychodynamic psychotherapy of a limited duration (34 sessions) occurring once a week. The therapy took place within an institutional setting (psychiatric clinic), enabling the client to be reimbursed for the treatment according to Federal Law.

Instruments

Therapeutic alliance. To monitor the therapeutic alliance, the patient and the therapist were asked to fill out the Helping Alliance questionnaire (HAQ-I) developed by Luborsky (1976; Alexander, & Luborsky, 1986) at the end of each therapy session. This inventory consists of 11 items rated on a 6-point Likert-scale (ranging from -3, I strongly feel that it isn't true, to +3, I strongly feel that it is true). Only the mean score of all the items was used. The HAQ-I has been shown to have a good reliability and validity and it correlated with other well-validated instruments (.74 to CALPAS and .74 to WAI according to Hatcher & Barends, 1996). Internal consistency of the HAQ in the sample from which the case was extracted ranged from Cronbach α \square .79 to \square α =.89.

Defense Mechanisms. The Defense Mechanism Rating Scales (DMRS) was used to assess defense mechanisms (Perry, 1990; Perry et al., 2004). The DMRS is an observer-rated method that can be applied to the audio or video recording or the written transcription of various forms of interviews or of therapy sessions. Many studies have supported the validity and reliability of the method (e.g., Perry, 2001; Skodol & Perry, 1993). The defenses described in the DMRS are comparable to those listed and described in the DSM-IV (APA, 1994). The instrument includes a total of 30 defense mechanisms assigned to 7 hierarchical

levels of defensive functioning: high adaptive (mature), obsessional, other neurotic, minor image-distorting, disavowal, major image-distorting, and action defenses. Each of these levels includes 3 to 8 individual defenses. As each level of defensive functioning is weighted according to its level of maturity, an overall defensive functioning score (ODF) can be computed to reflect the patient's overall defensive maturity. This overall score is used in this study.

Transference. Transference was assessed by two methods, one well-validated (CCRT) and the other exploratory (Transference Dimensions Monitoring; TDM). We used both, in order to provide two perspectives on the same concept and to explore the pre-validity of TDM.

1. The Core Conflictual Relationship Theme (CCRT; Luborsky & Crits-Christoph, 1990) is a content-analytic method of the patient's relationship experience. The CCRT was originally developed to reliably identify interpersonal relationship patterns described in narratives told during psychotherapy. These narratives are the basis for the CCRT method which describes the relationship pattern in terms of 3 components: (a) wishes, needs, or intentions expressed by the subject (Ws); (b) expected or actual responses of the object (ROs); and (c) responses of the self (RSs), *i.e.*, the emotional, behavioral, or symptomatic reactions of an individual to the other's response. The most prevalent of each of the 3 components is used to formulate the CCRT which is the most pervasive relationship pattern across the self-other interactions. Negativity scores of RO and RS, in comparison with the W, may be computed.
2. The Transference Dimensions Monitoring (TDM) is a qualitative rating that we developed for this research. The instrument assessed two independent dimensions: (1) the nature of the transference (which refers to the maternal or paternal quality of the transference) and (2) the valence of the transference (which refers to the positive or

negative valence of the transference). For the coding, the two orthogonal dimensions are placed on a target graph. After each session, the therapist placed a point in the target graph that best represents his perception of the two dimensions of the transference during the session.

Procedure

Alliance and transference evolutions were depicted as graphs (Figures 1 and 2) and submitted to all co-authors, including the therapist, in order to identify “significant” episodes over the course of the psychotherapy on these variables. All ratings (alliance and transference) were available to all co-authors at that time, in order to be able to make cogent decisions for further analysis. Several consensus meetings were organized, intersticed with personal reflection; thus, the consensus procedure was inspired by the Ward method in qualitative psychotherapy research (Schielke et al., 2009), yielding an iterative process towards consensus. Thus, the team met about 10 times during a one-year-period. The authors identified two significant episodes: (1) sessions 4, 5 and 6 and (2) sessions 21, 22 and 23. The first sessions of each significant moment may be described as “alliance rupture process” (sessions 4 and 21), and at the subsequent two sessions, the alliance scores reach the local means, again (sessions 5 and 6; sessions 22 and 23); thus, they may be called resolution sessions. These sessions were transcribed and analyzed using the DMRS and CCRT rating scales.

Results

Therapy Phases

Using notes taken during the treatment sessions as a basis, the therapist sought to describe the evolution of the psychotherapy in function of the themes and relational movements (alliance and transference) throughout the psychotherapy. This work resulted in the description of four successive phases of the treatment. Therefore, the status of what

follows is the subjective interpretation of the therapist (and first author). We first describe the therapy process from the clinical viewpoint – from the therapist’s perspective – and then report the results from the scales.

Phase I. Initial stage (sessions 1 to 4)

In the first few sessions, Julia appears rather inhibited: « With women we talk more easily than with men. » The therapist tells her that she hasn’t made things easier by choosing a male therapist. For her, men seem more knowledgeable, which takes the therapist back to her early years marked by a fairly positive paternal transference. Is she trying to attain this phallic force which women to a certain extent lack ?

She bears in mind those women who are not as ambitious as she is. In fact, this is exactly what she would like to have at the moment – a female boss; she says she needs such a female role-model. She compares herself with her mother who never worked fulltime. « My father did little at home. There was one bathroom for the men (her father and her brother) and another for the women (her mother and the two daughters). » She frequently refers to her mother during the first sessions. « She doesn’t really listen to me, as if she weren’t really interested in what I do, » she says, « but I don’t doubt that she loves me.» She sadly recalls her parents’ divorce, seemingly disillusioned : « It came as a complete surprise ». She realizes that it was « the world upside-down » with the parents leaving the family home and the teenagers staying behind !

She appears uneasy in the therapist’s presence, who reminds her of her father with whom she has trouble talking about her feelings. Is it because she thinks the therapist holds a certain knowledge, like her professors who exclude her from certain decisions against her will? The therapist points out the connection between this distress and such decisions as her parents’ divorce, when she also felt excluded. Then other memories come back – her departure for another country at the age of 16 and the anger she felt because she had the

impression that nobody took her opinion seriously. The therapist links this moment with where she is right now in the process of psychotherapy, for she has to take part in deciding whether to undertake psychotherapy and in which environment (session 4) .

Julia also recalls her return two years later when she was 18 and her parents' separation. Here the first signs of sadness become apparent and for the first time she says what she felt like when she was faced with a broken home. This leads her to become aware of the fact that she has been blocking out her sadness. The therapist interprets what she has often told so far, that if the separations weren't important and that she had spent all her childhood and adolescence feeling sad about other things without really knowing why, just as she doesn't know why she is now seeking treatment. After a moment of silence she tells that some years ago she read a novel which made her cry floods of tears for no real reason. She cannot remember the name of the book.

Phase II. Concerning self control (sessions 5 to 17)

In the following session (5) she refers to her sister's various illnesses which upset the whole family. There is a contrast between her sister and herself, who is in good health and has no problems. This reminds her of her mother, who, when Julia was thinking of seeking treatment, told her that in her opinion Julia did not need to see a psychotherapist. The therapist notes how difficult it must be to accept her sadness and to talk about it. Will he agree to see her, or will he just minimize the situation, as her mother did?

In the next session (6), she goes back to the difficulty she has to admit that she is not well and needs attention. Then memories come back to the time when she found it so difficult to find her place when for the first time she moved to a foreign town at the age of four. If ever she should return there, she would like to visit the places of her childhood, including her school. As the latter has been pulled down, she wonders « if this is not really like a whole part

of my life which has disappeared », and this upsets her. She is starting to find it hard to attend these sessions and cries and realizes just how much she has suffered and how much she has kept bottled up. Shaken by the emotions aroused, she comes back to the choice between sacrificing a career or a family, which she sees as not only inevitable but also unbearable. Does her professional choice have something to do with her father ? Will her whole therapy consist of settling something with her father?

The first break in psychotherapy sessions lasts two weeks which is a relief to her (8). She brings back the subject of her career and comparisons with her father. Her own ambition is put in question. At 18 she found herself alone, as she refused to return with her parents. In fact, she remembers that it wasn't so easy, and that sometimes she drank too much at the week-end. Was this to forget her solitude ? She finds it hard to come to the therapy sessions. Don't we always talk about the same things ? The therapist tries to work on her resistance to facing up to certain suppressed affects. She recalls images of this period, remembering that her parents' divorce seemed to be the end of the world to her. A dramatic separation. She is beginning to feel furious with her father for leaving for another woman.

In the following session (10) she says that she finds she had been overemotional. She once again sets up her defensive system. She talks about memories of her departure and her life in Canada, how she feared talking about it at school. Then she remembers that one evening, with a schoolfriend, she got into the school and set fire to the board with all the holidays marked on it, so that time would stand still. But what she particularly found hard at that time enables her to evoke the positive sides of this uprooting. She gives a lot of thought to her relationship with her father. He suggests that she could spend her holidays with her stepmother and him but she hesitates. Can she bear his traits of character which she knows she has too ? Several times she speaks of the conflictual aspect which frequently comes to the fore in her relationship with her father. From now on, several sessions will focus on this

relationship. A certain inhibition is becoming apparent, and a symptom comes to light – her phobia of driving since she returned to her hometown. She is terrified of running over someone. The therapist points out the aggressive element. As he sees it, she also needs to be driven now whereas she has always said that she could manage alone. She becomes aware of the repetitive aspect of her journeys, playing an active part in such. This makes her think of material with regard to her own sexuality and the passive position in which she feels she is during sexual relations. Here too there is no medial position.

Is a positive paternal opinion, as in this case the therapist's, so necessary for one to be loved and to love oneself? She explains how uneasy she feels when she weeps during therapy (14). The therapist asks her if it is really necessary to do everything right to be loved and need she really hold back her tears here as she does with her father. Identifying herself with her father means having few emotions, and expressing even fewer. The place where I always used to cry, she says, was at the gynecologist's. Is this specific to her female identity (15) ?

A fascinating discussion with experienced colleagues strengthens her ambition to continue in research (17). The therapist points out to her how pleased she was to sit at the same table as her superiors. She is annoyed with the therapist for linking her pleasure in this case to her father. As if, the therapist tells her, linking him to something detracts something from him. The therapist's remarks make her doubt about herself, like those of her father. She feels she is her father's daughter because she is identifying herself with him. The therapist intervenes and wonders if she could choose a path because her father chose it before her or because it is the best for her. She is affected by these words.

Phase III. Concerning greediness (sessions 18 to 23)

Her contacts with her father are improving (18): a « reconciliation » which leads her to tell herself that she needs to make some compromises regarding her career. Financial problems arise concerning the therapy, once again making a link with her father and the

question of money. She wants to assume her responsibilities but, after a period of (anal) self control, she shows far more oral voracity. She talks about her relationship with food, her craving for sweet things, which she no longer wishes to limit, this hunger which also makes her remember conflicts with her mother who tried to keep her greediness in check. As the therapist mentions her greediness, her fear of going out, the question of security, money and food, she thinks of an apple which her mother used to put in her school bag, just in case. Her mother was not necessarily there but her apple was – the very same security which helps her feel close to the little baby in her who “is speaking”. She also mentions that on leaving the session, she often goes to buy a little bun, across the road, but won’t today. The therapist tells her that she doesn’t need to go because she has been able to talk about her greediness, moreover just before a two-week-break (20).

In the next session, she admits that she did in fact buy a bun when she left, as she was too scared of being hungry. Tense, with taut muscles in the nape of her neck, she talks again about her worries about her future. She feels that she is once again experiencing the sensations and emotions of her childhood and is surprised that she wants, maybe even needs to see the therapist again. What is troubling her is that she is not unique and that after her, there will be other patients. We talk about her greed and her desire to be exclusive, drawing a parallel between her mother’s apartment where she sleeps every time she goes to see her and the therapist’s office. She says she has trouble sleeping in her mother’s flat with her boyfriend. This opens a discussion, after the mention of her greediness, focusing on her rivalry and leading her to question her femininity and her sexuality. The therapist and the client then talk about the competition between her mother and herself. Feelings of incest and rivalry are uncovered. It is she who has kept in touch with her father, whereas her mother broke off all relations after the divorce (21).

Once this issue comes to light, a certain resistance becomes apparent and she starts to complain about being forced to come for therapy. Now she can accept that before they divorced, her parents also had a relationship. This leads to the question of her hopes of the choice of a husband, marriage, a family. The idea of being together then separating enables the therapist to remind her that the end of the psychotherapy is no longer so far off.

She comes to the following session with her first dream (22): « I was having a baby ! We were on a walk. I forget to feed the baby but he doesn't cry. After two days he starts crying; I wrap him up in aluminum foil to keep him warm.» This dream reminds her of her desire to be pregnant with images of larvae representing newborn babies. She thinks of breastfeeding, which creates a bond with the baby, this irreplaceable feature of womanhood. The therapist also recognizes her in this baby, who is left in her charge. Is this a part of herself which she is dealing with now? This interpretation makes her weep a lot, arousing sensations and feelings that she describes as coming from afar. It is both a memory of eating anything when she was very small, and other memories of having to eat when her mother did not come home at lunchtime and she had to get her meal herself. This expresses her sadness at certain times in her life when she felt an emotion without associating it with a representation. For instance, this week she cried a lot, quite out of proportion, because a colleague was leaving. This reminds her of her loneliness, particularly the fact that her boyfriend lives in another town and that she sees him only at weekends, which until now she has never mentioned. The therapist comes back to the baby in the dream, her greediness, her wish to be held in someone's arms, and the therapist's and the client's upcoming separation. That makes her think of an umbrella because she wants to distance herself from the wet tears. Then come the sadness and reproaches that the therapist will be leaving her, for she likens this to a mother who used to leave her in a nursery rather than hold her in her arms. As if she could at last admit how much she had suffered. Thinking again of the photo album the nursery gave her,

she speaks about the first separation when she was 4-5 years old, after the family moved home. Shortly afterwards, she heard that her infant school teacher had died. The therapist links this death to the disappearance of her childhood memories which she has repressed until now and to a two-week interruption in therapy sessions (23).

Phase IV. Talking about the end (sessions 24 to 34)

When she comes back (24), she says that she feels that something has changed in the consulting room, which leads the therapist to relate this to the separation and the changes that she is going through. At this point she meets a teacher who she finds fascinating as she is both the mother of several children and very successful career-wise. In a burst of self-identification, she sees her as a role-model. Time passes. Then the client speaks about separation and the desire of being pregnant comes up again. The therapist links this to the baby she dreamt about, to herself. Once again she misses a session for professional reasons. Then she returns and comments on the fact that the throw on the sofa has been changed and other alterations have been made in the therapist's office (27). The therapist points out that obviously quite a number of things have happened in her absence ! After criticizing all these changes, she thinks of her father who she realizes now also hesitates from time to time in certain situations. She sees changes in her relationship with her father who seems to be less idealized. She comes back to all the current transformations in the office which greatly disconcert her; she realizes that she needs a stable place, probably because this is the last session before the separation of the summer holiday. She understands that this office has its own life, that it exists even when she is not there. She can link this with what happened with her parents when she was away. Other changes occurred in the family within a very short lapse of time. That was when she decided to take up an academic career thus following in her father's footsteps.

At the time of the separation the desire to have a child is intense and urgent. How can she remain a woman and have plans for a career, yet still mourning self-fulfilment since « I thought that I had everything but I'm a woman ». She is working on her ideals, on negotiating with her boyfriend, but becoming somewhat conflictual in her plans.

She comments (32) on the fact that for the first time she has come to the session by bike and is proud of herself. The therapist succeeded, she tells him, signifying by this the end of the therapy. The therapist reminds her of this image and she replies that she now knows how to get around and that the therapist can now let her manage alone. This is followed by a series of memories about her father to whom she wanted to show that she had grown up. The bike is in fact her father's birthday present. She is less afraid of following the route she has taken and less afraid of driving.

When she turns to the discussions with her boyfriend, she mentions that they have decided to wait a while before having a child. It's not absolutely necessary for her to do exactly the same thing her parents did. In the final session (33) she comes back to the image of the bike: the small wheels have been taken off! Is this a coincidence? She has worked hard on her thesis and carried out the last experiment. She has projects and has at last managed to tell her father about her wedding. He took this well and things seem to be sorting themselves out for the table layout for the wedding meal. « It is my parents' problem to decide whether or not to come to the wedding together and I do not have to adapt to their own conflictual problems ! »

Therapy Process: Results of the scales

Alliance and Transference

Comparing time series data is often difficult and confusing. We chose to smooth the data set to create an approximating function that attempts to capture important patterns in the data, while leaving out noise. The algorithm chosen was the "moving average" of three

sessions. The results are depicted in Figures 1 (for alliance) and 2 (for transference). Two significant episodes of alliance ruptures and resolutions are analyzed more fully (based on the raw data of alliance as rated by the patient; see Figure 2): (1) sessions 4, 5 and 6; (2) sessions 21, 22 and 23.

Psychodynamic characteristics

Overall Defensive Functioning (ODF) tend to increase within each of the significant moments. At moment (1), ODF evolves from 4.28 to 4.87, both in the narcissistic range of defensive functioning; at moment (2), similarly, ODF evolves from 4.53 to 4.92 (also narcissistic range). Note that these are micro-evolutions on the overall coefficient of defensive functioning; they were not tested statistically, but they are illustrated using the clinical material.

The Core Conflictual Relationship Theme showed high levels of negativity for Julia on the six sessions analyzed. We found in particular the rupture sessions (sessions 4 and 21) to be associated with high negativity scores, from the CCRT perspective (100% of negativity for RO and RS). The CCRT of resolution sessions (in particular the last of the chosen triads, *i.e.*, sessions 6 and 23) present a lower level of negativity, which is associated with positive outcome in different psychotherapy studies.

In conclusion, over the two episodes chosen, alliance rupture sessions tend to present lower, *i.e.*, less adaptive, defensive functioning and higher conflictuality in Julia, whereas the subsequent sessions of rupture resolution tend to present slightly more adapted ways of defensive functioning and a lower conflictuality in Julia.

Discussion

Using session notes as a basis, it was possible to divide the entire psychotherapy into four main phases. The confrontation between this model of clinical comprehension with the various measures of the process suggests the following findings.

First, it is important to note that the alliance is generally positive and follows a positive trend: the patient and the therapist evaluate the alliance as increasing in strength during the process, which reflects the positive atmosphere in which the psychotherapy took place and which no doubt benefited the treatment. This corresponds to the positive correlation found on the overall sample between the evolution of the alliance and therapeutic success (Kramer et al., 2009). The alliance rated by the therapist is generally slightly below the patient's rating, as observed in previous studies (Kramer et al., 2008; Fitzpatrick et al., 2005), moreover, the therapist's alliance evolution presents less fluctuations; therefore, we based our interpretation on the patient's evolution of alliance only. We should state once again that the patient did not present any psychiatric diagnoses and global severity index (general symptomatology) was in the normal range at intake, during therapy, at discharge and at 12-month follow-up; therefore, we do not discuss the therapeutic outcome. Nevertheless, based on the process information, we may conclude that the outcome of the psychotherapy was highly positive, from both the therapist and the client perspectives, as well as the research team's perspective.

Second, we observe that the alliance assessed by the patient and the nature of the transference, as assessed by the therapist, co-vary with the four main phases of the therapeutic process:

- *Phase I.* The therapeutic alliance (assessed by the patient) lessens and the transference becomes more and more maternal.
- *Phase II.* The alliance tends to increase in a linear manner and transference changes from the maternal pole to the paternal pole.
- *Phase III.* Both measures show more instability: the alliance lessens then increases (rupture-resolution process) whereas the transference varies while remaining in a paternal pole.

- *Phase IV.* The alliance shows a more marked episode of diminishing then returns to the average (rupture-resolution) whereas the transference once again passes from the maternal pole to the paternal pole and reaches the same level as at the beginning of the therapy.

The evolution of the alliance, as assessed by the therapist, together with the valence of the transference seem less sensitive to the different phases of the process described by the therapist. The latter alliance tends to increase more or less linearly throughout the treatment, but with a decrease which reflects that of the patient during the end of treatment phase. As for the transference valence, this remains relatively stable throughout the therapy.

Even if we refer to three separate components of the therapeutic relationship, that are the real relationship, the therapeutic alliance and the transference-countertransference (according the model proposed by Gelso and Carter, 1994) which occur simultaneously and interact in a complex manner, the nature and the role of each in psychodynamic psychotherapy has been a controversial issue. Our observations on the case of Julia show that at least the two (out of three) phenomena measured co-vary to a certain extent, without overlapping completely.

The link between clinical work and psychotherapy research is complex. It remains difficult to establish meaningful bridges between what happens clinically in the therapeutic process and the empirical data stemming from questionnaires or rating scales. Two visions, which, by analogy with the human's sight, need a chiasm to allow them to benefit one another and to lead to the beginnings of binocular vision. The comparison of the alliance and transference measures with the clinical material of the sessions in this case study show that more regressive material and the use of more regressive defense mechanisms are associated to a maternal polarization of the transference. We hypothesize that the clinician does not examine the details of the defense mechanisms during the session, as done by the Defense

Mechanisms Rating Scales (based on the session transcript), but intuitively builds up a Gestalt of the individual's whole "defensive organization". It is this Gestalt the therapist is working with and reacting to in terms of his counter-transference. We hypothesize that the rupture sessions, the patient's most regressed position in terms of defenses and conflicts, may be described as a "transference crisis" within the therapy, which, at the same time, opens up to the core interpersonal problem in the patient (Safran, 1993). Finally, the resolution sessions may represent the resolution of this transference crisis, if done in a constructive manner, by enabling the patient to make a corrective emotional experience. The positive outcome of the entire psychotherapy with Julia makes us suppose that this corrective emotional experience took place at least twice, during sessions 6 and 23, during the therapeutic process.

When and how did the clinical change take place? In the case of Julia, the psychotherapist describes in his clinical narration what he observed throughout the sessions. In particular, he noted certain moments he found to be crucial. These are the sessions where the psychotherapist thinks that his patient is undergoing a psychic change which corresponds to what is commonly called *insight* in psychotherapy research. The following conversation from the 15th session is an good example :

Julia talks a lot about the activities she shares with her father, then about her boss's publications, in which she collaborates. She talks about her fear of being judged, her fear of other's regard and the effort she makes to satisfy him by remaining amenable, even if sometimes her true feelings are very different. The psychotherapist points out that it seems that she has to behave well to make the men in her life love her. The patient continues to talk, seemingly untouched by this comment then, suddenly, wonders why she never weeps in the psychotherapy sessions, whereas elsewhere, for no reason whatsoever, she does. The psychotherapist suggests that here she retains her tears, just as she used to retain them when she was with her father, for fear of

disappointing him and not being loved. Deeply moved, she recalls memories involving her « nordic, cold » father, memories in which she prevented herself from expressing her emotions.

Bringing the patient's infantile conflictuality into the *hic et nunc* and into the transference is interpreted. In some ways, this is a deconstruction followed by a reconstruction of the link between the affect representation and the word representation. Such moments of insight are to be paralleled to what the Boston group describes as « moments of meeting » which, in its view, is the crux of the change process (Stern, 2004). According to this group of authors, however, these moments of meeting would not seem directly linked to the verbal material but rather part of the wider context of the interpersonal encounter between the patient and the therapist, including affective and non-verbal markers.

How can these changes be objectively looked at? A metaphor may be used: a seismograph records an earthquake as the earth's crust feels it. Such a shock is also perceived by a human observer if it is sufficiently strong. However, if it is only slight or the movement extends over a long lapse of time, it is usually ignored. The use of a seismograph allows the movement to be measured objectively and examined in more detail. By analogy, we can query whether what the psychotherapist calls a "change" can be seen objectively when measures such as ours are applied. So, are the movements described by the clinician in his narration, truly objective with the help of repeated measures? They definitely produce evidence of a process underway. Certain connections could thus be made between the process and insight. To continue with our analogy: it is certain that advances made in seismography have allowed us not only to witness what is happening but also to forecast future events.

Several research implications ensue from the present case study. The use of self-reported and observer-rated process information over the course of psychotherapy in order to inform about the client's process may be used in different treatment modalities and

therapeutic approaches. We think it is particularly useful to monitor the alliance evolution, session by session, and link this information to the clinical evolution of the case. More studies in this field might enhance the collaboration between psychotherapy researchers and clinicians and inform about the “how” of specific psychotherapy processes. It would also be interesting to apply such a methodology to bad outcome cases where process information would be particularly helpful.

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Table 1
Psychodynamic characteristics

Variable	Moment (1)			Moment (2)		
	4 ¹	5	6	21	22	23
DMRS						
ODF	4.28	4.80	4.87	4.53	5.25	4.92
CCRT						
Negativity %	100	100	83	100	100	60

Note. DMRS: Defense Mechanisms Rating Scales; ODF: Overall Defensive Functioning;
CCRT: Core Conflictual Relationship Theme.

¹ Sessions of the psychotherapy chosen based on consensus procedure.

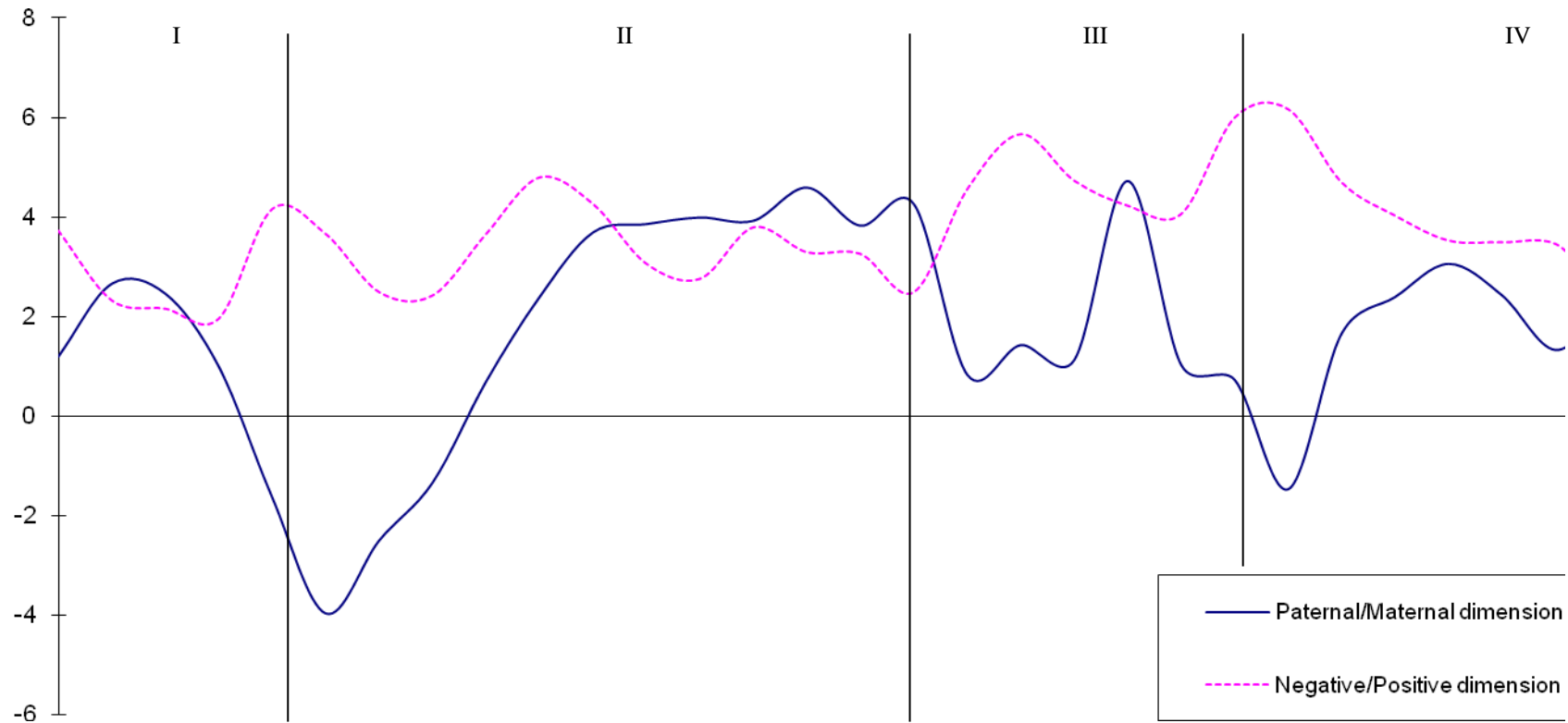


Figure 1.

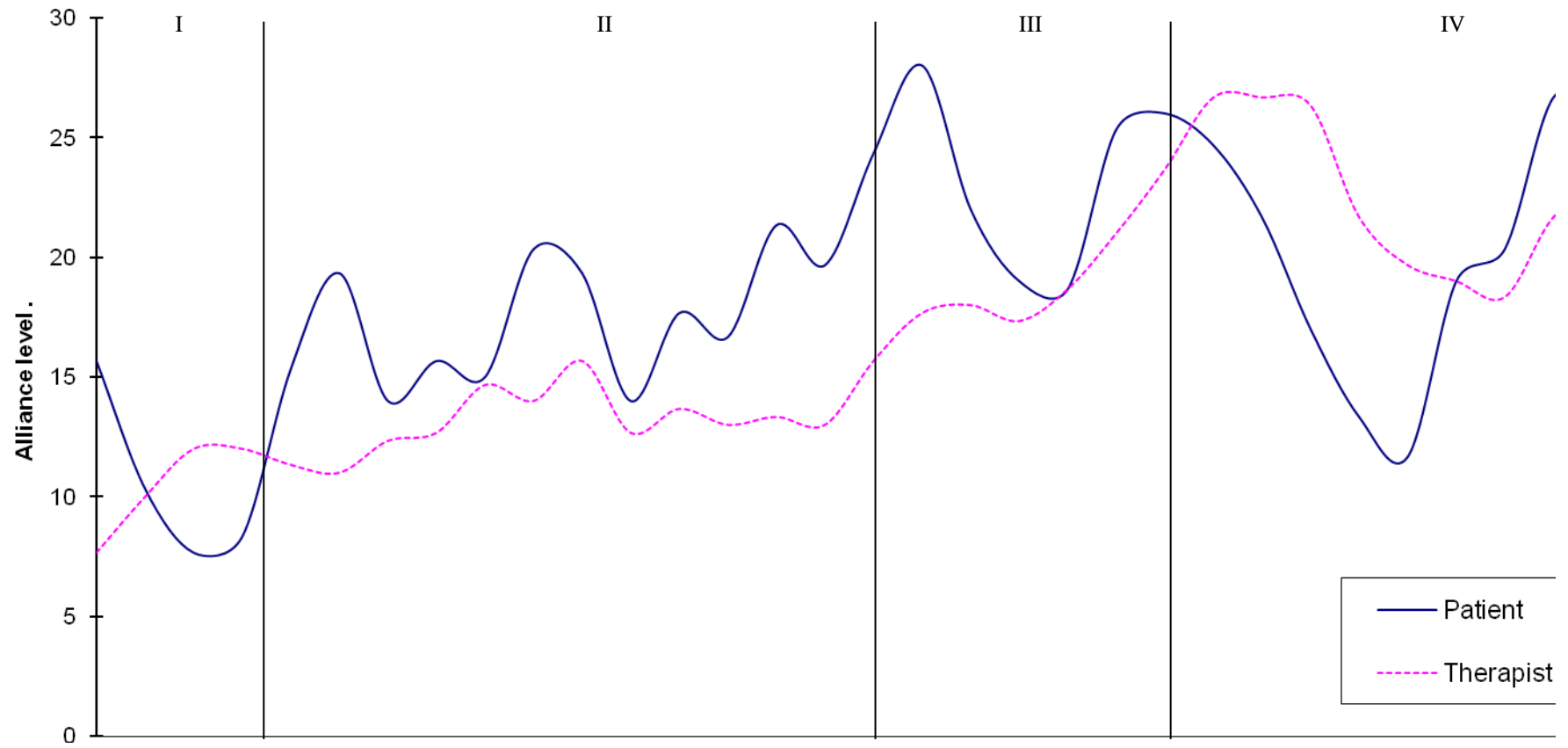


Figure 2

FIGURE CAPTIONS

Figure 1. Evolution of therapeutic alliance (I, II, III and IV are phases of therapy - Establishment; Control; Anxiety; and Toward the End. Data plotted are smoothed. Each point represents the moving average of three sessions)

Figure 2. Evolution of Transference (I, II, III and IV are phases of therapy - Establishment; Control; Anxiety; and Toward the End. Data plotted are smoothed. Each point represents the moving average of three sessions).