MICRO AND MACRO CHANGE

IN THE PSYCOTHERAPEUTIC PROCESS:

AN EMPIRICAL ATTEMPT

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The first part of our presentation, by Alice Faccini, focuses on the theoretical frame of a relational/ intersubjective approach to the analytic process and change.

Our research was inspired by the studies and theorizations of Daniel Stern and the Boston Change Process Study Group (BCPSG) which concern the need for “something more” than interpretation in order to bring about change in therapy.

To start with, we would like to detail the theoretical framework from which our presentation takes shape.

In the last few years, in response to the need to exchange and compare each other’s differences and specificities, psychoanalysis and neuroscience have opened dialogue regarding the theme of intersubjectivity and the field of Infant Research, the likes of which share significant common ground.

Studies of the early mother-child relationship have shown that the development of the child’s psychological world, more than being driven purely by instinctive forces, as described by the original Freud’s instinct theory, is formed as a result of the actual interaction experienced between the caregiver and the child. Such interaction includes, in particular, all the pre-verbal, gestural and bodily messages which form the implicit relational knowing. The basic concept that emerges from these studies is that the human mind is constructed and consolidated thanks to an intersubjective exchange between the Self and the other, which ‘feeds’ the mind and facilitates its ability to develop. As Daniel Stern and the Boston Change Process Study Group (BCPSG) explain, “there is no mind without continuous interaction with the other,” or rather, “our mental life is the fruit of a co-creation, of continued dialogue with the mind of others, which I call the intersubjective matrix” (Stern 2005).

Focusing on the intrapsychic world, attention has slowly moved towards a model of relational development and internal representations of the child-caregiver relationship: the mind grows influenced by another, and vice versa.

Such procedural understanding of the relationships is implicit and occurs beyond focused attention or the conscious verbal experience; it is represented as implicit relational knowing, which integrates emotion, cognition and the interactive-behavioural dimensions of interpersonal and intersubjective relationships, in other words, the “the ways you are with the other” (Stern, 1985; 1995).
On the neuroscience front, in the early nineties, a group of researchers from the University of Parma, under the supervision of Giacomo Rizzolati and Vittorio Gallese, made an extremely important discovery: mirror neurons. These neurons activate themselves when we watch someone else do something, not just when we directly do that something ourselves. This mirroring ability is not restricted to motorial aspects, it also encompasses those pertaining to perception and emotion and has a significant role regarding processes of identification and empathy in that said mirror neurons capture behavioural intent.

Gallese (2001; 2003; Gallese and Senigaglia 2011) calls this neurobiological predisposition to intersubjectivity, displayed by only humans and macaques, a process of embodied, automatic and pre-reflexive (implicit) simulation. The activation of this process facilitates the linking of two dimensions: identity and alterity. And so it is that the fields of psychology and neurobiology, that yesterday were treated as totally separate entities, today are joining forces. The relational dimension of change in psychoanalysis, in fact, has been central since it was first conceptualized by Freud, and today it appears to be supported by Infant Research and neuroscience.

In Gallese’s conceptualization, mirror neurons allow the intersubjective union between bodily Selves: we can therefore refer to “direct mapping of the other in the Self” and “mapping of the Self in the other.” This is also a reference point for Stern who considers the primary matrix of his intersubjective construct a motivational system in the form of implicit knowing associated with bodily interaction (looking at, touching, talking to, getting closer to, moving away from one another, and verbal and proxemic coordination). The connection between these interactions and those between patient and analyst, referred to as OI (Intersubjective Orienting), SINT (Attunement), DISSINT (De-attunement) etc., will be addressed in more depth later on. Gallese also views the motorial component as going hand in hand with the affective component, originating the relational experience rather than integrating it: no longer “cogito ergo sum” but “ago ergo sum” (doing instead of thinking).

“Our motor actions and our sensorial nature appear to form the true transcendental base upon which our experience in the social world is founded.”


The consonance with Stern is remarkable: the psychodynamic macro-level and the micro-level of bodily interaction, along with their interpretations/narrative, are based on the same principles (Stern, 2006).
Dialogue between neuroscience, Infant Research and psychoanalysis highlights the fact that the mind stems from an intersubjective relational matrix, and that this is also intimately reconnected to the body from the outset, in a reunification; via the mirroring processes of the mirror neurons, the body is the base of relational psychological phenomena such as empathy, identification, projection, attunement, disruption and repair in psychotherapeutic dialogue.

For psychotherapy, the other significant implication of said dialogue is the enhancement of the implicit record (pre-symbolic, non verbal symbolic, metaphorical etc.) and of the empathetic dimension, reformulated in the light of the mirror neuron theory. A reappraisal of the therapeutic change concept in which Stern’s “something more” plays an essential role, one which goes beyond orthodox tools and techniques such as interpretation, transference etc., is also possible.

This brings us to the concept of change in psychotherapy, which will be addressed in more depth later on. The change postulated by psychoanalytical theory is a change in the patient’s personality; it is structural, profound and persists over time. This concept appears to differ from the original operationalization and empirical research on the process. It now seems that it can be referred to in terms of change and increased possibility of relational configurations rather than in terms of elimination/resolution of intrapsychic conflicts. Change would therefore depend on the patient’s propensity for adaptive management of critical situations thanks to the insight and relational experience in which they are reflected within the therapeutic relationship. (see also Thomä, Kächele, 1987).

But how can one see this process of change within the therapeutic relationship?

Micro level empirical analysis of the caregiver-child interaction has made it possible to read the analyst-patient interaction at the micro level: in “Infant Research and treatment in adults” (2002) Beebe and Lackmann identify the three organizational principles of early representations of interactions: the principle of ongoing regulation, disruption and repair, and heightened affective moments.

For the principle of ongoing regulation, the patient and the analyst actively compete in exchange regulation from moment to moment, creating reciprocal expectations regarding efficacy, predictability and reciprocal interaction regulation. The forms of ongoing regulation include nonverbal behaviour such as changes in posture, facial expression, tone of voice etc., because these interactions repeatedly indicate the disadaptive features of the patient; in the psychotherapeutic process, these can be modified, confirmed or disconfirmed, even without verbalization or verbal symbolization.
The principle of disruption and repair is a special extension of the ongoing regulation principle which organizes the violation of expectations and, therefore, the attempts to overcome expectation disruptions of the ongoing regulations (Stechler, Kaplan, 1980; Horner, 1985; Tronick, Cohn, 1989; Beebe, Lachmann, 1994). This principle applies to all phases of treatment and is just one of the possible ways to bring about structural change. It should be noted that disruptions are not affected by the analyst’s countertransference or the patient’s resistance; they are inevitable elements of the interaction process which allow the co-creation of repair, the continual negotiation of self-regulation and reciprocal regulation (Beebe and Lachmann 1994).

The principle of heightened affective moments defines the powerful transformative state, positive or negative, that presides over the interactions: offering the opportunity of new experiences and also re-actualizing emotions and old relational configurations, such heightened affective moments can also be expressed nonverbally, but they always involve a symbolic level and therefore the possibility of transformation, even intentional, of the type of self- and hetero-regulation of the patient.

In conclusion, the implications of this systemic-dyadic model for psychoanalytic theory and practice concern the distinction between implicit and explicit processing, meaning between verbal and nonverbal dialogue; the role of expectations and reciprocal regulation in the development of implicit relational knowing (procedural) and, therefore, in the action and therapeutic change; the efficacy of the analyst’s interventions, including those implicit or nonverbal; the relationship between the past and the present (therapeutic relationship) for the purpose of therapeutic action and change.

Lyons-Ruth (1998) noted that only a small part of the patient’s implicit relational knowing becomes the subject of verbal narrative exchange or transference interpretations during treatment and that, consequently, the implicit procedural record is far more pervasive and has much stronger organizing potential than the explicit form. With this in mind, it is impossible not to reconsider the theory of therapeutic action or the definition of change, as agreed by many contemporary authors including Bucci (1997), Shore (1994, 1996), the previously cited Lyons-Ruth (1998), Stern and the Boston Change Process Study Group -BCPSG (1998) collaborators.

The research of the Kairōs group that we are here proposing looks precisely at both the importance of micro-level interaction and the implicit record of therapeutic dialogue.
The second, by Marina Bertoni, illustrates the basic concepts of the micro-analysis of the single session and the procedural items requested by our research, as well as their critical points in the operational phase and for the matching with the clinical reasoning.

Focusing on the implicit dimension of therapeutic relation, the BPCS Group defines:

“Moving along” as the process at the local level. Its path is not known in advance. It is characterized by attempts to achieve a greater and more coherent intersubjective field, co-constructed by patient and therapist, who both are building it continuously by trouble and patience. Moving along is unpredictable, nonlinear and sloppy. It consists of Relational Moves, moments of awareness, and conscious present moments that rise like emergent properties of the process, called Now Moments and Moments of Meeting. All these Present moments “are the small steps in negotiating and fine-tuning the intersubjective field”.

“Moving along” reveals the human living need to establish intersubjective contact in the clinical situation; along it relational moves (silence as well as “Mmh” and non verbal elements included) occur and change.

It will be clear why the items of our research work are: relational moves, now moments, moments of meeting. Here the definitions:

Relational Moves (RM) are “the smallest units for which an intention to alter or adjust the relationship can be attributed by an interactive partner or observer. They make up the moving along process.” (Stern, 2004, p. 245)

Relational Moves are all the Present Moments of a session, that represent the continuous minimal adjustments of the two partners and can lead to “now moments” and “moments of meeting”.

The “Now Moments” (NM) are particular forms of the intersubjective Present Moments that is Relational Moves (RM): almost all turns of communication in a session are Relational Moves. We can find variations too, when a Relational Move is proposed again and again, with particular aspects, without changing the nature of RM. In our research, we consider them “Variations of the previous or ongoing RM”.

Now Moment is a particular form of Relational Move:

“Now Moment suddenly arises in a session as an emergent property of the moving along process. It is an affectively charged moment because it puts the nature of the patient-therapist relationship into question. This usually involves bumping up against or threatening to break the usual framework or
“rules” of how they work together and are together.(…) A crisis that needs resolution has been created.” (Stern, 2004, p. 245)

Another type of relational move is Moment of Meeting:

“Moment of Meeting is a present moment between two partners that potentially resolves the crisis created by a now moment. It thereby reshapes the intersubjective field and alters the relationship. (…) there is an intersubjective sharing in this moment that alters the intersubjective field between the two.” (Stern, 2004, p. 244).

Now Moments and Moments of Meeting are rare but very significant moments in therapeutic work; they are unexpected and unpredictable.

Along a such moving along, a large number of implicit changes occur in the therapeutic relationship; they are factors of the desired final change, i.e. the positive outcome of the therapeutic work. But we stress what the BCPSG Group writes: “Moving along has not the only purpose of preparing for these charged Present Moments (Now Moments and Moments of Meeting), but effects changes in its own right, forcing the analyst to shift her/his focus onto the moving along process to see how it works. Two are the consequences, for our viewpoint:

1) Such implicit knowing can be generalized to similar situations as they arise between patient and therapist.

2) It may also gets generalized beyond the therapy to similar situations in other relationships” (Stern, 2004, pp.178-179)

The construct of “Implicit Relational Knowing”, connected with Intersubjective Motivational System’s one, enlights the value of the analysis at the local level, moment by moment. In fact, each καιρός or Relational Move or Present Moment resume and re-present all the patient’s and the patient-analyst relationship’s past: the past patient’s “implicit relational knowing”, as well as the shared past of the patient/therapist’s therapeutic relation. This process leads to the co-creation of an intersubjective consciousness, or “dyadically expanded states of consciousness” (Tronick, 1998).

Three main intersubjective factors push the clinical process: Intersubjective Orienting (OI), Enlargement of Field (AC) and Mirroring (RISP)

Factors of the clinical (intersubjective) process:
- Intersubjective orienting (OI*)
- Enlargement of the intersubjective field (AC*)
- Mirroring (RISP*)

*into Italian, in our protocols

Intersubjective orienting (OI) consists of seeing where each of the partner is in the relational field at one very moment. It involves the moment-by-moment testing, mostly out of consciousness, of
where the patient/therapist relationship is, and where it is going. This is a precondition of working together.

Enlargement of the intersubjective field (AC): the goal is to share experience, to be known. This involves the desire to constantly increase the intersubjective field – in other words, the mental common field. Every time the intersubjective field is enlarged, the relationship is implicitly altered. That means that the patient is experiencing a new way-of-being-with the therapist and hopefully others. This change is implicit and becomes part of the patient’s implicit relational knowing.

Mirroring: the goal is to define and redefine oneself by the reflection of the Self in the other’s eyes. One’s own identity is reshaped or consolidated in this process. (Stern’s, page 152).

These goals are achieved at the local level by the sequences of relational moves and present moments that make up the session.

The method of our group, obviously called “KAIROS GROUP”, codes the Relational Moves for each partner, even if “Relational Move” is a relational concept describing changes in patient/therapist interactions that, ideally and theoretically, cannot consider a move like an singular event. In fact, we code the Relational Moves of one of the two partners only in relation to the Relational Move of the other partner. It is possible to code Relational Moves only considering the beginning and the development of the clinical dialogue in that particular sharing. It seems the most innovative feature (and the most coherent link between the theory frame and the clinical and research work and assessment) in our single case quality research.

The drive of INTERSUBJECTIVE ORIENTING is the most basic and general one, in order to build the relationship between the patient and the therapist; the drives of ENLARGEMENT OF THE INTERSUBJECTIVE FIELD and MIRRORING are more specific, but always expressing an intersubjective orienting.

We will see in the next part of this workshop (thanks to Mauro Ambrosini) what happens, according to our method, between patient and therapist in the single session and along the entire treatment.

Now we would like to anticipate and stress the difficulties of the coding method.

Anyway, concerning our material, we present some observations, hoping to be more clear and to receive some contributions to clarify our doubts by the participants to this workshop.

According to our coding system, for every Relational Move we specify its quality by the following cluster: Proposal, Attunement, Disattunement.

The Relational Moves of Intersubjective Orientation, Enlargement of Intersubjective Field and Mirroring (respectively: OI, AC and RISP) may assume three qualitative forms:
- Proposal (PROP*): offering something new (for example a different theme or opening of the session, or stopping a silence moment…):

- Attunement (SINT*): it means to agree to the other’s proposal intersubjective orienting or en-largenment of field from an emotional and cognitive (but non always conscious) point of view. This attunement of emotional dimensions does not mean that the partner agree with an explicit acceptance of the manifest content of the other’s statements.

- Disattunement (DISSINT*): explicit or implicit/unconscious refusal of the emotional/intersubjective invitation of the other partner.

*into Italian, in our protocols

This is an important point: in an “ideal” process there is a continuous sequence of attunements and disattunements. In an intersubjective prospective, in fact, the relationship is co-constructed in a continuous and troubled way and the harmony, the “just known and shared” is not better or more therapeutic than the inevitable and useful disruptions and “not yet known” trends. In fact, we desire and fear simultaneously new intersubjective rhythms and configurations; we are reassured but also unsatisfied by too frequent well known assessments. The Infant Observation taught us very much on this point.

During the application of our method, we decided not to code expressions like: “Hello”, “Good morning”, etc. because they are conventional forms of greetings in our culture.

We also decided to code the first statement of each session like a relational move of “Intersubjective orienting-Proposal”, because this is the first offer of a theme or of a new or old ground for the relation and for the new moving along that each session opens.
The third, by Mauro Ambrosini, shows the direct applying of our research protocol to a sample of sessions and treatments, so to make “live” the relational Moves in their qualitative and quantitative features, graphically illustrating data and results.

Our group has completed the coding of the sessions of three patients, treated for over three years with two weekly sessions on the couch. The sessions, audio-recorded and transcribed, have been chosen following the time series blocks methodology suggested by Thomae and Kaechele (2003, 2006) for the single case studies in psychotherapy research. The coding system we applied is based on the assumption that the real and unique experience and therefore the unique change process emerge from the clinical dialogue moment by moment during a session.

We consider the clinical process as an intersubjective dance, in its sloppiness, unpredictability and novelty. At each step, we do not know what will happen next, in the seconds that follow. In such a perspective, the attention to the adjustment in the intersubjective field moves into the foreground. They are the continuous but not always explicit (as well as conscious) adjustments that all the therapists make with their patients, all the time, that usually remain unremarked, left undone by written or spoken discussions. A session is driven forward, in large part, by the need to establish and fit an intersubjective contact the patient as well as the analyst, differently but simultaneously, need to do so.

An example of coded transcript will help us enter into the method.
<table>
<thead>
<tr>
<th>Turn of conversation</th>
<th>P/T</th>
<th>Transcription</th>
<th>N° Realational Move</th>
<th>P/T</th>
<th>Coding</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>154</td>
<td>P</td>
<td>Mmm. <em>Maybe, everything happens because I do not feel being understood. When I realize I have not been understood….anyway...</em></td>
<td>70</td>
<td>P</td>
<td>O</td>
<td>SIN</td>
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<td>155</td>
<td>T</td>
<td><em>You think you are bad!</em></td>
<td>71</td>
<td>T</td>
<td>A</td>
<td>SIN</td>
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<tr>
<td>156</td>
<td>P</td>
<td><em>Yes, I do!</em></td>
<td>72</td>
<td>P</td>
<td>O</td>
<td>SIN</td>
</tr>
<tr>
<td>157</td>
<td>T</td>
<td><em>Do you understand that this is the question? Thinking you are bad and wrong... that is the point.</em></td>
<td>VAR IAZ 1</td>
<td>T</td>
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<td>SIN</td>
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<tr>
<td>158</td>
<td>P</td>
<td>Mmm.</td>
<td>&quot;Yes, go ahead!&quot; - the patient seems to say in this moves. &quot;Tell me something more, I’m not scared&quot;. <em>(The patient usually tries to over-tune with the therapist and his moves, starting immediately talking and talking. It happens also in this session)</em></td>
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<tr>
<td>159</td>
<td>T</td>
<td>Thus, as if you do authorize the other inside of you... do you understand... to go away... then you run and say: no, no, no!.. I was wrong, I won't do it again. It is not by change that you thought of being naughty, as if you ere afraid of being naughty.</td>
<td>VARIAZ 2</td>
<td>T</td>
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<tr>
<td>160</td>
<td>P</td>
<td>Mmm, mmm. [8” of silence ]</td>
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<td>161</td>
<td>T</td>
<td>Shortly, a little bit, as if asking for love, for attention, for consideration or something like that... exclusivenn.... It meant to be naughty.</td>
<td>VARIAZ 3</td>
<td>T</td>
<td>A</td>
<td>SIN</td>
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Thus, as if you do authorize the other inside of you... do you understand... to go away... then you run and say: no, no, no!.. I was wrong, I won’t do it again. It is not by change that you thought of being naughty, as if you were afraid of being naughty.

Silence: The therapist and the patient are waiting for something to happen. Who will take the initiative?

The same relational move is currently played intersubjectively.

The therapist here goes ahead, sharing the same intersubjective field but proposing, stoutly after the silence, a larger direction where their relation is going.
<table>
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<th>Page</th>
<th>Line</th>
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<tbody>
<tr>
<td>162</td>
<td>P</td>
<td>Mmm</td>
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<tr>
<td></td>
<td>P</td>
<td>O</td>
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<tr>
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The patient is not moving forward or closer. Nonetheless, he is implicitly expressing his wish to maintain the contact with the therapist, even if not withdrawing.

[19” of silence]

There is another silence: it does not mean that the intersubjective field is unstable; rather, it looks like a different “way-of-being-with”, implicitly induced, encouraged by the therapist.

This silence is not so short for their usual patterns of working together. So that it is implicitly known by both of them that something will happen soon.

| 163  | P    | As you say, to be naughty, that is what I am afraid of... then, maybe. |
|      | P    | O    |
|      | O    | I    |
|      | I    | SIN  |
|      | SIN  | T    |
|      |      |      |
|      |      |      |
|      |      |      |
|      |      |      |

The patient starts again and tries to orient the intersubjective field.

| 164  | T    | No, it in not as I say; it is you who spoke of being naughty. |
|      | T    | O    |
|      | O    | DIS  |
|      | DIS  | SIN  |
|      | SIN  | T    |
|      |      |      |
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|      |      |      |

But the therapist forces the play go back, sharing the intersubjective field as proposed by the patient in the previous relational move, but breaking their dual previous tuning...
Few things seem to happen between them. But we can note that the therapist and the patient are “moving” continuously, each of them positioning intersubjectively inside the field and towards the other.

The therapist and the patient are establishing their implicit knowledge about how they are working together. They are constructing and defining the implicit patterns of their being together, so regulating their intersubjective field and preparing the conditions for the creation of new possible intersubjective patterns. The intersubjective process, session by session, is becoming their “history”, an experience of learning of unstable dyadic states (Stern, 2005).
After transcribing and coding the different sessions, we tried to give a moving graphic representation of the couple's interaction, their dance, by building "dynamic graphics". In them you can see the various signed relational moves, the tunings, the detunings and the variations. An example

![Paolo session 80](image)

We also counted the number of different types of relational moves and of variations as shown in the following graphs.
Considerations on the change process and charts:

From an overall view, it can be seen that in general in the sessions there is the presence of different types of relational moves. There are no trends of increase or decrease over time of certain relational moves. They simply occur in very similar frequency in the various sessions and have a specific meaning and contribution in favoring the change process.

- (Now Moment and Moment of Meeting) In the 13 sessions we found only one “Now Moment” and “Moment of Meeting” in the 80th session of Paul, in line with what Stern stated: “However, we knew that now-moments and moments of meeting are quite rare events. Entire sessions can pass without any appearing. Nonetheless, progress and changes take place even during the quietest and least emotionally charged moments ... ”… ”We recognized that the process is not only aimed at predisposing these present moments emotionally charged, but in itself produces a change.” (Stern, 2005).

- (Enlargement of the Intersubjective Field) If the therapeutic change takes place also in small moments less emotionally charged, we believe that the coding of the ACs, present in all sessions especially by the therapist, identify these moments. In almost all the sessions we have AC SINT and OI SINT codes mutually between patient and therapist. We can say that every time the intersubjective field widens, the relationship also changes implicitly and that this process is the engine of the entire treatment, the productivity index of the process itself, albeit without the possibility of measuring this effectiveness and its variations over time. This means that the patient experiences a new "way of being with" the therapist and hopefully with others and that the therapist hopefully and clinically uses new ways of being with the patient. The change is continuous and implicit, in the sense that it does not need to be explicit or expressed in words, and becomes part of the patient's implicit relational knowledge. Our method only allows us to see the quantity and continuity of these changes, but it is only the clinical reasoning, which, moreover, our group has added to the coding, to explain the direction and meaning of that specific treatment.

- (Intersubjective Orientation) The charts show the prevalence of relational moves OI SINT (and related in Variations) and a lower percentage of OI DISSINT and PROP, which would seem to testify to the importance of intersubjective motivation of "intersubjective orientation", that is, a moment-by-moment verification of the point where the relationship
between patient and therapist is located, as well as its progress. This guarantees a sharing of the therapeutic work and its moving along. This flow of tuning orientation relational moves supports the possibility of field widening. This, as we have seen, more clearly demonstrates the modification of implicit relational knowledge and therefore of change as intended by the BCPSG ("The change in psychotherapy" of the BCPSG, p. 76).

(VARIATIONS) In our research work, we had initially underestimated the importance of the variations, but a more careful reading of the BCPSG theaters allowed us to re-evaluate them. In fact, the relationship between a verbal action by one of the two partners and the intention inferred is not immediate, much less expressed verbally. Analysis and translation of the action into intentions or meaning often require reiteration and redundancy (coded as VARIATIONS) in interactive sequences so that potential alternative "readings" can be assessed and excluded (BCPSG's "Change in Psychotherapy", p. 84). This process of inference and evaluation occurs several times during the session (about 30% of the total relational moves) and mainly at an implicit level, out of consciousness. The coding of the variations can therefore mean the need to better define each other's intentions, dedicating time to a mutual adjustment and adaptation: if this does not happen it is created in an interactive loop that if not recognized will stop the co-construction. Adaptation creates the potential for further processing of new forms of shared experience. It alters the intersubjective field, shifting the implicit relational expectations of each partner. With this move, an opening for the development of new initiatives (change) therefore becomes possible. In other words, the change in implicit relational knowledge is achieved by reaching more coherent ways of being together and the most coherent ways of being together are achieved through a process of recognition of the specificity of the adaptation of the initiatives of the two partners (the VARIATIONS).

We can therefore say in concluding this brief summary of our work, that the change and its arduous recognition by the two partners is continuous, tireless, surprising. But between this change and the structural change that psychotherapy proposes, as Alice Faccini reminded us in the first intervention, what relationship can we establish? We have added to the coding work the measurement of personality traits and psychopathological patterns of the three patients, first with PDM 1 and then with the publication of PDM 2, and with swap 200 at the beginning, after each year of therapy and at the end of the treatment. Paolo Vassallo will talk about this work.
The fourth part

The fourth, by Paolo Vassallo, illustrates and critically discusses our attempt to correlate the clinical reasoning, our research method and the SWAP-200 and PDM-2’s protocols for a concurrent inferring or measure of the patient’s change.

I would like to introduce our work, starting with three fundamental concepts that arise from the analysis of SWAP-200.

**Concept one:** the last part of the manual SWAP-200 describes two ratings (Personality Health Index – PHI and RADIO), which are responsible for assessing the good functioning of the personality and useful in assessing the outcome of the therapy.

In particular, the PHI and RADIO index, based on SWAP's 200 items, provide global indications of the healthy aspects of the patient's personality and illustrate its strengths and difficulties. In the SWAP-200’s manual we find the indications to compare the SWAP prototypes derived by Q-Factor analysis (the styles of personality) and the Personality Disorders presented in the DSM-5.

- The SWAP-200 describes the prototype matching method. The matching is between the SWAP-200 prototypes obtained through the Q-factors categories and the personality disorders (PD) presented in DSM-5.

- Q-factors are diagnostic categories empirically derived.

**Concept two:** In the third part of the manual, the authors describe the usefulness of the application of SWAP in measuring personality change in psychotherapy (psychodynamic and psychoanalytic orientation). Then a factorial-like analysis was applied, combining groups of cases with similar scores, from which 7 factors emerged:

1. Dysphoric Q: tendency to feel inadequate

2. Antisocial-psychopathic Q: tendency to be dishonest

3. Schizoid Q: tendency to have no friendships
4. Paranoid Q: a tendency to feel misunderstood and victimized

5. **Obsessive Q:** tendency to excessive control

6. Histrionic Q: tendency to be needy and dependent

7. Narcissistic Q: tendency to have unlimited fantasies of success.

8. In addition, obsessive patient profile is less severe than the obsessive patient profile of DSM 5.

9. The SWAP-200 has made possible to bridge the gap between diagnosis and the statement of the case.

10. The SWAP-200 is useful for research, clinic and supervision.

**Concept three:**

As research in psychotherapy has taught us, the effect of psychoanalysis does not seem to be mediated by the elimination of patients' nuclear conflicts, but by the acquisition of self-analytic capabilities that promote better management of these conflicts.

These conflicts can be reactivated in late phases of life, but are overcome more quickly and with less impact on the overall functioning of the patient.

- **Contents**

As widely shown by my colleagues who preceded me, we used PDM 2 as a diagnostic indicator of the psychodynamic functioning of the personality of our three patients, in the periods from phase 1 to phase 4 of the treatment.

The trend shows that the 3 patients go from a borderline or nevrotic level to a sane or nevrotic level with better functioning.
Analyzing in more detail the evolution trend through the Swap 200 applied in the 1 and 4 phases, with particular reference (to the Q / T points) in our three analyzed cases Mauro, Lorenzo and Paolo it is possible to observe that all cases show a progressive improvement during the phases of psychoanalytic psychotherapy.

In Mauro the narcissistic component moves from the value of 72.65 (frankly pathological) to the value of 48.27 (in the norm).

At the same time, his Depression High functioning grows from 55.44 to 65.76.

Consequently, the value of the obsessive component increases from 64.57 to 74.10.

MAURO

<table>
<thead>
<tr>
<th>swap-200</th>
<th>Mauro</th>
<th>Lorenzo</th>
<th>Paolo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antisoc</td>
<td>48.89</td>
<td>44.81</td>
<td>49.23</td>
</tr>
<tr>
<td>Obessivo</td>
<td>64.57</td>
<td>59.81</td>
<td>72.65</td>
</tr>
<tr>
<td>Diagnosi</td>
<td>44.78</td>
<td>59.44</td>
<td>36.98</td>
</tr>
<tr>
<td>Dep.</td>
<td>51.59</td>
<td>49.18</td>
<td>63.68</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phi &amp; Radio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categoria</td>
</tr>
<tr>
<td>Perc. PHI</td>
</tr>
<tr>
<td>Indice di salute della personalità (Phi)</td>
</tr>
<tr>
<td>Esame di realtà e processi di pensiero</td>
</tr>
<tr>
<td>Regolazione delle emozioni</td>
</tr>
<tr>
<td>Operazioni offensive</td>
</tr>
<tr>
<td>Integrazione dell’identità</td>
</tr>
<tr>
<td>Relazioni oggettuali</td>
</tr>
</tbody>
</table>
In the case of Lorenzo, we observe the same thing: the increase in the obsessive component went together with the increase in good functioning that we find in the value of high functioning and depressive high functioning.

In Lorenzo we go from phase 1 with obsessive functioning of 67.48 to the value of 75.38 in phase 4.

In the same way, Depressive High functioning goes from 55.65 in phase 1 to 63.26 in phase 4.

**LORENZO**
Again, the same trend is found in Paolo who goes from phase 1 with obsessive functioning of 67.72 to the value of 73.17 in phase 4.

In the same way, Depressive High functioning goes from 58.27 in phase 1 to 63.00 in phase 4.

**Conclusions:**

We can say that psychoanalytic psychotherapy increases the High functioning capacity described above all by the QT point (depression high functioning) which probably allows an increase in the obsessive QT tract.

These data in our opinion should be read as an index of greater attention and care for itself and its internal functioning (the key of our research).
This new attitude promotes an improvement in the general psychological functioning that is expressed with the index Radio and Phi all influenced by the advancement process of psychotherapy.
SOME CONSIDERATIONS AND PERSPECTIVES ABOUT RESEARCH, CHANGE AND TRAINING IN PSYCHOANALYSIS

DANIELA MAGGIONI

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(fig. 1, 2, 3)

At the end of our interesting but also hard, lasting (and obsessively, so to say, focused at the microlevel of the analytical dialogue) work, we wish to share some provisional considerations. (fig. 4)

Sigmund Freud’s followers of the XXI century as we are (fig. 5), ten years after IFPS Forum in Athens, where we presented a paper entitled “The relational dance” (fig. 5) we are more and more determined in our commitment to empirical research, and particularly to the single case one, and would like to encourage young colleagues and candidates to be interested in psychoanalytic research for two major reasons:

1. The future of psychoanalysis among psychotherapies and in the scientific field depends largely on its efforts to share and discuss clinical material, results and riddles recording, testing and empirically inquiring sessions and treatments of different therapists. If not, we are condemned to an isolation and scientific disrepute or, at least, to a sort of dangerous individual as well as institutional claustrophilia. (fig. 6) How can we claim for our success in the care of human distress and disease? How can we fascinate the young psychologists and psychotherapists by a serious but exciting theoretical-clinical training, that is well based, secure on its fundaments, opened to the new but proud of its past?? We all have been and are fascinated by psychoanalysis and its claims....

Why cannot we fascinate our candidates too and why we let them be attracted by other methods and theories, that present themselves as easier, simpler, quicker and faster in improving the patients’ performances?

Let me remember E. Kandel’s considerations in “A new intellectual framework for psychiatry”. (Am J Psychiatry 1998; 155:457-469) and „Biology and the future of psychoanalysis: a new intellectual framework for psychiatry
revisited” (American Journal of Psychiatry, 1999 Apr; 156(4): 505-24) just to support our view by a great biologist’s position, not a psychoanalyst’s one.

He wrote that psychoanalysis need a serious inquiry of its intellectual frame and must create more critical methods of training for the future, if it wants to survive as a strong intellectual power during the XXI century. He declares that psychoanalysis has revolutionized our knowing of the mental life and of human (irrational) motives of behavior up to the Sixties of the XX century, then its decline began, due in primis to its massive aim to defend itself against critiques and new methods of therapy instead to cultivate its early and specific curiosity for a deeper and deeper inquiry of the human inner processes and for a research for new objective tests of its own early insights. Kandel complains the intellectual and scientific decline of “the most coherent and intellectually satisfactory explanation” of the human mind.

2. Each of us is an on-line researcher, when we are with the patient in the analytic room, but each of us can be an off-line researcher, too, following Horst Kaechele’s suggestive dichotomy ("From Psychoanalytic Narrative to Empirical Single Case Research: Implications for Psychoanalytic Practice", 1998). We are off-line researchers when we think of a session or a patient, when we question about a clinical impasse or are looking for a technical or theoretical aid among our books or by a supervision, in absence of the patient. But, in a proper sense, why cannot we become offline researchers, i.e. applying research methods and protocols to our clinical fresh and alive material?

*In psychoanalysis there has been existed from the very first an inseparable bond between cure and research. Knowledge brought therapeutic success. It was impossible to treat a patient without learning something new; it was impossible to gain fresh insight without perceiving its beneficent results. Our analytic procedure is the only one in which this precious conjunction is assured* (S. Freud, 1927a, p. 255) (fig. 7)

Don’t you sense that a ghost wanders between our fears to betray Freud’s legacy and the so-called standard psychoanalysis and our refusal to test empirically our results
and to confront ourselves with other disciplines and clinical methods? That ghost is the very enemy of psychoanalysis, we think. On the contrary, we must recognize that our group’s work has enriched our clinical “ear” and commitment, not impoverished us or removed and keeping away us from our clinical strict attitude. We refer to the single case research, obviously, that is very very close to our clinical attitude to reflect upon our clinical sessions and treatments and to discuss our cases in inter-vision and supervision groups. (fig. 8)

We suggest to consider such a research as a bridge that connects theory and practice, the therapist-in-action and the therapist-out-of-session. And God knows if we need, nowadays, to build and re-build bridges instead of borders and walls. (fig. 9)

**Not only in scientific and psychoanalytic communities.**

We know that only science and knowledge’s development increase the opening of our minds and session rooms, our well consolidated “known” to the unknown or “unthought/not yet known”. We think that one core achievement of our work has been the recognition process of what happens between the therapist and her/his patient.

As described in Lyons-Ruth et al.’s (1998): “...the implicit relational knowings of patient and therapist intersect to create an intersubjective field that includes reasonably accurate sensing of each person’s ways of being with others... This intersubjective field becomes more complex and articulated with repeated patient–therapist encounters, giving rise to emergent new possibilities for more coherent and adaptive forms of interaction. During a transactional event that we term a moment of meeting, a new dyadic possibility crystallizes when the two partners achieve the dual goals of complementary fitted actions and joint intersubjective recognition in a new form. We argue that such moments of meeting shift the relational anticipations of each partner and allow new forms of agency and shared experience to be expressed and elaborated”.

We have just met this crucial notion of “implicit relational knowing” in Alice Faccini’s and Marina Bertoni’s previous expositions. Here we are only trying to stress the changes that happened in our way to encounter patients and to reflect, as therapists or teachers in our training Institute thanks to the Boston Change Study Group, led by Daniel Stern (died in 2012). (fig. 10)

It is “crucial” (etimologically, from Latin *crux*: *that holds a cross*) because the “implicit” knowing is not or may to be not unconscious, is much larger then unconscious, is symbolic but not verbal and is caught at the local or “superficial” level.
Therefore, as analytic clinicians, we consider their method, as we have made, as a heuristic device to see and enjoy the richness, the variety, the sloppiness of each session and the uniqueness of the relational rhythm of each analytic couple in their moment by moment moves. Shortly, a sort of VAR (Video Assisted Referee) for soccer games. But who is the referee?

In fact, as you have just noted (fig, 12), in our work we added to the protocol an item in the last column on your right: “Comments”. This is our choice: not only to note and number, as our research requested, the Relational Moves and their (implicit or conscious, in BCPG’s statements) intersubjective intentionality, but also the therapist’s observation, the clinic reasoning, So, we have been trying to match codes and clinics, the off-line research and the on line one.

<table>
<thead>
<tr>
<th>Turn of conversation</th>
<th>P/T</th>
<th>Transcription</th>
<th>N° Relational Move</th>
<th>P/T Coding</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>154</td>
<td>P</td>
<td>Mmm.</td>
<td>70</td>
<td>P O I SIN T</td>
<td>The patient moves forward the therapist, in order to share his experience.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Maybe, everything happens because I do not feel being understood. When I realize I have not been understood….anyway...</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>155</td>
<td>T</td>
<td><em>You think you are bad!</em></td>
<td>71</td>
<td>T A C SIN T</td>
<td>The therapist is taking a step even further, proposing a definite theme to expand their intersubjective field.</td>
</tr>
</tbody>
</table>
While reading the coded passage, the same we just proposed you in the previous part of our exposition, focus on the “Comments”, please. (fig. 13)

<table>
<thead>
<tr>
<th>156</th>
<th>P</th>
<th>Yes, I do!</th>
<th>72</th>
<th>P</th>
<th>O</th>
<th>SIN</th>
<th>T</th>
</tr>
</thead>
</table>

The Patient follows him and accepts his invitation. A large field of intersubjectivity is now stated and shared.

| 160 | P | Mmm, mmm.  
[8” of silence ] |  | P | O | SIN | T |
|---|---|---|---|---|---|---|---|

Silence: The therapist and the patient are waiting for something to happen. Who will take the initiative?

<table>
<thead>
<tr>
<th>161</th>
<th>T</th>
<th>Shortly, a little bit, as if asking for love, for attention, for consideration or something like that… exclusivenn…. It meant to be naughty.</th>
<th>VAR</th>
<th>T</th>
<th>A</th>
<th>SIN</th>
<th>T</th>
</tr>
</thead>
</table>

The therapist here goes ahead, sharing the same intersubjective field but proposing, stoutly after the silence, a larger direction where their relation is going.

<table>
<thead>
<tr>
<th>162</th>
<th>P</th>
<th>Mmm</th>
<th></th>
<th>P</th>
<th>O</th>
<th>SIN</th>
<th>T</th>
</tr>
</thead>
</table>

The patient is not moving forward or closer. Nonetheless, he is implicitly expressing his wish to maintain the contact with the therapist, even if not withdrawing.

At the end, we are going to summarize the goals of our research work:

1. A new and pervasive sensibility to the fitness of our clinical actions to the clinical couple and history (silence or interpretation or confrontation or affective reactions, both negative and positive, traditionally named “countertransference phenomena”) instead of their fitness to our clinical theory and ideal identity as psychoanalysts, that is of their dyadic efficacy and

32
meaning. In BCPSG’s words (2002): Both partners sense the fittedness of their actions to the relational potential of the other, and hence to the achievement of more complex joint dyadic activity in the service of joint goals (---) In applying dynamical systems theory to psychoanalytic process, we have come to the view that psychoanalytic therapeutic interaction is an inherently sloppy process. This sloppiness arises from the intrinsic indeterminacy of the co-creative process between two minds.

2. An increasing intellectual and clinical distress about the over-reductive view of therapeutic process as founded on interpretation/insight, unconscious conflict and defense, and about the hierarchical role of the analyst or, in some contemporary declinations, of the almost absolute role of the patient in determining the (often only) negative interpersonal events along the treatment.

3. Applying our protocol to sessions and treatments in teaching and supervising candidates, some of us realized the possibility of a more effective exchange and learning, limiting the classical splitting between an “omniscient” supervisor and a fellow-follower candidate: In addiction, working together on the transcripts of the candidate’s sessions favours the direct learning and training of a focused attention to each passage of the therapeutic encounter and to the potential richness of each Relational Move.

4. It would be clear that we are conscious of important failures of the research method we adopted: first of all, in coding and inferring the therapeutic change: for the BCSG is the continuous moving along process is the proof of change, but it is not enough, for our proposal. So, we matched our protocols with PDM-2 and SWAP-200 protocols, as Paolo Vassallo illustrated. But does the change at the micro-level coded by the RM method correspond to the change inferred by the clinical reasoning and by different assessment instruments like SWAP-200 and PDM-3? If so, how? In addiction: can the moments of meeting stand for the idealized psychoanalytical interpretation or can the interpretation assume the form of a moment of meeting?

5. The need to study the implications of the BCSPG’s reduction to the “implicit realm” or to the “real realm” for our unavoidable foundation on the
“unconscious realm”, in the light of contemporary Neuroscience but first of all of our claim to “touch” the repressed dynamic (that is unconscious) level to achieve the patient’s change. We found very intriguing what A.C. Morgan wrote in “Moving along to things left undone” (BCPSG,1999):

“To consider the “something more” than interpretation in treatment means that we are addressing previously recognized phenomena that much of psychoanalytic language has failed to explain with precision. Our focus is on the interactional process over time in the present between the person who is the therapist and the person who is the patient. It seemed important, given this focus, to distinguish this here-and-now part of the relationship from those aspects more dominated by symbols and expectancies from the past (i.e., those aspects seen traditionally as transference and countertransference). The “realness” of this here- and-now aspect of the relationship does not mean that transference and countertransference are not real. They are simply based more on the past than on the here-and-now.”

6. The issue is fundamental, in our view, but let us just to express the hope of a “psychoanalytic task force” dedicated to the theoretical research, to which the empirical research sends back; the proliferation of concepts, models and paradigms in contemporary psychoanalysis can demonstrate its vitality, but can also be dangerous for its future and its scientific status. We hope the the IFPS’s Institute of training will contribute to this task.

“Quousque tandem abutere, Catilina, patientia nostra?” (Cicero, 63 a,Ch, n,) I hope that you are not thinking, in this very moment of 2020 p, Ch, n,; “Quousque tandem abutere, Daniela, patientia nostra?”.

So, I I thank you very much for your attention and participation, also on behalf of our group.