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The Intensive Analysis of Psychotherapy Process: A Jungian Perspective

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THE INTENSIVE ANALYSIS OF PSYCHOTHERAPY PROCESS:
A JUNGIAN PERSPECTIVE

by
Catherine Milord

A Dissertation Submitted to the Faculty of the Graduate School of Loyola University of Chicago in Partial Fulfillment of the Requirements for the Degree of
Doctor of Philosophy
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My deepest gratitude is reserved for Diana, the woman whose consent allowed her work to enrich our theoretical knowledge and clinical practice. Her commitment and courage were the inspirations for this project.
VITA

The author, Catherine Therese Milord, is the daughter of Paul Milord and Maureen (McCamber) Milord. She was born May 18, 1953, in Evergreen Park, Illinois. Her elementary education was obtained at St. Joseph School in Homewood, Illinois. Her secondary education was obtained at Marian High School, Chicago Heights, Illinois, from which she graduated salutatorian of her class in 1971.

In September, 1971, she entered Loyola University of Chicago, and in June, 1977, received the degree of Bachelor of Science with a major in psychology (magna cum laude). While attending Loyola University, she was granted a University Honorary Scholarship in 1971-72. In 1974, she was elected a member of Alpha Sigma Nu Honor Society; in 1975, she was awarded membership in Psi Chi National Honor Society and in 1976 she became a member of Blue Key National Honor Fraternity.

In September, 1977, she was admitted to the Ph.D. program in Clinical Psychology at Loyola University of Chicago. She was granted a U.S. Public Health Fellowship in 1977-78 and worked as a research and teaching assistant in 1978-79. She was awarded a Charles Doyle, S.J. Graduate Fellowship in 1979-80 and became a member of the C.G. Jung Institute of Chicago in 1979. She became a student affiliate of the American Psychological Association in 1980. In 1982, she joined the Langley Porter Psychiatric Institute Alumni Association. She became a member of the Alumni Association, Center for Family Studies,
Northwestern University, in 1983.

Ms. Milord joined the Chicago Association for Psychoanalytic Psychology and the local chapter of Division 39 (APA) in 1985. She was awarded the D.W. Winnicott scholarship from the Center for Psychoanalytic Study in 1984–85. She became an invited member of a continuing workshop on the Philosophy of Psychoanalysis (Lacan) at the Center in 1986.

In 1981, Ms. Milord was an invited participant in a televised case conference moderated by Rollo May. She co-presented a workshop on dream analysis to the Chicago Psychological Society in 1982. In 1983–84, she presented papers on women's professional and animus development. She was an invited member of a consultation group on analysis of dreams in 1983. Her paper on the psychology of women was accepted for publication by Sophia, a multi-disciplinary journal, in 1985.

Ms. Milord obtained her professional training in clinical psychology at Lakeside and Hines hospitals (summers, 1978–79), at the Loyola Counseling Center (1980–81) and the Center for Family Studies at Northwestern University (1980–81). Pre-doctoral training was obtained at Langley Porter Psychiatric Institute, University of California, San Francisco. In January of 1983, she was awarded the Master of Arts in psychology from Loyola University. Presently, she is completing final requirements for the doctorate in clinical psychology.
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NOTE:

For the sake of convenience, the words "patient" and "client" will be used interchangeably in this paper. This is not to imply that their meanings are the same, only that their meanings are not well-enough specified to use precisely.

For the sake of clarity, the pronoun "her" will often be used when referring to both the therapist and client, since this was the actual case.
INTRODUCTION

Attempts have been made to dismiss Jungian therapy constructs for being "mystical" or not grounded in empirical reality. The processes of psychotherapeutic change were studied at two levels of analysis: 1) clinical and 2) empirical. The clinical focus investigated patterns of animus development in one woman over the course of one year of successful Jungian-oriented therapy.

One of the main tasks of development for a woman, according to Jungians, is confrontation with her unconscious "masculine" side, or animus. A positive relation to her animus brings to a woman a measure of objectivity, a spirited attitude and achievement in the world. The animus archetype is expressed in 1) the male dream figure, 2) Logos or traditionally masculine behavior, and 3) projection of inner masculine qualities onto others.

The client was a 29-year-old white female who presented with severe chronic depression and occasional suicidal ideation. During therapy, the client deeply explored and integrated repressed aspects of her psyche, including buried rage, which had been split-off from consciousness and had been operating destructively against her.

The empirical focus was a rigorous naturalistic investigation designed to empirically identify, operationalize and reliably code
clinically important patterns of client process change. This was the first study to systematically code meaningful Jungian changes at the intrapsychic (dream) and behavioral (Logos) levels. Since the primary strategy in process research is to examine process patterns in depth over time, the single case study was chosen as a fruitful approach for achieving such an intensive objective.

Jungian theory suggests that certain dimensions ought to change in a "successful" case, depending on the initial condition of the client's conscious relation to her unconscious, and her major psychological problem at the time. Jungian theory would propose that, given the conscious situation of the client at the start of therapy (one of timid social compliance and severe depression), her dreams would compensate by presenting the "missing" aggression.

If animus development was occurring, a certain pattern of change should have occurred such that the male dream figure would move from hostile/controlling to friendly/autonomy-giving in the second half of therapy. Animus development can also be traced through analysis of changes in behavior toward those exhibiting increasing Logos (Rossi, 1972). According to Jungians, a healthy relationship to a constructive animus would logically result in the client exhibiting more of her "masculine" (Yang, Logos) behaviors.

Psychodynamic theory in general proposes that intrapsychic change precedes behavioral change (Mahrer, 1985). Similarly, Jungians note that "... dreams tend to be a little in advance of and beyond current levels of consciousness" (Alex, 1971, p. 5). Jungian theory does not really specify when in a woman's life animus development
begins, and what exactly should occur at what points in therapy during
the process, or how far dreams change in advance of behavior change.
Thus, this study is an attempt to develop some more specific Jungian
microtheory by studying actual therapy episodes to determine more
clearly how animus development unfolds.

There is no claim that patterns of change found in this case
discriminate between positive and negative therapeutic outcome for
clients. It is simply not known yet. However, this single case was
evaluated as clinically successful; thus, this paper asks, "What
pattern of animus development characterized this one good outcome?"

This study purports to demonstrate that positive change
occurred, but it does not claim that therapy caused such changes. No
baseline was taken (except clinically), no specific or abrupt therapy
interventions were measured, and no outcome assessed (except clin-
ically). Thus, success of the case was assessed by the client's
self-report, the therapist's evaluation, two experienced clinical
supervisors who closely followed the case, and Jungian theory.
However, no formal questionnaires were distributed to the client or
others to assess outcome in this way.

Clinical hypotheses about patterns in this Jungian therapy
course (based in part on theory and in part on clinical evaluation
of the case) were advanced and transcripts coded to determine if
these patterns were visible to objective raters. Each of two blind
raters was given 38 randomly presented therapy segments to rate this
client's behavior, using Benjamin's (1981) Structural Analysis of
Social Behavior (SASB) as a measure of interpersonal transactions.
Two different raters were given 30 client dreams to rate for the male dream figure's behavior. This study represents an original application of the SASB to Jungian concepts. Data for the client's therapy were obtained with her written consent and were in non-identifiable, archival form. An attempt was made to integrate clinical and empirical findings.
Psychotherapy

There are no general definitions of psychotherapy which are universally accepted (Meltzoff & Kornreich, 1970; Strupp, 1978). The scientific aspects of the psychotherapy interaction were emphasized by Kiesler (1971). He urged clinicians to explicitly define the complex variables thought to be involved in the change process, and then to conduct empirical research. However, the author acknowledged that the creative-artistic components of therapy have made the search for precision challenging.

The practice of therapy is usually guided by theory; thus, the definition often depends upon which theory is espoused. Theories differ as to the relative importance which they assign to transformations of personality structure vs. changes in overt behaviors. Strupp (1977) conceived of psychotherapy as a symbolic interpersonal activity aimed at the psychological development of the client.

Psychotherapy Research

According to Hans Strupp (1978), psychotherapy research is an area of scientific inquiry which investigates salient clinical or theoretical questions. Most psychotherapy research studies complex human situations in context, using naturalistic rather than
well-controlled, experimental designs (Kiesler, 1971).

Why has it been considered important to conduct psychotherapy research? The most basic reason is that the field is relatively young and in need of gathering basic empirical data about therapy (Gottman & Markman, 1978). Research is needed to empirically ground budding clinicians, since training students to be proficient psychotherapists assumes an *a priori* knowledge of just what therapy really is. Although there are many theoretical ideas about therapy, there is little solid information about the essential mechanisms of therapeutic change which lead to good outcome. Another reason for performing this type of research has to do with professionalism; responsible theory-testing or exploration may contribute to the quality of clinical work (Strupp, 1978).

**Process/Outcome Distinction: An Artificial Dichotomy?**

Psychotherapy research has attempted to answer questions about therapy process and outcome. Process studies measure in-therapy patient change and attempt to answer "What goes on inside therapy?" (Mahrer, 1985). Outcome studies generally measure the end result of therapy, to determine whether therapy had positive effects (Bergin & Garfield, 1971).

One of the problems with the traditional definitions of therapy research is that it had created a spurious division between in-therapy positive change and the "final success" at the end of therapy (Greenberg & Pinsof, in press). Kiesler objected to this division in his 1973 book on process and asserted that movement within therapy is just as important an outcome as the final change.
A process study may focus on in-therapy changes that represent successful mini-outcomes; for example, an initially compliant client may begin to assert herself with the therapist, even if not yet with the rest of the world (a final outcome). Definitions of process depend on whether successful outcome is conceptualized as deep personality change, symptom relief or circumscribed behavior modification. For example, a process event for a Jungian may be a terminal outcome for a behaviorist. Symptom removal is a positive process change within a longer Jungian analysis, but may be the final endpoint of behavioral therapy.

Process Research

In 1969, Strupp and Bergin noted the "impressively small" body of empirical literature on process and contrasted it with the huge investment of energy put into the actual practice of psychotherapy. Rice and Greenberg (1984) argued for the importance of clinically identifying important change constructs, and then reliably coding the patterns of these constructs which describe the change process.

While a rich theoretical literature currently guides depth psychotherapists in their daily practice, powerfully impactful empirical studies relevant to Freudian/Jungian psychotherapy are rare to non-existent. Thus, Rice and Greenberg (1984) made a plea for a renewed focus on process research, so that ultimately it may be possible to identify which processes occur in the therapies of successful vs. unsuccessful clients. Therapists could then focus attention on those aspects of process related to productive outcome, for example, understanding of dream material. The credibility of
theories advocating a focus on such empirically validated "key" processes would then be strengthened.

**History of Process Research**

Gottman and Markman (1978) noted that process research began with the invention of the tape recorder in the early '30s, which made it possible for the first time to study actual transcripts of therapy cases. A desire to evaluate and increase their therapeutic effectiveness led at least some practitioners to investigate their principles in a more objective way. Increasing flexibility in clinical technique, especially in psychoanalysis, led to greater acceptance of using recordings to generate verbatim transcripts for process analysis (Rice & Greenberg, 1984).

However, for years process research consisted mainly of relatively chaotic "one shot" studies which used newly invented and non-validated measuring instruments. Few studies reported inter-rater reliabilities.

**Procedural Reasons for Neglect of Process Research**

"The problem has been one of developing research strategies that are at the same time creative-inductive, discovery oriented approaches and yet characterized by the use of disciplined method" (Rice & Greenberg, 1984, p. 1). Although many researchers in the field agreed that the intensive observation of process in context needed to occur, very little has been written on systematic procedures for carrying out this type of research. Further, research in the area can be extremely time-consuming (Benjamin, Foster, Roberto, & Estroff, in press).
Rice and Greenberg (1984) urged clinicians to brainstorm: "What is needed is a research method that can tap the rich clinical experience of skilled therapists in a way that will push them to explicate what they know, yielding a rigorous description of the important regularities they have observed" (p. 7).

**Current Status of Process Research: Pre-paradigmatic**

Orlinsky and Howard (1978) observed that process research is in the pre-paradigmatic stage of development, e.g., there are no standard models, or therapy phenomena which are universally considered to be "key" in the processes of change. No approved methodology yet exists, nor set of criteria for good design.

It was noted that there has been a very recent resurgence of interest in process variables, after an almost complete hiatus of studies in the '70s. "A fundamental appreciation (emerged) that change process constructs must be conceived in a more complex and highly differentiated way in order to reflect important clinical realities" (Docherty, 1985, p. 529).

One major methodological development reflects the successful effort to construct more refined measures of important, clinically-based structures in psychotherapy. This was the concept of critical change events promulgated by Rice and Greenberg (1984). They devised a method of identifying certain regularly occurring patterns of "events" in therapy thought to be crucial for personality change. Those events considered crucial depend upon one's theory. For example, in Jungian theory, a crucial event is a dream.

Rice and Greenberg's (1984) book presented several distinguished
research groups' varied design efforts. The more recent handbook of process research (Greenberg & Pinsof, in press) presented the "best" of the current investigations. From these studies, informal criteria of design adequacy can be culled. These criteria do reflect the historical infancy of this area of research.

Design Criteria

Those few investigators currently doing solid process research share several commonalities: Most are clinician/researchers; they study theoretically derived process variables; their constructs are clinically relevant and well-operationalized; their measuring instruments are among the most sophisticated, best validated and most reliable; many make use of objective raters; many use the N of 1 design; and many do not use statistics unless they can illuminate relationships. Finally, most are seeking an eventual a-theoretical integrative description of the key processes linked to positive outcome. Process researchers share the goals of exploring, identifying, isolating, describing, specifying and understanding the essential mechanisms of change. Rice and Greenberg (1984) advocated a research approach "that focuses on fine-grained process description of patterns in recurrent change episodes within specific contexts" (p. 14).

No Consensus: Evolving Strategies

Greenberg (in press) noted that there is no consensus about what the important process variables are, or what method of study is most appropriate; however, Greenberg (in press) argued that identification of in-therapy client patterns is the "key strategy" used in process research today. The nature of important process variables may not
become visible unless observed over time. Key properties of process phenomena may "become visible as changes over time in a particular variable (and)/or as a changing pattern over time in a relationship between a number of variables" (p. 30). Careful description and empirical ratings of theoretically-proposed patterns of change has yet to be done for many major client variables.

With no single governing paradigm, no common descriptive language, no common theory and therefore no shared phenomena of interest, researchers must concentrate on explicating phenomena and thus contribute to building a shared descriptive framework. This may take some time and great effort to develop, and it is in this spirit that the present study is conducted. This paper is a descriptive, rather than a causal or explanatory, study of process.

**Conclusions**

The body of empirical research investigating basic processes in psychoanalytic/Jungian therapy is extremely small. This state of affairs may exist partly because analytic historical traditions around patient privacy and analytic "temperament" converged in a manner which led to the favoring of clinical validation over more publicly observable process results. In addition, the complex and subtle nature of analytic constructs has made it difficult to explicitly define or measure variables. Further, the highly interactional nature of analytic process and the rich and multiple outcome goals have made it tough to test simple hypotheses.

Even those who have ventured forth into the area have been hampered by the lack of vigorous naturalistic research strategies,
the dearth of instruments measuring intricate human transactions, and
the absence of consensus on appropriate research design. The work
itself can be exceptionally time-consuming. Nonetheless, analytic
theory represents a treasure trove which is only beginning to be
explored. Specifically, depth therapy's inner patterns have yet to
be clearly described in an empirically-measurable manner so that
theory can be gradually modified and/or more firmly anchored in the
actuality of a client's real personality and/or behavior changes.

It is inescapably true that those changes which depth thera­
pists consider "positive" are laden with subjective values. In the
future, prospective clients may wish to seek out the therapy which
they believe offers the most meaningful conceptualizations of human
psychological "development," a by no means neutral word. Research
can help clients make more informed choices about what to expect in
a particular therapy process, with whom the process seems "success­
ful," and some possible reasons for the outcome.

Since the primary strategy in process research today is the
study of client patterns of change over time, the case study method
may be the most fruitful approach for achieving such an intensive
objective. That is, important nuances of client change may be
examined in-depth with a case study. The following chapter will
discuss the case study in more detail.
CHAPTER II

CASE STUDY: DESIGN OF CHOICE FOR PSYCHOTHERAPY PROCESS RESEARCH

Case Study: Definition

A case study is an intensive description and interpretive analysis of one person (Shaughnessy & Zechmeister, 1985). Case studies typically examine one slice of an individual's life, during which an especially compelling conflict or problem was occurring within a rich context (Runyan, 1982).

Case Study Method: Few Options

Runyan (1982) argued that the most serious criticism leveled at the case study is the dearth of appropriate and adequate research methods or designs. He reviewed some historical methods, some of which will be discussed here. Runyan (1982) advocated the use of the narrative case study as appropriate for describing the richness of an individual's experience. The narrative case will be discussed in the Clinical section of this paper at a later time.

Case studies with some empirical components were also discussed in Runyan (1982). One example not mentioned by Runyan is Shontz' (1965) idea of the "representative case." "The method comprises an integration of the case study approach with natural and remote control strategies. Its aims are to test deductively derived hypotheses, through the examination of single subjects, chosen for their specific appropriateness to the research problem of interest" (p. 234).
In this design, a single individual is selected for intensive study. The person constitutes the "representative case" and is not chosen at random; in fact, much information is usually gathered about her to establish her representativeness with respect to the theoretical propositions to be empirically evaluated. Shontz (1965) noted that conclusions can then be drawn about the subject and about others who share similar psychological qualities.

Shontz' model is not workable for process researchers at the present, because the field is in its infancy and true theoretically-derived "predictions" are not yet possible, since most constructs have not even been operationalized. The field is not at the true hypothesis testing phase as yet. Also, it is extremely difficult to establish whether a subject is really "representative" of other persons, since diagnostic categories are not yet refined enough to specify inner processes "typical" of each group.

Yin (1984) suggested two methodological strategies for the case study: pattern matching and time series designs. "For case study analysis, one of the most desirable strategies is the use of a pattern-matching logic. Such a logic compares an empirically based pattern with a predicted one... If the patterns coincide, the results can help a case study to strengthen its internal validity" (p. 103). If the case study purports to be explanatory, the pattern may be related to the independent variable, i.e., to a therapeutic intervention. This type of "explanation" is usually only possible in very simple behavioral models, with one circumscribed intervention affecting change in a "target" behavior.
Yin (1984) cautioned that there are no set rules for how to compare patterns to determine whether they "match."

At this point in the state of the art, the actual pattern-matching procedure involves no precise comparisons. . . the fundamental comparison between the predicted and actual pattern may involve no quantitative or statistical criteria. This lack of precision can allow for some interpretive discretion on the part of the investigator. . . Until improvements occur, investigators are cautioned not to postulate very subtle patterns. One wants to do case studies in which the outcomes are likely to lead to gross matches or mismatches, and in which even an 'eyeballing' technique is sufficiently convincing to draw a conclusion. (p. 107)

Pattern matching may be a good strategy for process researchers as they struggle to begin the empirical study of complex theoretical patterns. As Runyan (1982) noted, it may be premature to demand high levels of precision from the case study. He recommended continuing refinement and development of methods in the field, with the aim of gradual improvement and systematization.

The ability to trace changes over time is a major strength of the case study, noted by Yin (1984). "If the events over time have been traced in detail and with precision, some type of time-series analysis. . . may be possible, even if the case study analysis involves some other techniques as well" (p. 110). The essential logic underlying a time-series design is the match between a trend of data points compared to a theoretically significant trend specified before the onset of the investigation versus some rival trend, also specified earlier. ". . . If the actual events in a case study, as carefully documented and determined by an investigator have followed one predicted sequence of events and not those of a compelling, rival sequence, the single case study can again become the initial basis
for causal inferences" (p. 114). However, process research is not at the stage of prediction and explanation in the strictly causal sense, but rather is in the descriptive phase of development.

Runyan (1982) discussed the method probably most salient and useful for process research--configurational analysis. This is a "strategy for the recognition of individual patterns in human personality and psychotherapeutic change." Configurational analysis is concerned with the description and interpretation of individual cases. In this method, clinically-based assertions are made about patterns that characterize a patient in particular psychological context. The reliability of these statements is then checked by reviewing the raw data. Reliability of the method is ascertained by noting the degree to which a second or third rater, blind to the pattern ratings of the first reviewer, can follow the same scoring system with similar results. Horowitz (1979, 1984) is the major investigator using configurational analysis. His research program and those of others conducting key process research will be reviewed in a later section (Chapter V).

**Historical Impact**

In the last 15 years, there has been an implicit "Zeitgeist" in the scientific community favoring nomothetic over case study research. This has, arguably, led to an imbalance in the scientific dialog. The contrast between nomothetic and idiographic strategies reflects the struggles of two modes of thinking which Rychlak entitled dialectical vs. demonstrative:
The dialectical tradition holds no premise to be primary and true or devoid of possible contradiction; instead the dialectician views the world as being non-linear and multidirectional and as the place where explanation is sought through a conceptual understanding of patterns and forms of nature. . . (Marceil, 1977, p. 1053).

The rationales for single case research which follow are meant to be understood as "Figures" standing out from the "Ground" of a pervasive and complementary nomothetic literature.

Bolgar (1965) noted that the case study has had an important and provocative impact in the history of general psychology. For example, Dukes (1965) cited examples from nearly every area of psychological research from Ebbinghaus' 1885 investigation of memory and its generation of a verbal learning model to Kellog's 1933 project of raising a chimpanzee from birth to determine whether early experience might modify instinctual behavior.

Examples of case studies used in developmental research were also cited by Bolgar (1965). For example, Piaget formulated his principles of cognitive development from a tiny sample of his own children. Gesell and Buhler also investigated child and adolescent psychological growth through close observation of individuals.

The case study has also been used to research normal or creative human development. For example, Allport (1942, 1955, 1961) was the first academic psychologist to advocate a more extensive use of the case study. "Individuality. . . is a legitimate object of curiosity" (1955, p. 23). Murray (1938) was another academic who emphasized the importance of studying persons as whole units, with active inner lives and dynamic, goal-directed behavior.
Practicing clinicians and theoreticians have probably been the greatest proponents of the case study as a method for elucidating key dynamic processes underlying abnormal behavior. In his 1981 article, Kazdin noted that the intensive study of the individual has provided a goldmine of hypotheses about personality structure and dynamics and has served as a forum for innovative therapeutic technique.

In clinical psychology, all the major therapeutic traditions have drawn important theoretical principles from intensive study of the single case.

**When is Case Study Design Appropriate?**

*Method of choice for process research.* The case method is a natural starting point for a researcher who is entering an area of study about which relatively little is known" (Shaughnessy & Zechmeister, 1985). According to Kazdin (1980), the case study is ideal for beginning to provide basic descriptive data.

The intensive analysis of a few single cases of successful whole therapies, patient change episodes and moments of change is probably the method of choice for those who want to tackle questions about specific mechanisms of change. . . . It is through the intensive analysis of process that one comes face to face with what is actually occurring in psychotherapy and within the process of change. (Greenberg, in press, p. 52)

There is a need for depth therapists to begin to anchor their elusive theoretical concepts so that reliable empirical study can occur. For example, quantitative research of any kind on psychoanalysis comprises only a tiny percentage of journal articles. The body of Jungian empirical research is miniscule. Thus, very little has been discovered (empirically) about basic Jungian therapy.
process.

Method of choice for studying the complex person. According to Allport (1942), the case study method is clearly advantageous when the goal of the investigator is to examine a person's complex, integrative functioning in depth. Investigation of one person's psychic organization is useful when a researcher wishes to study the process of structural acquisition or change (much as embryologists study the slow unfolding of organismic structure).

Dukes (1965) noted that case studies are useful when one investigates data embedded in "situational complexity," such as psychotherapy sessions, which are "extended in time, require expensive and specialized training. . . or entail intricate and difficult to administer controls. . ." (p. 78). When one wants to study one human motivational system in detail, in order to delineate clinically and humanly important variables, the case study may be best suited (Angell & Freedman, 1966). Non-intrusive research methods are ethically most appropriate when studying actual ongoing psychotherapy, since the therapist's primary responsibility is to fulfill the clinical requirements of a private relationship. The case study is valuable when one wants to look at complex changes in personality structure, especially if one wants to know whether the theoretically proposed changes in personality structure are reflected in actual, observable patterns of empirical change.

Case Useful for Studying Patterns

Bergin and Garfield (1971) stated that an advantage of naturalistic strategies such as case studies is that ". . . many behavioral
aspects can be studied simultaneously and their interrelationships determined with relative lack of interference with natural processes" (p. 55). The case study is well suited for study of those phenomena most important today in process research—patterns of change over time, with the eventual goal of elucidating the nature of key variables. "The important issue here is that intensive analysis leads to the possibility of discerning patterns in their context" (Greenberg, in press, p. 53).

Clinical Importance

Much as Jung had urged a dialectic between unconscious and conscious processes, many researchers have urged a dialogue between case study and group approaches. Barlow (1981) lamented the lack of knowledge integration between researchers and practicing clinicians, and the concomitant lack of influence which research has on actual clinical practice. Barlow attributed at least some of this division between scientist and practitioner to the limitations of clinical research strategies, especially group comparisons as applied to psychotherapy studies. For example, statistically "significant" (or non-significant) findings often bear little relation to clinically important or provocative results.

Greenberg (1984) argued that findings based on group averages offer little guidance to the practicing clinician who is faced with an individual with unique and immediate needs. Fine discriminations and subtle nuances can be lost in nomothetic designs in which individuals are leveled in reports of group results. Kiesler (1981) observed that intensive case studies have played a key role in
"bridging the gap" between scientist and practitioner.

Clearly, the case study's major advantage is its clinical relevance. A larger sample of a person's life cycle can be analyzed than would be possible in a nomothetic study. The real-life and compelling setting of psychotherapy itself offers a further advantage for finding clinically meaningful results. Another related advantage is the richness of the material obtained, from which useful hypotheses about personality functioning may be drawn and from which innovative treatments may be engendered.

For those who practice depth psychotherapy, exploration of unconscious processes is crucial for personality transformation. The case study method is eminently suitable for the study of unconscious processes. As Allport (1942) noted, "Dream records constitute an entirely practicable form of the personal document, and probably one of the few avenues to the unconscious regions of personality..." (p. 92).

Theoretical principles can often be better illustrated and clarified by a case demonstration. "It frequently happens that a complex abstract theoretical idea cannot be adequately conveyed in conceptual terms alone" (Shontz, 1965, p. 70). For example, Freud's case discussion of the Rat Man describes typical obsessional dynamics in a starkly vivid manner.

The case study has been the preferred method of clinicians, probably due to interest in complex interrelationships between literally thousands of variables simultaneously forming the living texture of a whole case. Many clinicians assert that there is an intrinsic
value in the case study's yield of subjective understanding of one individual. This is a philosophical value judgment, and obviously cannot be refuted or supported by any experiment.

Case studies can be used clinically to begin to formulate normative data for the typical processes of a diagnostic group (Fiske, 1977). After study of many individuals' patterns, one prototype may be extracted that best explains change in each group. Barlow (1981) noted that a recent NIMH conference mandated that future outcome studies report data for individual clients, closely following up each client, particularly those who failed to benefit from treatment. Barlow (1981) recommended that clinicians collect data on thousands of individual cases over a series of years, noting degree of improvement, percentage of improvement, and failures to improve. This information could be used by larger research centers to design studies assessing the impact of "effective" treatments on patients who failed to benefit, in order to understand how individual patient characteristics interact with treatment.

Advantages and Disadvantages of the Case Study

It is important to remember that both group and N of 1 designs have advantages and disadvantages. Group designs allow one to argue for both the robustness and generalizability of findings, look at the interaction of multiple variables and test hypotheses. The best research strategy may be one of alternating between nomothetic and intensive cases.

While critics have argued that it is not pragmatic to conduct a case study of every person, Runyan (1982) maintained that it is
certainly possible and valuable to focus intensive attention on individuals of special interest. For example, Freud's famous cases were used to illustrate his dynamic concepts. It was not Freud's intention to imply that each of these individuals (such as the Wolf Man) was entirely unique. As Runyan (1982) suggested, "... idio graphic (should) be redefined as that which is particular or specific to the individual (which may or may not be shared with others), rather than that which is unique" (p. 174).

**Problem of Causality**

One problem noted by Bergin and Garfield (1971) is that causality cannot be discerned from a single case; that is, which variables cause which changes is often unclear. Intensive case studies are better for generating than for testing hypotheses, in most instances.

Case studies rarely provide conclusive evidence for or against a point of view, even when they are well executed. Their lack of control (if they purport to be causal or explanatory) usually leaves room for many questions and diverse explanations of their data; and it virtually impossible to establish convincingly in a single case report that the author's opinions are the only acceptable alternatives under the circumstances. (Shontz, 1965, p. 68)

It must be noted that this is only a problem if an investigation purports to be explanatory; a descriptive case does not claim that there is only one explanation of the data because it is not designed to make such a claim.

Runyan (1982) acknowledged that more than one explanation can be likely and consistent with the available evidence, in either case studies or nomothetic research. For example, a psychoanalytic and a Jungian account can be supplementary, with both being fruitful and
equally adequate in certain cases. Both theorists were scholars of
the first rank, their theories were based on extensive and discrimin-
ating clinical experience, their theories are comprehensive and rich,
and they both gave major importance to unconscious processes. Thus,
if the purpose of a case study were only to describe complex person-
ality processes and their patterning across therapy, either of these
theories could be expected to shed important light, although there
would be major differences in conceptual language used, relative
emphases on certain life phases, etc.

Runyan (1982) suggested taking a stance of "epistemological
relativism."

Relativism does not mean that one ignores evidence or
throws out procedures of critical inquiry, but rather that
empirical evidence and logical inference are employed within
the context of a particular perspective. . . the (case
study) can be evaluated for its use and interpretation of
empirical data, its theoretical persuasiveness, and its
literary style. (p. 35-36)

Runyan (1982) argued that other theorists' examination of the same
case can be welcomed as a way of more sharply clarifying the subject
through the use of different prisms or vantage points.

Procedures to Strengthen the Case Demonstration

Kazdin (1981) argued that case study methodology can be designed
in order to minimize threats to internal validity so that some highly
tentative statements about the effects of treatment can be made, even
in a primarily descriptive or exploratory study.

Case studies can include objective information, including
ratings by others and other measurement strategies. "... objective
(vs. anecdotal) information is a basic condition of a case study that
has important implications for drawing inferences about the effects of treatment" (p. 185). If the client is assessed continuously over time, rather than at two or three points in the therapy, one can better rule out assessment effects on findings. If the assessment via objective ratings occurs after treatment, the changes that coincide with treatment are not likely to result from exposure to repeated testing or changes in the instrument. Similarly, regression to the mean from one data point to another, a problem with assessment conducted at only two points in time, is eliminated. If repeated observation (by raters) over time shows a pattern in the data, extreme scores cannot account for the pattern of performance for an extended time.

Kazdin (1981) further suggested that information on the stability of the clinical problem in the past and its projection into the future be included. If the problem (such as chronic depression) has been stable for an extended period, changes that coincide with treatment could suggest that therapy may have led to positive change. "Research may suggest that a particular clinical problem is very likely to improve, worsen, or remain the same over a period of time. These alternative prognoses may be important when drawing inferences about treatment effects in a given case. . ." (p. 186). For example, if a patient had a history of stable, chronic depression with multiple suicidal gestures, there is an implicit clinical prediction of continuing depression and further suicidal attempts. Essentially, there is an implicit prediction of the effects of no treatment-suicide.

One final way of strengthening conclusions from a case is to
consider rival hypotheses accounting for results (only if the case strives to be "explanatory"). One asks if the data pattern that was found "matches" that predicted or described by one theoretical model better than that described by another.

External Validity: Generalizations From a Single Case

External validity refers to the establishment of a domain to which a study's findings can be generalized (Yin, 1984). One of the most cited criticisms of idiographic study is the question of how a researcher can generalize from one subject's results. It is true that this is an important limitation of the case study. Runyan (1982) addressed this issue by asserting that a legitimate goal is to produce generalizations at "three levels of inquiry about persons--universal, group and individual." These levels are at least partially autonomous or "semi-independent"; thus, while Runyan advocated studies of all three levels of analysis, "... the fact that inquiry at one level does not automatically answer questions at the other two levels is not a telling criticism" (p. 172).

Researchers in human perception often conduct N of 1 studies based on the notion of "ecological" generalizability. "In fact, proper sampling of situations and problems may in the end be more important than proper sampling of subjects, considering... that individuals are probably on the whole much more alike than are situations among one another" (E. Brunswik, 1956, p. 39). The case method is an excellent approach for studying a subject across situations.

Although interpretations formally confined to the single subject investigated is a problem with case studies, Kiesler (1981) suggested
that interpretations can be considerably strengthened if a series of case studies are done as direct and systematic replications, which address issues of internal and external validity. Kiesler (1981) argued that there is a need for multiple case studies, as well as experimental group designs. "Each study will be flawed, but we will come to 'know' the domain, albeit temporarily, through the cumulative efforts of (investigations), hopefully each with a different set of methodological shortcomings" (p. 13). Similarly, Marceil (1977) noted that in multiple intensive case studies, a reliable relationship found in a single subject will be replicated to determine whether the relationship holds from subject to subject.

Case Study: Criteria for Evaluating Adequacy of Data Sources

There are no universally acknowledged criteria available by which the formal adequacy of a single case design may be evaluated. However, Allport (1942) suggested some considerations which can strengthen case methodology. The personal document is an important data source for many case studies, and must be evaluated as part of a good design. Allport (1942) defined the personal document as "any self-revealing record that intentionally or unintentionally yields information regarding the structure, dynamics and functioning of the author's mental life" (p. xii). Archival psychotherapy transcripts may be considered highly reliable, authentic and genuine samples of the subject's inner psychological functioning.

Allport (1942) discussed criteria for evaluating the adequacy of the personal document (in this case, therapy transcripts) as a data source. The transcript should be credible and authentic, and
have a high degree of internal consistency. Internal consistency was defined as "a document that... represents a structured configuration of human life, which harbors no impossible contradictions" (Allport, 1942, p. 128). Anonymity and confidentiality must be guaranteed to the client to prevent deliberate falsification, deception or unintended self-idealizations. For example, dream material may be considered uncensored and free of a subject's conscious attempts to present a socially acceptable self. Allport (1942) recommended the use of an archival document, or data collected in a clinical rather than in a research context. He also urged that data be collected for a sufficient length of time (such as one year) to mitigate effects of history, maturation or transient mood shifts. The focus of the next chapter will be on establishing the theoretical framework for understanding the case.

Case Study: Criteria for Evaluating Adequacy of Design

Several researchers suggested criteria for evaluation of the case study's methodological design. Inter-rater reliability should be reported in a good case study. The case should be conceptualized in a unified way through parsimonious theory-based integration of findings. Data should be detailed, immediate and objective. For example, verbatim therapy transcripts make for more detailed and immediate data than process notes. Observers should be trained to rate case study data according to standardized instructions. Personality variables ought to be related, via theoretical propositions, to behaviors in particular contexts.

Units of analysis should be specified; for example, certain
segments of therapy transcripts will be rated. The logic linking data to propositions must be articulated. The case study should strive to make an original contribution. The case should be characterized by a sense of "completeness"; that is, the boundaries of the case are given explicit attention and the study should convincingly demonstrate that the investigator expended exhaustive effort in collecting relevant evidence, within the boundaries of the case. The case must display and analyze sufficient evidence. It is preferable if the case study is composed in an engaging manner (Allport, 1942; Shontz, 1965; Yin, 1984).
CHAPTER III

KEY CONSTRUCT: ANIMUS DEVELOPMENT

Theoretical Propositions

What are the essential aspects of the ambiguous process called psychotherapy? There is no universal agreement; it depends on the theory's overall conception of personality change and the goals of psychotherapy. Each theory has its own ideas about what comprises the active ingredients of change.

There is agreement among process researchers that variables should derive from an explicit, theoretical framework that permits generation of propositions about the way the variable might behave. "What a theory of psychotherapy provides is a coherent framework for ordering clinical phenomena" (Strupp, 1977, p. 11). Psychodynamic and Jungian theorists have rarely applied empirical methods to study their process data. No established methodological paradigm has been established. The focus of this chapter will be on establishing the theoretical/clinical context from which the paper's propositions derive.

Analytic Goals

Rice and Greenberg (1984) noted the importance of making explicit the theoretical principles guiding the selection of process variables since one's theoretical framework influences concepts of change in psychotherapy. Jungian ideas informed this researcher's thinking about
personality and its transformations. "Analytical psychotherapy is an attempt to create, by means of a symbolic approach, a dialectical relationship between consciousness and the unconscious" (Kaufmann, 1984, p. 108). One goal of Jungian analysis is transformation of the deep structures of the psyche. Transformation connotes the most radical meaning of the word change—change of the basic form of personality. What are these "structures" which change across therapy?

Structures of the Psyche

The psyche is comprised of several dynamic systems, according to Jungians. These structures are: The collective unconscious, containing archetypes (such as Persona, Shadow, Anima and Animus), the personal unconscious (with complexes), and the conscious ego. The totality of the personality is the Self.

The ego is defined as "...the center...through which all experience...is sifted toward integration and increase of consciousness" (Wheelwright, 1984, p. 50). The personal unconscious is roughly equivalent to Freud's unconscious realms of repressed historical memories, subliminal perceptions, etc. Complexes are groups of memories, feelings, thoughts or images which constellate together by virtue of their meaningful associative connections; for example, seemingly disparate experiences may be unconsciously stored together because of their association with "father."

The collective unconscious was Jung's most original concept (Hall & Lindzey, 1978). Jung based this notion on an unproveable assumption that the human species not only shares similar physical structures such as the brain, but also shares similar psychical
structures which predispose each human to enact certain life experiences according to ancient pre-existing "forms" or patterns which are salient presumably because they helped the species to survive.

The contents may differ, but the idea is that the formal structures of the psyche predispose humans toward certain activities in life, just as the brain's structures predispose the human to speak and think. For example, Jung assumed that even faith in a God grew from collective psychological necessity for assurance of meaning in an uncertain and ambiguous world. It is unclear where the collective unconscious is "located," but the question of its location may confuse the level of metaphor with physiology. The "location" of the psyche itself is now known.

The collective unconscious is comprised of archetypes which in themselves are unknowable, in that they are merely formal potentials which express themselves in images, symptoms and in other ways that indicate their natures. For example, all humans do experience birth and death; thus, these tend to be among the most powerful archetypal forms. There are as many archetypes as there are primordial human experiences. Jung explored a number in his lifetime such as the Dragon, the Hero, the Wise Old Man, the Great Mother and so forth.

Some archetypes which are commonly activated (rather than lying latent) are the Persona, the Shadow, the Anima and the Animus. Humans presumably experienced the necessity of dividing the public from the private self in order to form stable civilizations. The Persona is that which one shows to oneself in society. The Shadow is thought to
derive from our most primitive ancestors in that it is the potential for amorality, a living before the formation of even a rudimentary conscience. The Shadow obviously can run amuck or add color and earthiness to a well-balanced personality. Jung also believed that there are moments of split-second emergencies in which the Shadow's instinctual knowledge of what action to take is invaluable.

The Anima and Animus are the contrasexual psychic aspects in each human. Jung assumed that, just as there are characteristic male and female physical components in each gender, there are also "masculine" and "feminine" cosmic or psychic principles which are present in both genders, although the contrasexual element is often underdeveloped in a given individual. The feminine in man is called Anima, while the inner man in woman is the Animus. This paper will focus on the Animus, since the client's problems with the inner man related to her severe and chronic depression.

"The Animus is the deposit, as it were, of all woman's ancestral experiences of man" (C. Jung, 1953). It is perhaps more accurate to name this masculine principle Logos or Yang because these terms are free from the implication that certain developed human psychological qualities inhere "naturally" in the male.

The Self encompasses both male and female principles in one psyche. The Self was described by Jung as the principle and archetype of orientation and meaning (1965). It represents the totality of the psyche, including all unconscious aspects (Whitmont, 1969). The following diagram may serve to clarify the positions and functions of some of the major psychic structures, according to this author's
The Jungian theory of personality change centers around the inferred process of individuation. The aim of analysis is to facilitate the natural individuation process.

Since the Self rather than the ego is the initiator, the individuation process exhibits a somewhat regular pattern based on encountering certain motifs. The individuating person integrates both personal and collective unconscious contents (such as persona, shadow, animus) and differentiates and strengthens inferior functions (such as thinking, feeling, intuition or sensation).

Jung conceived of individuation as a life-long task, the aim of which was the eventual replacement of the ego as center of personality with the Self. Jung believed that the Self has pre-existing knowledge of where an individual's development is tending and what he values. Recognition of the Self as the center prevents installation of the ego in too high a position as "director" of one's destiny. Although the ego ("I") makes plans for the future, the Self has plans for the maximal development of the individual. Jung believed that if the Self's plan is not recognized, eventual disturbance of the ego is inevitable. That is, parts of the psyche may act without consulting the center, with resultant dissociation/disintegration of the psyche or difficult
conflicts. According to G. Adler (1961), neurosis is the Self's effort to enforce its aim of wholeness and integration by making it too painful for the person to continue in their current path. The ego often resists assimilating unconscious contents because "it is threatened with the erasure of a former construction of identity" (Stein, 1982, p. 41).

An alliance formed between the ego and the Self, on the other hand, can protect against psychological breakdown which can arise when different psychic parts pull in conflicting directions. An alliance leads to basic feelings of inner unity, solidity and strength in crises or in facing the tasks of life (Jacobi, 1965). According to Wickes (1963) "The cooperation of a disciplined ego that is capable not only of definiteness and direction but also of sacrificing its direction to an active receptivity is needed if the wisdom of the unconscious is to be available for conscious choice" (p. 159).

Gerhard Adler (1961) wrote a detailed narrative case study of one person whose processes illustrated the stages of her individuation in an exceptionally clear and rich manner (in The Living Symbol).

Individuation involves reconciling psychic polarities or opposites of consciousness/unconsciousness, viewed by Jungians as "complementary aspects of a single totality" (Singer, 1979, p. 15). Out of this unity emerge new conscious stances and behaviors. "I have therefore called the union of opposites the 'transcendent function.' This rounding out of the personality into a whole may well be the goal of any psychotherapy that claims to be more than a mere cure of symptoms" (Jung, 1959a, p. 289).
According to Gordon (1979), individuation includes the search for personal values, meaning and self transcendence. An individuating person can theoretically make decisions which are more in harmony with the totality of her/his psyche. Jung's notion of individuation resembles Buber's (1974) definition of a free person:

A free person believes in destiny and also that it needs him. It does not lead him, it waits for him. He must proceed toward it without knowing where it waits for him... It (may not) turn out the way his resolve intended it... but (it) will come only if he resolves to do that which he can will. (p. 241)

Jung spoke in a similar fashion when he asserted the importance of one single person's development:

... it is taken for granted that our civilization does not drop from heaven but is, in the end, produced by individuals. If the great cause fails, it is because individuals fail, because I fail. So I must first put myself right. And as authority has lost its spell I need for this purpose knowledge and experience of the most intimate and intrinsic foundations of my subjective being... (quoted by Mahoney, 1966, p. 240).

A Key Phrase of Individuation: Animus Development

Since individuation is considered a life-long developmental process, the whole unfolding cannot be measured in one segment of a person's life. The focus in this paper was on a woman's development of a good relationship to one of the archetypal figures met along the way of individuation: the Animus. Selection of the Animus for focus was influenced by theory and suggested by the client's case material. Essentially, animus development had emerged as the most salient therapeutic issue in the subject's life at the time. "All these figures irrupt (sic) autonomously into consciousness as soon as it gets into a pathological state" (Jung, 1959a, p. 285).
The process of animus development was studied in depth by examining a single subject over time, rather than by comparing "slices" of therapy process for different subjects. This construct of animus development is important to psychotherapy in several ways: 1) it specifies what kinds of changes in a patient's functioning are essential for personality transformation; 2) it establishes a rough clinical sequence through which this development should occur, and 3) it defines a process basic to optimal personality functioning.

How do Jungians conceptualize this major process construct? As Greenfield (1983) noted, Carl Jung's writings focused mainly on analyses of a man's anima. Writing on a woman's animus is scarce, even in this specialized literature. Yet, the animus is an archetypal figure of "great importance" (Jung, 1972, p. 1). This paper will discuss much of what is proposed about this construct, and add some new ideas as well.

The animus was defined as the "unconscious masculine principle," exhibiting both negative and positive aspects (Wheelwright, 1984). Jung's habit of personifying the contents of the human psyche is useful in that it enables a person to relate to her own inner psychological realities in a vivid, experiential way rather than solely in an abstract or cognitive manner. The personified animus figure is partly derived from archetypally influenced images of the "Masculine," and partly from subjective experiences with significant men such as father, brother, lover, husband, son, etc. (Matoo, 1978).

**Index of Psychological Growth**

One Jungian criterion of psychological growth in a woman is how
highly her "animus" qualities are developed. A woman with an initial-
ly negative relation to her animus can be ridden by negative "male"
characteristics such as indifference, insensitivity, intolerance,
sarcasm, judgmentalism, punishing or abusive criticism, and vengefulness.
In other words, her behaviors are a parody of tough masculinity and
the opposite of the discerning male who encourages the woman to aspire
and achieve individual goals. It is perhaps more common to find that
women turn this negative animus against themselves. In a depressed
woman, for example, her inner male invisibly ignores her needs,
controls and manages her through undermining confidence in her own
thoughts and abilities, and in severe cases viciously attacks such
that the woman may harbor suicidal ideas. In childhood, the young
girl is often cut off from her own sense of inner authority, and obeys
father and later husband out of fear, dependency or love.

A negative relation to the animus is often the result of a
woman's neglect of her spirit (Welch, 1982). Depending on the depth
or length of time of this neglect, the animus clamors for attention
via fierce or troubling dreams, unpleasant bodily sensations or health
problems, distortions of feeling, automatic, blind or cliched think-
ing, deteriorating relationships with the primary men in her life,
sense of job stagnation, suicidal panics or outwardly directed
violence.

A woman's task, according to Jungian theory, is to make the
animus conscious, achieve some genuine relatedness with it, and
develop and integrate its functions. This frees a woman from domina-
tion by its negative aspects and evokes positive experiences
(Wheelwright, 1984). The positive animus brings a measure of objectivity, perseverance, a "spirited" attitude, discipline, and achievement to a woman's life. A woman must learn to develop "constructive initiative" (Mattoon, 1978). According to Emma Jung (1972), it is very difficult for a woman to learn to complete difficult intellectual tasks for herself, not for the sake of another person. Women have historically been caught up in vicarious living via men rather than in developing their own "promise" and potentials. The collective "gain" from this was an exoneration of responsibility for making individual qualities real. The issues noted above probably make the notion of animus development an even more important construct for woman than Jung originally thought. The positive animus reinforces the tendency in women that "directs attention toward actuality; an enterprising spirit of courage, determination, vigor that moves ahead with forcefulness and authority. These qualities of animus allow a woman to be effective, powerful and competent in the world" (Wiedemann, 1984, p. 176).

**Relationships.** In a woman's relation to men, the negative animus functions as a jealous lover who is "adept at putting in place of the real man an opinion about him, the exceedingly disputable grounds for which are never submitted to criticism" (C. Jung, 1953, p. 206). The task for a woman is to sharply limit the negative animus' power over her vision. "... it is important for the development and good of the relationship that the woman should be able to take an objective, impersonal attitude" (E. Jung, 1972, p. 40). A client in therapy learns to look with increased clarity at the men in
her life—her father, the analyst (even when a woman!), her inner man (with his destructive and creative potentials) and her colleagues, lovers, etc. (Johnson, 1976).

The Jungian goal of this phase of work is to establish a lifelong relationship with the inner and outer man. A woman learns to converse honestly with men, expressing her actual self, genuine values and authentic ideas.

Mediator. A positive animus functions as a guide for a woman's inner journey. Often the conscious search for meaning, knowledge, and understanding in therapy strengthens a woman's animus function (Welch, 1982). A developed animus can become a mediator between unconscious and conscious realms, helping each part discover what is actually there. That is, "the animus becomes a Logos, (and) gives to woman's consciousness a capacity for reflection, deliberation and self-knowledge" (C. Jung, 1959b, p. 16).

Animus Development: How Can it be Traced?

How can transformations of the animus be detected over 38 therapy sessions? Development can be traced through examining the three main expressions of the animus in 1) dreams, 2) Logos behavior, and 3) projection. Each of these expressions may have a negative and a positive aspect. The chart below may help clarify how the animus is expressed in these three modes.

**DREAMS**

Animus = Male Dream Figure

- : indifferent, controlling, or violently attacking the female dream ego. "He snuck up behind her and shot her in the back."
+ : benevolent, autonomy-giving.
  "He put his head together with her and said, "You have the
  strength to face a tough reality."

LOGOS BEHAVIOR

Power, Word, Meaning, and Deed

- : female client is submissive, fearful, cliched, unconscious,
  compliant. "It's ok with me if you leave after sex."

+ : female client is assertive, articulate, conscious, original,
  active. "Stop calling me Blatz, my name is Diana."

PROJECTIONS

- : a woman projects her own inner masculine qualities onto an
  actual man. "He is a great poet." (projecting her creative
  qualities); "Nazis are inhuman." (projecting her evil
  possibilities).

+ : "I have a talent for poetry." (she owns her quality).
  "I have the potential to commit evil human deeds, and I am
  responsible for making choices about expressing this
  potential."

Expressions of Animus: Dreams

The human psyche personifies itself in dream images. The animus
figure is a motif commonly found in dreams due to the presumably
similar structure of all humans' psyches (Mattoon, 1978). In dreams,
the animus is a symbolic personification (image) of an ineffable
inner experience (Whitmont, 1969). The animus often appears as a
masculine figure(s) in a woman's dreams—-as sage, stranger, etc. In
young adults, ". . . archetypal activation occurs principally in terms
of the individual's attitudes to work, to his fellow human beings,
friends, foes, competitors, beloved ones and to his social group"
(Whitmont, 1969, p. 128). Thus, the dream image of a young person's
animus is likely to be of a human male figure, rather than a primitive
god-beast or cosmic figure. The image can then simultaneously represent a real figure in the external world (such as the dreamer's father) and a subjective part of the psyche (such as the animus).

"These figures are not . . . merely representations of aspects of the parents' behavior or qualities, but are infused with the individual's own impulses . . . projected onto the dream's images" (Mack, 1970, p. 59). If the father was a threatening figure to the girl, she may develop an initial animus image of man as the alien outsider. In dreams, masculine figures may appear as rapists, killers, frightening or insensitive figures. Internal images of men are built from both perceptions of actual men filtered through the child's needs, fears, rages, etc., but are also shaped by archetypes of Father/Sky God/Zeus, etc. Thus, it should be clear that a person's image of another may bear little relation to the other's reality (G. Adler, 1961).

In an immature woman the animus appears as a multiplicity of undifferentiated beings. Only as the animus figure begins to be differentiated can the true soul mate come to take his place in the dreams, or can the woman become capable of genuine intimacy with one particular man (Harding, 1952). The animus may be personified as baby, youth/virgin, Don Juan, trickster, strong hero, mature man/friend, father, lover, wise old man (Johnson, 1976). "The fact that the unconscious spontaneously personifies certain affectively toned contents in dreams is the reason why I have taken over these personifications in my terminology and formulated them as names" (C. Jung, 1959a, p. 285).
According to Whitmont (1969), conscious examination of inner images can form a bridge or connection to the elements in oneself which have been neglected (split-off, dissociated). Often a woman must first face the Shadow: "To confront it involves recognizing the dark aspects of her personality as actually present and morally binding. Such confrontation is the essential condition of any kind of self-recognition" (Mahoney, quoting C. Jung, 1966, p. 108).

The animus can be developed into a conscious (Logos) function, integrated rather than split-off from the total personality. The positive animus appears in dreams as "a man with whom the dreamer is united, either by ties of feeling or blood, or by a common activity" (E. Jung, 1972, p. 38). The positive animus is validating and inspiring. For example, the appearance of the wise old man is thought to herald development, since he is the symbol of the principle of the "primordial, masculine spiritual Logos" (Jacobi, 1965, p. 46). In this study, it was hypothesized that the client's male dream figure would move from controlling-attacking to friendly, autonomy-giving toward the female dream ego, in the second half of therapy.

**Expressions of Animus: Logos Behavior**

The animus represents the masculine principle of consciousness: power, word, meaning and deed. These were the four expressions of Greek Logos (E. Jung, 1972). Logos is "the defining word that speaks with authority of central meaning and gives structural form and pattern to reality" (Wickes, 1963). Carl Jung's concepts of Eros and Logos are used to describe psychological qualities.
"... I do not wish to give these two intuitive concepts too specific a definition. I use Eros and Logos merely as conceptual aids to describe the fact that women's consciousness is characterized more by the connective quality of Eros than by the discrimination and cognition associated with Logos" (Jung, 1959a, p. 14).

Essentially, Logos is given form through pursuit of a vocation while Eros is lived out in relationships. Today, the developmental task of many women is to bring this unconscious Logos aspect to consciousness in order that they may act in the world from their discriminating center (Matoon, 1978).

The negative animus may be "seen" through his effects on a woman's behavior. For example, without conscious animus contact, the feminine ego may take either an overly aggressive or a weak, insufficient stand or a combination of both extremes alternately (Whitmont, 1969). A woman in this position often maintains a vague attitude of wishing, rather than knowing what she wants and acting to achieve it (Harding, 1952). As a result, she has difficulty expressing her needs or feelings because she is not clear about what they are. Often in childhood the girl's spontaneous and original feelings and thoughts were suppressed. In adulthood, the woman often automatically suppresses her genuine individuality (Fromm, 1974).

Societally, a woman is not encouraged to ask, "What do I need?" nor to freely express herself. As a woman takes the time to focus on herself and develop a relationship with her animus, she strengthens her ability to think independently, choose consciously and to "work with integrity for the goal she has chosen" (Wickes, 1963). Women
can learn to perceive objects more clearly, represent them accurately inside, fear them if they threaten to harm, and act to protect themselves when necessary. A woman in positive relation with her animus becomes more aware of what she is doing, rather than behaving in an unreflective manner. With this increased consciousness of her actions, there is increased space for change.

One manifestation of this inner transformation is the woman's increasing self assertion. "Since these assertion drives are closely related to the formation of the ego, their degree of conscious development will be closely correlated with the degree of a woman's ego strength" (Whitmont, 1969, p. 212). Thus, mature assertion is the hallmark of an evolving animus. It requires ego strength for a woman to hold her ground in the face of opinions of the patriarchal culture, father, male employers, colleagues, lovers or friends who believe they know what she "should" do (Sanford, 1978). The feminine way of assertion is to take a stand which represents her individuality, while honoring and remaining in relation to the other person. It is difficult for many woman to credit themselves with their accomplishments and speak their own 'word' (Perera, 1981; Wheelwright, 1984).

Improved animus functioning results in a woman's ability to clarify her actual meaning and to say what she means. Other "Yang" qualities which become developed are the ability to say a creative "No," to refuse to assist all who ask, especially in the service of a cause. A woman's individuality can become submerged by the collective demands of her culture, which often identifies the feminine with the maternal being who is all-giving. This drains energy from a woman
needed for her own development. Thus, development requires inner strength to shape, form and limit her scattered life energies. Letting go of others' lives, lovers, children and friends, frees them to also shape their own destinies (Johnson, 1976).

Logos behavior is characterized by the creative, generating, aggressive, and active, as well as by brightness, clarity and force. There is an increased capacity to judge "What is the actuality here?"

Logos is theoretically motivated by more conscious choice, rather than driven by unconscious motives, or responding from the dark, as it were (Matoon, 1978). A positive relation to her own masculine side enables a woman to act with decisiveness and responsibility; (often a woman projects these strengths onto men, not realizing her own potentials in these areas). The father imago in these cases is a "superman," larger than life. This quality may be projected onto men and lead to a fascination which cannot be explained by reference to the man's real nature (Johnson, 1976). A woman's task is to look the man in the face, get to know who he is, and compare her "picture" of him with his reality.

The animus or masculine side of a woman needs the challenge of work in the collective, outer world, a feeling of holding her own in life. According to Wickes (1963) a woman may finally ask "What is my life for? It is a question of taking up her own life. . . . the task of living is an individual one" (p. 51). Part of this development includes the capacity to share "one's original psychological experience with others" (Rossi, 1972).

A woman with a developed animus freely chooses and shapes the
direction of her life and commits to those choices. She is responsible for forming her own values and deciding how to act. According to Fromm (1974) "Modern (woman) is... afraid of taking the risk and responsibility of giving (herself) (her) own aims. Intense activity is often mistaken for evidence of self-determined action..." (p. 148). With increased Logos, a woman can develop what Jungians call her Eagle nature. A woman can reach a higher perspective so she can see her own situation more objectively, as if sitting apart on a mountain top, observing her own travails. Eagle vision increases one's range of seeing, so one can take in more of reality (Johnson, 1976). According to Wickes (1963), Logos must be directed by Love, and Johnson (1976) cautions that humans might well learn to keep a balance between Yin and Yang, Logos and Eros.

In this study, it was expected that the female client would express more overt Logos behavior toward the therapist and other significant others. It was hypothesized that the client would become more genuinely affiliative and autonomous in the second half of therapy.

Expressions of Animus: Projection

Inner figures of the animus may be manifested in the outer world via projection onto men (Jacobi, 1965). A woman may encounter her own masculine aspect in projection, in her own emotional reactions to another person. Projection is thought to be unconscious, and it distorts our view of others' reality, their subjective actuality, thus interfering with our ability to relate consciously.

What is the mechanism of projection? "The East calls it the
'Spinning Woman'--Maya, who creates illusions by her dancing" (C. Jung, 1959b, p. 11). Projection can be useful in that a person can learn to "see" a part of her/his own nature (Harding, 1952). According to Emma Jung (1972) "... a man to whom the animus image has been transferred is expected to take over all the functions that have remained undeveloped in the woman in question, whether the thinking function, or the power to act, or responsibility toward the outside world" (p. 10).

The father seems to be the first carrier of the animus projection (C. Jung, 1959b). However, "There is every likelihood that the numinous qualities which make the (father) imago so dangerously powerful derive from the collective archetype of the (animus), which is carried anew in every (fe)male child" (C. Jung, 1959b, p. 14). Other carriers of the projection can be one's friend, mate, especially one's enemy (for the Shadow projection) and the 'ghostly lover' (or fantasy man such as Elvis Presley in his younger days!). "When a woman fails in the task of relatedness to the masculine within herself, she frequently looks for a man to live it out for her" (Wickes, 1963, p. 240).

The animus is projected onto an actual male who greatly attracts, fascinates or repels a woman (Sanford, 1980). Projection can make a "god" out of the other or a "demon" or witch (C. Jung, 1953). Generally, the inner animus is projected onto a real man who at least in some manner does resemble its image--this is called the "hook" for the projection, or the grain of truth in the perception. However, the woman then tries to make the man behave as the animus
should; that is, she expects him to be an animus figure for her and not his real self (Emma Jung, 1972).

One can suspect the presence of projection if a woman gives an exaggerated value to whatever trace of a quality is actually in a man. For example, if a man writes a decent poem, he becomes "a genius, a great poet." In essence, withdrawing projections is a way of differentiating oneself from the object, realizing that one is distinct and radically separate from another, and basing relatedness on the realization of differences.

Probably most relationships are founded on projection, at least initially. According to Sanford (1980), for a relationship to last, the illusion must be gradually cut through and replaced by a focus on the reality of the other person. "Relationships to the other sex are almost bound to be initiated by anima or animus projections... Actual relatedness between one person and another, namely a meeting of 'I' with 'Thou,' is therefore impossible until the most unrealistic anima or animus projections have been dissolved--no small matter to accomplish" (Whitmont, 1969, p. 195).

Why take back projections? The best reason is that then we claim what is truly us, and we distort others less (Guggenbuhl-Craig, 1977). How does one "pull back" a projection?

Jung suggested that a person start by "... acknowledging the symbolic value of the object (person)" (Jung, 1969, p. 265). The recognition of what is inside oneself is for a woman a difficult act of cognitive discrimination and involves recognizing a duality within, the man in her, in order to distinguish the animus from her ego and
to relate to him (E. Jung, 1972).

Some examples of withdrawing of projections appear in Shakespe­
are. In The Tempest, the character of Caliban carries the evil side
(Shadow) of Prospero until the projection is recognized. "This thing
of darkness I acknowledge mine" (James, 1967, p. 141).

Once the animus projection(s) are withdrawn, Jung recommended
recognizing the Yang qualities within, and developing them. For
example, a woman would be faced with decisions about what to do with
her aggressive energies and how to express her creativity in the
world (Johnson, 1976).

It takes time to differentiate one's projection from the reality
of the other. Jung believed that true and genuine relationships were
extremely rare (Hall, 1983). A woman can notice the incongruity
between the image and man. This incongruity is inevitable since "An
archetype, such as the animus represents, will never really coincide
with an individual man. . ." (E. Jung, 1972, p. 11). According to
Sanford (1980), "... what we yearn for sexually is a symbolic
representation of what we need to become whole" at a certain period
in our development (p. 89). The more the animus is developed, the
less it appears in projected form.

The expression of animus in his projected form is discussed in
the Clinical section, Chapter IV.
CHAPTER IV

CLINICAL CASE SUMMARY

At the time she sought therapy, Diana was a 29-year-old, twice divorced, white woman. She was currently single, living with four roommates, and employed as an administrative assistant while attending night school.

Referral Source and Statement of Problem

The patient was referred by Emergency Services personnel, who had seen her the night prior to her first interview with a Psychology Fellow. For the three days prior to her first session, the patient had felt increasingly depressed and anxious and had thoughts of cutting her wrists, which were very frightening to her.

Presenting Problem

The patient stated that things had become progressively worse in the three days prior to her first session, but she had been depressed over the past month. She described a decrease in the quality of her sleep, but no major eating problems or difficulties functioning at work. Most of her problems over the month had centered around her feelings of being overwhelmed with school, work, love, family and friendship obligations.

The particular precipitant of her emergency visit was her intense panic the "morning after" a party at her home. She reported
having felt tense and upset with her boyfriend, who had planned the party without consulting her wishes, and then attempted to set a narrow time limit on his own attendance. The patient reported "passing out" at the dinner table at the exact moment her boyfriend was scheduled to leave. She dated this man, a 43-year-old divorced artist, no more than once or twice a month because he wanted "no strings" on him. She had recently told this man that she loved him, only to have him disappear for three months.

Summary of Past Psychiatric Disorder and Treatment

The patient had no history of psychiatric treatment prior to her Emergency Services visit. She reported that she had had a helpful experience with Rolfing for painful back problems. The patient stated that she has had chronic bouts of depression that last an average of two months. She related these episodes to her continuing difficulties with her father and the residuals from her marriages. When depressed, she had generally attempted to cope by moving, leaving her job, "running." She has had suicidal ideation at those times, with thoughts of overdosing or taking her life in some way which would not be painful.

Summary of Past History and Baseline Personality

The patient is the oldest of five children. Her parents divorced when she was 12. The patient noticed a shift from "happy" to "gloomy and dark" in the home atmosphere at this time. According to the patient, her mother abdicated responsibilities for child care and household management and left them to the patient. The patient recalled her mother saying, "Now you will be my mother."
Fights between the patient's mother and father (including physical violence) continued for about six years while her father lived down the street. These resulted in numerous trips to court and at least three bitter child custody battles. The patient was the only child who was "permitted" to decide which parent she wished to live with and for how long. During most of this time, she stayed with her mother out of necessity, she felt. Her mother continued to rely heavily on her in a way that the patient experienced as stifling and undermining of her attempts to gain independence.

At the age of 18, the patient had a car accident, "totaling" her mother's automobile. Her mother's recriminations and her own guilt seemed to trigger her impulsive decision to move out and live with a boyfriend whom she later married. The patient stated that she did not love him, but wanted a way out of the house. They were divorced a year later. She then married an Armenian man, whom she felt used her to obtain citizenship. She divorced him for this reason.

After the divorce, she lived temporarily with her father and his new wife in another town. Her father, a scientist, had offered her the opportunity to attend a technical school. She eagerly accepted, excited about the chance to renew her relationship with him. However, the tensions between herself, her father whom she vainly tried to please, and the stepmother proved too difficult to resolve.

The patient moved to another town, and started job and school. She felt she finally had a chance to realize her "creative potential" which she viewed as having been submerged by her relationship problems.
Initial Treatment and Course (With a Previous Therapist)

The patient was seen for 11 sessions of individual psychotherapy, psychoanalytically oriented. The patient worked very effectively within the context of therapy. Suicidal ideation rapidly abated, but the patient expressed a desire to continue exploring in order to avoid similar problems in the future. The patient was transferred to the author of the present study, after her previous therapist moved to another state.

Summary of Mental Status

The patient was a petite young woman, who dressed in an attractive and unique manner. Her voice was pitched high and was somewhat "childlike" in tone, and she spoke easily and freely with the therapist.

Thought content centered around her desire "to be taken seriously" by her therapist and others, and her feelings of depression for the last several weeks. She had been physically evaluated and found normal. No tests were administered.

Treatment and Course (With the Present Author)

Diana was seen in weekly, individual, Jungian-oriented psychotherapy for a total of 38 sessions. The focus of therapy centered on the individuation process which Diana was following. Sessions often centered around dream material and were frequently affectively intense. Diana was a highly motivated patient with considerable intelligence, sensitivity and other ego resources at her disposal. She made excellent use of her sessions, in addition to continuing the work of self-reflection outside of therapy.
In the initial phase of therapy, Diana formed a positive working alliance with this therapist within which complex transference interactions were productively examined. Diana's metaphorical descriptions of her phenomenological experiences made sessions particularly rich and difficult to summarize succinctly.

Diana's fearful feelings toward her father were played out and examined in the transference. For example, Diana was afraid to make a simple request of the therapist for fear that she would be harshly and punitively attacked. This issue was worked through intensively, with Diana owning her projections, and expressing her deeply buried rageful feelings toward her father, and becoming more assertive at work, with the therapist, and with others.

The dreamwork progressed such that the initial destructive relation to the "masculine" (animus) moved toward a beneficent relationship with "a wise, kind older man" who comforted and helped her face a tough reality successfully.

Therapeutic work had other consequences:

a. Diana severed a tie with a boyfriend whom she viewed as emotionally withholding.

b. She was able to plan for her future in a decisive, organized way.

c. She was able to assert herself with several important authority figures with less fear of damaging counter-attacks or fear of destroying them with her rage.

d. She became more able to see how her defensive projections prevented her from establishing an intimate relationship
with a male peer.

e. Diana better understood her depressive episodes and suicidal feelings as stemming from unconscious wishes to atone for her guilt-provoking anger toward her parents.

Diana's angry, disgusted, and deprived feelings vis-a-vis her mother were played out in the transference. However, this was not the main theme of this particular year of therapy. At termination, it became clear that a probable next phase of work for Diana would be on her relation to the "feminine." Her disturbingly problematic identification with her mother was apparent. The work was important also because it represented the beginning of Diana's integration of the Shadow, a mutilated, obese, and depressed inner mother imago. An initial gain in this area was Diana's increased ability to limit women friends' manipulative dependency on her. She had always hoped for a return of nurturance from women, but had been disappointed.

There were also pre-Oedipal issues which arose and were likely issues for future exploration. These revolved around Diana's feeling of existing with a wounded "hole" in her heart which was empty and painful and was experienced along with suicidal feelings. Themes of oral greed, fears of engulfment and incorporation were prominent. Separation anxiety was also evident. Fear of becoming like her mother emerged. The "hole" had to do with grief over the felt loss of mother love and with the feeling of deprivation and neediness, which Diana centered around wishes to break free of mother's "control" and become more autonomous. It was felt that these pre-Oedipal issues could be productively analyzed before true Oedipal concerns
would emerge as paramount.

Diana became more deeply aware, through the process of intensive self-exploration, of the origins of her depression and nature of her conflicts. She began to examine the psychic strategies (defenses) which she had learned to use to survive and how she could now use them more flexibly. She began to affirm a meaningfulness to her life which existed in counterpoint to her suicidal wishes. She became aware of the inner experiences accompanying her parents' divorce, and her self-punitive feelings around earlier, crucial life events, including a feeling of "survivor's guilt" over her own continued growth and development, while she viewed her family as having "died" after the divorce, perhaps because of her. We explored the "killing off" of her natural expressiveness at an early age.

Diana became more trusting and shared erotic/aggressive fantasies more frequently with the therapist as she progressed. She became more assertive and began to use her animus power and wisdom to face reality issues, without cruelty to herself or destruction of others. There was some evidence that she internalized the therapist's positive relation to the animus, or "masculine" aspect of her psyche.

Diana's self-presentation became more flexible and mature and less docile and compliant. Psychic shifts and inner transformations in the course of therapy helped Diana begin to integrate the seeming opposites of light/dark, good/bad, etc., especially in the transference where, for example, she felt both angry and loving toward the therapist, and yet could relate to her as a whole and multi-faceted
person. There was much evidence to indicate that Diana now took herself seriously.

Termination. The departure of this therapist had been discussed with Diana several months prior to actual termination. Termination occurred only because of the therapist's move to another city. Ending therapy aroused a variety of feelings in Diana ranging from grief, to fears of falling apart, to anger at abandonment. She began to identify with the therapist and expressed appreciation and curiosity about her life. She asserted the strength of the connectedness which she felt toward the therapist and worked through her tendency to try to preserve the therapist in idealized form.

Diana requested referrals and was given the names of two sources. Her dreams had themes relating to Diana's capacity to function independently. There were clear indications that one future focus of therapy would be on integrating her Shadow mother figure and her negative relation to the feminine.

Diana spoke in her last session of the kinds of relationships she wished to form, using the therapeutic relationship as a model. She reviewed plans for the future and identified a further issue for therapeutic work—a deep exploration of her resistance to joyful experiences, and its relation to early loss and depression.

Diana's final primary diagnosis was Neurotic Depression, with mixed histrionic and narcissistic features. It was recommended that Diana continue psychotherapy and follow up on one of the referrals that she had requested (to private Jungian therapists). Her condition at the time of closing was judged to be improved. However, Diana was
still in the early "middle phase" of therapy and may still experience depressive episodes.

**Animus Development Through Therapy**

The state of Diana's animus development was clinically monitored at four levels throughout therapy. Diana's relation to her own animus revealed itself in:

1) her **remembrances of things past**, or her early childhood recollections of significant men, such as father and brother. These men were the first carriers of the archetypal animus projection. They were the first embodiments of YANG, LOGOS or the MASCULINE. In their more human roles, these males were introjected as the first "inner men," and influenced the masculine qualities of Diana herself;

2) her relation to her **current "inner man,"** primarily found in dreams;

3) projections of her animus onto her female therapist (transference);

4) **projections of her animus onto current men in her life such as boyfriend Alex, boss, former husbands, male friends, etc.** Her relation to her animus was also manifested in the **extent of Logos behavior** she exhibited in the world.

Diana's animus development in the **first and second half of therapy** will be narratively discussed. **Clinical assessment of her states (at each of the four levels) and their changes will be supplemented with examples from the case. Initially, the therapist was relatively inactive, receptive, listening and empathic. Therapist interpretations in the first half of therapy focused mainly on dream**
material, past history, characteristic defenses and previously repressed memories. Transference was observed. In the second half of therapy, the therapist became moderately active, empathic, and moderately interpretive of transference behaviors. The focus was chiefly on understanding here-and-now interpersonal patterns, integrating dream material, and consciously examining typical behaviors with significant others in the client's life, relating them to genetic roots, and exploring alternative construals and options for action. An acceptance of the past and a movement toward a responsible future were highlighted at termination.

Roots in Early Childhood: First Half of Therapy

Apparently, Diana sacrificed a great deal of her vitality as a child in order to survive in her household. One therapeutic task was to allow her to reexperience her spontaneous self in therapy. Her choice of entering therapy indicated some concern for her true self.

Diana felt defrauded, let down, exploited and deceived by her father. She had learned to attune to his needs to prevent physical punishment or abandonment. The persona she developed for her father was entertaining, pretty, cheerful, sympathetic and admiring of him. Diana learned that she was not free to act or express herself spontaneously, yet she retained an essential kernel of her core self, and some awareness that when she was being false, it was play-acting. The core was never totally lost, but was heavily repressed and kept out of awareness much of the time.

As a child, Diana was far from mistress of her fate. She felt betrayed by both parents because she had put her trust in them, and
then felt not only unprotected but also injured by them as well. She spontaneously used the metaphor of Auschwitz to describe her survival in a chronically violent family life. One memory she recalled may serve as an example of the sort of chaotic situation she experienced, and how she chose her defenses to ensure survival. As a small child, Diana was witness to her father physically beating her brother. She remembered deciding that she must figure a way to avoid such a beating for herself. She acted as if she did not "see" the scenes in front of her, and she literally stopped up her mouth to avoid being injured. She lived with guilt that she did not intervene in such situations, but instead chose to survive herself. She realized her helplessness as a child to stop her father, and this may have been one root of her impaired sense of autonomy—she could not will the scene to stop, she could not have an effective impact. She remained feeling helpless to stop abuse by men as an adult, until she entered therapy.

Since she had witnessed her father abusing power with a child, she unconsciously believed that to assert her power was to either destroy others or to court retaliation by one more powerful. A child may experience a parent's power as absolute. A child has "no exit" existentially from the family web, and is imprisoned in its chronic problems, with little realistic chance of escape until adolescence. Diana experienced control through violence and was apparently beaten a few times herself by her mother.

Diana internalized a male image which attacked her in dreams. She treated her own needs in a callous and indifferent way, mirroring her own early treatment. Her superego operated like a Nazi fascist,
another spontaneous image arising from her dreams.

The defenses which Diana devised to prevent abuse served her well as a child but interfered with her life as an adult. At first, she "hid" certain parts of herself from her parents; later this became so unconscious that she habitually dissociated from her own experience in conflictual situations. Here is an example from therapy:

D: That's really disturbing. This reminds me of the whole thing that started things off in counseling. X (my former therapist) said to me... I had told her I had passed out at 10:30 at my party with Alex there. I had had no sleep Thursday night, Friday night. I had taken a Valium at 6:00 in the morning on Saturday, the alcohol. I was exhausted... I had all these reasons! And I would never have said to myself that I passed out because I was mad at Alex. But how could it be? I make myself pass out like that?! I had enough physical reasons.

Diana was often unclear as to how she truly felt, what she actually experienced. Her inner core had too thick of a wrapping around it. Her real emotions often came through the ring of repression in a muffled, muted way.

Diana carried a great deal of depressive guilt. She felt guilty at not being able to prevent the marital dissolution of her parents, her mother's depression, her own neediness, her abdication of authenticity, and her father's anger toward others. The guilt of the survivor springs from the notion that one must not save one's life at the expense of the lives of others. She felt guilty for complying or collaborating with her father's beating of her brother. She had chosen to use cunning, tricks and pretenses while her more "pure" brother had openly thrown rocks and gotten beaten. Therapy reframed her survival choice as a testament to her inner strength and self respect
and hope for a better situation in the future. Her guilt was not warranted objectively, yet subjectively it was an important human quality which separated her from the psychopath. As a child she could not have saved her brother and so was guiltless; yet her feeling guilt was a signal of her caring for others, her humanity.

As a child, Diana did resist the arbitrary power of her father by initially tantrumming, and later by going "underground" with her real self and behaving defensively. It was only later, in adolescence and young adulthood, that ideas of suicide became very threatening. It had become more and more difficult for Diana to distinguish which was her true and which the false self. She was easily penetrated by the outside world's demands and the ring of repression was becoming ever tighter, as she play-acted through life, complying here, pleasing there. Eventually, the repressed aspects of her self burst through in suicidal ideation, and violent dreams.

The roots of her suicidal wishes were complicated. They represented partly the sense that her life was not her own, to shape with purpose, and partly reflected her sense of despair and low self-worth. The wishes probably were manifestations of her repressed rage which attacked her from the inside in the form of "bad" introjects. Other roots were the senses of estrangement from herself, and the loss of a feeling of personal significance.

Her suicidal response was triggered by the narcissistic injury of having her boyfriend leave after sex, leaving her feeling devalued. The loss of meaning and her own repressed rage may have combined to form the suicidal wishes upon awakening from the "pass-out."
Another suicidal trigger may have been her guilt over experiencing her family as psychologically dead, even though physically living, while she was still involved with life. An example from her therapy will illustrate this:

T: What I'm hearing is a lot of feeling of unconnectedness. . . that somehow the relationships weren't really relations, um, related. . . ness.

D: Yeah.

T: In your own family, the relatedness of your family was broken apart at the time that your father left.

D: Oh, I just remembered. . . I have always wondered how someone can live through a thing like Auschwitz, losing your family and then going on. Because there are people that have done that. And I've always thought, how can they do it? At the time, that same night, that's what I was thinking about, that I did exactly the same thing. To me, it was the same thing as somebody in a concentration camp, seeing their whole family killed in front of them. And then going on and living for several years afterwards.

You just reminded me. . . I was thinking of it for about two days, then it went out of my mind.

T: So the living after can really feel like a burned-out experience. . .

D: Sort of like, maybe it would have been better if I would have died with them.

See, I kind of view that whole thing. . . see, I used to feel like that about the people, too. They must feel like they would have rather died with them than go through all this pain.

T: So you're the one that survived. You survived. You didn't wither away. Sometimes there is guilt associated with just still being alive and able to channel energy toward living.

D: I do. Even when I talk to my brother, I do feel like I have survived more than any of them. The three younger ones are really screwed up.

Her suicidal impulses could be seen as a way of joining the family death, a way of annihilating her family and herself at once, or as a
way of punishing herself for harboring murderous fantasies against her parents, and killing her false self. Suicide would wipe out her guilt, her aggression and her despair.

In therapy, she searched for the meaning of these early events.

D: I've thought about the survivor's guilt all week. This gave me the answer of why I kept doing this to myself. Also, the suicide thing. I think maybe every time I started to do... It did follow after... big highs. Every time I felt like killing myself was after a big high. So maybe it has to do with every time I got happy, I thought, "Why should I be so happy? I should be dead." Just like them. I've always wondered, where has that idea come from. You know, where does a person get that idea from? Other people get depressed, yet they don't think of suicide. Why did I always think of suicide?

**Inner Dream Man: First Half of Therapy**

Diana was initially out of relation to her true self. In therapy, she dialogued with her unconscious as a way of reconnecting with and developing a better relation to the masculine within. She presented an initial dream:

My father has three unusual dogs. They're hurt, bleeding, and lying on the ground. I tell him, "They're dying!" He's petting them. I scream to him that they're dying. He ignores me and says, "No, they will be alright."

The injury that she suffered in the dream was narcissistic, in that her father seemed oblivious to her pain. Thwarted in her efforts to reach her father, did she have to bleed to death in front of him in order to get his attention? Even then, he denied her reality.

Diana had an initially poor relation to her animus—it ignored or attacked her.

D: He sneaks up behind her when she is peacefully swinging in a hammock. He is behind her about 15 feet. She never turns but intuitively begins to feel danger. Her face gradually transforms into terror. It is then that he shoots her in the
back. And she opens her mouth and screams and her mouth becomes bigger and bigger, and it finally covers a whole movie screen. I am looking into the 6-sided shapes that make up the back cells of her throat. It was reddish, also yellow and dark red.

Apart from the pre-Oedipal significance of this dream (oral), it seems clear that Diana felt internally attacked, abused, injured. Her initial response to these attacks was frightened endurance. She presented a dream in which a rapist was trying to break in her house, and then discussed it with the therapist.

T: So you ran around locking out something that wants to come in. Possibly whatever is trying to get in or through to you, feels like an invasion or violation. But somehow, too, it seems related to the knives in your earliest dreams.

D: I felt terror and a trapped feeling.

T: In the dream you don't call the police.

D: (laughs) I told my friend Michael about it, that we have a pay phone in our kitchen, and he said, "What's wrong, didn't you have a dime?" (laughs). "To call the police?" (laughs). I didn't think of it. I just accepted that I was trapped.

T: So something that's seeming intrusive and scary right now is at the door, banging on it.

As a defense against the anxiety which awareness of her unmet needs would arouse, she dissociated from her actual experience of mounting anger, disgust, disappointment and hatred. These feelings manifested themselves instead in her dreams. Essentially, her dreams led her to discover one of her prime defenses. In the next dream, Diana witnesses a man murdering someone, and behaves as if it never happened.

D: The guy I was with was robbing him. And then shot and killed him. So I just went "uh!". And I thought, "Oh my God, what a terrible thing!" But I didn't say anything because immediately I was frightened for my life. I thought, going on
intuition, how should I react?

I just knew the guy was going to watch to see how I reacted. And it would matter if I reacted favorably. I could get away with it. Get away with my life. And if I didn't react favorably, I'd seen him kill the guy, so he'd have to kill me. So he just turned around and said, "How did you like that?" And I said, "Well, it was quite a surprise!"

T: Your strategy in the dream was to cover your outrage and fear, and feign a nonchalant surprise... after the shooting...

D: What I would really have liked to have done was told him that... I thought it was the most terrible thing I ever saw. There was no reason for it. How could you do this? I never want to see you, or associate with you. All of that. That's actually what I would really like to have said. But, I was afraid that I would be killed. I didn't feel good about not... you know, I find myself feeling that way in a lot of situations. They're not life and death, but to me, they are life and death.

D: I take it very seriously. And I haven't said things all along that I really thought. That must be part of the choking. I don't think a lot of myself then. Thinking back on the dream, and the way I reacted... in one way, I think it's good. It shows I'm a survivor. But in another way, it's being really cowardly. If this life is going to mean anything, you have to stand up for what you believe.

To stand up for what she believed was problematic for Diana, because it involved using power. Because she associated power with her father and disregard for other persons, she became unable to assert herself.

I was sitting in a bar, talking to a man who was bald. I thought he was a friend, then realized he was a Nazi. The whole bar was full of Nazis and I had this really trapped feeling—how do I get out of this one? It was hard to breathe. I was scared.

Through her dreams, Diana reconnected with her own buried potentials for violence and dropped her conscious stance that people were good at heart, and that Nazis performed evil acts because they were inhuman. She accepted that there really was an Auschwitz, and that human cruelty did exist, in other humans and in herself. She
harbored a Nazi in herself who both tortured her and with whom she was also identified in her wishes to torture others. The aggressive part of her had been denied free expression for so long that it had become murderous. She had felt destructive inside.

In therapy, she began to integrate her more primitive aggressive impulses without becoming overwhelmed or psychically fragmented. She became aware of the discrepancy of these inner furious figures and her own inability to express even mild anger at those with whom she was displeased. With her aggressive wishes no longer repressed, she was able to exert conscious control and was free to choose how and when and in what form to express her aggression.

Transference and Relation to Therapist: First Half of Therapy

At first, Diana seemed dissociated, unfocused, not there, not present with the therapist. This was one way she had learned of not attaching too closely and not allowing herself to feel vulnerable. She dissociated from her immediate experience and from her attachment to the therapist in the present. Dreams became a way of processing her experience since they sent her a message later about what she had not consciously experienced immediately.

One therapeutic aim was to help Diana stay in contact with her experience in session. Basic trust issues emerged early in therapy, such as would the therapist "hold" her or "drop" her? Would our relationship be serious? With time, she developed increasing confidence in the stability and reliability of the therapist.

A goal of therapy was to assist Diana to rediscover her core by showing herself to the therapist. While this involved the risk
of shame and exposure, Diana found that she could internalize the "loving gaze" of the therapist, in which she was intrinsically validated. Diana was able to form a set of internal "eyes" with which to see herself as more solid inside and less in need of external sources of validation.

The fact that Diana was able to form a trusting relationship with the therapist suggests the probability of at least some adequate-to-good early parenting, as well as strong constitutional resources. Diana's struggle was to be her spontaneous self in sessions, and to let the therapist in to her world, so that she could have that world shared and validated. Gradually, this led to an opening to the larger outer world and eventual recognition of human commonalities, forming the basis for a sense of community. She slowly learned to love the reality of her being and the world.

One period of resistance to therapy occurred when Diana felt herself becoming attached to the therapist. It was difficult for her to examine what feelings this stirred up in her, for it aroused the hope that her needs would be met and fear and disappointment that they would not. In therapy, her dreams formed an initial language of depression which she used to communicate to the therapist her pain, her rage, and her yearnings. Her conscious dialoguing with her own images helped her to articulate and integrate these long-buried aspects.

Sharing her experiences allowed Diana to feel "held," cared for, respected, and deserving of attention. Diana's presenting problem was her feeling of not being taken seriously. This problem was non-verbally addressed by the therapist's consistent psychological
engagement with her in a serious way. It was healing for Diana to
tell someone of what had happened to her, to learn its meaning so she
could create space for a better future. The therapist's listening
validated Diana's subjective point of view, which allowed her to "open
her mouth" and say what was on her mind. The therapist also offered
alternative perspectives on Diana's construals of life.

T: So the price for all of this could be... depression.
Here you had all these feelings inside, and to spare everyone,
because they would die if you tell them, what happens to
you? What happens to the truth?

D: It doesn't get out. But there must be something in me very
strong, because there were so many times I wanted to kill
myself and I didn't do it. There were so many burdens that
I took on that other people have taken on much less, and
yet it's broken them.

Diana needed the therapist's commitment and empathic presence.
She was accustomed to running away, muffling or distancing herself
from her own experience. The therapist attempted to amplify or make
louder and more distinct the subtle aspects of Diana's self.

D: I just don't know if there's anything else I would work on
in here. I'm starting to think differently. I could go
over the past for ages... but I don't want to...

T: It's hard to choose your own direction.

D: That worries me. I would have rather heard you say, "I
agree with your decision." I'll rethink this and come back.

In therapy, Diana was able to explore her own transferences or
particular ways of responding to others, and the origins of these
characteristic patterns.

D: I have some things I want to ask you. Um... last time I
was here, you know, when I had coffee?

T: Mmhmmm.
D: It really bothered me because I see a trash can over there (under therapist's desk) and I started to give the cup to you and then I thought, "Well, maybe I should just take it out of the room because it seemed really awkward.

T: Beyond it's feeling awkward, is there anything else that...

D: I want to know if it bothers you in some way.

T: I wonder if it bothers you, and what about it might...

D: Well, because everybody has their own ideas of the way things should be done. I felt like you were looking at me strangely so...

T: What did my look convey to you?

D: It looked like you were thinking, "Why are you handing me this?"

T: So you were worried about stepping over some kind of boundary...

D: Yeah, I would rather know if you would rather... I bought a lady some flowers one time for helping me out with the phones and she... I found out later that she did not want me, she didn't want to put flowers on her desk. And there's no explanation for it.

Diana's concern with pleasing and not offending others by a spontaneous act may have had roots in her early life. Later in the same session, she told the therapist, "If you had been my father, you would have yelled, 'Throw it away yourself!!'" Diana anticipated and expected others in her world to punish her for behaving freely; thus, she often walked on eggs and allowed herself to tread only softly with others.

As therapy progressed, Diana risked new ways of being with the therapist. The risk consisted of giving up the familiar ways of construing her past and present, her defenses, some friends and lovers, her ways of relating—in the name of her evolving self. Diana
wondered why she had come to therapy and invested in herself while her family had not. She pondered her free decision to rebuild her personality and her life, while others chose differently. She became aware of a soft part of her which forgave her childishness and felt compassion for the child she had been. She attempted to recover lost meaning from her past. She began to realize her own resources and worked strenuously in therapy. Diana used her will to understand her own life. The process involved building a self from the center of her own experience.

Projection/Logos Behavior: First Half of Therapy

Attachment was associated for Diana with deprivation, exposure, loss, disappointment, humiliation, fury and sadness. Thus, not expecting to get what she really wanted, not even sure she believed in love's existence, Diana would settle for crumbs and hang in with boyfriends while her inner self was feeling more impoverished and degraded. She defended against her own feelings of rage over this situation by experiencing things as not quite real or "for keeps," by remaining not quite fully present, not really close or wholly invested.

Diana's sense that happiness and love were illusions stemmed from extremely early disillusionment with the sources of joy and well-being in her family. She tolerated her boyfriend Alex's cavalier disregard for her feelings. This was part of an old and mainly unconscious habit of "putting up with" difficult family problems. Relating to others in this defensive way became a habit, fueled by the strong fires of survival, but became maladaptive for Diana later in
life. It prevented contact with loving others.

Her experience of sexuality without tenderness was part of her fantasy hope that if she engaged a man sexually, this "meant" he cared for her and that they were close emotionally. Diana's projections operated such that she found herself magnetically attracted to those men who frustrated and deprived her of attention, time, dignity, caring and respect. She also attracted women who leaned on her, depended on her, and "fed" off her emotional resources. The parallels with her position in the family were evident. Diana expected men to disregard her perceptions, wishes, etc.

D: The first time Alex took me home, when he woke me up, after we made love, he woke me up and um (laughs anxiously) um, when he took me home, I mean it was obvious that I was angry and I was telling myself not to be angry. I thought, "Diana, just hold your tongue, don't say anything" but my physical... the way I was feeling, it was very obvious that I was mad.

For much of her adult life, Diana had opened herself for exploitation. She "fell into" sexual relationships with little active decision. Her energy and hope were being sapped by her inability to gain strength from her core self or from truly intimate emotional ties to others.

D: Yeah. But it feels like I'm angry with my brother, but I don't feel angry with Alex. I just feel like, uh, ok, what the hell else can I do? That doesn't feel like anger to me. It's more like... giving up. Though I'll probably see him several more times... With the feeling I have now, unless he moves, as long as he doesn't question me about anything else, I could probably see him whenever the hell he wants. And I don't have that yearning. I just sort of... I've just given up.

As the reality of her relationship with Alex crept through, she dissociated from her rage by "passing out."
D: Because I felt like I couldn't call it off. And I wanted to. And I felt trapped. Because I made a commitment to Alex. I felt like I couldn't. . . since I had made a commitment to him, I couldn't back down on it. It was like a life or death thing. And then when he called me up and started to back out of it. With my father, you don't back out on a commitment. At all. And I never did before. Never. I would follow through, even when it was killing me.

So Alex came to the party and he said, "You are a spoiled little brat, and I hope you feel guilty." And I said, "I don't feel guilty at all!" Of course, I did feel guilty. So then, I just backed away and just kept drinking some more.

On one level, Alex "conned" Diana, pretending to care for her; on another level, Diana conned herself by overlooking signs of his non-caring because she needed him. To redeem the Remote One or change him into the loving one is to magically make the early mother/father the way one wanted them to be.

T: Your voice comes through as very soft, very gentle. It has a quality of gentleness and consideration to it.

D: Mhmm.

T: Part of that giving. It's almost as if you say "I will also give with my voice" to others. . .

D: (laughs) Yeah.

T: It could make it tough for people to know when you really are angry, bugged, hurt. . .

D: I never yell!! And I don't want to yell. . .

T: You were the one with the tantrums. . .

D: But that was a long time ago. . .

T: That's true. What happened when you tantrummed. . .

Her feelings of anger and depression occurred as a signal of conflict between Diana's true and false self. Therapy provided a forum where she could give these feelings attention, becoming gradually aware of
the conflict. As she allowed her feelings to emerge more fully into consciousness, her anxiety dissipated.

**Early Roots Examined: Last Half of Therapy**

Diana began to realize that she was an object of confusion and conflict for her parents, while she tried to involve herself in an intimate way.

D: With my mother, see, I don't consider her as intelligent as my father. I guess I really wanted affection from her, touching, maybe some of a feeling of security, which I didn't have at all.

Diana faced her past, realizing that she didn't get what she needed in some ways, and that she had imprisoned herself in a false existence. Behaving in a dissociated manner interfered with something very basic—her sense of self and reality. One therapeutic aim was to help Diana consciously mourn her psychic losses and move slowly toward an acceptance of her personal past.

Due to an immature ego, a child is often unable to assess reality accurately and so can blame herself if a parent is punishing. If father was beating his children, they could not be worth much, so the reasoning would go. It had not occurred to her that father may have had his own problems.

D: My brother was beaten so badly that he had broken blood vessels on his legs. Also, that's when he started stuttering. He had quite a problem for several years. He was sent to X clinic to get over the stuttering. Now I remember my father being very cruel. That's where I think I got that Nazi theme from in that one dream. And I remember that he, um... when he lost control of his anger, he lost control completely.

Diana made the painful acknowledgment that she had "missed" her parents, missed something important at a critical time. Yet she also
acknowledged that this did not close off all possibilities for her for all time—that healing was possible, and was in fact happening within her.

Part of the healing was contacting her rage, because it was a part of her real experience which had been split off from consciousness and had been operating destructively against her own self. It was a necessary step in re-integrating the self, reconnecting.

D: I did ask my brother, "How did you forgive our father?" I mean how can you forgive him? That wasn't the only time! He continually did things like this. But that must have been a really big incident in my life... I must have thought then that I never trusted him and figured out a way so he wouldn't be harming me that way.

T: And the way you figured was to not say how you felt about what you saw.

D: Actually, I probably felt like killing him then. I mean I don't know if a three-year-old can feel like that! But...

T: So the way you figured out was to suppress your own anger to avoid being beaten, and because you just saw some anger out of control... used to hurt someone badly... anger got mixed up with rage. It was as if your anger could annihilate people.

D: This is going to take... a lot of work. And another thing, I don't know what to think of my father now. I was thinking we just started to establish a relationship. If he was here, I would ask him... I mean, this is so many years later, he's 60 years old! But if he was here I would be extremely cruel right now. Because I think that's one of the most disgusting things you can do. I think I... want to kill him right now but I don't actually feel, I don't see myself killing him.

The power of her father derived from his chance position in the family system as the adult and not the child. Only when Diana could imagine her own father as a lonely, powerless child could she begin to form a core of adult empathy for him and let her pain and anger go.
She began to gain a realistic sense of others' limits and incapacities, and ceased blaming herself for being deficient. One of her major insights was her realization of ambivalent love for her parents, the depth of her loss, and bases for her present yearnings.

T: I wonder what's different now in you...

D: I think facing the things with my father. And facing the pain. And now starting to realize that I will love both of my parents, but they were not too much of what I needed. Just being more realistic about...

As Diana began breaking free from the prison in which she had held herself in the past, she began to let go of the pain from early deprivation.

D: Yeah. Even if I had thrown my body onto him, it wouldn't have stopped the beating. He would have beaten two people. I must have known that.

T: Perhaps it stayed with you so long because it was so painful. At first, you didn't remember it...

D: That's true.

T: So it's hard to work on something you don't remember.

D: I'm sure it's my dad who feels guilty! I am letting it go. I think a lot of the sadness is realizing that, in a way, I did waste 26 years, trying to make up for it. This is why I want to start having some fun! (laughs).

In therapy, Diana realized she had greater freedom of choice than when she was a child. She became aware of her patterns with men, their roots and their inappropriateness to the present. She consciously worked on catching herself while acting out the pattern, and stopped to reflect, decide and choose. She experienced a growing sense of living her real life. Blame of her parents shifted to an acceptance of them as imperfect human beings, and to a taking on of
responsibility for her own present and future.

Diana recognized that it was she who was adult now, and that she could initiate a new relationship with her parents. She realized she could make an impact as an adult, and began to reach out to her parents by writing, saying what she wanted.

T: In terms of the mouth, that's been stopped for so long.

D: Yeah. And I wrote my mom a letter. I told her I would be calling her in a few weeks and that I really loved her a lot. And I hoped that we could straighten all this stuff out. But that she's going to have to be willing to listen to my anger. And um... listen to me. What I'm saying, for once.

And I also said, I remembered when my mom was in her mid-30s, and she tried to talk to her mother. It was a real big scene. She was crying. They were driving away from my grandmother's house and everything was horrible. And, of course, my grandmother didn't listen to her. And they never resolved it. So I brought that up and said, wouldn't it be nice if we could change this problem between mother and daughter.

Diana began to examine how she had expressed herself, even in the way she dressed.

D: Um... but I was the mother figure, very much so. I was helping L get out of a really big mess. That was the turning point of her life. Because she was 20. And M was starting to become an alcoholic at that point. And I was wearing these very high-neck things... I mean, now I see these glasses and I think, "Why did I pick those?" They were like what older women, around 55-60, wear? Those kind of glasses? That's what I was wearing. Very old-lady type shoes. And, in fact, when my mom came to see me, she brought all these creepy clothes up! That she bought at the swap shop. And I said, "I can't wear any of those things." She had the idea that I was always going to dress like that.

Dream Dialogues: Last Half of Therapy

Diana began discovering repressed parts of herself through inner dialog with her dream images. She was able to contact authentic
aspects of herself in dreams.

D: Alex called me a baby, a spoiled brat. I had trouble seeing myself with my own eyes. . .

T: In the dreams, you were able to take a look. . .

In therapy, Diana strengthened her thinking function through trying to understand and comprehend her experience conceptually and cognitively, as well as emotionally. The task was to help make her world comprehensible. Her conceptualizations were initially vague and tentative; she didn't boldly put forth concepts for fear they would not really explain her own process. She had more trust in what she felt or intuited about her life.

Although she was an intelligent woman with the capacity for articulation, she had difficulty speaking clearly, because literally nothing was clear. Her depression reflected the muddy, murky state of her psyche. Consciously focusing on her dreams and interpreting them were an initial step in transforming the language of the unconscious into the language of "daylight" consciousness. Naming her experiences had the effect of comforting her. Each time she comprehended why things happened as they did, she freed herself further from the sense of the helpless arbitrariness of the world, and from her own sense that she had caused early rejection.

Diana acquired the ability to work on behalf of her own growth. The inner caring figures helped her become more emotionally self-reliant. Her capacity to think in depth developed as she reflected. The following dream represents a softened superego and helpful inner resource inside Diana.
Mr. Jones, the top boss in our office, was asking me if I wanted a promotion. Actually he was looking at me and saying, "Anything you want to do, you can do. Just let me know, so I can help you."

This dream is in striking contrast to her initial dream of the indifferent male watching the bleeding dogs, or shooting a woman in the back.

Diana began to think about investing in a career. Her animus helped her to run forward toward new possibilities. The deepest level of hope is manifested when one begins to contemplate a serious life project. There was an accent on the future, and a belief in the meaning of her own life which was antithetical to suicide. One's ability to imagine inner strength can be the first step toward realizing it.

Then I was outside talking to the gas station owner. An older man with gray in his hair. We had our heads together and were talking in low tones. We were kind of walking, maybe touching shoulders. We were talking, looking at the ground. He was taller than me, but confiding in me. I felt really good... calm. I was attracted to him, also. I felt much better being around him. A Latin woman said, "Three Cuban babies will be hard to find." Then the older man put his arm around me in a comforting way and told me, "You have the strength to face a tough reality."

As the inner man became more nurturing, she began to feel a sense of purpose in her life as she planned a career which encompassed creative activity valued by her--landscape architecture.

Transference and Relation to Therapist: Last Half of Therapy

Diana began to explore what things were actually like for her. She addressed her initial fears of being neglected or abused by the therapist.

T: Do you have any notions about why this came up for you right now?
D: Well, I finally got the nerve to ask you!! I've been curious all along (laughs).

T: What do you think would have happened if you had asked me, back when we started working together?

D: I thought... that I shouldn't ask you. If it wasn't explained to me that I shouldn't ask.

T: And if you had asked anyhow?

D: Oh, I... I just didn't ask because I don't know... shyness or whatever... I wasn't afraid to ask you just now, but all this time I was. Hmmm.

One therapeutic task was to help Diana to "ground" herself in her own experience.

D: Yeah, but see, I now feel that I've gotten some... real groundwork done and I don't want to screw up. Even if it takes a long time. I'd rather go this way. Because I do feel that I've gotten... I do feel more integrated than I've ever felt. I don't feel this anxiety all over the place all the time. I get extremely sad and really depressed, but I don't feel like committing suicide anymore. So... I feel like I finally got my feet on the ground for the first time. I want to keep going in this direction.

Diana's sense of the reality of her self increased.

D: The car dream. I don't really understand this male-female thing, but I think it's real, I mean, I feel that it's real. I feel like before I was a completely cut-up person, part of me was not coming out. Part of me wasn't growing.

A major therapeutic aim was to help Diana engage more authentically in therapy, to take risks in deviating from her usual ways of relating until she could reliably differentiate the therapist from her mother/father, the world, her imagoes.

D: I did feel really afraid right now, even after talking about the dream, and understanding it more. I feel very afraid.

T: Can you get into... what that fear is about...?

D: It has to do with hurting people.
T: That unleashing this power on the world will leave a litter of dead people in its wake. . .

D: Yeah.

T: You wonder if Alex's been acting out in the world what you've been acting out in your dreams, and against yourself in your suicidal moments.

D: It must be more than anger!!

T: Getting in touch with it here. . . I won't die from it.

As therapy progressed further, Diana began to ask for what she wanted—validation of her perceptions, recognition of her value, respect.

T: Maybe we can go back again, because I think I missed something here. . .

D: About you??

T: That you care whether I trust you?

D: Right. That's why I kept thinking. . . remember I said I wanted to bring in Alex's book of poetry? Because I wanted you to see that it was real, what I've been telling you was real.

Then I wondered, why would I think that she (therapist) doesn't think it's real? Then I thought that I'm not positive that she (therapist) trusts me.

T: When you first came to therapy, you wondered who would take you seriously. That it would matter to you that I take you seriously. That it would be important. That I would trust that when you talked about your experiences, trust that you were rendering them as they were for you. That is, your experience, is real. And would I take it seriously?

Diana experienced a new way of attaching, based on the true response of another.

D: Well, I will always think about you, so it isn't just curiosity. I'm getting really upset now (tears in eyes). (Cries quietly).
T: It just struck me how emotionally distant that may have sounded to you, what I was just saying.

D: (Silence) Um. . . I think you're the only person that has ever been really honest with me. And also you're the only one who's ever helped me. So it's very, very upsetting that it's going to end. But I also want to know what you're going to be doing with your life because I'll always be thinking about you.

The main therapeutic task was to assist Diana in healing the severed connection and deep wounds of childhood, to connect the child and adult self, so Diana could be a good parent to herself. It was hoped that Diana internalized a stable, caring object to strengthen and solidify her inner psychic foundation. This strengthened ego could then serve her as a source of energy, protection, vitality, freshness, replenishment, security, comfort, safety, humor and love.

As therapy evolved, Diana developed a new view of herself as worthwhile.

D: I'm sure I was an affectionate and pretty baby. I would have loved me.

T: Maybe you still can. . .

Diana recovered some capacity for experiencing life more directly, including moments of delight.

D: I guess I can pretty much rely on my dreams, I mean being able to understand myself better in that way.

T: (Silence)

D: I want to tell you one thing, though. I hope this cracks you up and doesn't upset you. When you first told me (indistinguishable), every time I looked at you, I loved your dimples!!
T: (laughs).

Diana's hopelessness was gradually replaced by an inner conviction that it was of value to continue living.

Projections/Logos Behavior: Last Half of Therapy

The impersonal nature of Diana's attractions to men was a sign of their transference or projective base. A man was a need-filling object, whose reality was overlooked. As Diana withdrew her father projections, her sense of reality improved and she could make better judgments as to men's suitability.

T: I wonder if you worried you'd lose him?

D: Oh, I was, I was. Definitely. I still have a long way to go on my self-esteem, but then I had very little confidence. And I was amazed that this man wanted to go out with me at that time. I just thought he was gorgeous. Not just physically, but everything he was doing, poetry and everything, being older... I was swept off my feet, kind of. It was very romantic, but it was not realistic.

Diana did less objectifying of herself and more asking, "What am I experiencing?" Her task was to go beyond the "seeming" appearance of things, especially in her relationships with men, into the reality.

T: How do you see it now?

D: I think it was a sign. And I completely ignored the rest of the signs. He's not the right kind of person for me. Unless... see, I always think there's a little hope, though! Unless he would change, which he's 45 years old. He's done everything he could to show me that he's never going to change.

For Diana, taking herself seriously meant accepting her desires for intimacy as valid, and actively doing the work of self-development necessary to achieve her goals of professional and personal satisfaction. As her relation to the masculine principle improved, she felt
strong enough to assert her needs, and to tolerate losses and dis-
appointments without a severe depressive reaction.

D: So I said to Alex, "Oh, ok." So I get off the phone and
said, "What a jerk!". I mean, he wants to meet me a 6, have
dinner, run home, have sex, and run away! By 9:30. So I
called him back 5 minutes later. He did get away
with this 3 or 4 other times during the time I've known him.

I said, "Alex, I, um, haven't told you something that I
don't like. But I do not like time limits." And he said,
"Oh," and he was very shocked. He tried not to be and said,
"Well, no, you haven't told me this until now." And I said,
"Well, yeah, I'm going to be telling you a lot more that I
haven't told you!" (laughs) And I kind of laughed! You
know, I was trying to keep it light, but it was very to
the point. So he said, "Alright, then maybe we can just
say goodbye. That's it."

As Diana realized feelings were not mutual with Alex, her fan-
tasizing was replaced with a desire for reality, or the truth of the
situation in relationships. As self-regard was strengthened from
the inside, she had less need to use men as validating "mirrors" to
show that she was acceptable. She took responsibility for ending
this relationship for conscious reasons.

Diana began to acknowledge her increasing wish for mutuality
of investment and for a committed relationship. She started to
balance her own wants and needs with those of others. Her psycholog-
ical autonomy increased as she began "leaving" the bad introjects
and their projections in boyfriends.

T: When you said you felt like beating Alex up, what did you
mean?

D: I think he did feel something for me at several points.
And the anger was for his killing the feeling that he had.
And he just passed it off like it was nothing. That doesn't
make me feel too good about the kind of person he is. I
think it's really cruel.
T: Does that killing of the feeling... is that something unusual?

D: No, my father... even though they're worlds apart in other ways, that one thing is exactly the same. And it must have been the very seat of the attraction. That's why if I was attracted to someone like that again, I would not allow it to go anywhere. I would just keep trying to work with it.

As Diana began to feel stronger, she contemplated asserting herself with others in her life. At first, she was afraid of destroying others with her anger, or being injured in return.

D: ... if he really knew what I was thinking... he would fire me. Which I don't care if he fires me. It makes me uneasy, but I don't want to be there very long anyway.

But what bothers me is he is a 62-year-old man. I would be crushing him, if I said what I really thought. He's lived this way all his life. He's not going to change. Who am I to try to change him by saying what I really feel? But if I told him "I think your jokes stink?"

Diana related her "holding back" from saying what she wanted to its early roots.

T: Now wait a minute. Did you think that if you had kept telling the truth, maybe they would die?

D: Yeah!! I felt like they couldn't take it. If I really said the truth, they could not take it.

T: So you stopped telling the truth.

D: Yeah.

T: To save your family. Did it save them?

D: They're still alive, physically, but I consider them all dead. Still, even now.

Diana began testing out the expressing of her true self.

T: So you told her you were angry, and what happened?

D: Well, she immediately called me.
T: You mean she didn't fall apart?

D: No, she didn't. She didn't fall apart.

After further strengthening of the animus, Diana felt more comfortable speaking her mind.

D: I also feel a very great need to start telling these people... I've thought about teaching again. If I did, I'd try to hear the children's voices instead of telling them to focus on something outside of themselves.

T: Making your voice heard... this reminds me of some of your dreams. Like the mouth that got closed when people didn't want to hear what you had to say. And the fear that if you said what was on your mind, that you would be killed or someone else would be, for punishment. It sounds like your mouth is getting unstopped.

D: Yeah, it's really going overboard! (laughs)

Diana developed strength and autonomy within herself which had previously been projected onto her father. She regained the ability to passionately assert and object.

T: You were depressed, and now you are "yelling" at men at work. What's going on?

D: I know! It's completely different. I know they expected me to run out of there crying. I left and got the mail. Came back. Then the two guys left for a business meeting (laughs). They came back around 2:30 and I could tell they were watching to see what was going on (laughs). It was really funny. And then Ed and I didn't talk the rest of the day.

T: How is that related to the letter to your dad?

D: Well, I feel like I'm finally realizing why I was afraid to talk, because of that dream. And that they're not going to hit me. That I can say what I want to say. I know I've been doing a good job.

Diana began to see that what she did could make a difference.

D: My teacher calls me by the name "Brune," mispronouncing my name. But I liked him so much that I didn't want to say anything. Then Wednesday night, I didn't plan on doing
anything. It's a real big class and I didn't want to say anything. So he called my name and immediately I said, "Brown!" real loud. And I didn't even know that I was going to do that! So he stopped, looked up and said, "Oh, Brown." (laughs) And I said, "Yeah" and he kind of laughed (laughs). And he just went on. Because he's been calling me by the wrong name the whole semester!

Diana affirmed her singular self, with more presence, pride and substance. Her relatedness was built more on the real, with less playing and pretending. In the next example from therapy, Diana told her top boss not to call her by his invented name for her, "Blatz."

T: Blatz?
D: Yeah (laughs).
T: (laughs)

D: Yeah, It was funny, part of it was funny. When I changed my last name, he got mad. He's sort of a fatherly figure. Because I didn't tell him anything about it. I didn't tell him because it's none of his business. But he does like me, and he does have a sort of fatherly attitude.

So when I came in, he was also in one of his moods that day. And he was really angry. So he just... I told him I thought my new name was more poetic. I mean, because I didn't feel like I needed to go into explanations. So he said, "Well, I think 'Blatz' is more poetic! Diana Blatz, how do you like that?!" He was really grouchy that day. So then it stuck. And from that time after, for six months he called me "Blatz." He never called me Diana. He never called me Ms. B. He called me "Blatz."

Then the general regional manager who got transferred there started calling me Blatz. Then Ed started calling me Blatz. It was just all the time! But I never did anything about it.

T: What was bothering you about it?

D: I felt that my name change was a real important thing in my life. That it was a serious decision. And that I wanted to be respected. That I didn't think he was giving me respect. He was also patting me on the head like a little kid.
T: So he wasn't taking you very seriously.

D: Yeah.

T: Which recalls to me the very first session when your friends were not taking you seriously. So here it is again, the not having what you experience or think or feel taken seriously.

D: Right. And in this case I can see why. I mean, I let him do it. And I laughed along with it for a long time. Until it built up to a point where I finally said something.

T: When you talked to him. . .

D: Well, I was on the point of crying. I told him I didn't feel I was being respected. He said he never meant any harm by it. And I said I knew that. And then he said, "You know, you are very much respected here. And there is an opening and we definitely think you can handle it." And I said, "Yeah, yeah, I know." But after that I didn't talk about it because I was on the point of crying. So he said, "So, if you have anything else to talk to me about, don't wait so long. Just talk to me." And we have a very good feeling now between us. There haven't been any more problems.

In a similar way, Diana chose to stop "helping" women so much, since it left her feeling ripped off and robbed with the lack of mutuality. She turned over responsibility for their lives and growth to her mother and friends and turned her focus on her own development. She learned to set limits to others' demands.

D: In fact, it was a Monday morning and I had just put my phone back on and she called just before I went to work. And she said, "Are you alive? I've been trying for two weeks to call you." And I said, "Yes, I am. I took my phone off." And she said, "Why?" and I said, "Because when it's not an emergency I don't appreciate being woken up early." So she said, "Well, you could have at least talked to me about it." And I said, "I've been telling you for fifteen years!" (laughs)

Diana began to contact her true wants: to finish school, maintain an affectionate relationship, move toward a more meaningful job.
D: I don't know if I want to have a family, and I don't know if I want to have a husband and maybe Alex would be a great person to have an affair with for a long time. But I do need the affection. And I get very angry when I don't get it. And I'm finally realizing that. But I never expressed that to him. And I let him do what he wanted to do. And he controlled everything. I would have a lot more to say now than I ever said. Now I would say a lot more.

With her animus strengthened, Diana exerted more power over her own life to shape her future in the direction she wished.

D: Sometime I'd like to finish (laughs). I really respect people who really know a subject and can do something with that. Do you think that will just take care of itself by going to school?

T: What do you think?

D: I have to take care of myself; I guess "it" isn't going to take care of anything! (laughs)

Diana (at the close of this phase of therapy) had decided to enter a career in landscape architecture or horticulture, combining nurturing with art, and perhaps a reconnection with a more primal Mother. There was an openness to the possibility of marriage and children. This phase of therapy with me ended with the feeling that Diana could move on in life from here.
CHAPTER V

INTEGRATIVE PROCESS STUDIES AND
THE STRUCTURAL ANALYSIS OF SOCIAL BEHAVIOR

Integrative Process Studies

There are no empirical Jungian process studies in the literature, to this author's knowledge. However, there are a limited number of investigations which share either a focus on a) $N$ of 1, b) clinically meaningful process variables, c) empirical analyses of change patterns and/or d) the use of a sophisticated scoring instrument. A few of the more representative and best-designed studies will be reviewed to provide a flavor of current research in this area. To say that a coherent body of findings has not emerged is an understatement, and reflects the state of the field.

One group of researchers has focused on developing instruments for measuring subtle process constructs. Some of the variables measured have been: newly emerging unconscious material (Horowitz, Sampson, Siegelman, Wolfson, & Weiss, 1975); patterns of clinical states (Horowitz, 1979); phenomenological experiencing in dyads (Barrett-Lennard, in press); the client's internal perceptions of therapeutic interventions (Toukmanian, in press) and interpersonal attitudes in therapy (Orlinsky & Howard, in press).

Exploratory studies. Some researchers have attempted simply to
explore and identify key mechanisms of process change inside therapy, without explicitly linking their findings to final outcome. These investigators have attempted to "map" or take a snapshot of the inner workings of therapy, similar to a physician looking inside the abdomen during a puzzling exploratory surgery. Those who are conducting exploratory research do not claim that the process patterns they discover and report discriminate between good and poor outcome. They are doing the spadework so that others can check the patterns with other cases.

Horowitz, Sampson, Siegelman, Weiss and Goodfriend (1978) conducted a case study of one female client in psychoanalysis. The authors postulated two major interpersonal processes: cohesive (moving toward others) and dispersal (moving away from or against others). It was assumed that in a successful analysis the patient becomes more able to experience and express both sets of behaviors directly and initiate them by conscious choice. The patient was a woman who had initially poor controls. She felt she could not straightforwardly do what she wanted. She would, for example, yield when she wanted to express anger and would convey anger when she wanted to be affectionate. In addition, she would sometimes be inhibited while at other moments explode.

The researchers simply examined changes in both cohesive (affiliation) and dispersal (non-affiliation) behaviors across the first 100 hours of analysis. Three independent clinicians identified therapy segments containing C and D behaviors. A 4-point scale was developed to assess the direction of C and D stances. Each segment
was rated by four naive psychologists, according to rules not clearly specified in the study. It was found that directness of expression for both behaviors had increased, but progress in dispersal preceded improvement in cohesiveness.

Authors concluded that the patient first had to feel grounded and consolidate her own psychological differentiation from others before she could engage in affiliation with others. When she could comfortably disagree or disengage from others, she could move toward them with less unconscious conflict. Presumably, she could more consciously choose which impulses to express.

One research group wanted to understand the process involved when a client experienced a depressive mood during therapy (Luborsky, Singer, Hartke, Crits-Christoph, & Cohen, 1984). Essentially, the group wanted to examine the sequence of states which occur as one client enters and then shifts out of a depressive mood.

The therapist of Mr. Q (client) completed a checklist indicating whether depressive mood shifts had occurred after each of 244 therapy sessions. The investigators selected 10 of these sessions for transcription. Only the nine segments in which mood shifts occurred were rated on a 5-point depressive mood scale. Inter-rater reliability was reported to be $r = .75$.

The process variables which changed most before and after the shifts in depression were helplessness, hopelessness, loss of self-esteem, feeling blocked by self or other, and guilt/hostility toward the self. It was noted clinically that the moments of shift occurred when the patient was experiencing changes in relation to the therapist.
Stress with the therapist preceded shifts to client depression, while feeling close to the therapist preceded liftings of depression.

Elliott (1984) wanted to know what he could find if he directly asked the client and therapist to name the most significant moments of change. Essentially, the author wondered what happens before and after an insight is achieved. The client and therapist in this study separately identified the most important events of each session. Then four episodes were pulled for rating. Each episode contained an "insight event" and was 3:12 minutes in length; for example, "Oh, the dream meant that...I've never thought of this before!". The events were rated using Elliott's Interpersonal Process Recall instrument.

It was found that just before an insight occurred, the client was actively struggling to understand a core interpersonal issue, and felt distressed but working. The therapist then interpreted in an affiliative context, and the client experienced an inward sense of cognitive/emotional newness, relief, accuracy and alliance with the therapist.

Patient transference was a salient process variable for Luborsky, Crits-Christoph, and Mellon (1986). They reviewed a few measures which have attempted to capture transference phenomena. The most unstructured measure reviewed was free clinical formulation, in which therapists simply used their own experience to judge the amount of transference present in 30 5-minute therapy segments. There was relatively low inter-rater agreement (.46). However, most agreed that there were higher amounts of affect in high transference states.
The next measure briefly reviewed was PERT (Patient's Experience of the Relationship with the Therapist), which was used to guide clinical judgment. A reliability of $r = .63$ was reported for PERT. The authors then offered a new measure of transference called CCRT (Core Conflictual Relationship Theme). The system was designed to help clinicians judge what the central relationship patterns were in each session.

Ten relationship episodes were isolated from nine patients' analyses. Episodes were selected from two early and three later sessions. Each episode was rated using CCRT to determine the patient's wishes, the other's response, and the patient's response. Reliability was reported at $r = .88$.

The group concluded that CCRT was a reliable and useful measure of transference and therapeutic improvement because results tallied well with nine ideas which Freud had offered about transference:

1) As Freud had theorized, it was found that each patient had one main transference theme;
2) each patient had a unique transference pattern;
3) there was an erotic base for transference patterns;
4) patients were judged to be aware only partially of their own pattern;
5) there was a consistent pattern over time;
6) nonetheless, a change in that pattern was possible with therapeutic intervention;
7) the relationship with the therapist was a good example of the patient's transference pattern;
8) it was judged that the pattern had early origins; and
9) transference occurred both inside and outside of therapy.

Russell and Trull (1986) discussed the need for analyses of therapist-speech sequences in order to better specify mutual influence
patterns in therapy. They recommended that more studies focus intensively on one dyad at a time. In their review of sequential analytic studies they reported that 1) non-controlling therapist interventions occurred before client insight; 2) penetrating interpretations aroused more client resistance than moderate ones; 3) client hostility was followed by novice therapists' avoidance.

Cooke and Kipnis (1986) explored the process of therapist influence on the client. Five female and six male therapists each submitted two therapy tapes. The parts of each session containing "influence acts" were pulled for rating. Ratings were on 5-minute segments and were selected from the beginning, middle and termination of each session. Each time the therapist spoke was coded on a 7-point scale for strength of attempt to influence (weak to strong) and for goals of influence (interpretation, information seeking, instruction, etc.).

The authors found that male therapists tried to influence and pushed for a response significantly more frequently with women clients than with men. Both male and female therapists told women clients what to do more often than with male clients. It was concluded that the process of therapist influence may be influenced itself by cultural stereotypes in which women are portrayed as weak childlike creatures with little power.

Two groups of researchers have recommended the multiple case design for future exploratory process research. The Menninger group recommended studies designed to track shifts in the therapeutic alliance within one session or case (Frieswyk, Allen, Colson, Coyne,
Gabbard, Horowitz, & Newsome, 1986). Another group called for a series of systematically and theoretically comparable/contrasting cases to be studied and replicated (Howard, Krause, & Orlinsky, 1986).

Process studies: Hypothesis testing. Most process studies, by definition, do not focus on outcome but rather on inner shifts during therapy. A few have attempted to test hypotheses about which processes are signs of clinical improvement, and which processes may discriminate between good and poor outcome. The following is a representative review.

One group predicted that one client's dreams would move toward a more transformative mode across therapy. They collected 654 dreams culled from 5⅔ years of baseline pre- and during-therapy dreaming. The dreams were divided into 10 time-segments of 6 months each. Dreams were rated according to the Process Scoring System, developed by the authors. It was found that the client's dream and behaviors simultaneously moved toward more direct and complete expression of feeling as therapy progressed (Corriere, Hart, Karle, Binder, Gold, & Waldenberg, 1977).

In an interesting clinical study, Horowitz, Marmar and Wilner (1979) analyzed one female patient's shifts in states of mind across 12 sessions of psychodynamic therapy. It was predicted that certain states would increase or decrease across therapy. Configurational analysis was used to assess change by comparing state frequencies and qualities at different times in therapy. Ten-minute segments from the second half of each session were randomly ordered and rated. There was a 72% agreement rate on the time of state transition and
naming of the new state.

The initial client problem states were depression, or "hurt but not working" and "artifical and engaging." The group identified triggers of these state patterns. For example, when feeling abandoned or rejected by a person she cared for, the client changed from the "artifical and engaging" to the "hurt and not working" state. This descriptive state analysis contributes to the model of the client's cycle of states. The client moved in therapy toward her ideal state of being more authentic, competent, vigorously engaged, self-confident, happy, honest, and womanly.

A few years later, the group reanalyzed the same client's sessions (Marmar, Wilner, & Horowitz, 1984) for quality of states. They reported inter-rater reliabilities of 74% agreement rate, and Cohen's kappas of .59 and .63. Essentially, they found that the patient became less hurt in the "hurt but working" state as therapy progressed. They also found that the exaggerated part of the "artifical but engaging" state had diminished over therapy.

Greenberg (1984) was interested in the process variables of client splits, or conflicts. These are moments when aspects of oneself are in opposition. For example, "one part of me wants it, and one part of me does not." The author wanted to study how clients resolved these splits right in the therapy session.

According to Greenberg (1984) the ideal Gestalt theoretical pattern for this resolving of conflict occurs when the client separates and creates contact between the two opposing parts of the self. A dialog ensues, in which the validity of each part is
recognized, and the client responsibly owns both views. The client then tunes in to and heightens the experience of each part of the conflict by embodying it in the session. It was suggested that a forum for one part talking to the other is the empty chair.

Client splits in session were rated on the Experiencing Scale. The author found that in successful cases, the internal critic softened its attitude. The two initially opposing parts became integrated by a process in which one side experienced itself more deeply while the other side became more affiliative. Detailed measures of these process patterns validated Gestalt clinical constructs.

Rice and Saperia (1984) examined one client's successful case to discover what process components were key. They examined the two most successful sessions and isolated instances in which a client was having a "problematic affective reaction" such as "I overreacted to Jim." Each client response was rated on task analytic categories such as focusing inward, reexamining value systems, etc. Inter-rater reliabilities were reported as kappa = .68. The authors concluded that a successful client went through a certain process to resolve affective tasks. This process involved an emotional re-experiencing and reprocessing of a problem, exploration of subjective construals of the situation, and thinking of new options available when confronted with such a situation again.

The investigators also hypothesized that segments in which the client was entering a new inner awareness would be rated as having a focused vocal quality, while responses reflecting others' views would be rated as having a limited or "thin" vocal tone. Hypotheses
were supported and it was concluded that clinicians can use vocal quality as a process index of the client's awareness of change.

Pinsof (in press) wanted to know what processes discriminated between advanced and neophyte therapists. He developed a sophisticated instrument called FTCS (Family Therapist Coding System). Eight experienced and eight novice therapists were taped conducting the first session of 16 different cases. Three 5-minute sessions were coded according to FTCS categories for each tape. After 30-60 hours of training, inter-rater reliability was 75% agreement, with a kappa of .63.

Results showed that advanced family therapists were more active, used a wider range of interventions, were more interpretive, more attentive to sequences and to communications of feeling between family members. The trainees were more focused on family content, rather than relationship process. It was found that advanced therapists honed in more on painful affects, self-defeating behaviors and on the marital couple.

Measuring the Process of Change

How can process patterns associated with clinical improvement be tracked or analyzed? Because therapy process research is a relatively new area of scientific focus, many investigators are struggling to invent useful instruments and methodologies (Greenberg & Pinsof, in press). Kiesler's (1973) book, the first devoted exclusively to process research, summarized most of the existing therapy coding systems. It was noted that the operationalization and measurement of theoretical constructs was in its infancy, so that critical evaluation
or integration was not attempted, since it would be premature.

The goal of Greenberg and Pinsof's (in press) handbook is to stimulate research on process, and to discuss the best and most innovative models since the '70s. Only in the last 10 years have instruments for measuring the process of therapy reached any level of sophistication. Nonetheless, there is still little cumulative knowledge about what goes on inside of therapy. "... The indices yielded by existing systems of process-analysis emerge as rather primitive and crude attempts at objectifying human events that are elusive in the extreme" (Suh, O'Malley, & Strupp, in press).

Selection of Clinical Variables

Each personality theory presents a vision of ideal in-therapy movement or process which signifies improved psychological functioning. How can that process be measured? First, clinically meaningful variables must be selected, formally defined and related to other key constructs in the theory. The variables are then operationalized, and tied to a coding system's categories by specifying appropriate rules of correspondence (Shontz, 1965). The coding system is used to track patterns of change in the variables over time. The Jungian process variable of animus development was selected for this paper and has already been discussed in Chapter III.

Selection of Samples From the Therapy Course

When one is interested in describing the events of an entire psychotherapy course, one must sample or be overloaded with data (hundreds or thousands of pages of transcripts). Many researchers take one sample from each interview. The sample must be coherent
enough to yield meaningful results. Benjamin recommended that
"intense but relatively brief highly relevant samples be selected"
(Benjamin, Foster, Roberto, & Estroff, in press, p. 11). Sampling
represents a judgment call; most researchers have sampled 5 to 20
minute segments of each therapy session. Within each segment, what
units ought to be scored? Each coding system has offered its own
solution—theme blocks, syntactic units, etc. Benjamin, Giat and
Estroff suggest in their manual (1981) that elements representing a
complete psychological thought be rated. This paper's method uses
one page of transcript as the "meaning unit" to be rated.

**Selection of a Coding Instrument**

How can one code or rate process? A variety of coding systems
have been developed to measure the essential aspects of therapy.
Kiesler (1973) and Greenberg and Pinsof (in press) have reviewed
major process instruments. Most systems were developed to make
publicly visible what had previously been clinically intuited.
There is no general system in use because the basic constructs of
psychotherapy process have not yet been well-operationalized. Given
that there are no standard measurements of process, Benjamin et al.'s
(1981) Structural Analysis of Social Behavior (SASB) was selected
because of its strengths vis-a-vis other systems.

**Strengths of SASB**

a) The SASB is well respected by researchers in the field. "The
recent circumplex model of interpersonal behavior presented by Benja-
min... is the most detailed, clinically rich, ambitious, and con-
ceptually demanding of all contemporary models" (Wiggins, 1982,
Benjamin's system received plaudits from Pinsof (1981) as being high on reconstructivity, or the ability of an instrument to allow clinically meaningful reconstruction from its abstract coding categories. Strupp (1985) personally recommended the SASB's use for this study (personal communication).

b) The SASB is a general purpose or omnibus system. Items were derived from theory, yet coding language is sufficiently atheoretical so that the SASB can be applied across therapeutic modalities (family, individual) and orientations (Freudian, Gestalt). The same categories can be used to rate any communication in a session. The SASB can be used to code the verbal responses of any and all participants (therapist, client) and even intrapsychic events such as dreams.

c) Kazdin (1980) noted that measures with demonstrated validity and reliability increase confidence in conclusions drawn about whether change has occurred. The available reliability and validity data argue for the use of the SASB. While not extensive, evidence shows that the SASB is the best validated and most reliable of the process instruments at the present time. As Rice and Kerr (in press) observed, most studies of process are of necessity testing the coding instrument as well as the hypotheses.

d) Benjamin's system has shown its value by its being used in a constant and expanding manner (not one-shot). It has been widely applied by other investigators, adding to the cumulative knowledge in the area.

e) Benjamin's system is manageable yet it retains complexity; it is not an overly simplified model. Benjamin's categories are
specific enough to be observable, yet rich and contextual enough to be theoretically meaningful. The SASB has two generic dimensions, yet highly specific points along these dimensions to adequately characterize complex process and differentiate among subtle clinical states. Of course, no instrument can be expected to comprehend the entire complexity of therapy process, but Benjamin's circumplex has been shown to be sensitive to subtle process change and patterning.

f) Benjamin's instrument was chosen because her autonomous/affiliative categories can be viewed as central to the animus problem. This investigator judged that Benjamin's SASB affords an interpersonal evaluation of animus development; that is, raters can assess the quality of relatedness between internal objects (dream male figure and female dream ego), between the client and her inner world (the dream male figure's impact on her conscious experience and behavior, and her own conscious interaction with the inner male) and between the client and her outer world (the therapist and others in the external environment).

Does Benjamin's model provide a satisfactory index or measure of the concept it was designed to evaluate? Since there is no Jungian measure of animus development, it is unknown whether SASB is a valid reflection of this construct. This study is partially a test of SASB's validity when applied to a Jungian concept. The SASB system was derived from Sullivanian theory, and not from Jungian theory; however, the SASB was judged to be the closest expression of animus development available. SASB can tap the three manifestations of animus development (dreams, behavior, projection) via autonomy and
affiliation changes.

Animus development is what Shontz (1965) would term a "level 4" concept, that is, a "postulated process that incorporate(s) a variety of phenomena into a single, more inclusive unit" (p. 40). Animus development is a phase in a woman's life which may induce her to behave in certain ways. The categories on the circumplex describe some of the ways of behaving that are characteristic of people undergoing change in relation to their own animus. The sample of behavior represented by circumplex categories is incomplete, and therefore the model will not necessarily identify all aspects of animus development nor all persons undergoing change in this way.

Limitations of the SASB

The SASB is similar to all process systems in that it is still at a basic stage of development. There simply are no models yet that have been designed exclusively for measuring process. Although Benjamin reports the most extensive reliability and validity data in the field, reliabilities obtained have often been moderate, even after literally hundreds of hours of training and the use of generous kappa coefficients.

To some extent, the validity of the model rests on the validity of the underlying Sullivanian theory. No personality theory can claim to be "valid" at this time in history. Thus, it is not certain whether Sullivanian constructs are adequately conceptualized or whether they are the most "key" factors in human transformation. Each paper which applies the SASB is testing its validity.

Even though the model's categories are complex, no system can
begin to measure the thousands of variables in a psychotherapy course which affect outcome. The patterns or configurations of these variables which distinguish good from poor outcome is not yet known in any consistent or cumulative way.

**Benjamin's Circumplex**

Interpersonal constructions of personality and pathological behavior arose from Sullivan's neo-Freudian theory. Researchers in the area have sought to invent a systematic language to describe and measure interpersonal transactions (Wiggins, 1982). According to Lanyon (1984) "... the circular or circumplex model has particular advantages and is perhaps the most appropriate integrative conceptual approach to personality structure" (p. 671).

Wiggins (1982) reviewed the major circumplex systems. Two dimensional models reflecting a circular ordering of variables are called circumplexes. Variables are located in two dimensional space. For example, in Benjamin et al.'s (1981) system, interpersonal variables may array around and represent blends of the two central dimensions of affiliation and interdependence. Circumplex models attempt to measure the structure of interpersonal experience and behavior, and changes in that structure (Wiggins, 1982). Thus far there is no consensus as to which interpersonal variables are most important or which measuring methods are best. Since there are no standard circumplex models in use, Benjamin et al.'s (1981) system was chosen for this study for exhibiting the unique strengths already cited. For a more completed review of the relation between the SASB instrument and other circumplex models, one can consult Benjamin's (1974) article.
**Description of the SASB**

The SASB is an observer-based, circumplex rating system designed to provide an interpersonal classification system (Benjamin, 1984). The SASB model is related to the work of Murray (1938), Leary (1957), Schaefer (1965), Lorr, Bishop and McNair (1965) and other researchers using circumplex models to measure social behavior (Benjamin, Foster, Roberto, & Estroff, in press). The system was derived from the Sullivanian notion of the importance of an interpersonal relations context for understanding a particular behavior (Suh, O'Malley, & Strupp, in press). Benjamin’s model measures subtle social relations and their intrapsychic counterparts (Benjamin & Humphrey, 1985).

The SASB interpersonal circumplex is represented by three planes, distinguished by interpersonal foci of attention, and comprised of two orthogonal dimensions. The model consists of 36 descriptive interpersonal categories or statements arrayed in a circle. The first plane is Focus on Other and involves attention and energy directed toward another. The second plane is Focus on Self and involves one's own responses to another. The third plane is Focus on Introject, and involves actions turned inward on the self. The horizontal axes of all three surfaces represent the dimension of affiliation while the vertical axes describe interdependence. Two foci of the SASB model are presented pictorially on the next four pages (Benjamin, Foster, Roberto, & Estroff, in press, Figures 1-4).

For each Focus, the affiliation scale describes varying degrees of friendliness on the horizontal axis. The vertical scale describes degrees of interdependence, from controlling to autonomy-giving,
FIGURE 1. MODEL: STRUCTURAL ANALYSIS OF SOCIAL BEHAVIOR: SASB
FIGURE 2. MODEL: STRUCTURAL ANALYSIS OF SOCIAL BEHAVIOR: SASB
FIGURE 3. STRUCTURAL ANALYSIS OF SOCIAL BEHAVIOR: THREE LEVELS OF COMPLEXITY

The SASB model is presented at three levels of complexity. The simplest level, the Simple Diamond, is at the center of the figure (Quadrants I-IV). The middle section provides names for 8 subdivisions called Clusters. The outer ring of boxes is called Fine Points, and is designed to give coders a highly specific description of the nature of each model point within a cluster. Notice that Clusters are numbered from 1-8, while the Fine Points have three-digit numbers.
FIGURE 4. STRUCTURAL ANALYSIS OF SOCIAL BEHAVIOR: THREE LEVELS OF COMPLEXITY
from submissive to autonomous, from self-restraint to letting the self be. An interpersonal event can be rigorously rated on these dimensions (Benjamin, in press). The extreme scores on each axis represent the more intense or unmixed aspects of a behavior, such as sexuality or murder. The other points are presumably blends of these primary social colors (Wiggins, 1982). Each plane of Benjamin's model is analogous to a distinct 36-category interval coding scale. Pinsof (1981) argued that these scales are interval scales because the scale points or categories are conceptually equidistant. He noted that Benjamin's is the only interval scale in the field of process research.

Rating Instructions

Raters essentially make three inferential decisions when coding material. Instructions to raters of the client's therapy sessions are given in detail in Appendix C. Briefly, each of two blind raters is given 38 typed, one-page transcripts to rate, one at a time. Each transcript represents a slice or sample from a different therapy session. The transcripts are randomly ordered. The client's responses are rated, rather than the therapist's. Each transcript receives one Affiliation and one Interdependence rating.

Raters are instructed to read each session for the main clinical theme. Each rater first decides if the client is mainly friendly or mainly hostile toward others, including the therapist, in that session. This is a clinical judgment. Each rater pinpoints mentally the right (friendly) or the left (hostile) side of the simple diamond in the Complex Model.
Then each rater decides whether the client is mostly complying or mostly asserting herself with others in that session. Raters pinpoint mentally the upper (assertive) or the lower (submissive) half of the simple diamond. These two decisions have converged to place the rater within one quadrant of the simple diamond (for example, Quadrant I). The raters are instructed to look at the Clusters nearby (Clusters 1, 2, and 3). They read the clinical statements in the Fine Points box of each Cluster, and make one rating which best fits their clinical impression; for example, #217 "Asserts, holds own without needing external support." This is a nominal, categorical rating.

Then Benjamin's model provides a translation of this Fine Point rating into interval ratings for Affiliation and Interdependence. The rater simply refers to the Simple Model. The rater counts from the exact center of the diamond in this Simple Model horizontally, and then vertically, until she reaches the Fine Point number of 217. The number of points she counted horizontally is the Affiliation rating (+3), while the number of points counted vertically is the Interdependence rating (+7). Reliabilities are computed from these two separate interval ratings.

The rating instructions for dream protocols are essentially the same, although a different Focus on the SASB was chosen for that measure, based upon clinical judgment. Explicit details are given in the Method and Appendices sections. These instructions are adaptations of those in Benjamin et al.'s (1981) manual.
Development of SASB: Reliability and Validity

The SASB model was built on behaviors which Benjamin (1981) believed to be basic to the human evolutionary process; that is, the system included the essential biosocial behaviors common to most theoretical schools. Benjamin's goal was to devise a valid and reliable way of measuring therapy process without losing its dense texture (Benjamin & Humphrey, 1985). Benjamin has published a group of technical validity/reliability studies; for more complete details these reports can be directly reviewed (Benjamin, 1974, 1981, 1982, 1984, 1985).

Reliability

Benjamin's measures are mediated rather than immediate because scores depend upon interpretations by raters trained to draw inferences from the data. Benjamin (1981) reported results of studies showing that the instrument can be used to make reliable ratings and to quantify clinically meaningful dimensions of therapy process. Reliability was measured chiefly by a coefficient of internal consistency (Benjamin, 1981).

A training manual was developed to clarify the coding procedure so that other investigators could use the system. It contains more explicit guidelines and scoring criteria. Codes were identified which could organize observations about social behavior. Benjamin (1981) noted that it is easier to achieve high reliability with a simple coding system, but such systems are often not valid measures of complex process phenomena, and have not as yet yielded useful information about process.
If the clinical material to be rated is ambiguous, dense and complex, this affects both reliability and validity. It is harder to agree on what is inferentially there and harder to apply scoring categories to difficult material not covered by scoring examples. Raters must often understand the clinical thrust of material and may not focus on the appropriate level of process to be rated. For example, raters may score obvious aggression in a session and miss the point, which is the patient's authentic self-disclosure. Thus, raters can agree and have high reliability, but may not be rating material accurately. The latter issue is discussed later in this section. Raters may disagree more often if the instrument's categories are subtle and require a relatively high level of inference.

Benjamin's instrument is probably the most reliable of the sophisticated models. Benjamin (1981) reported Kappas between independent experienced clinicians after 80-100 hours of training ranging between .70 and .85 on difficult material. Another investigator trained graduate students to code videotaped family arguments and reached Kappas ranging between .65 and .78 for process (Benjamin, Foster, Roberto, & Estroff, in press). Benjamin and Humphrey (1985) reached Kappas of .61 to .71 after 100 hours of training. The Pearson correlation reached was .71. These are the best reliabilities of any process instrument which attempts to validly measure extremely complex material.

Validity

Content validity has been formally assessed by a dimensional ratings procedure. Construct validity has been tested by
autocorrelations, factor analyses, circumplex analyses, and appropriate other correlations (Benjamin, 1985b). One method of testing the content validity of items is to have naive judges directly rate the items for the hypothesized dimensions. Such a dimensional ratings procedure was applied to 1978, 1980 and 1983 versions of SASB items. Naive student judges agreed that SASB items contained predicted amounts of affiliation and interdependence, and that focus was present in the way described by theory (Benjamin, 1985a).

As for construct validity, autocorrelations provide a test of the degree to which a rater's responses show the internal consistency expected on the basis of the structure hypothesized by the SASB model. If ratings are internally consistent, items hypothesized to be similar should receive similar ratings; items hypothesized to be opposite would receive opposite ratings, and items hypothesized to vary "step-wise" in similarity would show these changes in ratings. Correlations provided by Benjamin (1985a) suggested similarity, opposition and orthogonality as hypothesized.

Another way to assess construct validity is via factor analyses. Benjamin logically analyzed Sullivanian theory to extract key interpersonal constructs. Then she developed an instrument to measure the constructs. She extracted items from the constructs and then factor analyzed them to discover the central orthogonal dimensions underlying most interpersonal behavior. Factors emerging from analyses of individual items were affiliation and interdependence. According to Benjamin (1985a), "The factor analyses of . . . items provide a
stringent test of construct validity by showing that the two hypotheti-
cal dimensions actually exist in the interpersonal perceptions of
self and other people" (p. 11). Pilot applications of the instrument
have led to modifications and continuous revisions since 1968.

Clarly, Benjamin's categories are both theoretically and empirically
grounded.

Applications of Benjamin's SASB

a) Application to the problem of diagnosis. SASB provides a
general approach which is useful with normal and pathological social
functioning (Benjamin, in press). Benjamin called for the restor-
ation of intrapsychic and social variables to the psychiatric diagnos-
tic manual. She is currently exploring the possibility of incorpor-
ating self-concept and psychosocial variables into DSM-III, or of
developing an entirely new classification of patients on the basis of
their interpersonal behavior (Benjamin, Foster, Roberto, & Estroff,
in press). As a psychiatric diagnostic system, SASB would be used to
understand the patient from a social-environmental perspective. That
is, SASB would seek to specify typical patterns of behavior seen in
different diagnostic groups to better comprehend how the patterns
originated, what their symbolic meanings might be and how best to
intervene in therapy. Each patient would receive an "interpersonal
diagnosis" rather than the current label such as "schizophrenia."
Benjamin has demonstrated that her model does successfully operation-
alize many psychodynamic concepts (Benjamin, 1981). The explicit
quantification of social/intrapsychic variables via SASB ratings
permits statistical comparison between diagnostic groups and with
normal samples (Benjamin, in press).

b) **Applications to person perception research.** The SASB can be used for measuring the social perceptions of self and other: patient, therapist, staff, family and so forth (Benjamin, in press). It can be used as a clinical tool for mapping a patient's/therapist's perception of events. Classification of a patient's perception can sharpen understanding of the meaning of a social event (Benjamin, 1984). For example, a patient's perception of self was friendly while the attending medical student rated him as highly attacking. This interesting discrepancy highlights the point that knowing a person's perception of his surround can provide insight into the meaning of otherwise baffling behavior. If the world is perceived as hostile, then a person will behave in ways consistent with that often hidden perception (Benjamin, 1984). Social descriptors of inpatients showed meaningful differences between manic-depressive and schizophrenic groups. It appears that diagnostic groups may have typical social characteristics which can be more precisely measured by SASB (Benjamin, in press).

c) **Operationalization of conflict.** Benjamin maintained that the structure of SASB inspires ideas for specific treatment interventions tied to social etiologies of pathology (Benjamin, Foster, Roberto, & Estroff, in press). SASB can help identify dynamic conflicts such as interpersonal contradictoriness. Essentially, a dynamic conflict can be operationally defined and coded by SASB (Benjamin, in press). The SASB was used to characterize power distortions in couples having one alcoholic member (Chiles, Strauss, & Benjamin, 1980).
d) Validation in clinical constructs. Many classical clinical constructs can be validated using the SASB approach. For example, coded ambivalence and double-binding was found in a schizoaffective sample (Benjamin, in press). One application of SASB with families is that it can operationalize important family systems constructs, and improve empirical study of these phenomena. For example, Humphrey and Benjamin (1985) chose four central family process concepts and used SASB to refine their measurement. Benjamin is beginning to attempt to measure the structural parallels to social behavior, cognition and affect, with separate models (Benjamin, Foster, Roberto, & Estroff, in press).

e) Measuring the structure and process of therapy. The SASB has been shown to be quite useful in clarifying the structure of difficult interactions, such as therapy process (Benjamin, 1984). The model allows measurements of very intricate aspects of psychotherapy process while retaining the richness of the interactions. The SASB can be used by objective raters to code videotapes, or transcripts of psychotherapy, whether they be of group, individual or family (Benjamin, in press). The SASB was used to structurally analyze a family in therapy by describing family dynamics, measuring process changes and guiding treatment interventions (Benjamin, 1977). The model was used to define the clinical problem of differentiation failure (Benjamin, 1979a) and to characterize patient-therapist interactions and therapy sequences using Markov chaining (Benjamin, 1979b). The SASB can be used to measure the outcome of family therapy (Benjamin, Foster, Roberto, & Estroff, in press). "The SASB model presumes to apply to all
possible types of social interaction, and so it should be applicable at any point in the sequence: definition of problem, solving the problem, measuring the effectiveness of the solution" (Benjamin, Foster, Roberto, & Estroff, in press, p. 42).

Studies of Integrative Process Using the SASB

Benjamin (1977) performed a structural analysis of one family in therapy. Her goal was to explore conflictual processes between generations and to more precisely measure and describe changes across three years of therapy. Family members rated selves and others on a SASB questionnaire. Benjamin used results to analyze resistance and plan effective treatment.

Benjamin (1979) conducted an exploratory study intended to isolate patterns that could reliably discriminate between disturbed and normal families. The disturbance was failure of an adolescent to differentiate psychologically from the family. Benjamin (1979) found that pathological families involved the identified patient in symbiotic maneuvers designed to keep the patient enmeshed in the family ego-web.

Such families were found to sabotage the patient's attempts to separate. However, the undermining was disguised in seemingly normal family process interactions. Benjamin (1979) offered her SASB instrument as a vehicle for analyzing and revealing the often hidden interpersonal binds found in cases of differentiation failure. Her model was suggested as a guide to therapeutic intervention and as a measure of successful outcome.

Humphrey and Benjamin (1985) examined one family of a bulimarexic
adolescent girl. Their purpose was to produce a SASB analysis of the interaction patterns between the teen and her family. They asked the family to role play (10 minutes) a discussion about the girl's separation from the family. The family discussion was coded with SASB, and members also rated self and other.

A process analysis found a pattern to this family's interactions. Mother was mostly "watching and managing," while daughter was "sulking and appeasing." The authors also performed a pattern analysis from the family ratings. Their patterns were compared with those found for normal and bulimic families. These analyses guided treatment in suggesting that the girl needed to differentiate from her enmeshed position in the family.

Benjamin, Foster, Roberto and Estroff (in press) wanted to generate meaningful quantitative descriptions of dynamics in one family of a paranoid schizophrenic, to learn more about inner processes. To obtain a brief sample of interactions, the family was given a consensus task. They were asked to reach agreement on a number (0-100) which best described how well a SASB description applied to mother, father and significant other when interacting with the schizophrenic. The authors ignored the final rating given by the family; what they were interested in was the process of reaching agreement, which was videotaped, transcribed and segmented.

Coders reading the transcript for the first time found it bland and ordinary, with the family appearing to be polite and agreeable. However, after coding with SASB, the group discovered a pattern. Passages were identified suggesting thought disorder, or at least
that anyone who did not agree with the family consensus might feel they had deficient reality testing. Surprisingly, the daughter became hostile and controlling whenever mother attempted an autonomous or assertive response. Basically, family control was hidden in a net of pseudo-mutuality, in which no direct conflict was permitted. Daughter was characterized as communicating in an ambiguous, hostile-autonomous way.

One research group used SASB to discover what interpersonal processes discriminated between good and poor outcome in 8 cases (Henry, Schacht, & Strupp, 1986). Four therapists each submitted one high- and one low-change case. The first 15-minutes of the third session of each case were rated according to SASB. Both therapist and patient speeches were rated. In successful cases, the therapist evidenced more "helping and protecting" and "affirming and understanding" and less "blaming and belittling" than in poor cases. The successful patients frequently "disclosed and expressed" while those with poor outcome "walled off and avoided" or "trusted and relied."

**Unique contributions.** This dissertation must be characterized as both exploratory and hypothesis testing. The study makes a number of important contributions to the area of process research: 1) This study is a ground-breaking attempt to "map" the terrain of Jungian therapy process by operationalizing and rating subtle constructs; 2) it is one of the few intensive case studies which samples every session in the course of a year's therapy, rather than selecting only slices out of the total context for analysis; 3) it is the first study to empirically investigate patterns of change reflecting a
Jungian process assumed to be crucial to client development; 4) it represents an original application of Benjamin's SASB instrument to Jungian concepts; 5) it tests hypotheses about whether patterns actually found correspond to "ideal" theoretical patterns of animus development; 6) it empirically identifies which therapy processes are associated with clinical improvement; 7) it integrates clinical with empirical findings. It is hoped that this study will stimulate further research on Jungian process.

Purpose. The paper's purpose is to empirically map out an important part of Jungian therapy process for the first time. The study represents an initial effort toward greater clarification of what the important variables are, how they can be operationalized and measured, and what their patterned unfolding looks like. Hypotheses were derived from Jungian theory about animus development.

Hypotheses

H1: The male dream figure should become more friendly in the second half of therapy (last 19 sessions).

H2: The male dream figure should become more autonomy-giving in the second half of therapy.

H3: The female client should become more friendly in the second half of therapy.

H4: The female client should become more assertive in the second half of therapy.

H5: The male dream figure's friendliness should be associated with the female client's assertiveness.

H6: The male dream figure's autonomy-giving should be
associated with the female client's assertiveness.
CHAPTER VI

METHOD

Both intrapsychic and behavioral process changes over the course of one year of therapy were studied.

Subject

This investigation is a systematic, intensive case study, using one subject only. The subject's written material is in non-identifiable archival form, in the possession of the investigator. The subject was a white, 29-year-old female seeking therapy from a private, outpatient clinic. (A full discussion of her psychotherapy course is given in the Clinical Narrative section of this dissertation).

The subject gave written, informed consent to the use of her clinical material for research purposes, in accord with APA safeguards of confidentiality. Therapy occurred within a wholly natural context. The subject's material was not considered for research use by the investigator until after therapy was terminated. Thus, both the subject's and therapist's responses were uninfluenced by feelings of being studied. Sessions were recorded for clinical supervision.

Criteria for subject selection. Clinical material was examined by the therapist, after therapy had terminated. A qualitative interpretation of the material suggested the special research value of this subject's material. The subject was selected as representative of
women who present with initial clinical evidence of an animus problem. She was also selected for her representativeness as a member of a group of persons who seek psychotherapy for neurotic depressive disorders.

This study is not solely idiographic in that it does not investigate the subject as a purely unique entity. The study hopes to add knowledge about the larger group's intrapsychic and behavioral processes by studying intensively one of its diagnosed members.

**Materials**

Materials for this study consisted of two data sources and one rating instrument. The data sources were: 38 therapy segments, each six minutes in length, and 30 client dreams. The rating instrument was the Structural Analysis of Social Behavior (SASB).

Units to be rated. Since whole sessions would require hundreds of hours to rate, segments of each therapy session were taken. A review of the literature suggested that sampling randomly from the last half of each session would more likely capture the desired phenomena. This material may be seen as most reflective of the client's character and deepest concerns. As Kiesler (1973) noted, "several studies have shown that neurotic patients... were talking most meaningfully about themselves near the end of the hour" (p. 44).

Verbatim segments (6 minutes) were randomly extracted from the last half of each of 38 audio taped therapy sessions. Each segment was typed and these transcripts formed the materials for one set of raters.

In addition, all dreams reported by the client at the time of therapy had been extracted from audio tapes and typed for Jungian
clinical supervision. These 30 dream reports formed the archival materials for another set of raters. (See Appendix A for examples of actual therapy and dream material). These materials represent a spontaneous case history, since the therapy responses were not elicited in an investigative, research context.

**Instruments.** Two planes of Benjamin's (1981) SASB were used as the rating instrument to measure therapy process. (See Chapter V for illustration of the instrument). Although Benjamin's system has many clinical and research applications, its usefulness for this study is in its ability to tap patterns of change over time. Benjamin et al. sent their most current, revised scoring manual (1981) for use in guiding raters' observations.

**Procedure for Rating Therapy Segments**

The procedure for rating therapy sessions was as follows. Verbatim transcripts of the client's 38 therapy segments were typed on individual sheets. A master list was prepared containing the chronological number of each session. To keep raters blind to the therapy sequence, the order of presentation of the 38 sessions was randomized, with each segment assigned a code name.

**Raters.** Multiple objective raters, blind to hypotheses, were used to ensure reliability of observations and minimize bias. Raters were selected following Benjamin's (1981) recommendations. Two recent Ph.D.s, one male and one female, were selected as raters for the therapy segments. Neither rater was a professional Jungian, but both were conversant with psychodynamic theory, with appropriate levels of clinical and research experience.
Training. In order to enhance the reliability of ratings, raters underwent training using an adaptation of Benjamin's (1981) manual to a criterion level. Training was on sample transcripts independent of this study's data. (See Appendix B for instructions). Raters had to demonstrate discriminating sensitivity to the subtle phenomena embedded in ambiguous material. A relatively high degree of clinical inference was required of raters. Training continued until a criterion reliability of $r = .90$ was achieved. This required about 6 hours of training on 6 full samples.

Rating instructions for therapy segments. Each rater applied the SASB to the real therapy segments. Each transcript was rated for client behavior belonging to one of 36 categories of Benjamin's circumplex model. The attentional focus selected was Focus on Self, measuring behaviors of the self such as "Owns identity, has own internal standards." This plane of focus was used to measure the female client's overt therapy behavior. This Focus was selected because clinical material suggested that the client's problem was her excessively fearful compliance toward others, and that progress would be indicated by a movement toward expressively asserting herself. The "Focus on Self" diamond captures these dimensions well. (See Figure 5, the Simple Model of "Focus on Self," on the next page).

Raters make three inferential decisions when coding material. Explicit, detailed instructions to raters are in Appendix C. These instructions are adaptations of those in Benjamin et al.'s (1981) model. Each of two blind raters was given 38, typed, one-page therapy transcripts to rate, one at a time. Each randomly presented transcript
represented a sample from a different therapy session. Client responses were rated and not therapist verbalizations, although such verbalizations were included to provide clinical context.

Raters read each session for the main clinical theme. Each rater decided individually if the client was either mainly friendly or mainly hostile/fearful toward others (including therapist) in that session. This was a clinical judgment. Each rater then pinpointed mentally the right (friendly) or the left (fearful/hostile) side of the simple diamond at the center of the Complex Model of the SASB, Figure 6, shown on the following page.

Each rater then decided whether the client was mostly complying or mostly asserting herself with others in that session. Raters pinpointed mentally the lower (submissive) or the upper (assertive) half of the simple diamond at the center of the Complex Model.
FIGURE 6. STRUCTURAL ANALYSIS OF SOCIAL BEHAVIOR: THREE LEVELS OF COMPLEXITY
These two decisions converged to place the rater within one quadrant of the simple diamond; for example, Quadrant III.

The raters looked at the Clusters nearby that Quadrant (Clusters 5, 6, and 7). They read the clinical statements in the Fine Points box of each Cluster, and made a rating which best fit their clinical impression; for example, #231 "Is obviously terrified, very fearful of person, is extremely wary." This is a nominal, categorical rating.

Benjamin's model translates each Fine Point rating into interval ratings for Affiliation and Interdependence. The rater referred to the Simple Model on page 129. She then counted from the exact center of that diamond horizontally, and then vertically, until she reached the Fine Point number of 231. The number of points she counted horizontally was the Affiliation rating for that session (-8) and the number of points she counted vertically was the Interdependence rating (-1).

**Procedure for Rating Dream Protocols**

The procedure for rating dream protocols was as follows. Verbatim transcripts of the client's 30 dreams were typed on individual sheets. A master list was prepared containing the chronological number of each dream, and the number of the therapy session in which the dream occurred. To keep raters blind to the dream sequence, the order of presentation of the 30 dreams was randomized, with each segment assigned a code name.

**Raters.** Multiple objective raters, blind to hypotheses, were used to ensure reliability of observations and minimize bias. Two clinical psychology graduate students, one female and one male, were
selected as raters for the dream reports. Both raters were psycho-
dynamic in orientation, and had clinical and research experience
appropriate to their level in graduate school.

**Training.** In order to enhance reliability of ratings, raters
underwent training using an adaptation of Benjamin et al's (1981) manual to
a criterion level. Training was on sample dream reports which were
independent of this study's data. (See Appendix D for instructions).
Once again, a relatively high level of clinical inference was required.
Training continued until a criterion reliability of $r = .90$ was
reached. This required about 6 hours of training on 12 samples.

**Rating instructions for dream protocols.** Each rater applied
the SASB to the real dream reports. Each dream report was rated for
dream male's behavior belonging to one of 36 categories of Benjamin's
circumplex model. The attentional focus selected was Focus on Other,
measuring behaviors directed outward toward another, such as "Encour-
gages separate identity." This plane of focus was used to measure the
male dream figure's stance toward the female dream ego. This Focus
was selected because clinical dream material suggested that the dream
male was attacking and controlling the client from within, at the
start of therapy. Progress would be indicated by his moving toward
friendly affirmation of the client as she was. The "Focus on Other"
diamond captures these dimensions well. (See the Simple Model of
"Focus on Other, Figure 7, shown on the following page.)

Raters made three inferential decisions when coding material.
Explicit, detailed instructions to raters are in Appendix E. These
instructions are adaptations of those in Benjamin et al's (1981) model.
Each of two blind raters was given 30, typed, one-page dream protocols to rate, one at a time. Each randomly presented dream was obtained from a different psychotherapy session.

Raters read each dream for the main clinical theme. Each rater decided individually if the male dream figure was mainly friendly toward the female dream ego or mainly hostile in that dream. (The female dream ego's responses were not directly rated.) Each rater then pinpointed mentally the right (friendly) or the left (hostile) side of the simple diamond at the center of the Complex Model of the SASB, Figure 8, shown on the following page.

Each rater then decided whether the dream male was mostly ignoring, trying to control, manage or constrict the female. Raters pinpointed mentally the lower (controlling) or the upper (endorsing freedom) half of the simple diamond at the center of the Complex Model.
Complex Model

FIGURE 8. MODEL: STRUCTURAL ANALYSIS OF SOCIAL BEHAVIOR: SASB
The two decisions converged to place the rater within one quadrant of the simple diamond; for example, Quadrant III.

The raters looked at the Clusters nearby that Quadrant (Clusters 5, 6, and 7). They read the clinical statements in the Fine Points box of each Cluster, and made a rating which best fit their clinical impression; for example, #133 "Harshly punishes person, takes revenge, makes person suffer greatly." This is a nominal, categorical rating.

Benjamin's model translates each Fine Point rating into interval ratings for Affiliation and Interdependence. The rater referred to the Simple Model on page 133. She then counted from the exact center of that diamond horizontally, and then vertically, until she reached the Fine Point number of 133. The number of points she counted horizontally was the Affiliation rating for that dream (-7), and the number of points she counted vertically was the Interdependence rating (-3).
In this Results Section, inter-rater reliabilities (Pearson $r$) will be reported for Affiliation and Interdependence ratings, on both therapy and dream material. Then, ratings from the first and second halves of therapy will be compared for each of the 6 hypotheses with t tests.

**Inter-rater Reliabilities.** The inter-rater reliability for the Dream Male's Affiliation ratings was $r = .96$, and for the Dream Male's Interdependence was $r = .70$. High reliability on Dream Affiliation ratings was probably due to raters' greater familiarity with the common social concept of "friendliness." It was easier to discern whether the Dream Male was friendly than whether he was autonomy-giving (a more ambiguous concept). More inference was probably required to rate the degree of Interdependence in the Dream Male's actions. Thus, there was more opportunity for raters to use private, moderately differing inferential anchors for rating that dimension.

The inter-rater reliability for Client Affiliation ratings was $r = .63$ and for Interdependence was $r = .60$. It is probable that reliabilities for the therapy transcripts were lower than for the dream protocols because the therapy material was more lengthy, and thus there was more chance for the client to express several
contradictory stances in the same six minutes. For example, she may have started out mildly assertive, and then become somewhat submissive, with varying degrees of affiliation throughout the segment. The raters had to agree on the one main theme that best characterized the client in that session, and this was evidently a complex task which apparently affected reliability. Nonetheless, ratings were sufficiently reliable to form structured graphs demonstrating level changes across therapy on all four dimensions. Four hypotheses were supported despite the greater probability of error due to only moderate covariation. Moderate reliabilities merely limit upper boundaries; thus, any effects found are attenuated by the lack of consistency between raters. Thus, in all likelihood, the effects were there, and would have been even more pronounced in a more reliable measure of the dimensions. Raters had a similar enough conception of the SASB categories, and of the client's clinical realities, to capture salient process changes.

The moderate reliabilities obtained in this study are comparable to those obtained by Benjamin and other process researchers reviewed in Chapter V of this paper. For example, graduate students trained for 80-100 hours to code family therapy process reached kappas ranging between .65 and .78 (Benjamin, Foster, Roberto, & Estroff, in press). It is important to note that the raters in the present study were only trained for 6-7 hours, and that the Pearson r reliabilities are less generous than kappa coefficients, in general.

Humphrey and Benjamin (in press) reached a Pearson r of .71 in a study after 100 hours of training. These are the best reliabilities
reported for any process instrument which attempts to validly measure extremely complex material. The only other coding instrument which rivals Benjamin's is Pinsof's FTCS. After 30–60 hours of training raters on a family therapy task, the kappa was .63. Thus, reliabilities of this current study are not out of line with other published studies in the area. Of course, it would be highly desirable had reliabilities been higher, and possibly more training might have raised the figures somewhat.

Procedure for computing reliabilities. Inter-rater reliabilities (Pearson $r_s$) were computed as follows: 1) Therapy transcripts were returned to chronological order. 2) Each therapy session had received one categorical rating of the client's behavior, from each rater. For example, one rater may have given a randomly presented session a #216 "Client is straightforward, clearly expresses positions so person can give them due consideration," while the other rater may have given the session a #214 "Client expresses thoughts in clear and friendly manner so person has every opportunity to understand well." 3) The next step was to translate each categorical rating into two interval ratings for each transcript. The procedure for this was described in Chapter V and in the Method section of this paper. Essentially, the Simple Model diamond was used to count units from the center, horizontally and vertically, until the Fine Point categorical rating was reached. The number of horizontal units was the Affiliation score, and the number of vertical units was the Interdependence score. If the last session received a #216 from one rater, the interval ratings would be Affiliation +3 (pretty friendly) and
Interdependence +6 (very autonomous). If the last session was rated by the other rater as a #214, the interval ratings would be Affiliation +5 (very friendly) and Interdependence +4 (pretty autonomous).

4) Every session's categorical, fine point ratings were translated into interval ratings in this manner. For all 38 sessions, both raters' Affiliation scores, for example, were correlated using a hand calculator to produce a Pearson $r$ coefficient of reliability for Affiliation dimension. The same procedure was followed for Interdependence ratings.

For Dream transcripts, essentially the same steps were followed as for the Therapy sessions, using two different blind raters' scores and using the interval ratings from the Dream Diamond on the Simple Model to compute Dream Affiliation and Dream Interdependence reliabilities.

Hypotheses

1. It was hypothesized that the male dream figure should become significantly more friendly in the second half of therapy. The data for the Dream Male's Affiliation are presented as a bar graph in Figure 9. It seems visually evident that the dream male became more affiliative toward the female dream ego over the course of therapy.

The mean Dream Affiliation rating for the first half of therapy was 3.33, while the mean for the second half of therapy was 14.3. In order to perform a $t$ test to determine whether the difference between these two means was statistically significant, assumptions for the $t$ statistic had first to be met. A key assumption of regression models (including $t$) is that errors are random, unrelated, unpatterned,
FIGURE 9
uncorrelated. Given that data from this study were generated from a single subject over time, it was likely that errors were correlated.

The hypothesis says that how friendly the dream male is depends on what therapy session he is in. Autocorrelations make it difficult to distinguish how much his friendliness reflects his being in the second half of therapy from how much his friendliness reflects his being in a more similar mood in sessions which were close together in time.

Since the data's errors were probably correlated, knowing how friendly the dream male was in the first week would help one guess how friendly he would be in the second week. It is statistically assumed that anything which is measured over time is more likely to be closely related if the units are close together in time, than if they are not. Autocorrelation refers to the notion that the closer points are in time, the more highly correlated they are. The subject's data made it difficult to pull out the pattern of change related to being in a particular half of therapy.

What needs to be done before performing the t test is to somehow "correct" or adjust for these autocorrelated errors. The way to do this is to use an autoregression model called ARIMA, introduced by Box and Jenkins (1976). The first step in the modeling procedure is to look at the sessions which were close together in time, such as session 1 and 2, 2 and 3, etc. until all 30 sessions containing a dream are examined. These close-together sessions are examined to see if actual friendliness ratings really were very similar in closer sessions. This step is calculated by correlating the entire series of
sessions (1-30) at different lags with itself. The ARIMA generates a set of correlation coefficients which should start large at a lag of one and get small quickly at larger lags if very close-together sessions (1 session apart) are autocorrelated. The correlations yield an autocorrelation function which is an estimate of the form of the autocorrelations in the actual data.

If errors in the actual data are strongly autocorrelated, they should generate a noticeable pattern of error, according to the ARIMA model.

The pattern of autocorrelations in this subject's data was compared with the estimated linear pattern of autocorrelation generated by the ARIMA model. Since the autocorrelation function from this subject did fit the line drawn by ARIMA, it was concluded that the actual data were autocorrelated. That is, if data were autocorrelated, then the line should have a slant due to patterned error, rather than it being flat (which indicates random error). This was found for my data. The model showed that the subject's data were autocorrelated in that one could make a good guess how friendly the dream male was this week from how friendly he was last week, regardless of which half of therapy he was in.

The ARIMA shows how to "remove" these autocorrelations from the subject's data. One subtracts the model's "guessed" rating on Week 2 (which was based on an assumption of a linear pattern starting from Week 1's rating) from the dream male's actual rating on Week 2, and
one uses that difference as the "new" friendliness rating. That is, the difference or deviation of the dream male's actual friendliness ratings from the autocorrelation line shows the part of his friendliness not due to similarity with sessions close in time.

The next step is to plot these "new" ratings and see if the regression line is flat. If so, then the error in these data is now random. The model "pulled out" patterned error due to observations being close in time. If the "new" ratings are plotted and there is still a slanted line, then the autocorrelations were not modeled well.

How can one test to see if the error modeled well? If no autocorrelated error is left in the "new" ratings, then there is a certain test statistic (Q), computed from the "new ratings", which should have a chi square distribution. Q is a complicated test (see Box & Jenkins, 1976) for whether the errors from the "new" flat regression line are a good fit to the model. If the model was correct, Q should fall within the nonsignificant part of the chi square distribution and not within the tail. Chi squares were nonsignificant, thus there were not autocorrelations remaining in the data.

Next, the data's original regression line was re-examined to see if the autoregressive parameter of that equation was still showing autocorrelation (significance). The equation was:

\[ Y_I = (Y_{I-1} \cdot \phi) + a_1 + \alpha \]
That is, this week's observation \( (Y_i) \) is a function of last week's observation \( (Y_{i-1}) \) times \( \phi \), plus random error \( (a_1) \) plus being in a particular half of therapy \( (\alpha) \). A complex procedure (Gauss-Newton) was performed to estimate the value of \( \phi \). It was found that \( \phi = 0 \), so each session's score was only related to the half of therapy the client was in, plus random error, and not due to the autocorrelation between observations close in time. Thus, this is the meaning of the "autoregressive parameter" of the equation was not significant; autocorrelations were gone.

The results of the analyses are as follows. The autoregressive parameter was not significant and the data were not autocorrelated after this modeling; \( t = 1.14 \) (27 df). Finally a \( t \) test was performed to determine whether the difference between the means of the first and second half of therapy was significant. The difference in mean Dream Affiliation ratings between the first and second halves of therapy was statistically significant; \( t = 10.9 \) (27 df), \( p < .005 \) (one-tailed).

2. It was hypothesized that the male dream figure should become significantly more autonomy-giving in the second half of therapy. The data for the Dream Male's Interdependence are presented as a bar graph in Figure 10. It appears visually that the dream male endorsed more autonomy for the female dream ego as therapy progressed.

The mean Dream Interdependence rating for the first half of therapy was 8.0, while the mean rating for the second half of therapy was 10.9. Once again, an autoregressive model was used to correct for autocorrelations among data points.
FIGURE 10
The results of the analyses are as follows. The difference in mean Dream Interdependence ratings between the first and second halves of therapy was statistically significant, $t = 2.16$ (27 df), $p = .025$. The autoregressive parameter was not significant (data were not auto-correlated), $t = -0.26$ (27 df).

3. It was hypothesized that the female client should become significantly more friendly in the second half of therapy. The data for the Female Client's Affiliation are presented as a bar graph in Figure 11. It seems that the female client became more friendly toward others (including the therapist) over the course of therapy.

The mean Client Affiliation rating for the first half of therapy was 5.4, while the mean for the second half was 11.3. The results of analyses are as follows. The difference in mean Client Affiliation ratings between the first and second halves of therapy was statistically significant, $t = 5.35$ (35 df), $p < .0005$. The autoregressive parameter was not significant, $t = .18$ (35 df).

4. It was hypothesized that the female client should become significantly more assertive in the second half of therapy. The data for the Female Client's Interdependence are presented as a bar graph in Figure 12. It appears that the female client became more autonomous as therapy progressed.

The mean Client Interdependence rating for the first half of therapy was 6.0, while the mean for the second half was 13.9. The results of analyses are as follows. The difference in mean Client Interdependence ratings between the first and second halves of therapy was statistically significant, $t = 6.52$ (35 df), $p < .005$. The
FIGURE 12

CLIENT'S INTERDEPENDENCE OVER TIME
autoregressive parameter was not significant, $t = -0.84$ (35 df).

**Evaluation of results.** This paper was an attempt to clinically understand one woman's animus development over the course of one year of successful therapy. Jungian propositions about expected patterns of change were empirically examined through this intensive case study as well. The first four hypotheses were supported. The inner dream animus did become more supportive and endorsing of freedom in the second half of therapy. Similarly, the female client did become more authentically friendly (rather than compliant) and assertive as therapy progressed. She displayed more Logos behavior. Results suggest that the aspects of animus development (dreams and Logos behavior) measured by SASB do provide a satisfactory description of process change across time in crucial patient behaviors.

Figure 13 illustrates how the client changed (both behaviorally and intrapsychically) on the dimensions of Affiliation and Interdependence, as therapy progressed.

A visual inspection of Figure 14 shows that data points for the Dream Male lie along the perimeter of the diamond defined by Benjamin's SASB system. Each point on the figure represents approximately one "Fine Point" on Benjamin's diamond model. Each fine point represents a clinical blend of Affiliation and Interdependence. Clearly, fine point ratings differ for the first and second halves of therapy.

In the first half of therapy, the dream male was in the hostile-controlling quadrant of Benjamin's diamond (see reproduction of Benjamin's model in Chapter IV). In the second half of therapy, the dream male was in the friendly/autonomy-giving quadrant.
DREAM MALE'S AFFILIATION AND INTERDEPENDENCE

FIGURE 14
A visual inspection of Figure 15 shows that data points for the Female Client lie along the perimeter of the Benjamin diamond. Again, fine point ratings differ in the first and second halves of therapy. The female client moved from a fearful-compliant to a more openly disclosing-assertive position as therapy progressed.

A cluster analysis (single-linkage) was performed. This is a logical analysis, and not a statistical test. It was performed as another way of demonstrating that the first and second halves of therapy differed in Affiliation/Interdependence ratings. The cluster analysis was obtained by taking all therapy sessions, dividing up sessions into those in the first and those in the second half of therapy, and noting what pattern of ratings were found in each half.

Results showed that there were two main clusters, one the first and one the second half of therapy. The method ensures that every session in the first half of therapy is more similar in ratings to at least one session in the first half than it is to any session in the second half of therapy.

A visual inspection of Figures 16, 17, 18, and 19 show that there was a distinct difference between the first and second halves of therapy on all rated dimensions. As can be seen in the figures, most of the ratings for the first half were in the hostile-control quadrant while those for the second half were in the friendly-autonomy quadrant. Both the dream male and the client became friendlier and more interdependent as therapy progressed. Results show that subtle intuitions can be translated into objective terms. What was clinically perceived as change was able to be perceived by objective raters. This
FIGURE 15

CLIENT'S AFFILIATION AND INTERDEPENDENCE

HALF OF THERAPY: • • • FIRST • • • SECOND
DREAM MALE'S AFFILIATION AND INTERDEPENDENCE
AND CLIENT'S AFFILIATION

LEGEND:
CYLINDERS -- 1st half of therapy
PYRAMIDS -- 2nd half of therapy

FIGURE 16
DREAM MALE'S AFFILIATION AND INTERDEPENDENCE
AND CLIENT'S INTERDEPENDENCE

CLIENT INTERDEPENDENCE

DREAM AFFILIATION

LEGEND:
CYLINDERS -- 1st half of therapy
PYRAMIDS -- 2nd half of therapy

FIGURE 17
CLIENT'S AFFILIATIVENESS AND INTERDEPENDENCE
AND DREAM MALE'S AFFILIATION

FIGURE 18
CLIENT'S AFFILIATIVENESS AND INTERDEPENDENCE
AND DREAM MALE'S INTERDEPENDENCE

LEGEND:
CYLINDERS -- 1st half of therapy
PYRAMIDS -- 2nd half of therapy

FIGURE 19
was a test of clinical reliability. Results do not contradict Jungian theory but results are also consistent with a number of other approaches. Although the theory itself was not directly supported (until results are cross-validated on at least one other subject), Jungian theory served as an interpretive framework for understanding this pattern of results.

5. It was hypothesized that the male dream figure's friendliness should precede or be associated with the client's assertiveness (affiliative autonomy).

The results of analyses are as follows. Once again, the autoregressive parameter was not significant.

A t ratio was used to test whether there was any linear association between Dream Affiliation and Client Affiliation. A t statistic was used to test whether the slope of a best fit regression line was significantly different from zero. This statistic was chosen because it met the assumptions needed to analyze data from a single subject (autocorrelations were already out) and it was the most powerful of the available tests of association for a single subject. The level change between the first and second halves of therapy was significant, \( t = 3.77 \) (27 df), \( p < .0005 \). However, once the association due to autocorrelation and level change were controlled, the association of Dream Affiliation and Client Affiliation was not significant.

Similarly, once the association attributable to autocorrelation and level change were controlled, there was no statistically significant association between Dream Affiliation and Client Interdependence.
6. It was hypothesized that the male dream figure's autonomy-giving should precede or be associated with the female client's assertiveness (affiliative autonomy).

The results of analyses are as follows. Again, the autoregressive parameter was not significant.

The level change was significant for both Dream Interdependence and Client Affiliation, $t = 3.98$ (27 df), $p < .0005$. However, once the association attributable to autocorrelation and level change were controlled, there was no statistically significant association between Dream Interdependence and Client Affiliation. Similarly, once the association attributable to autocorrelation and level change were controlled, there was no statistically significant association between Dream Interdependence and Client Interdependence. A visual inspection of Figures 20, 21, 22, and 23 show the significant level change for both the client and the dream figure from the first to the second half of therapy on the rated dimensions. However, while client and dream ratings are both low in the first half of therapy, they are not statistically associated with each other. Similarly, while both client and dream ratings are both high in the second half of therapy, they are not associated with each other. Their association is probably because of whatever factor (such as therapy, history) makes both of them change over time.

The dream and behavioral aspects of the animus seemed to change in a parallel fashion across therapy. This was contrary to the expected pattern of inner change preceding or being associated with behavioral change.
CLIENT'S AND DREAM FIGURE'S INTERDEPENDENCE

HALL OF THERAPY: • • • FIRST • • • SECOND

FIGURE 20
CLIENT'S INTERDEPENDENCE AND DREAM MALE'S AFFILIATION

FIGURE 21
CLIENT'S AND DREAM FIGURE'S AFFILIATION

HALF OF THERAPY: *** FIRST  *** SECOND

FIGURE 22
CLIENT'S AFFILIATION AND DREAM MALE'S INTERDEPENDENCE

HALF OF THERAPY: • • • FIRST • • • SECOND

FIGURE 23
The contribution of this study has been that it filled the need for more intensive case studies in personality research. In the 1985 Annual Review, Pervin strongly urged researchers to design studies which demonstrated "... appreciation of the complex, integrated, organized, dynamic, and patterned quality of human personality functioning" (p. 84).

This study contributes to the Jungian literature by starting to answer the question: What actually occurs in this class of change variables (animus development)? An empirical delineation of animus development has never been done. Thus, a Jungian process crucial for change has been identified and tracked by objective raters; changes across therapy associated with good outcome were mapped out with some precision and replicability.

This investigation represented an original application of SASB to Jungian concepts. Results show that Benjamin's SASB was sensitive to subtle but clinically important process dimensions related to client change over therapy. Thus, this study can be seen as supporting the efficacy and validity of Benjamin's instrument as a fruitful research tool in understanding and testing hypotheses about Jungian process. Coders apparently construed the client's clinical reality somewhat accurately and validly (that is, there was a good match between their rating patterns and theory). Coders also agreed relatively well about to which SASB categories the client's reality belonged.

What was objectively coded may not have been "animus development"; but that is the interpretative construct which will be used...
to understand this pattern of results. One reason for interpreting the changes this way is that it fits well with the clinical assessment of the client's major dynamics.

This study is a first step in building more specific microtheory about what Jungian process changes are associated with clinical success. Hopefully, results will help refine Jung's more general theory of personality and ultimately benefit practicing therapists and their patients. Movement in both the intrapsychic and behavioral realms of client process was associated with clinical improvement. This process can be related to outcome now in a more systematic way by investigating whether those who show this pattern of "animus development" have successful outcome.

The clinical section was an attempt to understand one woman. As Jung (1957) noted, "(I) am merely concerned with the fate of the individual human being—that infinitesimal unit on whom a world depends. . ."(p. 125). The clinical and empirical "views" of therapy process in this paper converged. A deeper clinical understanding of Jungian psychotherapy process occurred through a careful reading of the circumplex statements.

It was observed empirically (via SASB categories) that as therapy progressed, the "animus" played a more supportive role internally, and, in a parallel manner, the woman client moved from fearful submission to more straightforward assertion.

This study contributed some unique statistical analyses and graphic figures which may be appropriate for other N of 1 data. For example, the problem of autocorrelated data was adequately resolved.
Value of this study. This investigation has helped place this type of research within the context of psychotherapy process research in general, especially those which are intensive cases. Scientific knowledge of how to conduct an intensive study of complex changes has been expanded. One major value of the study was its operationalization of patterns of animus development, and its location and adaptation of a sophisticated instrument to measure such development. This research has helped solve the problem of what statistical or other analyses of data are appropriate for N of 1 cases. It has also helped illuminate the connections between theoretical concepts, clinical realities and empirically observed patterns.

Conclusions/Implications. Results obtained from the study show that a single case can make a scientifically important contribution to knowledge. Meaningful theoretical phenomena can be made empirically intelligible as well as clinically understandable. Results were consistent with Jungian and other depth theories of change. Part of the pattern described by Jungian theory was demonstrated by empirical ratings and by clinical assessment.

Interpretation of the patterns' meaning is open to question, but this probably reflects the infant stage of consensus which exists in the overall area of psychotherapy theory.

Apparently, animus development does occur and was validly and reliably measured, but perhaps its unfolding is not as neat as was hypothesized. It may have been therapy itself which impacted on both Diana's inner and outer worlds, resulting in progressive but relatively independent changes in her dreams and behavior, from week to week.
Her inner male was becoming more caring and she was developing her masculine qualities in the world. Yet it seemed that these two aspects of herself were moving along as if each had its own path to follow, which was not directly related to the other's domain. It appeared that both her unconscious and conscious psychic realms were contacted and responded well to therapy. These findings may represent a challenge to the Jungian proposition that the animus functions as a more or less direct "inner guide." The model of change proposed by Jungian theory may be in need of modification, in light of these findings. The animus as an inner figure seems important to therapeutic growth, but it is unclear how he influences or relates to a woman's actual behavior. On the other hand, perhaps there is no simple or linear association between such interactive unconscious and conscious variables. Jung often asserted that change occurs in an interactive, circular, spiral manner across time. Thus, current statistics (designed to measure mainly linear changes in groups) may not be well-suited to the real association between mutual feedback systems such as dreams and behavior. There is a need for new statistics specifically designed to capture integrated change.

Another possibility is that the time unit used in this study may have been inappropriate for measuring the clinical association between dream and behavior change. Jungian theory does not specify how far in advance of behavior change key dreams occur. Perhaps it takes as long as a full year from the time a dream symbol appears to the actual client behavior change. One way of testing this would be to collect different therapists' final summaries to ascertain which
clinical issues were successfully "worked through"; for example, a "father" conflict. If Jungian theory is useful, one would expect to find more dreams symbolizing father had been reported in that particular course of therapy than dreams of mother. Further, one would expect that the father symbols developed and progressed across therapy, while the mother symbols did not. Blind raters could be used to code dreams.

One could also look at therapy summaries in which the client had not successfully resolved a problem issue. If dream symbols were unrelated to the key problem or did not develop, but stagnated over time, then one could assert that there was some support for the notion that behavior change on a key issue does not occur without related symbolic change, and in this way they are related.

In this case, the dream male did become more nurturing and freeing, and the client attacked herself less harshly and less often, allowed herself more free expression, and cared for herself and others more deeply and genuinely than at the start of therapy. Clinical supervisors judged this case to have been considerably "improved." These empirical findings have contributed to a more anchored definition of the meaning of clinical improvement.

**Internal validity.** Even though this study does not purport to be explanatory, a few factors concerning internal validity will be discussed. The study was not designed to show whether therapy caused the pattern of change observed. There was no empirical baseline taken before therapy, and no abrupt intervention during therapy. However, the first half of therapy could be taken as a relatively "pre-change"
level of animus development, while the last half could be considered the "change" level.

It is possible that something may have occurred between therapy sessions which accounted for progress (history). However, this is not likely as the client reported no job change, relocation, death or other major event until near the end of therapy. The client may have progressed anyway as a function of some internal process even if she were not in therapy. This is not probable, since she had a life history of chronic continuous depression (a clinical "baseline"). The depression was not seriously alleviated until later in therapy.

The effects of being measured are not relevant since her therapy was not originally intended to be studied in a research context and there were no measurements taken during therapy; it was clinical and natural.

There were probably no instrumentation effects because, again, she was not being researched at the time of therapy.

**External validity.** Since this was a case study, it was necessarily low on control and representativeness, but high in richness. The diagnostic group (population) from which the subject was drawn was neurotic depressive. Inferences about the general population are limited and conclusions are meant to be suggestive. It is unclear whether all persons in a diagnostic group share similar underlying processes, since the groups themselves are heterogeneous and poorly defined. Thus, one cannot assume that the client's process is typical or represents any process other than her own. In addition, the subject was not randomly chosen, but rather both sought therapy and
later volunteered for research, and so may differ from her diagnostic group in unknown ways.

Thus far, the processes and evolving sequences which differentiate the diagnostic groups have not been precisely specified. For example, Jungian theory has not specified which subjects are most likely to follow this pattern of animus development, or whether schizophrenics and depressives would show different patterns of process on this dimension.

It is not the purpose of this study to claim that the Jungian is the only possible "interpretation" of resultant patterns. The paper is not really explanation-building because it is not postulating causal links between therapy and the patterns, at least not conclusively. However, an initial set of theoretical propositions or hypotheses was formulated about what the pattern should look like, and the results of this single case were compared against such a set of hypotheses. The purpose of further research would be to revise the theoretical propositions in light of findings and then compare the revisions to findings of other cases. Repeating this procedure would eventually clarify the concepts so that they could serve as general "explanations" for a number of individual cases.

**Future research.** There are no normative data on "typical" process patterns which reflect animus development. This study could be seen as a first step toward building such norms for the depressive neurosis group, a significant proportion of the clinical population. Ongoing awareness of such patterns can also perhaps assist clinicians to assess therapeutic improvement. Other studies can investigate
whether these patterns generalize across clients. Cases with a similar diagnosis could be tested to see if the same patterns could be objectively discerned. Different diagnostic groups could be checked to determine which features of process are similar across individuals and which unique. For example, studies could contrast the patterns of depressives vs. psychopaths.

Designs could be improved by specifying in advance exactly how the subject will manifest the patterns being studied. Another design could test whether these patterns would have occurred anyway over time without therapy by using a control group and tracing its dreams and behaviors over one year's time.

Further research can be conducted to determine whether this pattern of change is prototypical of successful patients. If it occurs in good and not in poor outcome cases, there is support for the discriminant validity of the construct animus development. If Jungian propositions are supported repeatedly, then the theory is strengthened in its position as a useful model of change. Findings such as these would support the emphasis in Jungian training on facilitating dream analysis as a way to develop animus functioning.

One swallow does not make a summer, but the accumulation of single cases may build a picture of commonalities solidly based in scientific reality. The case study method, used in succession, is a very viable method in the study of therapy process. This may be only the first in a series of case studies of Jungian process, but, hopefully, it has served as a useful beginning and a stimulus to other Jungians to move their explorations into this new area. It is a
challenge to other Jungians to anchor their extremely resonant constructs in empirical ways, without damaging their rich meanings.

It is difficult to compare research results from other intensive studies because there are few shared variables or coding systems, so what actually occurs in therapy is construed or coded in many different ways.

The findings of this study were most similar to the cohesive/dispersal study (Horowitz, Sampson, Siegelman, Weiss, & Goodfriend, 1978). It was reported that the female patient was increasingly able to directly express both cohesive (affiliative) and dispersal (assertive disagreement or disengagement) behaviors across 100 hours of therapy.

The results were also in accord with findings on client splits (Greenberg, 1984). As Diana conversed with her own unconscious parts, the inner male objects ceased attacking her, became friendly and endorsed her freedom to be herself. Diana was able to experience and integrate her aggressive side more deeply.

Finally, this paper's findings agreed with Henry, Schacht, & Strupp's (1986) results which reported that cases with good outcome more frequently "disclosed and expressed" (as rated by the SASB) than those with poor outcome. In a sense, all the process research being conducted may be seen at least partially exploratory. Replicated team research on agreed-upon variables with uniform scoring systems will help build a cumulative body of valuable knowledge.
REFERENCES


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APPENDIX A
EXAMPLE OF ACTUAL THERAPY SEGMENT

CRONUS

T: Maybe we can go back again, because I think I missed something here. . .

C: About you??

T: That you care whether I trust you?

C: Right. That's why I kept thinking. . . remember I said I wanted to bring in Alex's book of poetry? Because I wanted you to see that it was real, what I've been telling you was real.

Then I wondered why would I think that she (therapist) doesn't think it's real? Then I thought that I'm not positive that she (therapist) trusts me.

T: When you first came to therapy, you wondered who would take you seriously. That it would matter to you that I take you seriously. That it would be important. That I would trust that when you talked about your experiences, trust that you were rendering it as it was for you. That is, your experience, is real. And would I take it seriously?

C: I just talked about being taken seriously in a conversation with Steph yesterday. It just came out. She's from the East, and she's always making fun of X state people, needing their "space." And all the weird things people are into out here. And before I used to go along with this. Even though I'm one of these people! Because I wasn't able to cross her, because of the whole mother thing, not being able to talk and say what I wanted to say.

So now, in the last month, she's become friendly again toward me. So I reciprocated. It's not the same as it was before. We're both different people now. We've both grown in different ways. But she's being friendly and complimentary. So I was doing that back to her. So then on Sunday we were both in the kitchen and she read me this thing that Maria Muldaur was saying about X country and how people there are searching for "spiritual fulfillment." And she was making fun of it. And I said, "That's really something. That's really beautiful." (laughs) That shocked her. She made some sarcastic remark about it. And so I said, "I've been searching for this all my life, and I take it very seriously."

So then the whole conversation changed, because she thought I was going to do what I did before. Which was go along with her, and laugh, and say, "Oh, yeah, isn't this stupid?" So then we talked about what's inner peace for her? And a Mercedes Benz was inner peace for her (laughs). And for me, I'm not interested in material things.
T: So how is it that you were able to disagree with her at this point in time?

C: Because whatever's happening, as far as this filling up and not needing a mother and father figure now, I'm not afraid to say what I want to say. I'm not afraid they're going to reject me, and also I'm not afraid that she will kill herself. She's obviously not going to. She'll probably take it better than almost anybody I know. Because she's pretty... tough.

I also feel a very great need to start telling these people... see, I'm very against, after the thing with my brother and sister, I'm very against people using things instead of feelings. And... I just want to make my voice heard now. That's... if I start writing, it's going to come out in writing. I've thought about teaching again. If I did, I'd try to hear the children's voices instead of telling them to focus on something outside of themselves.

T: Making your voice heard... this reminds me of some of your dreams. Like the mouth that got closed when people didn't want to hear what you had to say. And the fear that if you said what was on your mind, that you would be killed or someone else would be for punishment. It sounds like your mouth is getting unstopped.

C: Yeah, it's really (laughs) going overboard! (laughs) No, it's not going overboard. But now I'm watching their reaction and they don't want to tackle these things.

T: It sounds like you're taking yourself more seriously. I wonder where that concern came from, that people would not take you seriously? That everyone from myself, to your dad, to the bosses, to your friends, might...
EXAMPLE OF ACTUAL DREAM REPORT

HADES

I went on a double date with... it must have been someone that liked me. It was someone that liked me... I don't know who it was. A blind date. We were in the back seat of this car, an old round Ford, a 20-year old Ford. Another couple was up front. I wasn't sitting really close to him. We pulled into a gas station.

The gas station attendant was... I think they said they wanted something from him. Anyway, he reached into the car to either give something to somebody or get something. It was kind of like... we were robbing him. The guy that I was with was robbing him. And then shot him and killed him. So I just went, "uh!" and I thought, "Oh my God, what a terrible thing!" but I didn't say anything because immediately I was frightened for my life. I thought, going on intuition, how should I react?

I just knew that the guy was going to watch to see how I reacted. And it would matter if I reacted favorably. I could get away with it. Get away with my life. And if I didn't react favorably, I'd seen him kill the guy, so he'd have to kill me. So he just turned around and said, "How did you like that?" And I said, "Well, it was quite a surprise." Then we drove back and I thought, "Oh my God, how am I going to get away from this guy?" He kept calling me after that, threatening to kill me and I couldn't get out of it.
INSTRUCTIONS TO RATERS OF SAMPLE THERAPY TRANSCRIPTS

1. You will be given a total of 38 typed, one-page transcripts to rate, one at a time. Each transcript represents a slice or sample from a different psychotherapy session. They are randomly ordered.

2. At the top of each transcript you see a code name, such as "ZOTZ." The letters "C" and "T," respectively designate who is speaking at any given time, client or therapist. Rate only Client (C's) speech/behavior.

3. You will be given one coding sheet on which to record all ratings. Simply record your initials, the code name of each transcript that you rate, the date, and two scores you will be trained to discern.

4. What do you rate and how? We will first familiarize ourselves with the rating instrument. Look at the model.

5. See the model. Explain. Give them a sample here and talk through it.

6. Each transcript gets one "Affiliation" and one "Interdependence" rating. We will read, score and talk through 3 samples, establishing rules of thumb to resolve any questions which arise about procedure. Then you will silently score 3 more samples, and we will once again talk about any discrepancies. Once a reliability which is reasonably high is reached, you will score the actual 38 transcripts on your own.

7. Read the therapy session for the main theme. For the Affiliation score, if it seems like the female client is mainly friendly toward the therapist or others in her life, pinpoint the right-hand side of the diamond. If she seems mostly hostile toward others at the time, pinpoint the left-hand side of the diamond. Make a mental note or lightly mark off which side of the model is being tapped.

8. For the Interdependence score, read over the same transcript and decide if the client is mostly complying, deferring, or pleasing either the therapist or others in her life. If so, pinpoint the lower half of the diamond. If she seems to be mainly asserting herself, holding her ground, or disclosing authentically, then look at the top half of the diamond.

9. Now you have zeroed in on 1 of the central diamond. Let's say it's Quadrant I. Look at the clusters nearby. They are Clusters 1, 2, and 3. Read the statements in the "Fine Points" box of each cluster. Which statement "fits" best with your clinical impression? Write down the number; for example, #217 "Asserts, holds own without needing external support." It is here where your clinical judgment is needed. I will provide scoring examples for each "Fine Point" number. Refer to these when in doubt about appropriate score.
10. Now look at the Simple Model. Locate #217. Now put your pencil point in the exact center of the diamond. Count from the center horizontally and then vertically until you reach your 3-digit number. How many points did you count on the diamond horizontally? (+3) That is your Affiliation score. How many points did you count vertically? (+7) That is your Interdependence score. In which direction from the center did you count (left and down is negative, right and up is positive). Record both Affiliation and Interdependence scores on code sheet.

11. Move on to next transcript.
NOW YOU'RE READY TO CODE ACTUAL THERAPY TRANSCRIPTS

(brief instructions)

1. Take your coding sheet. Fill in your rater's initials, today's date, and transcript code name.

2. Now take your transcript. Relax deeply. Read it. Let the material flow over you. Allow your pencil to underline key phrases in the material. Let the meanings emerge naturally and swiftly. Let the clinical sense form itself inside of you. Enjoy the feeling of the main theme in this client's life for this page.

Key phrases are those that strike you as the client being hostile vs. friendly, or as being complying/submissive vs. autonomous/assertive.

3. OK, now go to the Complex Model of SASB. Globally, is the client mostly friendly or hostile toward others today? Lightly mark off the right (friendly) or left (hostile) side of the central diamond.

4. Now, is she behaving or is her reported behavior mostly complying/yielding/submitting or assertive/disclosing authentically/holding her ground today? Lightly mark off the top (autonomous) or bottom (submissive) half of the diamond.

5. You should now be inside one Quadrant. Look at the clusters nearby this Quadrant. Read the "Fine Points" in boxes for these nearby clusters.

6. One of the statements will feel about right. No exact precision is needed here, or even possible. Merely consult your internal sensations, resonant feelings, intuitions and thoughts about context to decide which fine point statement "fits" best. Choose the tiny 3-digit number and record it on your coding sheet. Refer to "Scoring Examples" when in doubt.

7. Now go to the Simple Model of SASB. Find your 3-digit number. Count from the center of the diamond horizontally and then vertically until you reach your 3-digit numbered statement. How many points did you count horizontally? That is your Affiliation score. How many points did you count vertically? This is your Interdependence score. Note which direction you moved for + or - signs. Record your Affiliation and Interdependence scores on the code sheet.

8. Move on to next transcript. Record its code name and score.
INSTRUCTIONS TO RATERS OF SAMPLE DREAMS

1. You will be given a total of 30 typed, one-page dream protocols to rate, one at a time. Each dream was obtained from a different psychotherapy session. They are randomly ordered.

2. At the top of each protocol you will see a code name, such as "Venus." A dream may contain several characters, or dream figures. Rate the male figure only.

3. You will be given one coding sheet on which to record all ratings. Simply record your initials, the code name of each protocol you rate, the date, and the two scores you will be trained to discern.

4. What do you rate and how? We will first familiarize ourselves with the rating instrument. Look at the model.

5. See the model. Explain. Give them a sample here and talk through it.

6. Each protocol gets one "Affiliation" and one "Interdependence" rating. We will read, score and talk through 3 samples, establishing rules of thumb to resolve any questions which arise about procedure. Then you will silently score 3 more samples, and we will once again talk about any discrepancies. Once a reliability which is reasonably high is reached, you will score the actual 30 dreams on your own.

7. Read the protocol for the main theme. For the Affiliation score, if it seems like the male figure is mainly friendly toward the female dream figure, then pinpoint the right hand side of the diamond. If the male seems mostly hostile, pinpoint the left-hand side. Make a mental note or lightly mark which side of the model is being tapped.

8. For the Interdependence score, read over the same protocol and decide if the male figure is mostly ignoring, trying to control, manage, or constrict the female. If so, pinpoint the lower half of the diamond. If the male seems mainly to endorse the female's freedom, or encourage her autonomy, or support her psychologically, then pinpoint the upper half of the diamond.

9. Now you have zeroed in on 1/4 of the central diamond. Let's say it's Quadrant III. Look at the clusters nearby. They are clusters 5, 6, and 7. Read the statements in the "Fine Points" boxes of each cluster. Which statement "fits" best with your clinical impression? Write down the best statement (the tiny 3-digit number); for example, #133—"harshly punishes person, takes revenge, makes person suffer greatly."
10. Now look at the Simple Model of SASB. Locate #133. Now put your pencil point in the exact center of the diamond. Count from the center horizontally and then vertically until you reach your 3-digit number. How many little points did you count on the diamond horizontally? (-7) That is your Affiliation score. How many little points did you count vertically? (-3) That is your Interdependence score. In which direction from the center did you count (left is negative score, and right is positive). Record both Affiliation and Interdependence scores on code sheet. Move on.
NOW YOU'RE READY TO CODE ACTUAL DREAMS
(brief instructions)

1. Take your coding sheet. Fill in your "rater's initials," today's date, and "dream code name."

2. Now take your dream. Relax deeply. Read it. Let the material flow over you. Allow your pencil to underline key phrases in the material. Let the meanings emerge naturally and swiftly. Let the clinical sense for itself inside of you. Enjoy the feeling of the main theme in this client's dream.

Key phrases are those that strike you as the male being hostile vs. friendly or being indifferent/controlling vs. encouraging autonomy/supporting female's efforts.

3. OK, now go to the Complex Model of SASB. Is the male figure mostly friendly or hostile in this dream? Lightly mark off the right (friendly) or left (hostile) side of the central diamond.

4. Now, is he mostly controlling or encouraging autonomy in this dream? Lightly mark off the bottom (controlling) or top (encouraging freedom) half of the central diamond.

5. You should now be inside one Quadrant. Look at the clusters nearby this Quadrant. Read the "Fine Points" in boxes for these nearby clusters.

6. One of the statements will feel about right. No exact precision is needed here, or even possible. Merely consult your internal sensations, resonant feelings, intuitions, and thoughts about context to decide which fine point statement "fits" best. Choose the tiny 3-digit number and record it on your coding sheet.

7. Now go to the Simple Model of SASB. Find your 3-digit number. Count from the center of the diamond horizontally and then vertically until you reach your 3-digit numbered statement. How many points did you count horizontally? That is your Affiliation score. How many points did you count vertically? That is your Interdependence score. Note which direction you moved for + or - signs. Record your Affiliation and Interdependence scores on the code sheet.

8. Move on to the next dream. Record its code name and score.
APPROVAL SHEET

The dissertation submitted by Catherine Milord has been read and approved by the following Committee:

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The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

4/16/94

Date

Director's Signature