Relational and classical elements in psychoanalyses: an empirical study with case illustrations

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Abstract

The first aim of this paper is to report a newly developed measure of therapeutic process, the *Dynamic Interaction Scales* (DIS). When combined with the *Analytic Process Scales* (APS; Waldron et al., 2004a,b), the two instruments permit a reliable and fine-grained assessment of technical and relational aspects of psychoanalytic and psychodynamic psychotherapeutic process. The Shedler-Westen Assessment Procedure and Personality Health Index (SWAP and PHI; Westen & Shedler, 1999a, b; Waldron et al., 2011) permit a reliable and fine-grained assessment of the changes during treatment.

The second aim is to demonstrate how combining results from these instruments permits exploring the relationships between processes and outcomes of treatment. We illustrate the utility of this approach by a demonstration project, applying the instruments to two treatments started 21 years apart. The results show different relational and classical approaches of the analysts, and different outcomes. Both patients had a similar level of psychological functioning at the outset of treatment, but one made a much more extensive recovery than the other. The difference in outcomes may reflect different patient pathology, in spite of their initial level of functioning. But it may also reflect the impact in the better outcome case of a more relational approach, combined with a more extensive use of classical analytic interventions judged to be of higher quality.

KEYWORDS: treatment outcomes, Analytic Process Scales, Shedler Westen Assessment Procedure (SWAP), Personality Health Index (PHI), Dynamic Interaction Scales (DIS)

There is increasing evidence that psychoanalysis and long-term psychodynamic therapy are beneficial to patients (Bachrach, Galatzer-Levy, Skolnikoff, & Waldron, 1991 ; Leichsenring & Rabung, 2008 ; Leuzinger-Bohleber & Target, 2003 ; Sandell et al., 2000 ;Shedler, 2010 ; Wallerstein, 1986). Yet, the elements contributing to the success of these therapies continue to be debated, with an increasing importance attributed to the relational ones (Beutler & Castonguay, 2006; Binder, 2004; Levy, Ablon, & Kächele, 2012; Luborsky, 2000; Wampold, 2001).

Meanwhile, many psychoanalysts and dynamic practitioners have turned in the last twenty years from a more "classical" psychoanalytic approach to a more "relational" one. This "relational turn" (Mitchell, Aron, 1999) implies several changes in the technical approach to the patient. Just a few examples: The relational analyst endorses being more active, less convinced of the value of the silence of the analyst and of short and unsaturated communications (Mitchell, 1997); more available to talk about him/herself and his/her subjective experiences (self-disclosure; Renik, 1995) and to use them for understanding the communications of the patients (Ogden, 2001); more open to a full emotional involvement in the therapeutic relationship and to communicate his/her feelings in the here and now to the patient (Aron, 1996). The relational analyst ascribes value to the emotional attunement and implicit relating with the patient together with specific kinds of explicit interventions (Boston Change Process Study Group, 2010). A more warm, supportive and straightforward analytic stance is considered desirable, and (s)he is convinced of the basic unavoidability of a certain measure of enactment, both on the patient's and on the analyst's part (Renik, 1998). In this frame of thought, the knowledge that the patient acquires about him or herself during the treatment is considered a co-construction (Orange, 1995), more than a re-construction, depending both on what the patient says and "discovers" about him or herself and on what the therapist says and "does" in the analytic room (Weiss, 1993; Aron, 1996). Self psychologists consider empathy to be therapeutic (Kohut, 1984), in addition to a way of knowing the patient's psychology. Both relational analysts and self psychologists give a great importance to a *joint* exploration of the problematic relational patterns of the patient and to the integration and differentiation of transferential and extra-transferential relational patterns (Hoffman, 1998). This relational approach builds on the exploration of the transference with the help of the analyst that has been at the heart of more "classical" ego psychological psychoanalytic work (Brenner, 1982).

This characterization might be seen as implying a clear distinction between relational and classical analysts, but it would be inaccurate to imagine that the different viewpoints on technique adumbrated in the previous paragraph would remain solely the possession of one training center or another, and that these changes would not be experienced in varying degrees

and ways by all analysts as the decades have passed. Furthermore, many so-called classical analysts undoubtedly related and relate to their patients intuitively, depending on their patients' needs, in the manner so well explicated in recent years by relational writers. Attunement has been considered very important long before the writings of the relational group (e.g. Stone 1973). There is also the likely discrepancy between analysts' expressed beliefs about technique and what they actually do.[1] So there is a clear need for assessment of the techniques occurring in any given psychoanalysis or psychoanalytic psychotherapy .

In this paper, we will demonstrate that it is possible, using recently developed research tools, to study systematically *the degree to which* these different approaches occur in recordings of sessions, a first step necessary in evaluating any hypothesized relationships between the processes of therapy and outcomes. In order to bring alive the account, we describe both patients studied, provide brief examples of the clinical work, and then give a systematic assessment of the therapeutic processes of their analyses, followed by a detailed systematic appraisal of the patients' level of psychological health, both at the outset of treatment and at its conclusion.

The opportunity for such a study stems from the availability of 27 fully recorded psychoanalyses, spanning the period from the 1970s to the present, all in the collection of the Psychoanalytic Research Consortium (http://www.psychoanalyticresearch.org, see Waldron 1998). Francesco Gazzillo, of the Department of Dynamic and Clinical Psychology of "La Sapienza" University of Rome, Italy, and Sherwood Waldron, Chair of the Psychoanalytic Research Consortium (PRC), New York, with their respective groups of colleagues, are collaborating to accomplish the study of these cases using quantitative and qualitative means.[2]

We compare a more recent case, "Daniel," whose treatment recently concluded with a very good outcome, with another case, "Vincent," treated in the 1970s using a more classical technique with a poor outcome. The differences found between the approaches of the two analysts are not based upon the avowed views of the two analysts (although those views are

[1] For example, in a classical study Sloane, Staples, Christol, Yorkson, and Whipple (1975) showed that behavior therapists were making psychoanalytic interpretations during their "behavioral" sessions and not remembering that they did so. And in a small study (Waldron & Helm 2004) the level of core analytic activities in sessions of CBT was substantial, although less than in the psychodynamic sample.

[2] Colleagues from Rome contributing to this study in addition to the authors include Federica Angeloni, Antonella Cirasola, Valentina Mellone, Mariapaola Nazzaro, Francesca Ortu, Chiara Ristucci, Annalisa Tanzilli. U.S. contributors to the development of the instruments used in this study include Anna Burton, James Crouse, Stephen Firestein, Marianne Goldberger, Fonya Helm, David Hurst, John Jemerin John Lundin, Seymour Moscovitz, Karl Stukenberg, Robert Scharf, Jonathan Shedler, and Kenneth Winarick.

consistent with their techniques as actually measured by us) and were not known to the raters.[3] The comparison permits us to introduce our newest instrument for assessing the nature of the interaction between patient and analyst, called the *Dynamic Interaction Scales* (DIS). The reader may compare his or her clinical understanding of the patients and their treatments, based upon our summaries and a small sample of interaction from each treatment, with the systematic assessments of the two patients, once we have introduced the instruments used and reported their reliabilities. The descriptions below have been prepared on the basis of the study of 20 sessions from each case.

Clinical description of the two patients and their treatments

Daniel and his analysis

Thirty-two years old and single when he first came for therapy, Daniel was leading a strikingly isolated life a considerable distance from the major metropolitan area where he sought help. He was withdrawn and afraid of reaching out to others. He had sought a referral from the psychiatrist who had treated his brother some years before — a brother who had a breakdown after dropping therapy and ended up killing himself in a psychotic state.

Daniel described such a severe social phobia that, although he seemed personable and attractive, he had no girlfriend and very few friends. He had inherited money when he lost his father at 21 and had made some efforts to find meaningful employment, but he mostly liked to surf, an activity that he did very well and that had taken him widely over the world. He had worked for a year or two in a distant place as a deck hand on a boat that took people to sea for entertainment, but he always felt very inadequate. His father had been a very successful businessman and had given Daniel and his five siblings the assurance that they need not make a serious effort at developing a career, because he had enough money for them all. After his father's death, the amount of money was found to be insufficient.

[3] A detailed description of the nature of the training of the two psychoanalysts, including their exposure to relational theory, supervision, etc., would of course be of considerable interest, but must be omitted. It is important to keep the psychoanalysts unidentifiable in order to fully protect the confidentiality of the patients. But of course it is clear that Vincent's treatment began before the relational movement had gotten underway, whereas Daniel's started twenty-one years later, when the expression of the relational point of view was coming under wide consideration in American psychoanalysis. Daniel's analyst's analytic education was about fifteen years later than Vincent's.

Early in the treatment, he described a considerable sensitivity to slights and feeling helpless to defend himself or to protect his self-esteem when someone tried to dominate him. His mother, far younger than his father, had felt overwhelmed by the children and had regularly beaten and threatened them, particularly when they behaved in a way that she felt might shame her.

In the sessions, he was soft-spoken and apparently unassertive. Rather soon, he agreed to go from twice weekly therapy to four times weekly analysis using the couch, and at the same time he had moved from his more distant house and found an apartment not too far from his analyst. The analyst was very active in promoting the conversation, in encouraging him to articulate his feelings, including his negative feelings about himself and other people; otherwise he tended to fall silent. One important theme discussed was his withdrawal from a more active dating life 6 years before when a girlfriend betrayed him with another man in a rather egregious way.

Within several months he dropped out after a midwinter break, maintaining that he was fine, and only returned 18 months later, at which time he acknowledged a need for more help and then continued four times weekly on the couch for another 2 years. During this time, the analyst focused on his need to minimize his own feelings for others, while anticipating a similar dismissal at the hands of others, and he started a romantic relationship with a young woman. Although still plagued by doubts about whether she really loved him or not, he developed the relationship and decided to go on an around-the-world trip with her, combining sight-seeing and surfing. His analyst succeeded in persuading him to continue sessions once-weekly by telephone, and this arrangement continued until his return from abroad, when he resumed analysis three times weekly.

Upon his return, he felt less depressed and anxious, and kept on feeling inferior and feared being manipulated by other people, his therapist included. Daniel felt that the analyst was not helping him very much, and was still quite angry with other people and self-critical. During this period, the therapist was quite confrontational with him, stressing how his self-regulation and relational capacities were improved, and his anxiety decreased. Moreover, the analyst worked interpretatively on how Daniel on one hand looked for the approval of a father figure, and on the other rebelled against the submissive role that this kind of need implies.

Meanwhile, Daniel was convinced that he needed some kind of serious occupation, and it was around this time that he and his girlfriend married. He had always had a love of physical

activity and working out, so he turned to one of the burgeoning physical activities programs, became a certified instructor, and not long afterward established his own business in town. His ongoing tendency to feel weak and inferior compared to others, and a person whom others would not want to befriend, gradually receded. He and his wife had a baby daughter, and he proved quite devoted to her care. The analytic work continued three- and then twice-weekly for another year-and-a-half. The demands of family life and business were the basis for reducing to once-weekly, which he continued for the next 8 years.

During this time, fate was not kind to him. His wife developed a rapidly fatal brain tumor, and he proved to be devoted to her and particularly to his young daughter during this trying time. After her death, he was successful both in supporting his business, his daughter, and starting a new relationship which went well, and he fulfilled finally a long-time wish to start a business, combining a program that he developed himself with the program in which he was certified. His termination was marked by his evident wish not to experience it as such, so that he gradually reduced telephone sessions without a specific plan to terminate. Daniel apparently continued to do well, even if he kept on feeling the need to keep everything under his control because he was afraid that things in his life could go bad, and he tended to have a parental attitude toward his new partner. The analyst helped Daniel to learn how to accept his new partner as she was, to work through the conflicts he had with his mother, and his tendency to become self doubting in response to his rage against his mother. Daniel had had a total of more than 900 sessions with his analyst over the course of 15 years.

Vincent and His Analysis

Vincent, a married man in his early thirties, started his four-sessions-a-week analysis on the couch because he felt unable to have a stable and satisfying love relationship or to be satisfied with his work. Undecided about his career, he was considering shifting from a job repairing a particular kind of mechanical equipment to becoming an educator or teacher. As a repairman, he became easily bored. When he switched to training as an educator soon after the beginning of his analysis, he was initially satisfied, but then became anxious about whether he was capable. To overcome this sense of inadequacy, which was quite invasive and particularly intense in the morning, Vincent tried to plan accurately everything he had to do, but his strategy based on control did not succeed in reducing his anxiety. He showed also a tendency to over-identify with the problems of his pupils in a specialized school for problem children.

After a few years of marriage, he no longer felt in love with his wife, and he had started some liaisons with other women, without having sex. He felt very jealous in these relationships, and added that probably one of the reasons for the lack of involvement with his wife was that he forced his wife not to spend any time with friends, so the couple ended up mostly alone together. He was frequently angry with his wife and got easily upset when she ignored his expressed preferences and chose to cook food he did not like. He interpreted these situations as evidence of a lack of caring and love on her part.

His father left the family when his sons were very little, and Vincent had only seen him a few times in his life subsequently, but he denied any feeling of loneliness or rage toward him. Now, he was afraid that the analyst also could let him down. His mother was described as an unempathic woman who treated her children as if they were “toys” and who had become depressed after her husband left her. And, again, Vincent added that he was afraid of finding the same unempathic attitude in his therapist and thought that his overwhelming worries about “adequacy” were due to his mother’s way of treating both him and his brother: she used to show them off to her acquaintances and to often said that they were “terrific” in a way he experienced as deeply false. Vincent described his younger brother as inadequate and a failure, and it was quite clear that he was afraid he was similar to his brother.

The first period of analysis was centered on his shifting self-esteem, and the analyst stressed his tendency to intellectualize and to elicit the responses of others to bolster his self-esteem. Another focus of the first analytic period was his fear of become attached to the therapist and then feeling let down or criticized. Vincent told of his previous analysis, from which he dropped out, describing his former analyst as cold and critical (in a way comparable to how he experienced his mother).

His difficulty in close relationships seemed also to be reflected in sexual difficulties: after some months he tended to lose interest both in having sex and in having a relationship with a woman. The reason for this angry disengagement was not clear, but it remained a central focus of the treatment. Meanwhile, he had resumed his work of educator, but his possibility of enjoying it seemed impaired by his tendency to envy the capacities of some of his pupils and by his ongoing sense of inadequacy. Vincent described feelings of pessimism and depression and felt angry with the therapist, whom he increasingly experienced as distant and unempathic. He reflected, about himself, that he seemed to have both a narcissistic and a borderline personality disorder, and needed to learn how to maintain a gratifying love

relationship based on trust and to stabilize his self-esteem. The analyst, on his part, tended to view these statements as intellectualizations and seemed more focused on discovering the deep reasons for his withdrawal from any significant emotional relationship, so they seemed to be working at cross purposes.

During the last part of his analysis, Vincent continued suffering from the same difficulties: he got divorced but was not able to find any other fulfilling relationship and seemed to be discouraged about his therapy. He wanted to leave the analysis and all the relationships with people with whom he was not satisfied. He kept on working as an educator and appreciated his work, but he kept on feeling deeply inadequate and very anxious. He felt rage toward the therapist and devalued the therapy, connecting this feeling to his relationship with his mother and her showing him off to other people as "terrific," fostering in him a sense of grandiosity under which there was a total lack of real comprehension and appreciation. He described himself as very afraid of the expectations both of his analyst and of his recent love interest. He kept on blaming his therapist for his suffering and himself for his incapacity to interrupt the analysis; he was full of anxiety and doubts, and nothing in his life gave him happiness. Having bought a house for himself, he was also afraid of not having enough money both to live a good life and to continue the analysis. While the analyst tried to explore the inner reasons for his unhappiness and his tendency to withdraw from people, he kept on blaming external factors.

In the last sessions of the therapy, the analyst stressed to the patient the necessity to understand better why, in every intimate relationship, Vincent ended up feeling frustration, anger, and fear and deciding to withdraw from the relationship, just as he had done with the previous analyst. The atmosphere felt stalemated, and Vincent discontinued rather abruptly. His analysis had lasted 660 sessions.

Methods, Instruments, and their Reliabilities

Structure of the sample studied

Two patients were chosen because the severity of their clinical conditions at the beginning of therapy seemed to be similar, but clinically there appeared to be clear differences in the technique of the analysts. We wished to evaluate whether our quantitative measures captured these clinical differences and whether these differences were associated with differences in outcomes.

In our ongoing study of the 27 cases, we evaluate 20 sessions for each case, 4 adjacent sessions from each of five periods: the first 4 sessions, 4 sessions after approximately six weeks of therapy, 4 sessions from the middle of the therapy, 4 sessions from approximately the sixth week before the termination and the last 4 sessions of the therapy. The study thus constituted requires the detailed study of 540 sessions. All twenty sessions from each case are used to assess psychoanalytic process variables. To study outcomes, we study together the 8 early sessions to evaluate psychological health at the beginning of treatment, and the 8 late sessions to evaluate psychological health at the end.

Outcome Measures: The Shedler-Westen Assessment Procedure (SWAP) with Personality Health Index (PHI) and RADIO scoring method[4]

The PHI gives an overall measure of a patient's psychological health-sickness, and the RADIO provides a systematic assessment of five dimensions of health-sickness. These measures are derived from the Shedler-Westen Assessment Procedure (SWAP), a widely researched and well-validated assessment instrument (Westen & Shedler, 1999a, 1999b, 2007; Shedler 2002) composed of 200 jargon-free items describing both healthy and pathological personality features, to be completed by a clinician with knowledge of the patient. In our study, this knowledge derives from listening to and reading the transcripts of 8 adjacent recorded sessions. Listening provides partial access to the non-verbal communication of the analytic pair.

The SWAP utilizes a Q-Sort method, which requires the rater to assign the 200 items so that a fixed distribution is attained (Block 1978, 2008; Shedler & Westen, 2007; Westen & Shedler 1999a), which helps to improve the reliability of ratings. The rater assigns a score from 0 to 7 to each according to how salient or characteristic the item is in that particular patient's functioning (0=not descriptive, 7=most descriptive). Only 8 items can be given the highest score of 7, 10 are scored of 6, 12 are scored of 5, and so on. The rater is obliged to assign scores from 1 to 7 to 100 of the items; the remaining 100 items are assigned scores of 0. This procedure results in the 100 chosen items being distributed approximately as one-half of a bell-shaped curve.

There is a minimal need for training for raters, as long as they are experienced therapists. The SWAP statements can be printed on separate index cards and sorted by hand, or they can

[4] The two versions of the SWAP, SWAP-200 and SWAP2, do not differ greatly. This study uses SWAP-200.

be sorted more conveniently on a computer program developed by our colleagues and ourselves (Shedler 2002, p. 434; Westen, Shedler, Lingiardi, 2003).

The SWAP provides a common vocabulary that organizes clinical observations and inferences about a patient's personality and provides a "snapshot" of a patient's psychological functioning. Although consisting of only 200 items, the SWAP provides nearly innumerable permutations that permit the capture of complex patterns (Shedler 2002). Further studies (e.g. Lingiardi, Shedler & Gazzillo, 2006) have shown that the 30 highest scored items provide a useful summary of patient functioning at any given point in a psychotherapy. Moreover, 24 of the 200 items express aspects of positive mental health, providing a corrective to an excessive focus only on pathology.

One of the outputs that the SWAP software provides is a profile of twelve personality prototypes that closely parallel DSM-IV Axis II diagnoses (the Personality Disorder or PD factors). The correspondence between the patient profile and the different PD factors is standardized as a T-score (average = 50, standard deviation = 10) in comparison with a nationwide sample of personality disordered patients. When the T-score for a given prototype is 60 or more, the patient is considered to have that personality disorder, and if the score is 55 to 59, the patient is considered to have features of the disorder but not the full-blown disorder.

The Personality Health Index or PHI (Waldron et al. 2011) is a percentile comparison of the health/sickness of the patient derived from the SWAP scores with 307 SWAPs of psychoanalytic outpatients from a nationwide clinical sample of patients in outpatient psychoanalysis (Cogan and Porcerelli 2004, 2005). The PHI has good construct validity and reliability (Waldron et al. 2011). Since the PHI is based on 200 separate clinical judgments, including 24 judgments of health dimensions, it is much less subject to varying global impressions of each rater than is the GAF. It also correlates significantly more than the GAF with 5 of 7 other indices of psychological functioning (Waldron et al. 2011). The results of the PHI are expressed as the patient's percentile standing, compared to the other patients, both in general and in regard to five categories (see below). This provides an easily comprehensible metric for each patient's health/sickness score, a baseline to assess change in the course of treatment, and a much wider canvas, as it were, to show changes than that provided by the GAF.

Our version of the SWAP also provides a clinically meaningful breakdown of the SWAP results for the patient, charted to permit comparison among any three different points in treatment at a time (Waldron et al. 2011). The clinical presentation of the patient is described, organizing the most relevant SWAP items in 5 categories: Reality testing and thought process, Affect regulation, Defensive operations, Identity integration and Object relationships, and is given the acronym RADIO.

In this study, the interrater reliability of the SWAP scores, based on the assessment of 20 groups of 8 contiguous sessions by two independent raters, is ICC .79 In reporting results, we have averaged the raters' scores to describe the level of personality functioning of the two patients at the beginning and at the end of their therapies. Waldron et al. (2011) have reported the development, reliability, and convergent validity of the PHI and the RADIO scoring methods.

Global Assessment of Functioning Scales (GAF)

This measure, which is the core of the fifth axis of the Diagnostic and Statistical Manual of Mental Disorder, IV edition - Text Revised (DSM-IV TR; APA, 2000) is derived from the Health-Sickness Rating Scale (HSRS; Luborsky 1962), but does not use clinical illustrations for the points on the scale, as did its predecessor. As a consequence its reliability has varied greatly (see, for example, Rey, Starling, Wever, Dossetor, Plapp, 2006). In our sample of 10 cases already assessed at the beginning and at the end of their analyses (N = 20), the ICC of the assessment of two independent raters is .65.

Process Measures

The Analytic Process Scales (APS)

The APS research group had developed the APS (Analytic Process Scales) starting many years ago in an effort to tease out those elements in the therapeutic communication which might well turn out to indicate a useful therapeutic or analytic process, and thereby distinguish successful from unsuccessful therapeutic engagements.

Thirty-two five-point scales (zero to four) were developed starting in 1989 to capture contributions of the analyst and patient to ongoing psychoanalytic and psychotherapeutic work, with a coding manual including examples at three of the five points (Waldron et al. 2004a). Most central were the Core Analytic Activities of clarifying, interpreting, addressing the patient's defenses, transference, and his/her conflicts. Also included were addressing the

patient's developmental years and problems with self-esteem. The analyst's affect (amicable or hostile) and the degree of confrontation were also evaluated, and finally the overall quality of the analyst's communication. Patients' communications were assessed as to how well they communicated their experiences and the degree to which they reflected about them and expressed feelings that were informative. Patients' communications were also assessed for their "productivity", defined extensively in the manual, and their responsiveness to the analyst's communications.

Since the APS was developed, there has been an increasing change from a more "classical" theory of technique, sometimes referred to as the "one person" point of view, to a more "relational" one in understanding the therapeutic situation. And we have found, using the APS, that *the quality of the therapeutic communication, as rated by clinician-raters, was the single most powerful predictor of subsequent patient increase in productivity, irrespective of the nature of the therapist communication (clarification, interpretation, supportive remark, etc.)* (Waldron, Scharf Crouse, Firestein, Burton & Hurst, 2004, Gazzillo & Lingiardi, 2007, and Lingiardi, Gazzillo & Waldron 2010. Our working hypothesis has been that the clinician raters were responding to relationship aspects as they listened to the therapeutic communications, and these were reflected in their ratings of quality. Also our finding about the role of "quality" in enhancing patient productivity is entirely consistent with the strong correlation in psychotherapy research among relationship features of the therapeutic relationship and outcome (Norcross, 2011). So the APS group decided to develop an instrument that would more directly assess aspects of the relationship than the APS was designed to do. The results of this effort are the *Dynamic Interaction Scales* (DIS).

The Dynamic Interaction Scales (DIS)

The DIS provides a more holistic, interactional set of measures than the APS, as described below. Twelve aspects of the ongoing psychoanalytic or psychotherapeutic process were identified by the APS study group as reflecting dimensions of how the two individuals were working together and relating to one another. In developing the new variables, the group followed their experience in developing the APS variables, defining them on the basis of accumulated clinical experience (averaging more than 35 years for each clinician), then iteratively applying them to clinical sessions and discussing disagreements, then modifying the language of the items or of their explanations. These explanations were collected in a coding

manual.[5] Following the development of the coding manual, the DIS was applied by the Rome group to a series of sessions from a case studied intensively (Colli, Condino, Gentile, Lingiardi, 2012; De Bei, Tanzilli, Aioub, Giovannetti, Miccoli, Dazzi, 2011; Di Giuseppe, Codazzi, Staolfa, Marseglia, 2011; Gazzillo, Lingiardi, Genova et al. 2011). The same procedure of progressive modification of scores described above for the APS was followed for the DIS. The resultant reliabilities were excellent among the Roman raters. The correlations among the raters in the present study (Spearman-Brown rho), derived by the assessment of 120 sessions from six different cases, are given in parentheses as each variable is listed below. The average Spearman's rho value for the DIS variables based upon 40 sessions rated was .93, ranging from .83 to .98, indicating a very good level of interrater reliability.[6]

The DIS consists of 12 variables which may be understood as addressing three subcategories: the contribution of the therapist, patient, and their interaction.

Therapist scales

1) To what degree is the therapist *straightforward* with the patient? (rho=.93)

2) To what degree is the therapist *warmly responsive* to the patient? (rho=. 97)

3) To what degree is the therapist *responsive moment-to-moment* to the patient's feelings? (rho=.92)

4) To what degree does the therapist convey aspects of his *subjective experience* or subjective response to the patient's specific communications, situation or needs at this time? (rho=.93)

5) How well is the therapist working with and helping the patient work with his/her *typical patterns of relating and patterns of feelings* which most trouble his/her life adjustment or satisfaction? (rho=.92)

Patient scales

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[5] A copy of the unpublished coding manual may be obtained from the senior author.

[6] For assessing the interrater reliability of our instruments we have used the Spearman rho coefficient because it can be applied to ordinal numeric variables and the correctness of its application does not depend on the normal distribution of the variable. We have calculated the Cohen's Kappa coefficient as well for all our variables to check whether raters' scores tended also to be at the same level for the same variable applied to the same clinical material. The Kappas for the DIS and APS variables were from .02 to .20 less than the Spearman Brown Rhos, reported in the description of the DIS variables, and this paragraph, indicating a good to excellent level of reliability for these variables.

6) To what degree does the patient *flexibly shift to and from experiencing and reflecting* in this session? (rho=.89)

7) To what degree is there a flexible *interplay on the part of the patient between conscious waking life and dreams* in this session? (rho=.83)

8) How well is the patient working with his/her *typical patterns of relating and patterns of feelings* which most trouble his/her life adjustment? (rho=.95)

Interaction scales

9) To what degree does the patient experience the therapist as *empathic*? (rho=.98)

10) To what degree is the therapist's contribution leading to the further *development of the patient's awareness* of his or her own feelings? (rho=.95)

11) To what degree is there an *integration of understanding of the relationship with the therapist to other relationships*, past or present? (rho=.97)

12) To what degree is the *engagement in the therapeutic relationship* by the two parties brought forward or experienced in an emotionally meaningful way? (rho=.96)

The DIS can be applied to audio recordings of confidentialized psychotherapy sessions, while the rater also reads the transcript. Listening to the audio is essential to pick up the "music", so to say, of the session and the relationship. The rater scores each of the DIS scales on a 5-point Likert scale, from 0 to 4, following the APS scoring format, scoring the maximum level reached during the session on each of the DIS variables.

The APS Variables

The Analytic Process Scales (APS; Waldron et al., 2004a, b), have been developed and validated in the past twenty-seven years by the APS research group, for application to recordings of sessions. Thirty-two dimensions of psychoanalytic or psychodynamic treatment have been defined, examples were developed of different levels of each dimension of the patient's and the analyst's or therapist's contribution to the sessions, and these assembled into an 81-page coding manual (Scharf et al. unpublished, 1999, 2010). Levels of each variable were from 0 (not present) to 4 (strongly present) on Likert-type scales. The anchoring of clinical judgments made possible by the APS Coding Manual facilitates accurate and reliable measurement of core psychoanalytic dimensions. In this study, we will report the results from comparing the two patients on "core analytic activities". Reliability correlations between our

study raters (Spearman rho) are shown in parenthesis after each variable below and were calculated on the basis of the assessment of 120 sessions from six different cases.

Clarification : the degree to which attention is called to insufficiently noticed surface features and how they may be psychologically connected, often by presenting several features as related to one another (rho=.95).

Interpretation: the degree to which the analyst's contribution transforms meaning by bringing aspects outside of awareness into full awareness (rho=.94).

Addressing defenses present in the session (resistance): the degree of focus on any means the patient uses to avoid experiencing objectionable impulses, affects, thoughts or fantasies (rho=.97).

Addressing reactions to the analyst or analytic situation (transference) (rho=.93).

Addressing conflicts: the degree to which the analyst focuses on aspects of the patient's conflicts in the session—impulses or affects, their feared consequences or moral concerns, and the connections between any of these, including related fantasies and memories (rho=.92).

We also report the degree to which the analyst addresses the patient's problems in *self esteem* (rho=.94), and the degree to which the analyst addresses the *developmental experiences* of the patient (reconstruction: rho=.94). Finally we report the results of the raters' evaluations of the *quality* of the interventions in each session (rho=.95)

We report the patient's contribution in several respects, including how well the patient *conveyed his/her experiences* in the session and self reflected. These variables were assessed in two categories: as they pertained to the analyst or analytic situation, and as they pertained to the rest of the patient's life.[7] The patient's *responsiveness* to the analyst's communications (rho=.94). and the overall *productivity* of the patient (rho=.91). were also reliably assessed (Waldron et al. 2004b).

The APS variables were originally developed to be applied to segments of each session, but the procedure has been expanded to rate the variables applied to each session in its entirety, so that we could accomplish a study of a much larger number of sessions. In applying the scales in this manner, the Roman group has modified the scoring as follows: each rater uses

[7] Reliability (Spearman's rho) for conveying experience in regard to the analyst was .98, and in regard to other than the analyst was .90. Self observation (analyst) was .98 and the same for self observation for other than the analyst.

pen and paper to record relevant scores on a work sheet, as they listen to and read the session. Then, as material emerges in the session, the raters keep on increasing the scores for any of the variables where new material warrants such an increase. As a consequence, the final scores do not represent an average, but reflect the highest level reached in that session on any given variable. And because they record the various communications in this ongoing manner, rather than simply at the end of the session, the interrater reliability is excellent, and much improved from the previous ratings of whole sessions by the New York APS group.

The average Spearman's rho of the APS patient variables was .85, ranging from .61 to .98. The interrater reliability of the APS therapist variables was similarly high, with rho averaging .94, ranging from . 88 to .99, indicating that these variables when applied to the session as a whole, using the slightly altered methodology described above, showed excellent reliability.

The raters were able to evaluate consistently even the variables at the highest level of inference, such as the patient productivity in the session (.91), the overall goodness of the analyst's communication (.95), and the engagement by both parties in the process (.96). In this research we applied 13 of the 14 APS patient scales and 16 of the 18 APS therapist scales, but we only report here the scales showing relevant differences, or where the failure to find a difference between the cases is considered significant.

Helping Alliance Rating Method (HAR)

A central finding of psychotherapy research is the importance of the therapeutic alliance in predicting outcome, usually measured very early in treatment. Consequently we assess the initial therapeutic alliance in each of the cases, to provide a general measure that can be compared to the various relational measures provided by the DIS, and to estimate whether the two patients began with markedly different therapeutic alliances, since such a difference alone might well account for different outcomes.

The *Helping Alliance Rating method* (HAR; Luborsky et al., 1983) is based on a model of the helping alliance as articulated in in two broad subcategories: the helping alliance of Type 1, defined as the perception of the availability of the therapist, depicts in what measure the patient experiences the therapist as capable of giving the necessary help; the helping alliance of Type 2, defined as a cooperative bond between patient and therapist, assesses in what measure the patient feels the treatment as a joint enterprise aimed at reaching the therapeutic goals. The average correlation between the HAR type 1 and 2 is .68. In this study, we have

calculated both HAR values taking as a whole the first 8 sessions rated of each treatment; i.e. the first 4 sessions and 4 sessions from the sixth week of the treatment.

Summary of Process and Outcome Measures Used

Eight early sessions (periods 1 and 2) are assessed with the APS, DIS, SWAP with PHI/RADIO, GAF, and HAR; the late 8 sessions with all these instruments except for the HAR; and the 4 middle sessions were assessed only with the APS and DIS (see Table 1).

Table 1

Sessions Assessed, Instruments and Focus

Period and sessions	Instruments	Focus
Beginning (first 4 sessions + 4 sessions from the 6th week)	SWAP, PHI, GAF HAR APS and DIS	Personality and overall functioning, helping alliance, therapeutic process
Middle (4 sessions from the middle of the analysis)	APS and DIS	Therapeutic process
Termination (4 session from the 6th week before the termination and last 4 sessions)	SWAP, PHI, GAF APS and DIS	Personality and overall functioning, therapeutic process

To evaluate if a therapy had a good or poor outcome, we compared the PHI score of each patient at the beginning and at the end of the therapy. We have chosen to define "good outcome therapies" as those analyses that showed a PHI increase of at least a third of the way to the maximum attainable in comparison to our reference sample of SWAPs from 307 analyses (Cogan and Porcerelli 2004, 2005). Among our 13 patients studied so far [in 2013], this means a PHI increase from early to late in analysis of at least 16 points indicates a good outcome.[8] For comparing the analytic processes of these two cases we have used the t-test applied to the APS and DIS assessment of all the 20 sessions selected from each case.

The Raters

The APS and DIS were rated by three raters independently: a senior rater with a PhD in dynamic psychology and a specialization in psychoanalytic psychotherapy, with more than five

[8] When more data become available from Cogan and Porcerelli (2004, 2005) we will be able to calculate more precisely what constitutes a clinically significant improvement (Jacobson & Truax 1991).

years of clinical experience, and two junior raters with master's degrees in clinical psychology who were completing their training in psychoanalytic psychotherapy.

The SWAP/PHI/RADIO evaluations were assessed by two independent raters: a senior rater trained in the assessment of personality using the SWAP by Drew Westen and Jonathan Shedler, and a junior rater with a master's degree in clinical psychology previously trained on 4 cases by the senior rater.

The GAF and HAR were rated by two other independent raters, both of them graduate students in clinical psychology.

The comparisons between the DIS and APS scores of our two cases are based on the average scores given to all the sessions of each case by the three raters. T-tests were used to compare the levels of the DIS and APS variables for the 20 session scores for each of the two cases.[9] All data analyses were conducted with SPSS 20.

RESULTS

PHI/RADIO description: Daniel and Vincent at the beginning of analysis

At the beginning of his analysis, Daniel's PD score showed an avoidant and a schizoid personality disorder, with dependent and depressive features.[10]

Daniel's PHI was at the 10th percentile, i.e. more severely ill than 90% of SWAPs of patients in psychoanalysis in a nationwide sample (Cogan and Porcerelli, 2004, 2005).

The RADIO categories give a more detailed sense of the nature of his disturbance (Table 2, and Tables 1 through 5 in the appendix). The SWAP output is divided into the five clinical categories, as described above, and the same procedure is followed for describing each patient's functioning in these categories as for the overall PHI, assigning a percentage score compared to the reference group from the nationwide sample (Table 2). Reality testing and thought process, Affective regulation, Identity and Object Relations all received low percentage scores, and only the score for defensive operations was near the middle. These results will be further elaborated below, with illustrative tables in the appendix for both patients.

[9] The results were the same comparing the variables with the non-parametric Mann-Whitney U test.

[10] The SWAP T score for these disorders were, respectively, 61.4, 60.1, and 59.5 and 59.4 for the dependent and depressive features.

Vincent at the beginning of his analysis showed a borderline and a narcissistic personality disorder, based on his SWAP scores, with a PHI slightly higher than Daniel's at the 18th percentile, and similarly troubled RADIO breakdowns in his problems, although his object relations were 20% higher than those of Daniel. (Table 2).

The GAF scores provide convergent confirmation to these findings, and the similarity in Daniel's and Vincent's severity of illness is clear (insofar as any two patients can be considered as similar).

Table 2

Daniel and Vincent at the beginning of their treatments

	Daniel (early)	**Vincent (early)**
Personality disorders (SWAP)	schizoid, avoidant, dependent	borderline and narcissistic
GAF	**52**	**64**
PHI	**10**	**18**
Reality functioning	**22**	**28**
Affective regulation	**17**	**15**
Defenses	**49**	**41**
Identity integration	**10**	**14**
Object relations	**10**	**30**

The two patients' initial alliances with their analysts were also at a similar level, with Vincent's alliance Type 2 scores being a little higher than Daniel's, and vice-versa for the alliance Type 1.[11] So all the data derived from the analysis of the first 8 sessions showed two patients with analogous psychological capacities and an analogous helping alliance, with Vincent slightly healthier in most of the domains investigated. On the basis of these findings, it would have been hard to anticipate that Daniel would benefit from his analysis much more than Vincent, but this turned out to be the case.

How did the patients work with their analysts?

We are interested in using our instruments to assess both the contributions of the patients and their analysts, in order to evaluate possible contributing factors to change. We first present (Table 3) the results of evaluating the patients' contributions. Since our Likert

[11] Daniel/Vincent: alliance type 1: 6.8/6.3, alliance type 2: 5.6/6.

scales range from zero to four on all the variables, the table demonstrates for several of our measures that the patients functioned at a high level, and about equally, in self observing about their lives, and in conveying their experiences so that their analysts (and the raters) would have the opportunity to understand them. The raters considered their maximum contributions in each session as productive analytically and responsive to the contributions of their analysts. They both were similarly high in the other dimensions measured by the APS (but not included in the table), such as addressing both sexual and aggressive conflicts during their sessions, referring in meaningful ways to developmental periods of their lives, and grappling with problems in self-esteem.

TABLE 3

The Patients' Highest Contributions in Each Session

			IN GENERAL:		ABOUT ANALYST:	
	PRODUCTIVITY	**RESPONSE TO THERAPIST**	**SELF OBSERVES**	**CONVEYS EXPERIENCES**	**SELF OBSERVES**	**CONVEYS EXPERIENCES**
DANIEL	3.1	3.3	3.8	3.9	1.6	1.8
VINCENT	2.8	3.1	3.9	3.9	**3.4**	**3.5**

Note. p<.01 for differences, for bolded and enlarged scores

In addition to studying the differences between the two pairs (using Students' "t" tests to determine significance), we also charted the variables over the course of the 20 sessions studied, to determine whether differences seemed to occur primarily early or late in each treatment, and whether the smaller sample in the middle contributed additional information. This examination may partly explain the two different sets of scores in our measures of transference-related material: there was a very considerable decline in such material in Daniel's late sessions, when he had been coming only once weekly for some years. When the sessions were more frequent, the material about the analyst and analytic situation was much more prominent, as would be expected clinically. In addition, Vincent's greater conveying experience and self-observing about his analyst appeared to reflect his ongoing struggle to deal with his negative reactions to the analyst as treatment proceeded.

How did the analysts work with their patients?

In contrast to the similarity, on our measures, of the patients' functioning in sessions, the two analysts differed significantly on most of our measures (Table 4). Daniel's analyst was consistently much higher on what we call "core analytic activities" as measured by the APS (Waldron et al. 2004a, b): clarifying, interpreting, addressing defenses present in the session and addressing intrapsychic conflicts were all much higher, as were approaches to issues of development (related to reconstructions) and to issues of self-esteem. A more broadly conceived technical item from the DIS showed similar differences between the two treatments: "How well is the therapist working with and helping the patient work with his/her *typical patterns of relating and patterns of feelings* which most trouble his/her life adjustment or satisfaction?" The average high score for Daniel was 3.6, whereas for Vincent it was 2.6.

Table 4

Daniel's and Vincent's Analysts' Technical Contribution

	Clarifies	Interprets	Addresses Defenses	Addresses Conflict	Addresses Develop-ment	Addresses Self-esteem
Daniel's Analyst	3.9	3.4	2.8	3.2	1.9	3.8
Vincent's Analyst	2.4	2	1.3	1.6	0.3	2

Note. p< .01 for all differences

The differences just described in the more classical aspects of analytic technique were accompanied by striking differences in what could be called the "analytic style" that are particularly evaluated by the DIS (Table 5). Daniel's analyst was much more relational in his approach: he was rated as substantially more warm, revealing of his subjective reactions, amicable and supportive.[12] The interaction between analyst and patient was judged as showing a patient who experienced much more empathy from his analyst, who became more aware of how his feelings were contributing to his difficulties, and the analytic couple were judged as

[12] Amicability and supportiveness were assessed by the APS.

much more engaged. To sum up, 7 of the 9 DIS scales assessing the therapist activity support the idea that Daniel's analyst was more relationally oriented than the analyst of Vincent.

The raters evaluated the quality of Daniel's analyst's best communications in each hour as averaging 3.5 across the 20 sessions, whereas Vincent's analyst received an best average score of only 2.0, most likely reflecting the raters' responses to perceived differences in both technical and relational aspects. We are particularly interested in the extent of these various process differences in our measures because of the difference in outcomes, to be reported below.

Table 5

Relational Aspects of the two analyses (from the DIS)

	Therapist Warm	Therapist follows patient feelings	Therapist reveals subjective response	Patient experiences therapist as empathic	Patient becomes more aware of feelings	Patient & therapist engaged
Daniel's Treatment	**3.7**	**3.5**	**3.6**	**3.2**	**2.8**	**3.6**
Vincent's Treatment	3.1	2.4	2.5	1.9	1.7	2.2

Note. p< .01 for all differences

We applied a simple measure that further illustrates the difference in approach by the two analysts to their patients. We tabulated the number of words spoken by analyst and patient separately for each of the twenty sessions.[13] Daniel and Vincent were about equally talkative early in treatment, but Vincent said less and less as treatment progressed (Pearson correlation of session with word count -0.59). In total, Daniel's more relational analyst spoke nearly half as much as his patient, whereas Vincent's analyst spoke far less, less than a tenth as much as his patient.

[13] We created a relatively simple WordPerfect macro which alternately plucked all the patient words and all the therapist words from the document into two new documents. The document properties showed the number of words.

On the basis of these results, the DIS and APS show that while Vincent and Daniel seemed to participate in their treatments in a comparable way and their level of analytic productivity was very similar(3.1 vs 2.8; p= .5), Daniel's analyst seemed to use core analytic activities much more (clarifying, interpreting, addressing defenses and conflicts, addressing the patient's developmental era) and connected with his patient with a more "relational" attitude, i.e. more warmly, in a more attuned and empathic way, expressing subjective responses, and the patient became more engaged in the analytic experience. In order to illustrate the differences between the two treatments, we present three excerpts from the transcripts. Of course, any such presentation can only have illustrative and not probative value.

From early in Daniel's analysis

P: The worst part is that I just feel like such a fool for, that's the worst part of it. I's not even / / gotten over it, gotten on with my life instead of like having it affect me for six years still / / my life still. / / the worst. you know, and I have friends, you know, my good friend John was like, you know, `Why? You shouldn't like still be . . . do you still talk about her in like regard? What she did to you was terrible. You shouldn't like, you know. putting her up on a pedestal, you know. She's a terrible thing.' I still kept doing it. Like I said and then that's like after that happened to me six years ago it was like, that was like the start of my like searching for some kind of, some kind of a survival or savior or something. I don't know it was like after that happened it was like: now where do I go from here? You know, I did a whole bunch of different things that I thought were going to like save me. Like I did that surf course and I did this, I went to cooking school and I did, you know, just all these things and I thought well after I do them then that's, then this, then my life's going to be set and it's going to be okay, everything will just fall in place after that so, it especially felt for like the last six years of my life's just been passing me by, I've just been spinning my wheels, you know.

T: An admired person who turns out to have feet of clay. A person you thought maybe you could even love and she turns out to be a person who's not decent, has no regard for you or for others.

P: Yeah.

T: That's, you know, that's what, so what does a kid do, or a person do when they're in that situation? One of the things they typically do is they'd rather save their image of the other person, even if it means tearing themselves down, and to a

great degree that's what you did. You said "what was wrong with me" rather than saying: "Boy, something was sure as hell wrong with her and I didn't know it".

P: Yeah.

T: If you can blame yourself, then you can spare the other person and keep them still as having value.

P Why would I want to do that?

T: Because it's so lonely not to have a mother.

P: Carla she was mother figure to me?

T: As soon as she treated you like shit she sure was. (P chuckles) I'm serious. That's exactly what happened.

P: Right. Yeah, I've been thinking, you know, that she was so much better than me and stuff. Why am I, I'm always attracted to women who I think are better than, better than me.

T: You're trying to find a good mother.

P: Yeah. And then yeah, then anybody who turns out to be human, then I think I'm better than them and I don't want to be, you know, with them. That's possible. I know I can, you know, find . . . . I wonder if she didn't, you know, hadn't like treated me like shit if I, if I finally would've dumped her and like started finding faults with her and it didn't last / /.

T: How soon was it that she had this affair or had this / / / ?

P: Uh

T: The way you described it, it sounded like it was like two weeks after she came.

P: Yeah, that's about what it was.

T: Yeah.

P: It wasn't very long, about two weeks.

T: She was really very destructive.

P: Yeah.

T: Just as your mother has always been.

P: Right.

T: You know, that's why you were telling me, one of the reasons I think why you were telling me the saga of, you know, your siblings as a way of saying to me "look what damage she wrought."

P: Yeah. it's not just me, I mean, yeah, you can talk to any of them.

T: Yeah, exactly.

P: You know, she's.

T: So there's a destructiveness involved.

P: Right.

T: That's really painful and horrifying actually.

P: And when I was going through that thing in California with that girl, I had this, that exact same hopelessness and loss of control and I can't do anything about it, you know, just desperately wanting her back and not knowing how to get her back and uh, you know, just foregoing any kind of you know, image or any kind of pride that I had just got, flew right out the window. If anything, I just wanted her back as desperately as I could, like nothing I've ever wanted in my life and you know, I still held on with the idea, I mean she left (sniffs) not too long afterwards and went back to the *area and I still have like fantasies of getting back together with her, you know. Sometimes I still do. Or sometimes I have fantasies of me being a great person and her knowing about it, you know.

T: At last she'll get to love me.

In this excerpt, taken from the beginning of the analysis of Daniel, we can see how his therapist used his subjective reactions to the patient's communications, together with his feelings, his previous knowledge of the patient and his mastery of analytic technique, both to help Daniel understand how he experienced his relationships with women and to help him to overcome his relational difficulties. A sophisticated clarification and interpretation that connect present and past difficulties of the patient, his need for a mother and his tendency to turn his

aggression toward himself in order to preserve a good-enough representation of the mother and the girlfriend go hand in hand with a warm and straightforward attitude on the analyst's part. Both patient and analyst seem clearly involved in the therapeutic enterprise, and while the therapist seems warmly responsive and follows the moment to moment shifts in patient material and feelings, Daniel seems quite able to receive and make good use of his analyst's interventions.

Two examples of the interaction between Vincent and his analyst:

From early in the analysis

P: I know what it was. . . . my mother invited several people to go to the Rosh Hashanah Yom Kippur services with her and then . . . let me try to think how it worked. . . she asked me to go and buy the tickets, that was it, at the temple where they're members and I guess, I'm a member too. She asked me to go and buy the tickets at a price that was absurd, was absurdly low, I mean, an unreasonable price to pay. And she knew that I had felt that way about it. She had told these people whom she invited that they would pay $10 or something like that. People who could afford to pay more and who appropriately would pay more. She knew that I felt that that was, uh, too cheap and that I certainly would be embarrassed to go and ask for tickets at that price and yet, she called and asked Tracy [his wife] to tell me to go over there and buy the tickets. That doesn't sound like much, does it? But it's something that bugged the hell out of me because she knew that it was something I would not myself do.

T: Well, it sounds as if you felt you were being used.

P: Well, I was. (chuckles) There's no question about it. And I'm also aware that as a kid I was used too. My mother thinks of children as toys. My mother, uh, thinks of kids as toys. Kids are for your own personal, uh, trip, you know. You show them off to people and you dress them up like dolls and you tell everybody how terrific they are and so on and so forth. They use children to somehow elevate yourself socially, to raise yourself in the eyes of your, of your friends. It's very unfortunate.

T: Very infuriating.

In this first excerpt from the analysis of Vincent, we can see how patient and analyst dealt with the difficult relationship the patient had with his mother. As the reader can see, the analyst tried to convey his empathic understanding of the patient's suffering with two short

clarifications aimed at stressing how the patient felt about his mother's treatment of him, and addressing implicitly the aggressiveness he must have felt toward the mother. Vincent, on his side, seems to try very hard to convey his feelings to the analyst in a precise and complete way. And yet, in comparison with the difficult situation Daniel and his analyst discussed about his former girlfriend, one might say there is a relative lack of connecting with the patient and helping him to elaborate his experience in a way that would facilitate greater sense of mastery and of being understood. The analyst may have missed an opportunity to make developmental and psychodynamic connections between Vincent's futile anger and his unchangeable, uninfluenceable, humiliating mother who makes him violate his own values. His inability to challenge her openly ended up being a model for his later futile feelings followed by a somewhat abrupt departure from the analysis.

From the middle of the analysis

P: (after 16 seconds of silence) ... I think my, my anger at you is sort of perpetual these days. There are specific things that come along from time to time that (another silence of 10 seconds) causes it to flair but I, I just sort of feel like you're unresponsive and unempathic and all these things and I'm just sort of generally displeased with you. (Another minute of silence) I guess my, my, my perception of you is uh, that you maintain your clinical correctness, but that something is missing, something else is not there.

T *What you feel is lacking I think in this instance is for example some failure on my part to understand your sense of futility where your anger is concerned, or some sense that I don't understand what you're talking about. The fact is I do. The fact is also that, uh, the futility of your anger is not what the realities of our situation are about. I think that's what's missing though, as you sense it.*

P: Yeah, I think you're right. Something like that. (20 seconds of silence) And what that stirs up in me is a sense of futility and frustration, and it really becomes overwhelming . . . and I guess I feel a need to protect myself from it somehow, and not to open it up. In other words, I feel like to fulfill that contract I have to keep . . . . stimulating painful feelings in myself . . . certainly consciously (1 minute of silence). The nature of my dreams has changed considerably, at least the ones I remember. I don't have vivid dreams anymore and those I can remember at all are kind of bland, there are no passionate scenes, there are no, no images which really strongly affect me emotionally, that I wake

up still feeling affected by the dream. That doesn't happen anymore. And actually I've had dreams which I've not been relating here, partly because I just don't think about them when I'm here and partly because they're so, the, the, the images are so, uh, gray that they just don't mean anything to me.

In this second passage taken from Vincent's analysis, the therapist seems less warmly responsive then Daniel's analyst, his communications are shorter and less colored by his feelings and he seems first to deny, from an "objective" point of view, the correctness of the patient's ideas, and then try to encourage him to elaborate on his feelings after having proposed a not very sophisticated interpretation of them. Vincent, on his part, tries to communicate what he feels toward his analyst and to use what his analyst says as best as he can, but seems stuck in his way of experiencing him and it is possible to guess that he deals with this situation by identifying himself with the analyst who is experienced as an uninvolved observer, and now he finds his dreams "gray" and without meaning for him.

Outcomes of Daniel's and Vincent's Treatments

At the end of his analysis, Daniel was found not to warrant any DSM diagnosis. His overall PHI had increased from the 10th percentile compared to our reference sample of psychoanalytic patients to the 85th percentile, and his GAF had increased by 28 points(Table 6). The PHI score at the end of treatment indicated that his score was healthier than 84% of the reference sample. As will be discussed in detail below, he showed improved capacity for reality functioning, fewer defensive operations, a better identity integration and improved object relations, while his capacities for affect regulation were still partly problematic. We can say that the outcome of his analysis was excellent. Quite different was the outcome of the analysis of Vincent, who at the end of the treatment still showed a borderline personality disorder (T =66.8), a passive-aggressive personality disorder (T=62) and features of a narcissistic (T= 57.6) and histrionic (56.5) personality disorders. His overall PHI stayed in about the same low range, nor was there a significant change in his GAF (Table 6). On this basis, we can say that Vincent's treatment had a poor outcome.

In order to document the changes, or lack thereof, in the clinical pictures of our two patients, we compare the pattern of their most prominent scores, for both health and pathology items, on their SWAPs from early and late in their treatments in regard to the changes found in our five categories: Reality functioning, Affect regulation, Defensive operations, Identity and Object relations (the "RADIO" division of the SWAP items).

For **Reality Functioning**, Daniel showed at least a two-point improvement in five of six of his top items: work life tends to be chaotic or unstable: is psychologically insightful; is capable of hearing information that is emotionally threatening, and can use and benefit from it; appears to have come to terms with painful experiences from the past and has found meaning in, and grown from such experiences: has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings; and is creative and able to see things or approach problems in novel ways. In contrast, Vincent had no improvements, and for four items had at least a two-point deterioration (Appendix Table 1).

Affect regulation was an important area for both patients. Daniel showed at least a two-point improvement in ten of twelve items: tends to feel unhappy, depressed, or despondent; emotions tend to spiral out of control; has difficulty acknowledging or expressing anger; tends to be shy or reserved in social situations; tends to feel ashamed or embarrassed; tends to feel listless, fatigued, or lacking in energy; appreciates and responds to humor: tends to be energetic and outgoing; generally finds contentment and happiness in life's activities; and tends to express affect appropriate in quality and intensity to the situation at hand. In contrast, Vincent only improved to that degree in one of ten (Appendix Table 2).

Defensive operations is a category which includes, by definition, only maladaptive items, a use of the concept of defensive functioning which is not the same as that of many writers (e.g. Perry, 1990), but which we have found to have heuristic value. We find that both patients improved substantially in this category. For Daniel, five of five items improved, and for Vincent three of four. In this regard, both analyses showed evidence of benefit (Appendix Table 3).

Both patients had initial trouble with **identity integration**. There were twelve items in this category for Daniel, including items indicating pathology and those health items that were relatively low at the early point in treatment. Daniel improved in ten of these (two points or more): appears inhibited about pursuing goals or successes; lacks a stable image of who s/he is or would like to become; tends to feel s/he is inadequate, inferior, or a failure; tends to avoid social situations because of fear of embarrassment or humiliation; tends to be insufficiently concerned with meeting own needs; tends to be conscientious and responsible; is able to use his/her talents, abilities, and energy effectively and productively; enjoys challenges – takes pleasure in accomplishing things; is able to assert him/herself effectively and appropriately when necessary; is able to find meaning and satisfaction in the pursuit of long-term goals and ambitions. Vincent improved in four of fifteen items, with no deterioration in any: tends to confuse own thoughts, feelings, or personality traits with those of others; seeks to be the center of

attention; has an exaggerated sense of self-importance; has fantasies of unlimited success, power, beauty, talent, brilliance, etc. (Appendix Table 4).

Object relations troubles are probably nearly ubiquitous among patients seeking the help of a psychotherapist. Daniel showed positive change (two points or more) in nine of ten items: tends to be ingratiating or submissive; tends to get drawn into or remain in relationships in which s/he is emotionally or physically abused; appears afraid of commitment to a long-term love relationship; has an active and satisfying sex life; tends to elicit liking in others; is able to find meaning and fulfillment in guiding, mentoring, or nurturing others; is empathic; is sensitive and responsive to other peoples' needs and feelings; is capable of sustaining a meaningful love relationship characterized by genuine intimacy and caring; appears comfortable and at ease in social situations; and is able to form close and lasting friendships characterized by mutual support and sharing of experiences. Vincent showed no improvements among the eleven items identified, and deterioration in two (Appendix Table 5).

The number and variety of the items, and the failure for Vincent to show substantial gains in health items provides substance to the differences in mental health achieved in the course of the two treatments.

Table 6
Comparing Daniel and Vincent's Personality Features Late (and early)
(scores from Table 2 included here for comparison in parentheses)

	Daniel late (vs. early)	Vincent late (vs. early)
DSM personality disorders	**no disorder**	**Borderline, passive aggressive**
GAF	**80 (52)**	**65 (64)**
PHI	**85 (10)**	**12 (18)**
Reality testing and thought processes	**85 (22)**	**12 (28)**
Affective regulation	**31 (17)**	**7 (15)**
Defensive Operations	**100 (49)**	**51 (41)**
Identity integration	**76 (10)**	**22 (14)**
Object relations	**91 (10)**	**6 (30)**

Discussion

The results of applying the same instruments to our entire sample of 27 patients will be presented separately [14].

[14] The original 2013 paper presented the results of studying 13 patients already evaluated at that time. The separate presentation will describe the results for the full 27 cases, with data analysis completed in 2016.

The detailed presentation of two cases cannot establish causation. But this report has permitted us to introduce the *Dynamic Interaction Scales*, providing a helpful and reliable way to characterize the relational aspects in assessing the participation of an analytic or therapeutic pair, and to further validate the *Analytic Process Scales*, demonstrating their excellent reliability when applied to whole sessions in the altered manner described earlier. There are a number of other instruments which have been developed to assess psychodynamic and other related psychotherapeutic processes, such as the Psychotherapy Process Q-set (PQS; Jones, 2000), the Comprehensive Psychotherapeutic Intervention Rating Scale (CPIRS; Trijsburg et al., 2002) and the Comparative Psychotherapy Process Scale (Hilsenroth, Blagys, Ackerman, Bonge, & Blais, 2005) . We have contributed the APS and the DIS because we believe our variables are more closely and extensively aligned with the way psychoanalytic clinicians think about clinical material, springing as they do from many years' development by experienced psychoanalysts (Waldron et al., 2004a, 2004b). Any systematic comparison of the other instruments with the APS and DIS would take us beyond the scope of this paper.

Vincent was analyzed before a tailored approach for borderline and/or narcissistic patients had become generally known and appreciated (Kohut, 1971; Kernberg, 1975). At that time narcissistic patients were mostly treated with the same "abstinent" attitude applied in the treatment of other neurotic patients, and the relevance of primitive defenses such as splitting and projective identification was underestimated. Not enough attention was dedicated to the "here and now" aspects of the therapeutic relationship (Gill, 1982), to the patients' experience of the therapists' lack of empathy, and to primitive/negative transferential aspects. Hence the poor outcome of Vincent's analysis may be partially the consequence of a lack of understanding and knowledge of his mental and personality functioning at that time.

Among the limitations of the study we include the relatively small number of sessions evaluated for each case (20 sessions). Also the differences in outcome may have primarily reflected differences in the pathology of the patients, with a more narcissistic set of problems for Vincent, whereas Daniel was much more avoidant and suffered from a much more pervasive lack of self esteem. The two patients also had two different trajectories of treatment: both were intensive originally, but the intensive period was then followed in Daniel's case by a long "tail" of mostly once weekly work, with his total time under treatment extending for fifteen years and 900 sessions, whereas Vincent had only 660 sessions over four years and two months.

There is another potential problem in the significance of our findings: it has been clear from prior work (e.g. Waldron et al. 2004b) that therapists are limited in the nature and quality of what they offer by the contributions of their patients. Therefore, the argument could be made that our findings of higher core analytic activities with good outcome cases may simply be a correlate of the process that naturally occurs with higher functioning patients, and not part of the causal chain leading to improvement. The degree to which higher core analytic activities and greater relational attunement contribute to better outcomes will be explored in the later report, in which we examine changes between adjacent sessions as a way of determining what elements lead to what changes (Crouse et al. 2003). The current report supports the value of good psychoanalytic work, carried out in a manner that is attentive to the patient's relational needs (Blatt 2008).

The use of the PHI and the RADIO description of the patients' functioning facilitate a detailed in-depth look at the functioning of each patient and the changes taking place in the course of treatment. This description, together with the diagnostic profiles, all deriving from our modified SWAP instrument, provide a means for tracking changes in patients systematically that promises a use in psychotherapeutic and psychoanalytic training as well as research. It is difficult for less experienced clinicians in training to grasp the overall picture of their patient, let alone being able to hold in mind the changes occurring in the course of months or years of treatment. Adoption of the SWAP-PHI-RADIO as a routine measure in training programs might provide both valuable feedback to student and supervisor, and valuable documentation of the benefits of therapies provided.

In the course of years of experience as psychoanalysts, we have developed the hypothesis that careful day-to-day psychoanalytic work by both parties is likely to lead to incremental changes in psychological health. These incremental changes in turn reflect many experiences within the sessions which have a variety of "corrective" impacts (Boston Change Process Study Group 2010). Clinical descriptions highlighting one or several very large impactful moments appeal to our need for a good story, but recent evidence supports a view of gradual change, which corresponds better also with our understanding of the impact of experience on neuronal connections in the brain (Grosse-Holtforth, M.[2012, June] *Corrective Experiences in Psychotherapy: Qualitative and Quantitative Findings.* Structured Discussion at the Annual Meeting of the Society for Psychotherapy Research, Virginia Beach, VA).

If careful day-to-day work by both parties has incremental effects, and if this work leads to new understandings and corrective experiences both within the session and outside of it, then we can anticipate that patients will do better the more alive, engaged and attuned the experience is in the room, particularly if the patients are able to integrate that experience with issues in their other current relationships (Castonguay, L. [2012, June] *Corrective Experiences in Psychotherapy: Qualitative and Quantitative Findings.* Structured Discussion at the Annual Meeting of the Society for Psychotherapy Research, Virginia Beach, VA); Hoglend et al.2007).

Previous researchers on short-term or even medium-term psychotherapy outcomes have generally not found that therapists' varying technical contributions to treatment account for much of the differences in outcomes (e.g. Wampold, 2001; Norcross, 2011). By contrast, the findings from our overall study [to be described later] affirm the importance of the therapist's contribution to benefit. This moves us closer to confirming what most psychoanalysts have believed for a long time: that *both* the quality of the analyst's relationship with the patient *and* the ability to provide useful verbal communications are crucial therapeutic factors. In other words, the differing emphases of relational and classical theory each have a contribution to the course of treatment that exceeds the benefit of either the relationship alone or interpretation and insight alone. And it seems clear that if, on one hand, interpretations and insights are a function of and happen in the context of a human relationship, on the other hand a human relationship is shaped by the reciprocal understanding of the people in the relationship (Høglend et al. 2007).

If the technical and relational differences in the approach of the two analysts described indeed contributed to very different outcomes, these developments herald a long awaited change in our ability as a field to relate psychoanalytic or psychodynamic psychotherapeutic efforts, by both patient and analyst, to outcomes.

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APPENDIX: Daniel and Vincent's changes in the course of treatment as shown by the RADIO Tables

There are many substantial differences in the five tables that follow, primarily in Daniel's psychological functioning. We have highlighted them by bolding and enlarging the items at the time when they were at least two points healthier than the other time period. If the earlier item is bolded and enlarged, this position indicates that the patient was better off in this respect in the earlier period than the later one, whereas bolding and enlarging an item in the second column (representing functioning at the end of treatment) indicates clinical improvement. We have chosen a change of two points on the SWAP eight-point scale (zero to seven) on a clinical basis as indicating a significant clinical change. In the future, when more of the data becomes available from Cogan and Porcerelli, we will be able to calculate more formally a clinically significant change using the Jacobson and Truax (1991) methodology.

The top RADIO items at the beginning of treatment were different for each of the patients, reflecting different pathology and strengths. For the methodologically inclined reader, the selection of items in the tables reflects the following. The top 30 among the 200 SWAP items are listed initially, whether health items (24) or pathology items (175). Then the remaining health items which did NOT make it into the top 30 are added to the 5 lists, with the word "LOW" in the leftmost column to indicate room for improvement in the course of treatment. The reason for this is that we consider all of the health items worth paying attention to in each case. The consequence is that the total number of items in the 5 RADIO lists can vary from 36 to 54, depending on how many health items were already included in the top 30 items.

All of this output is available to any clinician utilizing our version of the SWAP with the PHI and RADIO added (except for the bolding and enlarging, which we have added for purposes of this presentation). Contact the senior author if interested in using the software.

Table 1: Reality Testing and Thought Process

(When there is a change of two points or more, the healthier value is bolded and enlarged)

Health Item*	Early	Late	Daniel
	22%	85%	PHI Percentile for this Category
Healthy	5.5	6	092. Is articulate; can express self well in words.
	5.5	**1.5**	188. Work life tends to be chaotic or unstable (e.g., working arrangements seem always temporary, transitional, or ill-defined).
Healthy	5	**7**	183. Is psychologically insightful; is able to understand self and others in subtle and sophisticated ways.
LOW	4	**7**	082. Is capable of hearing information that is emotionally threatening (i.e., that challenges cherished beliefs, perceptions, and self-perceptions) and can use and benefit from it.
LOW	4	**6.5**	089. Appears to have come to terms with painful experiences from the past; has found meaning in, and grown from such experiences.
LOW	3	**5.5**	111. Has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings.
LOW	0	**6**	121. Is creative; is able to see things or approach problems in novel ways.
			Vincent
	28%	12%	PHI Percentile for this Category
Healthy	**6.5**	4.5	092. Is articulate; can express self well in words.
	6	6	079. Tends to see certain others as "all bad," and loses the capacity to perceive any positive qualities the person may have.
Healthy	**5**	2.5	183. Is psychologically insightful; is able to understand self and others in subtle and sophisticated ways.
LOW	**4.5**	2	121. Is creative; is able to see things or approach problems in novel ways.
LOW	**3**	0.5	082. Is capable of hearing information that is emotionally threatening (i.e., that challenges cherished beliefs, perceptions, and self-perceptions) and can use and benefit from it.
LOW	1	1	111. Has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings.
LOW	0.5	0.5	089. Appears to have come to terms with painful experiences from the past; has found meaning in, and grown from such experiences.

*Health items receive special markings in this column: if the early score is NOT among the 30 most characteristic items it is marked "LOW", to indicate an item one would hope to improve in the course of treatment. If health item is already among the 30 most characteristic of the patient at the early evaluation, it is marked "healthy".

Table 2: Affect Regulation

(When there is a change of two points or more, the healthier value is bolded and enlarged)

Health	Early	Late	Daniel
	17%	**31%**	**PHI Percentile for this Category**
	7	**4**	189. Tends to feel unhappy, depressed, or despondent.
	6.5	**4.5**	012. Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, excitement, etc.
	6.5	**1**	025. Has difficulty acknowledging or expressing anger.
	6.5	**3.5**	060. Tends to be shy or reserved in social situations.
	6.5	**4.5**	086. Tends to feel ashamed or embarrassed.
	6	**2**	030. Tends to feel listless, fatigued, or lacking in energy.
	6	4.5	057. Tends to feel guilty.
	5.5	7	035. Tends to be anxious.
LOW	3.5	**6.5**	068. Appreciates and responds to humor.
LOW	1.5	**4**	179. Tends to be energetic and outgoing.
LOW	0	**3.5**	101. Generally finds contentment and happiness in life's activities.
LOW	0	**3.5**	106. Tends to express affect appropriate in quality and intensity to the situation at hand.
			Vincent
	15%	**7%**	**PHI Percentile for this Category**
	7	6	016. Tends to be angry or hostile (whether consciously or unconsciously).
	7	5.5	103. Tends to react to criticism with feelings of rage or humiliation.
	6.5	**4.5**	098. Tends to fear s/he will be rejected or abandoned by those who are emotionally significant.
	5.5	6.5	035. Tends to be anxious.
	5.5	5.5	127. Tends to feel misunderstood, mistreated, or victimized.
	5	6	012. Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, excitement, etc.
LOW	1.5	0.5	068. Appreciates and responds to humor.
LOW	1	0.5	101. Generally finds contentment and happiness in life's activities.
LOW	1	1	106. Tends to express affect appropriate in quality and intensity to the situation at hand.
LOW	1	0.5	179. Tends to be energetic and outgoing.

Table 3: Defensive Operations

(When there is a change of two points or more, the healthier value is bolded and enlarged)

Early	Late	
		Daniel
49%	**100%**	**PHI Percentile for this Category**
6.5	**1**	001. Tends to blame self or feel responsible for bad things that happen.
6.5	**0**	018. When romantically or sexually attracted, tends to lose interest if other person reciprocates.
5.5	**0.5**	119. Tends to be inhibited or constricted; has difficulty allowing self to acknowledge or express wishes and impulses.
5.5	**0**	199. Tends to be passive and unassertive.
5.5	**0.5**	165. Tends to distort unacceptable wishes or feelings by transforming them into their opposite (may express excessive concern or affection while showing signs of unacknowledged hostility; disgust about sexual matters while showing signs of unacknowledged interest or excitement).
		Vincent
41%	**51%**	**PHI Percentile for this Category**
6.5	**4**	116. Tends to see own unacceptable feelings or impulses in other people instead of in him/herself.
6	5	076. Manages to elicit in others feelings similar to those he or she is experiencing (e.g., when angry, acts in such a way as to provoke anger in others; when anxious, acts in such a way as to induce anxiety in others).
5.5	**2.5**	077. Tends to be overly needy or dependent; requires excessive reassurance or approval.
5.5	**3**	100. Tends to think in abstract and intellectualized terms, even in matters of personal import.

Table 4: Identity Integration

Health	Early	Late	Daniel
	10%	**76%**	**PHI Percentile for this Category**
	7	**0**	033. Appears inhibited about pursuing goals or successes; aspirations or achievements tend to be below his/her potential.
	6.5	**0.5**	015. Lacks a stable image of who s/he is or would like to become (e.g., attitudes, values, goals, and feelings about self may be unstable and changing).
	6.5	**4.5**	054. Tends to feel s/he is inadequate, inferior, or a failure.
	6.5	**2**	124. Tends to avoid social situations because of fear of embarrassment or humiliation.
	5	**0**	088. Tends to be insufficiently concerned with meeting own needs; appears not to feel entitled to get or ask for things s/he deserves.
LOW	**4**	**5.5**	120. Has moral and ethical standards and strives to live up to them.
LOW	**2**	**7**	175. Tends to be conscientious and responsible.
LOW	**0.5**	**5**	002. Is able to use his/her talents, abilities, and energy effectively and productively.
LOW	**0**	**5**	019. Enjoys challenges; takes pleasure in accomplishing things.
LOW	**0**	**1.5**	037. Finds meaning in belonging and contributing to a larger community (e.g., organization, church, neighborhood, etc.).
LOW	**0**	**4.5**	063. Is able to assert him/herself effectively and appropriately when necessary.
LOW	**0**	**4.5**	196. Is able to find meaning and satisfaction in the pursuit of long-term goals and ambitions.
			Vincent
	14%	**22%**	**PHI Percentile for this Category**
	6	6	054. Tends to feel s/he is inadequate, inferior, or a failure.
	6	**1.5**	176. Tends to confuse own thoughts, feelings, or personality traits with those of others (e.g., may use the same words to describe the self and another person, believe the two share identical thoughts and feelings, treat the person as an "extension" of him/herself, etc.).
	5.5	4.5	015. Lacks a stable image of who s/he is or would like to become (e.g., attitudes, values, goals, and feelings about self may be unstable and changing).
	5.5	5	033. Appears inhibited about pursuing goals or successes; aspirations or achievements tend to be below his/her potential.
	5.5	**2.5**	048. Seeks to be the center of attention.
	5.5	4.5	174. Expects self to be "perfect" (e.g., in appearance, achievements, performance, etc.).
	5	**2.5**	004. Has an exaggerated sense of self-importance.
	5	**2**	049. Has fantasies of unlimited success, power, beauty, talent, brilliance, etc.
LOW	2.5	1.5	019. Enjoys challenges; takes pleasure in accomplishing things.
LOW	2.5	1	175. Tends to be conscientious and responsible.
LOW	2.5	2.5	196. Is able to find meaning and satisfaction in the pursuit of long-term goals and ambitions.
LOW	2	3.5	002. Is able to use his/her talents, abilities, and energy effectively and productively.
LOW	2	0.5	037. Finds meaning in belonging and contributing to a larger community (e.g., organization, church, neighborhood, etc.).
LOW	2	3	063. Is able to assert him/herself effectively and appropriately when necessary.
LOW	1.5	1.5	120. Has moral and ethical standards and strives to live up to them

Table 5: Object Relations

Health	Early	Late	Daniel
	10%	**91%**	**PHI Percentile for this Category**
	7	**0**	017. Tends to be ingratiating or submissive (e.g., may consent to things s/he does not agree with or does not want to do, in the hope of getting support or approval).
	6	**0**	026. Tends to get drawn into or remain in relationships in which s/he is emotionally or physically abused.
	6	**2.5**	158. Appears afraid of commitment to a long-term love relationship.
LOW	**3.5**	**6**	094. Has an active and satisfying sex life.
LOW	**3**	**4.5**	051. Tends to elicit liking in others.
LOW	**1**	**7**	055. Is able to find meaning and fulfillment in guiding, mentoring, or nurturing others.
LOW	**1**	**4.5**	059. Is empathic; is sensitive and responsive to other peoples' needs and feelings.
LOW	**0**	**5.5**	032. Is capable of sustaining a meaningful love relationship characterized by genuine intimacy and caring.
LOW	**0**	**4.5**	095. Appears comfortable and at ease in social situations.
LOW	**0**	**3.5**	200. Is able to form close and lasting friendships characterized by mutual support and sharing of experiences.
			Vincent
	30%	**6%**	**PHI Percentile for this Category**
	6.5	6.5	114. Tends to be critical of others.
	6	2.5	197. Tends to seek out or create interpersonal relationships in which s/he is in the role of caring for, rescuing, or protecting the other.
Healthy	**5.5**	1.5	055. Is able to find meaning and fulfillment in guiding, mentoring, or nurturing others.
	5.5	4.5	084. Tends to be competitive with others (whether consciously or unconsciously).
	5.5	7	158. Appears afraid of commitment to a long-term love relationship.
LOW	**3**	1	051. Tends to elicit liking in others.
LOW	2.5	2	059. Is empathic; is sensitive and responsive to other peoples' needs and feelings.
LOW	2	2	095. Appears comfortable and at ease in social situations.
LOW	2	0.5	200. Is able to form close and lasting friendships characterized by mutual support and sharing of experiences.
LOW	1	1	032. Is capable of sustaining a meaningful love relationship characterized by genuine intimacy and caring.
LOW	0	1.5	094. Has an active and satisfying sex life.