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Focus in Psychotherapy: Characteristics and trajectories through the therapeutic process.

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CONTENTS

	ABSTRACT.....	9
I.	INTRODUCTION.....	11
II.	THEORETICAL AND EMPIRICAL BACKGROUND.....	13
1	**Brief Psychotherapy: a necessity**…….	13
2	**Focus**……..……	15
2.1	Generic definition and usefulness……...	15
2.2	Conceptualizations of focus……	17
3	**Dynamic Formulation**……..……	22
3.1	OPD Foci ……..……...……...	25
3.1.1	Dysfunctional Relational Pattern (Axis 2)……..……	25
3.1.2	Internal Conflictual Configuration (Axis 3)…….……...……...	27
3.1.3	Structural Condition (Axis 4)……..……...……	28
4	**Change Process Research: the study through relevant episodes**..……	31
4.1	Psychodynamic change: How can foci change?..…….…….…….	34
4.2	Tracking Foci in the therapeutic process ……..…….……	37
III.	OBJECTIVES.....	39
IV.	HYPOTHESIS.....	41
V.	METHODOLOGY.....	43
5.1	**Participants**..…….…….……..……	43
5.2	**Instruments**……..……..……	45
	Generic Change Indicators (GChIs)…..……...…….	44
	Operationalized Psychodynamic Diagnosis (OPD-2)…...……..……..	46
	Heidelberg Structural Change Scale (HSCS)……..…….....	46
	Foci Presence Scale (FPS)……..……..……	48
	Outcome Questionnaire (OQ-45.2)……...…..……..	48
5.3	**Procedure**……...……	49
5.4	**Data analysis**…….…….	54
VI.	RESULTS.....	56
1.	*Descriptive*…..…….…….……..…….	56
1.1	Type of Foci ……..……..……	56
1.2	Foci Presence …..…….	56
1.3	Foci Integration Level...…….……...	57
2.	*Results about the relation of the variables in study*…….	59
2.1	Type of Foci and Level of Presence…….	59
2.2	Foci and Subjective Change…….	66
2.3	Foci and Level of Integration……...	69
2.4	Level of Foci integration and Subjective Change……	73

VII. CONCLUSION AND DISCUSSION..... 76

VIII. REFERENCES..... 84

IX. ANNEX..... 94

Annex 1…….. 95
Hierarchy of Generic Change Indicators

Annex 2…….. 96
OPD Potential Foci

Annex 3…….. 97
Levels of Foci Integration (HSCS)

Annex 4…….. 98
Foci Presence Scale (FPS)

X. Erklärung gemäß § 8 Abs. 1 Buchst. b) und c) der Promotionsordnung der Fakultät für Verhaltens- und Empirische Kulturwissenschaften..... 99

INDEX OF TABLES

Table 1. Compendium of authors and their conceptualizations of Focus 18

Table 2. Participant's Description 44

Table 3. Foci Identification for each therapy 45

Table 4. Mean agreement of Foci Identification for the three judges (Judges A) in each Therapy (K_w) 51

Table 5. Mean agreement of Degree of Presence for each foci for the three judges (Judges B) in each Therapy (ICC_s) 53

Table 6. Mean agreement on the Level of Foci Integration for each episode for the three judges (Judges B) in each Therapy (ICC_s) 53

Table 7. Episode count by Stage. 54

Table 8. Frequency of OPD Foci Identification in change episodes (N=70) 56

Table 9. Repeated Measures ANOVA for phases of the process by level of foci presence 60

Table 10. Repeated Measures ANOVA for level of foci presence by type of foci (focus 2: relational pattern; focus 3: conflict focus and focus 4: structural vulnerabilities focus). 61

Table 11. Repeated Measures ANOVA for the interaction of psychotherapeutic phase (phase 1: initial; phase 2: middle and phase 3: final) with type of focus (focus 2: relational pattern; focus 3: conflict focus and focus 4: structural vulnerabilities focus) in terms of the level of foci presence. 62

Table 12. Generalized Estimation Equation analysis for the variable "highly present" of relational pattern focus (axis 2), conflict focus (axis 3) and structural vulnerabilities (axis 4), according to the different phases of the psychotherapeutic process. 63

Table 13. Correlation between presence of relational pattern focus (axis 2), conflict focus (axis 3) and structural vulnerabilities (axis 4). 65

Table 14. Correlation between presence of relational pattern focus (axis 2), conflict focus (axis 3) and structural vulnerabilities (axis 4) in each phase of the psychotherapeutic process. 66

Table 15. Repeated Measures ANOVA for the variable foci presence dichotomized in "high presence" and "low presence" for each type of foci (focus 2: relational 68

pattern; focus 3: conflict focus and focus 4: structural vulnerabilities focus) in interaction with phases of psychotherapy for Generic Change Indicators.
Table 16. Repeated Measures ANOVA for the variable foci integration level in relation with the therapeutic phases. 69
Table 17. Generalized Estimation Equation analysis for the interaction of phase of the psychotherapeutic process and level of foci presence. 70
Table 18. Repeated Measures ANOVA for the variable foci presence dichotomized in “high presence” and “low presence” for each type of foci (focus 2: relational pattern; focus 3: conflict focus and focus 4: structural vulnerabilities focus) in interaction with phases of psychotherapy for the level of foci integration. 74
Table 19. Estimated score for the generic change indicators as function of the foci level of integration for each phase of the therapeutic process. 74

INDEX OF FIGURES

Figure 1. Stages of the Procedure 49

Figure 2. Level of Presence of the relational pattern focus (axis 2) for each psychotherapy through the change episodes. 57

Figure 3. Level of Presence of the conflict focus (axis 3) for each psychotherapy through the change episodes. 57

Figure 4. Level of Presence of the structural vulnerabilities focus (axis 4) for each psychotherapy through the change episodes 58

Figure 5. Average of the level of Presence for each of the focus; relational pattern focus (axis 2), conflict focus (axis 3) and structural focus (axis 4) for all psychotherapies through the episodes. 58

Figure 6. Evolution of the Level of Integration of Foci (HSCS) for each therapy through the therapeutic process (episodes) 59

Figure 7. Average presence of foci in general considering the different phases of the process. 60

Figure 8. Average of Foci Presence for each focus 61

Figure 9. Average of the level of presence for each focus in the different phases of the psychotherapeutic process. 62

Figure 10. Probability of Foci Presence relational pattern focus (axis 2), conflict focus (axis 3) and structure focus (axis 4) for each phase of the process. 64

Figure 11. Interaction of Phase in every level of the variable Presence dichotomized in “high presence” and “low presence” for the relational pattern focus (axis 2), for the Generic Change Indicators. 67

Figure 12. Interaction of Phase in every level of the variable Presence dichotomized in “high presence” and “low presence” for the conflict focus (axis 3), for the Generic Change Indicators. 67

Figure 13. Interaction of Phase in every level of the variable Presence dichotomized in “high presence” and “low presence” for the structural vulnerabilities focus (axis 4), for the Generic Change Indicators 68

Figure 14. Average of level of foci integration for each phase of psychotherapy 70

Figure 15. Interaction of the level of foci integration and the degree of foci presence for each phase of the psychotherapeutic process 71

Figure 16. Interaction of Phase in every level of the variable Presence, dichotomized in “high presence” and “low presence” for the conflict focus (axis 3), for the level of foci integration. 72
Figure 17. Interaction of Phase in every level of the variable Presence, dichotomized in “high presence” and “low presence” for the structural vulnerability focus (axis 4), for the level of foci integration. 72
Figure 18. Estimated score for the generic change indicators as function of the foci level of integration. 74
Figure 19. Estimated score for the generic change indicators as function of the foci level of integration for each therapeutic phase. 75

ABSTRACT

Over the last decades, brief dynamic psychotherapy has been increasingly important in the actual clinical practice. For its brevity focalization must be accomplished. The work on focus has shown to have many advantages; it consolidates the material, abbreviates psychotherapy and is considered to be a change mechanism. For this thesis the Operationalized Psychodynamic Diagnosis System (OPD-2) was used, for this system focus consists in the specific problematic areas that are significant for the patient's psychodynamics, specifically three are the areas that can became a focus; relational pattern, inner conflict and structural vulnerabilities. The study on foci and the relation between them becomes a research and clinical imperative. But also, the study of the process is of fundamental importance for advancing the science of psychotherapy, for this, change on foci must be considered. Relevant for this thesis is to consider the change in the level of foci integration as an indicator of foci change process. Few are the studies that analyze foci from a process perspective, and even fewer are the ones that study them in significant segments, called change episodes. The objectives of this thesis are to determine types of foci and its relationship, and to analyze its relation with change considered as change in subjective theories of the patient and to foci level of integration throughout the psychotherapeutic process. In order to cover the aforementioned objectives, a multiple single subject design was used, considering the analysis of change episodes of four brief dynamic psychotherapies done as treatment as usual. Raters were used for the different stages of the procedure with good reliability and a new instrument was developed to be capable to grasp the different levels of foci presence. As for the results, OPD foci were identified in all change episodes with a higher presence in the middle phase of psychotherapy. Specifically, dysfunctional relational patterns focus was more present in the initial phase, while structural vulnerabilities were higher in the final phase. On the other hand, generic change indicators related specifically with the presence of relational pattern focus and conflict focus. Also, these indicators showed a direct relation between them and foci integration level. Finally the initial phase showed that the high presence of foci associates with lower integration, but, in the middle phase, the high presence of foci associates with a higher level of integration of them.

RESUMEN

En las últimas décadas, la psicoterapia psicodinámica breve ha aumentado su importancia en la práctica clínica actual. Para su brevedad la focalización debe realizarse. El trabajo sobre un foco ha demostrado tener varias ventajas; consolida el material, abrevia la psicoterapia, y es considerado como un mecanismo de cambio. Para esta tesis el Sistema de Diagnóstico Psicodinámico Operacionalizado (OPD-2) fue utilizado, para este sistema el foco consiste en aquella área problemática que es significativa para la psicodinamia del paciente, específicamente tres son las áreas que pueden transformarse en foco; el patrón relacional, la conflictiva interna y las vulnerabilidades estructurales. Resulta un imperativo clínico y de investigación estudiar el foco y la relación entre ellos, pero también lo es estudiar el proceso, para esto, se debe considerar el cambio en el foco. Para esta tesis se considerará el cambio en el nivel de integración de los focos como un indicador de proceso. En la literatura son pocos los estudios que analizan el foco desde una perspectiva procesual, y menos son los que lo estudian en segmentos relevantes, también llamados episodios de cambio. Los objetivos de esta tesis son determinar los tipos de focos y establecer la relación entre ellos, también analizar su relación con el cambio considerado como cambio en las teorías subjetivas y cambio en el nivel de integración del foco a través del proceso terapéutico. Para lograr estos objetivos, se utilizó un diseño de múltiples casos únicos, considerando el análisis de episodios de cambio de cuatro psicoterapias psicodinámicas breves. Se utilizaron jueces para cada una de las etapas del procedimiento logrando una buena confiabilidad y un nuevo instrumento de desarrolló para identificar distintos niveles de presencia de los focos. En cuanto a los resultados, los focos OPD se pudieron identificar en todos los episodios de cambio teniendo una mayor presencia en la fase media del proceso de psicoterapia. Específicamente, el foco en el patrón relacional disfuncional está más presente en la fase inicial, mientras que la presencia del foco en las vulnerabilidades estructurales es mayor en la fase final. Por otro lado, los indicadores genéricos de cambio muestran una relación con la presencia de los focos patrones relacionales disfuncionales y conflictiva interna. Así también, estos indicadores mostraron una relación directa con el nivel de integración de los focos. Por último, la fase inicial del proceso mostró que la alta presencia de los focos se asocia a menores niveles de integración, pero, en la etapa media, la alta presencia de los focos se asociaba a una alta integración de éstos.

I. INTRODUCTION

Contemporary therapists have been called to provide treatments with higher levels of effectiveness and briefness. To bring this demand into actuality, the brief dynamic psychotherapy[1] practice has emphasized the importance of establishing a dynamic specific focus for the treatment (Scaturo, 2002). Thomä & Kächele (1985) point out that focalization is not exclusive to this type of psychotherapy. In fact, it has an eminently practical origin, because all therapeutic work always (and often intuitively) points towards the delimitation of a nodal aspect of the patient's problems. Focus is so relevant for dynamic therapy that even psychoanalysis is regarded as an "ongoing, temporally unlimited focal therapy with a changing focus" (Thomä and Kächele, 1987, p. 347).

In general terms, focus can be identified early on, it consolidates material and it abbreviates psychotherapy. On the other hand, focus gives shape and form to the patient's material and in doing so it makes a significant contribution to bringing the patient's inarticulate felt experience within the jurisdiction of form, and it also contributes in holding and containing that experience (Smith, 2006).

In this perspective, focus is regarded as a thematic center of gravity, built upon the therapeutic interaction and upon the basis of the material provided by the patient as well as the therapist's ability to understand it and conceive it (Thöma & Kächele, 1987). In addition, focus is not always one or the same during the psychotherapeutic process.

Although the usefulness and the necessity of the focus are accepted, there are many and different conceptualizations of focus and some of them derive from operationalizations and some of them from models of brief psychotherapy (e.g. Malan, 1963; Sifneos, 1979; Strupp & Binder, 1984). In spite of this diversity, these conceptualizations can be separated depending on whether they refer to intrapsychic conflicts or to dysfunctional interpersonal patterns. Also, they can be grouped according to their representation of focus as monoschematic or as multischematic.

For focus identification, a dynamic diagnosis must be performed. There are some operationalyzed systems that allow for dynamic formulation such as, the Psychodynamic Diagnostic Manual (PDM Task Force, 2006), the Shedler Westen Assessment Procedure or SWAP (Westen & Shedler 1999a, b) and the Karolinska Psychodynamic Profile (KAPP, Weinryb & Rössel, 1991). Even though these are good instruments, they lack the possibility

to identify focus and to identify more than one. The Operationalyzed Dynamic Diagnosis (OPD, OPD-Task-Force, 2008) accomplishes the foci identification by developing a system to be applied throughout the psychotherapy. The focus constitutes the specific problematic areas that are significant for the patient's psychodynamics (Grande, Rudolf, Oberbracht, Jakobsen & Keller, 2004), which will become the foci in psychotherapy only if they are observed to sustain the patient's psychic or psychosomatic symptoms. These are the dysfunctional relational patterns (Axis 2), internal conflictual configuration (Axis 3), and the structural condition (Axis 4). The structural condition results as an important input since it is a new territory for psychoanalysis and dynamic psychotherapy (Klug, & Huber, 2009).

To examine the patient's foci as usual, that is the therapist without the knowledge of the OPD system, is of both clinical and research importance but the examination of the foci throughout the therapeutic process becomes even more important since the study of the process leads to really comprehend how therapy generates changes in patients' difficulties (Greenberg, 1986; Llewellyn & Hardy, 2001). Therefore, studying the process of foci change is of fundamental importance for advancing in the science of psychotherapy (Elliott, 2010).

More than studying the whole session, significant segments can be identified and researched upon. Therefore, the delimitation of episodes of change is necessary. Krause et al. (2007) developed a list of Generic Change Indicators that function not only as "markers" for the identification of change moments and therefore the delimitation of change episodes, but also as change itself. For this thesis, change episodes are studied regarding the presence of each OPD foci in the therapeutic dialogue between the patient and the therapist.

Furthermore, the pressing need to prove the benefits of psychoanalysis and dynamic psychotherapy have intensified the search for suitable instruments measuring structural diagnosis (Rudolf, Grande & Henningsen, 2002) and change processes. Initial findings with the OPD diagnosis under psychotherapeutic treatments did not show massive change (Grande et al., 2001).Therefore, the Heidelberg Structural Change Scale (HSCS) was developed (Rudolf, Grande, & Oberbracht, 2000). This instrument has not been used to study in-session moments, as change episodes, which is the interesting enough reason to see on a moment-to-moment basis how foci change in terms of their level of integration.

In sum, when considering the psychotherapy process research reflections about the study of relevant episodes within the session and throughout the process, it can be expected that the foci may evolve, transform, or change. No studies have been found that examine the

[1] Traditionally the term psychodynamic refers to theories that explained psychic phenomena as the result of multiple (opposing) forces. The term dynamic is used in this thesis to include interpersonal theories.

foci, their relationship and their trajectory during the therapeutic process and not even their change during relevant episodes. Due to these observations and because of their importance for clinical practice, the foci will be studied in this thesis.

II. THEORETICAL AND EMPIRICAL BACKGROUND

1. Brief Psychotherapy: a necessity.

The emergence of brief psychotherapy is probably better explained as an effect of the social, political, and economic changes occurred towards the end of the 20th century rather than as the result of progress in theory or research. Several authors (e.g. Balint, Ornstein, & Ornstein, 1972; Messer, & Warren, 1995) highlight two elements identified as essential for the development of this approach. First, during and after World War I, it was necessary to provide large-scale, free analytic therapy (Balint, et al., 1972). Secondly, due to an increased access to mental health services after 1980, people from different socioeconomic levels in the United States of America were able to receive therapy. The pressures for the existence of this service increased, which resulted in long waiting lists and a growing need to establish brief but equally effective treatment models. At the same time, the growing popularity of psychotherapy in the media increased people's awareness of such treatments, and thus their interest in them increased (Wallerstein, 2009).

In order to respond to the need to abbreviate treatment forms, all theoretical approaches stress the importance of selecting a "focus" or thematic center to guide interventions (Scaturo, 2002). In general, this approach is based on the fact that patients tend to request psychotherapy due to problems that they have been unable to solve and which involve a high level of psychic pain. Their feeling of this pain is the reason that leads them to seek the assistance of the psychotherapist as well as the issue that must be solved during the psychotherapeutic process (Krause, 2005). Using a therapeutic focus makes it possible to work on the patient's problem areas while at the same time limiting the length of the treatment. Focusing on one aspect is fundamental for this psychotherapeutic approach (Messer & Warren, 1995).

Technically and theoretically, this demand especially had an effect on psychoanalysis, which up to that point it had mostly applied long-term therapies, employing techniques such as free association, free-floating attention, etc. As a result of these pressing needs, the Brief Dynamic Psychotherapy emerged. The process of brief dynamic psychotherapy unfolds around a central therapeutic focus which is explored within a limited period of time (DeLaCour, 1986). The focus constitutes a main aspect of this type of psychotherapy, making

it possible to be brief (Balint, Ornstein & Balint, 1972; Scaturo, 2002). This approach has led to the modification of theoretical assumptions and techniques which had been used for years (e.g., Mitchell, 1997), since maintaining a therapeutic focus requires, for instance, the therapist to be more active during the process.

However, the transformation of the "pure gold" of psychoanalysis into the "copper of direct suggestion" (Freud, 1919, p. 193) –in this case in the form of brief psychodynamic therapy– does not imply structural changes in the theory or the technique. As Jiménez (2000) points out (alluding to Freud's metaphor), all golden objects have varying proportions of copper, because this alloy is harder and resistant to time. Focus is the pivotal difference between two treatment approaches which derive from essentially the same theoretical base (DeLaCour, 1986), with the exception of the use of time limits. Brief dynamic psychotherapy employs the same theoretical basis as psychoanalysis (with different emphases for different authors), inasmuch as they consider that: 1) mental life is unconscious and includes thoughts, feelings, and motives. 2) mental processes, including affective and motivational processes, operate in parallel, so that individuals can have conflicting feelings toward the same person or situation that push them in opposing directions and often lead to compromised solutions, 3) stable personality patterns begin to form in childhood, and childhood experiences play an important role in personality development, particularly in shaping the ways people form social relationships later in life, 4) mental representations of the self, others, and relationships guide people's interactions with others and influence the ways in which they become psychologically symptomatic, 5) personality development involves not only learning to regulate sexual and aggressive feelings but also moving from an immature, socially dependent state to a mature, interdependent one (Westen, 1998).

Empirically, brief psychotherapy has been found to be effective. For example, it has been shown that patients are able to resolve their mental health issues and achieve their goals by engaging in this type of psychotherapy (Macdonald, 1994; Macdonald, 1997; Dejong & Hopwood, 1996). Specifically, brief dynamic psychotherapy has been found to be effective (Leichsenring, Rabung, & Leibing, 2004), and it has indeed received a considerable amount of attention in the empirical literature (Koss and Shiang 1993), through comparisons with long-term dynamic therapies (e.g. Piper, Debbane, Bienvenu & Garant, 1984), meta-analyses (e.g. Crits-Christoph, 1992), studies of the long-term effects of this type of psychotherapy (e.g. Høglend, 2003), and the use of process-outcome research (e.g. Piper, Joyce, McCallum & Azim, 1998).

On the other hand, there is a significant and long-standing discrepancy between idealized theory and real-world practice that concerns the number of treatment sessions undertaken by most patients (Shapiro, et al. 2003). Empirical studies have found that psychotherapy patients typically attend few treatment sessions (Hansen, Lambert, & Forman, 2002). This discrepancy is what Jiménez (2000) has identified as "the clinicians' illusion".

Brief dynamic psychotherapy involves a psychodynamic comprehension of the patient and the form of his/her illness and psychic pain; thus, it requires specialized knowledge and training because it is neither a dehydrated long-term therapy (Cummings 1986) nor just less of the same (Peake et al. 1988). Specifically, the task of focus selection is recognized as not only critical but as the aspect of brief therapy that is hardest to master (DeLaCour, 1986). In fact, therapists who have been trained in brief dynamic psychotherapy show better outcomes than those who have not (Burlingame et al. 1989; O'Malley et al. 1988; Rounsaville et al. 1988), and trained clinicians feel that they are better skilled in brief therapy than are their untrained counterparts (Levenson, Speed, & Budman 1995).

Establishing and working within a dynamic focus are among the most problematic issues which therapists coming from a psychodynamic background face when doing brief therapy. These situations challenge analytical practice, where no material is implicitly more important than any other. In time-limited therapy only material relating to the dynamic focus is considered significant, while clinical material which falls outside the focus needs to be discarded unless it has some relevance (Mander, 2002).

In sum, brief dynamic psychotherapy arises from the need for shorter therapies. In order to attain brevity, a focus must be established and worked on. This type of psychotherapy requires specialized knowledge and training, two aspects which the empirical literature has shown to be effective. Because of the importance of focus, this thesis studies the main aspect of brief dynamic psychotherapy: the use of focus and therapeutic work on it.

2. Focus

2.1. Generic definition and usefulness

Etymologically speaking, the focus (from Latin focus: fire or hearth) is the place where light rays or heat converge, or the real or imaginary place in which most of the force and efficiency of something is concentrated, and from which influence propagates or is exercised (Real Academia Española, 2009).

Psychotherapy is organized around the focus or center, thus making it possible to abbreviate the therapeutic process. The formulation and presentation of the focus are clearly

intended to resonate deeply with the felt experience of the patient, giving shape to it in a way that can be experienced as both meaningful and supportive. Maintaining a focus is considered to be an essential factor in limiting regression and in lessening the likelihood of the development of a transference neurosis. There is a clear purpose to every intervention that will be linked to the chosen focus and to the known and anticipated ending, all of which serves to push the process as fast and as far as possible in the chosen direction (Mander, 2002). Thomä & Kächele (1985) point out that focalization is not exclusive to this type of psychotherapy. In fact, it has an eminently practical origin, because all therapeutic work always (and often intuitively) points towards the delimitation of a nodal aspect of the patient's problems. Focus is so relevant for psychodynamic therapy that even psychoanalysis is regarded as an "ongoing, temporally unlimited focal therapy with a changing focus" (Thomä and Kächele, 1987, p. 347).

Even though various conceptualizations of focus exist (see next section), authors generally agree on three of its advantages:

- *It can be identified early on*; usually during the first psychotherapy sessions (Chernus, 1983, Safran and Muran, 2000), in the first meetings (DeLaCour, 1986),
- *it consolidates the material*; focalization is an operation that consists in reducing the patient's problems both theoretically and practically in order to make them approachable by the treatment (Poch & Maestre, 1994, Scaturo 2002), that is to say, it merges material ranging from the simple and current to the complex and biographical,
- *It abbreviates psychotherapy*; it shortens treatments by giving the therapist a heuristic theory which systematically guides his/her interventions (Safran and Muran, 2000).

On the other hand, focus gives shape and form to the patient’s material and in doing so it can be seen to make a significant contribution to bringing the patient’s inarticulate felt experience within the jurisdiction of form, and also contributes in holding and containing that experience (Smith, 2006). The aforementioned is one of the reasons why focus is considered to be a change mechanism, because establishing and working constantly and consistently on it in different contexts facilitates working on the process and allows the patient to integrate changes into his/her everyday life (Messer and Warren, 1995; Malan, 1976; Safran & Muran, 2000; Marziali, 1984; Crits-Cristoph Cooper, & Luborsky, 1988).

In this thesis, focus will be understood as the specific area of the patient's problems, which underlies his/her current difficulties, or how he/she can best explain them (Balint, Ornstein &Balint, 1972). In this perspective, focus is regarded as a thematic center of gravity, constructed in therapeutic interaction upon the basis of the material provided by the patient

and the therapist's ability to understand and conceive it (Thöma & Kächele, 1987). In addition, focus is not always one or the same during the psychotherapeutic process: based on the diverse material provided by the patient and the therapist's selective activity, new areas are explored which will eventually constitute new foci (Balint, et al. 1972; Thöma and Kächele, 1985). These sets of individually crucial areas can be regarded as nodal points in a network of dynamic interrelations on which other problems depend. They thus represent basal reference points for any treatment aiming at substantial therapeutic change (Balint, et al. 1972).

Also, focus serves to protect both the therapist and the patient from becoming overwhelmed by the clinical material which neither party may not, at times, clearly understand. Since it is mutually agreed on at the beginning and constantly borne in mind thereafter, the danger of the therapist imposing a therapeutic focus on the patient is reduced. It is not rigid, and it can change over time, enabling a sense of narrative cohesion which weaves together apparently unrelated sessions and helps to organize the therapeutic experience (Coren 2001).

In brief, the accepted notion is that foci[2]emerge from the interaction between the patient and the therapist, may change over the therapeutic process, and can be regarded as psychotherapeutic change mechanisms. Bearing this in mind, it is necessary to determine what the exact foci are, how they relate to each other, how they change over the therapeutic process, and what their relationship with change are in the patient.

2.2. Conceptualizations of focus

There is no consensus about the concept of focus in the literature. Authors have different forms of conceptualizing this notion and defining the specific areas of the patient's problems which must become therapeutic foci. In fact, within the psychodynamic context, the concept of focus can be traced to Freud, when he observed that ideas are linked together (Freud, 1950c; 1895). He stated that their concatenations crossed at "nodal points" and that it was the task of analysis to locate them: "The logical chain corresponds not only to a zigzag, twisted line, but rather to a system of lines and more particularly to a converging one. It contains nodal points at which two or more threads meet" (Freud, 1895, p. 290). At that time psychoanalysis was more like a brief dynamic psychotherapy, because it generally ran for six to nine months at most (Binder, 1977). In fact, Freud's treatment of Bruno Walter (Walter, 1940; Jones, 1955) lasted only some weeks, and his treatment of "Katharina" (1955) lasted

[2] From now on, foci will be the term used, since there is more tan one focus.

only a couple of hours. Later on, Freud became less partial to such practices, and adopted a passive role, with therapies which became increasingly unfocused.

At the same time as psychoanalysts abandoned achievement and focus, Thomas French (1944) introduced the ideas of "focal conflict" and "nuclear conflict". The focal conflict is closer to the surface (pre-conscious), which is where all the impulses converge and later are discharged through the patient's verbalization. Focal conflicts derive from nuclear, deeper conflicts, and their structure comprises a disturbing motive (impulse or desire) that conflicts with a reactive motive (response by the ego or super-ego), which creates a need for a solution (adaptive or defensive transaction formula) (Balint, Ornstein & Balint, 1986). The concepts of focal and nuclear conflict (French, 1944) became the psychoanalytic basis for the subsequent development of focal theory in psychotherapy. Balint's focal therapy (1972) takes this idea of focal conflict and develops the principles of focus-centered therapy: (a) a temporal limit, (b) a central axis for the treatment, (c) an active role for the therapist and, (d) the importance of the patient's emotional experience.

Since then many focus definitions have been developed. Even more, some of them derive from specific operationalizations of the central concept and have developed systematic guidelines for foci identification and others have decanted in psychotherapy models (Barber & Crits-Christoph, 1993). For a review of the different conceptualizations and operationalization of focus see Table 1.

Table 1.
Compendium of authors and their conceptualizations of Focus (chronological order)

Author/s	Focus Conceptualization	Focus Operationalization
Alexander & French (1946)	Focal Conflict and Nuclear Conflict	
Deutch & Murphy (1955)	Psychoanalytic Sector	
Wallerstein & Robbins (1956)	Core Neurotic Conflict	
Blos (1941); Ekstein, (1956)	Residual Trauma	
Malan (1963)	Neurotic Basic Conflict	
Racker (1968)	Central Transference Predisposition	
Sifneos (1972)	Oedipal Conflicts	
Balint, Ornstein & Balint (1972)	Focus	
Mann (1973) Mann & Goldman (1982)	Separation-Individuation	
Benjamin (1974)	Maladaptative Interpersonal Pattern	Structural analysis of social behavior SASB
Luborsky (1977)	Core Conflictual Relationship Theme	Core Conflictual Relationship Theme CCRT

Davanloo (1980)	Hidden Feelings and Conflicts	
Strupp & Binder (1984)	Maladaptative Relational Pattern	Cyclical Maladaptative Pattern CMP
Weiss & Sampson (1986)	Pathological Beliefs	Plan Diagnosis and Plan Formulation Method (PFM)
Budman & Gurman (1988)	Interpersonal Development (Existential Focus)	
Perry, Augusto & Cooper (1989)	Components of the Idiographic Conflict Formulation	Idiographic Conflict Formulation Method (ICF) Psychodynamic Conflict Rating Scale (PCRS)
McCullough-Vaillant (1997)	Core Psychodynamic Conflict	
Horowitz M. (1997)	Internalized scripts or working models	Role Relationship Model Formulation (RRM)
Klerman, Weissman, Rounsaville, et al. (1984)	Interpersonal Functioning	Interpersonal Psychotherapy
Fiorini (2000)	Focal Situation	

As seen in Table 1, of the classic authors, Malan (1976) describes "focality" (p.11) as an attempt by the therapist to tackle the patient's "basic neurotic conflict" (p.13). He talked of a ‘crystallization’ of the focus and of its ‘gradual emergence in the give and take between patient and therapist’, thus advising a judicious adjustment of diagnostic hypotheses at the very beginning of the therapeutic process (Mander, 2002). Malan (1963) introduced the idea of a focal problem –a nuclear (childhood) conflict which manifests itself in the present-. This conflict is framed by the patient's characteristics in terms of the defense-anxiety-impulse configuration, that is, the defensive form used by patients that he called the "triangle of conflict," which must be interpreted and connected with the "triangle of persons," the way in which this configuration is expressed with others (including the therapist).

Sifneos (1979), another classic author, focuses on intrapsychic conflicts which the patient has to face in therapy through the material that has been avoided in the past. Sifneos considers that the level of anxiety in therapy (reduced or increased) is crucial in fostering change (Stadter, 2009).He argues for an emphasis on oedipal issues and a continuous focus on eroticized attachment to the mother/father. The issues regarded as fundamental by the patient are approached in the context of the examination of his/her childhood relationship with his/her parents, especially with the parent of the opposite sex. Sifneos highlights the importance of interpreting oedipal material and transference, linking the latter aspect to the patient's concerns.

In the 1980s, some authors made progress in the conceptualization of focus, proposing ways to operationalize it. For instance, Strupp and Binder (1984) developed a dynamic-

interpersonal focus, the cyclical maladaptive pattern (CMP; Schacht, Binder &Strupp, 1984) which represents a cognitive map of a circumscribed area of the patient's dysfunctional mental activities and maladaptive interpersonal behavior, which can guide the therapist's approach to the patient. This formulation model reflects a theoretical view in which dysfunctional mental activity, maladaptive interpersonal behavior, and the restricted range of reactions evoked from others interact reciprocally (Binder, 2004). The CMP is a conceptual model representing, (a) a central or salient pattern of interpersonal roles in which patients unconsciously cast themselves, (b) the complementary roles in which they cast others, (c) the maladaptive interaction sequences, (d) self-defeating expectations, and (e) negative self-appraisals that result (Schacht et al., 1984). The CMP contains four structural elements which express, in schematized fashion, the following fundamental categories of action: (1) Acts of self, (2) Expectations about others' reactions, (3) Acts of others toward self, and, (4) Acts of self toward self (introject).

Furthermore, Weiss and Sampson (1986), based on cognitive psychoanalytic theory, propose that the focus must be on the patient's psychopathology. They suggest that psychopathology stems from unconscious pathogenic ideas or false beliefs that are typically based on traumatic childhood experience (Silberschatz, 2008). While attempting to adapt to these psychologically unhealthy environments, people develop invalid, negative beliefs about themselves and others which make them unhappy and do not allow them to experience effective and satisfactory lives (Rappoport, 2002). They enter psychotherapy with an unconscious plan for solving problems and disconfirming pathogenic beliefs. The patient's plan may be thought of as an unconscious strategy for disconfirming certain pathogenic beliefs that can be operationalized through the Plan Formulation Method (PFM, Weiss & Sampson, 1986).

Lastly, Luborsky (1984) presents a model in which the patient's interpersonal relationships, both with important people in his/her life and with the therapist, are a central aspect of the therapeutic approach. Together, the therapist and the patient explore the latter's maladaptive relational patterns and how they influence his/her functioning and symptomatology. The patient's understanding of his/her conflictual and hindering relationships is regarded as the first step towards symptomatic reduction. This is what the author calls Core Conflictual Relationship Theme (CCRT), which constitutes the focus of the therapy and which includes a) the patient's main wishes, needs, or intentions toward the other person, b) the expected or actual responses of the other person, and c) the responses of the self.

The conceptualizations described above are just a sample of the multiple ways in which authors have defined, operationalized, and/or developed psychotherapeutic approaches using focus. Due to this great variety, they can be grouped into two broad categories based on the elements used when focalizing which, if changed, would generate a change in the patient: (1) the first group of authors established focus according to the presence of internal and unconscious conflicts, understood it as clashing forces, tensions that generate the patient's disorder (e.g. Wallerstein & Robins, 1956; Sifneos, 1979; McCullough y Valliant, 1997 y Perry, Augusto y Cooper, 1989), (2)the second group of authors examined focus as the maladaptative interpersonal conduct which is considered as the fundamental factor in the formation and continuity of disorders (e.g., Luborsky, 1977; Strupp & Binder, 1984; Benjamin, 1974).

On the other hand, notions of focus can also be distinguished according to their assumption of a single and central focus or the assumption of multiple focuses. Some authors state that some patients, "…are better described by a monoschematic versus multischematic formulation…" (Barber & Crits-Christoph, 1993, pp. 582), therefore psychodynamic formulations may be grossly categorized along a dimension of complexity into those that yield a monoschematic (relatively simple) representation, such as the *Cyclical Maladaptative Pattern* (CMP, Strupp & Binder, 1984), and those that yield a (complex) multischematic representation, such as *Role-Relationship Model Configurations* (RRCM, Horowitz, 1989).What the plurality of concepts reveals is that focus alludes to a complex organization, of which these conceptualizations are only fragments (Fiorini, 2002). However, there are little data to support either a monoschematic model or a multischematic model. One exception is the study by Crits-Christoph et al. (2005), which demonstrated that data from one patient revealed the presence of multiple themes rather than one, single predominant theme.

The multischematic view confirms the clinical impression that patients start psychotherapy psychodynamically troubled by multiple issues, which must be focalized and worked through during the therapeutic process. These foci include both intrapsychic and relational patterns, which is evidenced by the fact that some notions of focus such as CCRT or CMP include intrapsychic components (i.e. wishes and intentions that can be incompatible with each other and can evoke expectations of negative responses from others) and interpersonal components (i.e. conflicts between one's actions and the actions, real or imagined, of others; Book, 1998; Luborsky, 1997a; Strupp & Binder, 1984).

Summing up, even though the notion of focus is not recent, definitions have varied over time. In some cases, authors have developed operationalizations to facilitate their

identification and have even generated different brief psychotherapy models based on them. In spite of this diversity, these conceptualizations can be separated depending on whether they refer to intrapsychic conflicts or to dysfunctional interpersonal patterns. Also, they can be grouped according to their representation of focus as monoschematic or as multischematic.

Clinical practice shows that patients enter therapy troubled by more than one issue –all of which are interrelated– which is why this thesis adheres to the notion of focus as multischematic (multifocal), including aspects of intrapsychic conflict and of the way in which patients interact with others, and even considers –as it will be discussed below– the presence of structural vulnerability aspects. Therefore, it is necessary to employ a conceptualization of focus which can integrate its different aspects in order to reflect the complexity of the patient when focalizing and that can be operationalized in order to direct and evaluate the process.

3. Dynamic Formulation

As it has been observed, the therapist needs an organizing principle to guide the selection, organization, and prioritization of clinical data into a coherent picture of circumscribed problems (Binder, 2004). In order to create the patient's coherent picture of those aspects that are relevant to the patient's change –named foci- first a dynamic diagnosis must be formulated. Diagnostic is not the same as assessment; "… is not only labeling a type of disorder (as DSM-IV or CIE-10). Diagnosis, is the identification of clinical phenomena according to a conceptual system…highlighting those dimensions that generate or maintain the problem… which are the focus of psychoanalytic work and which are expected to change in time…" (Altmann, Fitzpatrick-Hanly, Leuzinger-Bohleber, 2012, p.93).

This diagnosis allows to develop a case formulation -or as psychodynamic psychotherapists frequently call it, a dynamic formulation- which is crucial for brief dynamic psychotherapy, especially in today's clinical environment (Barber & Crits-Christoph, 1993). It consists in focusing on concise words, by making a psychodynamic formulation (Mander, 2002). The dynamic formulation should be idiographic (to the particular patient) and theory-based, that is to say, firmly rooted in analytic theory and psychodynamic thinking.

When examining the agreement among psychoanalysts in case discussions, the material has been interpreted in disparate ways according to their theoretical orientation (Pulver, 1987). That is the reason why there is a need to count on operationalyzed psychodynamic diagnosis. Some of these operationalized dynamic diagnoses are the Psychodynamic Diagnostic Manual (PDM Task Force, 2006), the Shedler Westen Assessment

Procedure or SWAP (Westen & Shedler 1999a, b) and the Karolinska Psychodynamic Profile (KAPP).

The Psychodynamic Diagnostic Manual (PDM Task Force, 2006) evaluates the individual's functioning in terms of his/her emotional, cognitive, and social levels, considering both superficial and deep manifestations. It emphasizes both the singular and the general particularities of the individual. This system evaluates three dimensions: (1) personality patterns and disorders (P axis), (2) mental functioning (M axis) and (3) manifest symptoms and concerns (S axis). However, its capability to make a thorough and dynamic diagnosis considering different areas of the patient is limited to go beyond this, aiming to the clinical practice. From this diagnosis there are no guidelines for psychotherapy and specifically no focus determination.

Another instrument is the Shedler Western Assessment Procedure or SWAP (Westen & Shedler 1999a, b), mostly used in diagnosis, because it allows for a fine description of personality disorders with a clinical approach (Shedler, & Westen, 2007; Westen, & Shedler, 2007). The difficulty is that it is a rather long instrument (200 items) because it uses the Q-sort methodology. Besides it evaluates specific criteria to identify specific personality disorders.

Finally, another instrument is the Karolinska Psychodynamic Profile (KAPP) designed by Weinryb and Rössel (1991). It achieves a comprehensive multidimensional empirical profile of mental functioning and personality traits as they are reflected in a patient's perception of himself and his interpersonal relations. It is based on a clinical interview closely modeled on Kornberg's structural interview (1984) and consists of 18 subscales that assess, among other things, the following areas: quality of interpersonal relationships, level of mental functioning, differentiation of affects, experience of one's own body, sexuality, and personality organization. Even though it is a multidimensional instrument it doesn't establish a focus to work on.

In sum, all of the instruments referred to before can be described as comprehensive diagnostic tools with a psychoanalytic background. However, they lack the possibility to identify the circumscribed areas that require therapeutic attention and where change must be accomplished by the patient. This Foci formulation is addressed successfully by the Operationalyzed Dynamic Diagnosis (OPD, OPD-Task-Force, 2008).

OPD is an instrument developed in Germany (Arbeitskreis OPD, 1996) and widely used in that country which has been translated into several languages, including Spanish (Grupo de Trabajo OPD, 2008). This diagnostic system was created and developed to grasp

the main psychodynamically relevant diagnostic features in a standardized format that was easy to handle and communicate, complementing the usual classification of mental disorders (based on descriptive-symptomatological criteria; DSM-IV and CIE-10). In order to achieve this result, the system uses an intermediate level of inference: neither so high as to become detached from observable clinical phenomena, nor so low as to display a low concordance level between clinicians (Goldfried, et al. 1997). The OPD is used both as a research tool and as an everyday clinical resource (Schneider, Lange & Heuft, 2002).

This system defines relevant axes for diagnostic, psychodynamic and descriptive areas and descriptive areas, constituting itself as a multiaxial system consisting of five axes which have proven their validity and reliability (Cierpka, et al. 2001). Each axis has a diagnosis inventory (with its corresponding response forms) and a manual for clinical training and application for therapists (Rudolf et. al., 1998; Grande et. al., 2000).

The five axes of the OPD are:

Axis1: Experience of illness and preconditions for treatment: this axis reflects the current severity and duration of illness, how it is experienced and presented by the patient, the lay concept, which the patient has about his/her mental disorder or illness and his/her resources for the impediments of change. It has a psychotherapeutic module that reflects the wish of the patient for a specific psychotherapy, his psychological mindedness as well as any secondary gains the patient may obtain from the illness.

Axis 2: Interpersonal relations: this axis depicts the circular or the transactional character of human interaction (interchange of subjective experience and response to the environment)[3].

Axis 3: Conflicts dysfunctional patterns[3].

Axis 4: Psychic structure; patient's level of functioning and integration is assessed on the basis of the structural capacities and vulnerabilities[3].

Axis 5: Psychosomatic and psychiatric disorders according to ICD-10, Chapter V (F)

In its second version (OPD-2, OPD-Task-Force, 2008) the system makes it possible to identify the foci which will be worked through during the psychotherapy. The focus constitutes the specific problematic areas that are significant for the patient's psychodynamics (Grande, et al. 2004), which will become foci in psychotherapy only if they are observed to sustain the patient's psychic or psychosomatic symptoms. Foci derive from the more psychodynamic axes of the OPD, such as dysfunctional relational patterns (Axis 2), internal

[3]This axis will be detailed in the next chapter.

conflictual configuration (Axis 3), and structural condition (Axis 4). The OPD then enables therapy planning by allowing the therapist to determine these therapeutic foci.

These dynamics in patients show the complexity of human beings, but mainly the importance of being aware that there is more than a single aspect on which to focus (the multischema concept), along with the need for a system that can grasp this complexity in a way that can be learned, taught, transmitted, and researched.

In sum, OPD fulfills these shortcomings, because it is an operationalized system which grasps the complexity of patients' dynamics in a way that favors a dynamic formulation and more over foci identification. This multischema approach considers areas to focalize such as the dysfunctional relational patterns, the internal conflicts, and the structure vulnerabilities. This last focus is an important input since it is a new territory for psychoanalysis and dynamic psychotherapy (Klug, & Huber, 2009). There are few systems that consider the multischema approach in spite of its relevancy for diagnosis and for the possibility of therapeutic work.

3.1 OPD Foci

As previously mentioned, in the OPD, dysfunctional relational patterns (axis 2), conflictive internal configurations (axis 3), and structural conditions (axis 4) are regarded as foci in psychotherapy only if they are observed to sustain the patient's psychic or psychosomatic symptoms.

Grande, Rudolf and Oberbracht (2000) have shown that the selection of five foci has been sufficient to identify important aspects of a patient's psychodynamic constitution. This study has also demonstrated that in every case the habitual dysfunctional relationship pattern should be defined as one of the foci. The remaining problems are selected from the areas Conflict and Structure.

3.1.1. Dysfunctional Relational Pattern (Axis 2)

Relational conduct can be defined as the expression of the dynamics between the more or less conscious desires linked to one's relationship with others, the anguish that consequently activates intrapsychically, and fears about how others could react to these desires (Luborsky, & Crits-Christoph, 1990).

Thus, usual relational behaviors can be understood as the formation of a more permanent psycho-social commitment between desires and fears in relationships, which is described as an attitude that is displayed as more dominant and generally operational in its

interaction with the environment (Anchin & Kiesler, 1982). These dominant relational patterns develop on the basis of early relational experiences. They are intrapsychic cognitive-affective schemes (Horowitz, 1991; Piaget, 1978) which undergo continuous confirmation and modification through relationships with others –they are observable and thus measurable patterns.

The diagnosis of dysfunctional relational patterns is fundamental for psychotherapy, especially because the manifestation of disorders in interpersonal relationships constitutes a major part of the reasons for seeking help in patients who receive psychotherapy (Strupp & Binder, 1991). Also, they form potential transferences, thus influencing the emergent therapeutic relationship, in which dominant relational models are re-staged. A change in the patient's mental representations should result in learning to deal with others more variably, and in turn, shape interpersonal situations in a way that are more satisfactory to him/her (Cierpka, et al. 2007).

In general, when evaluating dysfunctional relational patterns, two aspects must be considered. First, the method must come from a matrix that reflects the "circular" or "transactional" nature of human interactions. First, it must describe the interplay between (a) behavior and subjective experience and (b) the environmental response. Secondly, it must contain enough relational dimensions to account for the diversity of human behavior at a reasonably representative level (Stasch, Cierpka, Hillenbrand, & Schmal, 2002).

The OPD meets these requisites by evaluating the relational pattern as a circular matrix of interaction, standing apart from other instruments due to its comprehensiveness, its intermediate complexity, and its inclusion of the interviewer's subjective experience to reconstruct the interactional pattern. This is how the OPD employs the patient's description of his/her relationships during the interview and also what can be directly observed in the interaction with the interviewer (Cierpka, et al. 2007).

For OPD (OPD Task Force, 2008), relational patterns are specific interpersonal constellations within which the behavioral modes of a patient and his/her interlocutor are limited to a rigid configuration. For relational dysfunctional patterns identification, the OPD (OPD-Task-Force, 2008) considers four analytical units referred to as interpersonal positions:
(1) How the patient perceives others. This pattern refers to a relational behavior the patient usually perceives from his/her interlocutor that eventually causes the patient to complain about later on.

(2) How the patient perceives himself/herself, here the focus is placed on the patient's relational conduct. The interpersonal behavior that the patient frequently experiences, and which he/she relates in general terms, is described.
(3) How others repeatedly perceive the patient. In this situation, the point is to understand how others (including the interviewer) continuously perceive the patient. This perspective generally covers more than what the patient him/herself can describe, that is, even the unconscious aspects of what this relationship offers.
(4) How others repeatedly perceive themselves in front of the patient. In this situation, the objective is to consider the relationships that the patient can induce from the interaction, in the sense of offering a role (OPD-2, 2008).

These four positions make it possible to perform a relational dynamic formulation. This formulation reveals how the patient, in contradiction with his/her own experiential perspectives, actually establishes his/her relationships (unconsciously) so as to always induce responses from others which he/she later perceives as painful, disappointing, or threatening.

3.1.2. Internal Conflictual Configuration (Axis 3)

In its general meaning, conflict (from Latin *conflictus*, *conigere*: clash, antagonism) refers to the presence of discordant positions within a person (contradictory motives, desires, values, and representations) or in different people. Therefore, they are universal phenomena, characteristic of the human species.

The definition of conflict (OPD 2008) is not based on the traditional psychoanalytic conception. Instead, its operationalization follows that of basal motivational systems. Although intra and inter-system conflicts are discussed, there is no connection with the classic three-system model (Ego, Id, Super-ego). The conflict model used by the OPD refers to the experience of interactions with a conflictual load, that is, conscious motivational conflicts, fundamentally accessible in order to be worked through and solved during a relational episode. This experience can be worked through and traced back to its unconscious origins.

In contemporary psychoanalysis there is consensus that affects the primary mechanism of motivation in human beings (Pervin, 1982; Sandler, 1987; Spezzano, 1993; Western, 1985). In other words, people are attracted to certain actions, objects, or representations associated with positive emotions, and reject those linked to negative feelings or the possible elicitation from them. This motivational conception guided by emotions highlights the fact

that they are unconscious and that people respond simultaneously to multiple motivations which lead them in different directions.

From a psychoanalytic standpoint what is crucial to any reconceptualization of the concept of motivation are several elements of classical Freudian theory that remain central: Motives can (l) be active consciously or unconsciously; (2) combine and interact in complex ways; (3) stem from equally compelling wishes, fears, or internal standards in which a person has invested emotionally; (4) be rooted in the biology of the organism and hence not readily "shut off"; and (5) feel "it-like" (Freud's clinical concept of the "id," or "it"), or like nonself (Westen & Gabbard, 1999).

For OPD (OPD-Task-Force, 2008) conflicts show a tension between two positions, motivated by a guiding affect. Considering these, OPD offers seven possible conflicts:

1 Dependence vs. autonomy
2 Submission vs. control
3 Desire for care vs. autarchy
4 Conflicts of self-value
5 Guilt conflicts
6 Oedipal sexual conflicts
7 Identity conflicts

3.1.3. Structural Condition (Axis 4)

This axis evaluates mental functioning and personal integration, upon the basis of mental capabilities and vulnerabilities. The concept of structure in a psychological sense denotes the set of mental tendencies as a whole. Structure is in terms of a totality and is not linked to diagnosis (neurotic, borderline or psychotic, Kernberg) but as qualitative different psyquic functions (it's a structural capacity for….).

Structure is neither rigid nor immutable, but dynamic; it develops during the whole of an individual's lifetime, but so slowly that it appears to be static. Although it is based on innate tendencies, it is formed during childhood and undergoes rather extensive changes in a person's lifetime. On the other hand, mental structures are tendencies, and thus unobservable. They become concrete only in current and concrete situations, during which long-term character traits can be inferred (dynamic structure analysis) (Sundin, & Armelius, 1998).

In the OPD system, the term structure is used to describe clinical phenomena understood psychodynamically as expression of personality organization and the level on

which it functions. This concept encompasses ego-psychological aspects (Bellak & Hurvich, 1969), self-psychological categories (regulation of self-esteem, self-reflection, identity), and the pathology of internalized object relations (Kernberg, 1975).

Structure axis is described among four dimensions, each of which distinguishes between the relationship to the self and the relationship to others.

1. Perception of self (ability at self-perception) and objects (ability at object perception)
2. Self-regulation (ability to regulate own impulses, affects, and self-worth) and regulation of relationships (ability to regulate relations to others).
3. Emotional internal communication (ability to communicate internally via affects and fantasies) and communication with the external world (ability to communicate with others).
4. Attachment capacity: Internal (ability to employ good internal objects for self-regulation) and external objects (ability to attach and detach).

The sub-elements of the structure can be categorically established as therapeutic foci.

In sum, on the basis of individual OPD diagnostics of axis 2 - relational patterns, axis 3 -inner conflicts- and axis 4 -structure vulnerabilities-, therapeutic foci can be formulated. The causative characteristics which maintain the disorder and therefore play a decisive role in the psychodynamics of the clinical picture are the foci of therapy. OPD employs the logic that the therapist and the patient determine together at the beginning of treatment the important psychodynamic foci for the particular problems and choose the suitable therapeutic approaches to restructure these foci (Cierpka, et al. 2007).

3.2. Relation between Axes

OPD axes I to IV are not independent from each other in terms of what they evaluate but instead, they offer different perspectives of the dynamic comprehension of the patient. At any rate, these axes naturally interact naturally with each other.

It becomes evident that when examining these axes they overlap in some areas as far as the content is concerned but they also interact closely with each other. There are two opposite trends or movements that can be traced for the interaction among foci.

The first path starts from the patient’s description of his/her relationships and from his/her direct observations. These relationship patterns represent the surface where conflict potentials will become evident, and in turn, the patient will cope with them, in a compromise-like fashion in his/her encounters with others. The quality of this engaging or coping eventually addresses the patient´s functional capacities, that is to say, the structural

possibilities and limitations which will more or less set a framework for the dynamic interplay of psychic forces.

The second path is in the opposite direction, since the interaction among the foci can begin the consideration of the structural prerequisites. Structure to a very large extent, (co)-determines the quality and character of the other foci. The extent of the structural limitation influences and limits the weightthat conflictual dispositions the patient has acquired in his/her development. These conflictual dispositions agree with the origin and the maintenance of the patient's complains. This second path determines the habitual relationship patterns which, at higher degrees of structural limitation, become increasingly inefficient and brittle so that any establishment of a permanent relationship is eventually doomed to fail. Regarding this interaction, the metaphor of the theater and the stage is worth mentioning at this point (Rudolf, Grande & Henningsen, 2002). This metaphor implies the need for characters that interact among each other (relational patterns) and therefore, they experience conflict. On the same level, the play is performed over a structure. The structure (the stage) must be soundly built so that the play (the conflict) can develop successfully. Therefore, if the stage conditions are not adequate, the actors will not be able to perform their scenes effectively. In other words, the psychic structure, as it were, forms the backdrop against which conflicts with their well or poorly adapted interpersonal patterns for solution are performed.

Whatever the path is, the conflict and the structure are related to each other like content and form, that is to say, one refers to the "why" and the other one refers to the "how" of a disorder. If the structure is solid, the content and the meaning dominate, and if it is fragile, the impaired functional processes become prominent (OPD, 2008). On the other hand, relationship patterns, as an "epiphenomena", are closer to observation than the mental structure and the internal conflict (Grande, 2007). They can be understood as an expression of the internal conflict and the structural characteristics, and simultaneously, as an expression of the coping strategies towards their mastery. Therefore, they reflect problematical aspects in both areas.

Thus the selection of foci can be weighted in favor of conflicts or structural vulnerabilities depending on the severity of the structural impairment displayed by a given patient. This reflects the clinical experience of the way in which, depending on the nature and severity of an impairment, the diagnosis and treatment of the patient will place greater emphasis either on structural features or on unconscious conflicts.

However, these are only few investigations (Albani, et al., 2002; Zlatanovic, 2000) that give a first idea about the relationship among OPD foci. More empirical work must be

done to confirm this relational hypothesis. As a result, it is necessary to ascertain if these foci will be identified in the therapeutic work regardless of the therapist's knowledge of the OPD system. If these initially identified OPD foci by outside evaluators will appear during the therapeutic process, the following questions will consequently arise at this point: In which way will the Foci change over the course of the process? And finally, will the Foci show the expected relationship?

4. Change Process Research: the study through relevant episodes

About the intrinsic uniqueness of unfolding process in psychoanalytic treatment *"The only point of importance in any session is the unknown. . . in any session evolution takes place. Out of the darkness and formlessness something evolves"* (Bion, 1967, pp.273).

Being able to identify the OPD foci and evaluate the associations among them is clinically useful, but it is even more useful if the whole therapeutic process is studied. The study of the process is of fundamental importance for advancing the science of psychotherapy (Elliott, 2010). Change process research leads to really comprehend how therapy generates changes in patients' difficulties (Greenberg, 1986, 1991; Llewellyn & Hardy, 2001).

Change process research can be understood as the study of the processes by which change occurs in psychotherapy (Elliott, 2010). It focuses "on identifying, describing, explaining, and predicting the effects of the processes that bring about therapeutic change" (Greenberg, 1986, p. 4). As Greenberg and Pinsoff (1986) refer, change process research is the study of patient-therapist interaction in order to identify change processes in their joint work. Thus, process research covers all the behaviors and experiences of the participants which are related with the change process. Lambert and Hill (1994) suggest that process research must account for what happens in the sessions, while Llewellyn and Hardy (2001) understand the notion of process as the content of the sessions and the mechanisms through which change is achieved in patients, both in each individual session as well as in the whole process over time.

From a methodological point of view, an important step for the study of the therapeutic process is to disregard the pre-post evaluation paradigm, because it does not shed light on the mechanisms that produce change, and to focus on the study of the process.

Although some studies follow this paradigm, they only look at some sessions within the process (beginning - end or beginning - middle - end), taking various criteria into account (e.g. Grenyer & Luborsky, 1996). Although this method consumes less analysis time, it leads to the loss of vital information about how the process progresses. The other extreme includes studies which analyze the whole session in terms of patient-therapist interaction at all times. These studies are very rich and clinically useful due to the data that they yield about the process, but require a lengthy analysis process, which makes them difficult to carry out (e.g. Mergenthaler, 2000; Stiles, Shapiro, & Firth-Cozens, 1990).

An intermediate approach, which is gaining acceptance for process studies, is to segment the process. There are several methods for the segmentation of psychotherapy, many of these are illustrated in Kächele et, al. (2006), which review the findings of studies of a single psychoanalysis, the case of Amalia X. Especially important for this thesis is the event paradigm (Lewelyn & Hardy, 2001; Elliott, 2010). This approach relies on the segmentation of therapy into different episodes or events in order to understand process in the context of these clinically meaningful units. Breaking therapy down into classes of recurring episodes, prevents the therapist from being overwhelmed by the data through a selective focus on those episodes in the therapeutic interaction that hold promise of illuminating the change process (Rice & Greenberg, 1984).

Episodes paradigm research begins with the selection of a particular type of clinically significant event or “marker” and proceeds with an analysis of the event’s specific sequence and context (Stiles, Shapiro, & Elliott, 1986). The analysis of these relevant episodes (Bastine, et al., 1989; Elliott & Shapiro, 1992; Fiedler & Rogge, 1989; Rice & Greenberg, 1984; Llewelyn, Elliott, Shapiro, Hardy & Firth-Conzens, 1988; Martin & Stelmaczonek, 1988; Marmar, 1990; Rhodes, Hill, Thompson & Elliot, 1994) provides a useful strategy for studying psychotherapy and has the potential to bridge the wide gap between psychotherapeutic practice and psychotherapy research (Stiles et al.1986).

Delimitation of episodes is complex –it can be done from the perspective of the patient, the therapist, expert observers, through psychological measuring instruments, or using combinations of these alternatives– and requires qualitative analyses for their definition and delimitation (Hill, Thompson, & Williams, 1997; Stiles, 1997). For their identification, a "marker" must be selected, which can signal the beginning of the change event (Greenberg, 1986) or the end of it (Krause, et al., 2007). The researcher-clinician's choice of the class of events for intensive analysis is theory-based (Greenberg, 1984; Rice & Saperia, 1984; Wiseman & Rice, 1989).

There are different approaches for the identification and/or delimitation of change episodes. One of them is the symptom-context method proposed by Luborsky and Auerbach (1969), which evaluates the contextual variables observed immediately before and after the appearance of a symptom with theoretical or clinical relevance, such as changes in depressive states (Luborsky, Singer, Hartke, Crits-Christoph and Cohen, 1984), somatic symptoms (Lubrosky and Auerbach, 1969), momentary memory lapses in psychotherapy (Luborsky, 1977), interruptions (Jiménez, Pokorny, Kächele, 2006), etc. Another method is Rice and Greenberg's task analysis (1984), which identifies moments or periods in which the patient resolves important issues and achieves changes in his/her perspective. Finally, another example of the study of significant episodes is that defined by Horowitz et al. as "configurational analysis", which segments the psychotherapy according to the "states of mind", understood as recurrent patterns of experience and verbal as well as non verbal behavior (Horowitz, 1979).

A relevant and advanced approach for this thesis is that advanced by Krause et al. (2007), which follows the concept of Subjective Theory (Groeben, et al., 1998) to conceptualize change. This concept refers to cognitions about the view of the self and others in the world, and it is usually an argumentative structure which accounts for the way in which a person understands, explains, and functions in relation with the world and the self. Change is then subjective and it is expected to evolve during the therapeutic process; that is, subjective change is sequential and it can be regarded as a change in the representational sphere (Fonagy, 2001). In this view, identifying change in psychotherapy requires a change in the patient's subjective theory, which is observable during the therapeutic session and this change, in turn, makes it possible to identify the segment that facilitated the appearance of change in the patient, delimited as a change episode. Krause et al. (2007) produced a list of Generic Change Indicators (see Annex 1) which simplifies the identification of "markers" that can be selected from the session studies (Krause, et al., 2007; Echávarri, et al., 2004)have shown how therapeutic process shows advanced and backward movements with a non linearity characteristic (Assimilation Model; Stiles, et al, 1990),characterized by a succession of phases (Exploration, Insight and Action; Hill, 2005). Also, studies using counting words software (e.g. TCM, Mergenthaler, 2000) have shown the presence of cycles inside the therapeutic sessions (Lepper & Mergenthaler, 2005).

As it has been shown, the psychotherapy process research can be enriched and clinically meaningful studies can be conducted only through the study of change episodes. As it is evident that change moments evolve (Krause, et al., 2007), process variables may also

develop when studying them in these segments. As seen above, one relevant variable for brief dynamic psychotherapy is focus. Focus can be expected to evolve, transform, or change during a therapeutic process and to have an effect on patient's change according to the way the therapist and the patient interact. Even though the importance of analyzing foci during the therapeutic process –specifically in those segments where the patient has made a change in his/her subjective theory– no studies have looked at foci, their relations and trajectories through the therapeutic process, or even their change during episodes. This is a relevant issue, especially considering that it can be helpful for clinical practice, theory development, and practitioner training.

4.1. Psychodynamic change: How can foci change?

Traditional clinical research has focused on the reduction of symptoms as the primary method for assessing treatment response (Blatt & Auerbach, 2003), using instruments that operate on the surface (Grande & Jakobsen, 1998). There is little question that effective treatment involves the reduction of symptoms. However, a growing number of theorists, clinicians, and researchers have suggested that the benefits of psychodynamic psychotherapies are likely to go beyond symptom reduction (Levy & Ablon, 2009).

Psychodynamic process has "working-through" at its heart. Gabbard (2009) states that through the process, characteristic defense patterns and internal object relations of the patient emerge again and again in different contexts, and are repetitively clarified, confronted, observed, and interpreted by the therapist. By pointing out repetitive patterns that occur in the transference and in outside relationships, as well as their derivation in childhood relationships, the therapist ultimately helps the patient to begin seeing his/her own responsibility for creating situations in his/her life. Hence, one of the outcomes of working-through is an enhanced sense of agency whereby patients start to feel like authors of their own life experiences.

Because of this sense of agency, it becomes evident why psychoanalysis claims to achieve more than symptomatic change: it achieves structural change. In psychoanalytic theory, structural change is conceived as a complex change in the intrapsychic matrix that underlies symptoms and maladaptive behavior (Klug, & Huber, 2009). Many authors (e.g. Loewald, 1960; Mertens, 1990; Westenberger-Breuer, 2008) state that the reduction of symptoms ought not to be the only achievement, but a reduction that coincides with or it is accompanied by the knowledge of their causes and interrelations, so as to achieve lasting

change anchored within the personality. Structural changes greatly impact many life's domains and are associated with a change in the experience of the self (Wallerstein, 1965).

Moreover, structural changes are not exclusive to psychoanalysis, as Wallerstein (1986) showed by comparing psychoanalysis and a mix of expressive-supportive psychotherapies. They tend to converge, rather than diverge, in their outcome; even more so, the kinds of change often achieved were quite indistinguishable from each other, in terms of reflected real or "structural" changes in personality functioning (Wallerstein, 2006). It is assumed that changes at this deeper level of the personality are essential for attaining persistent therapeutic effects.

Actually, the pressing need to prove benefits of psychoanalysis and dynamic psychotherapy have intensified the search for suitable instruments measuring structural diagnosis (Rudolf, Grande and Henningsen, 2002) and change processes. Research in treatments may need to include measures specifically tailored to tap constructs closely related to the goals of psychodynamic psychotherapy in addition to traditional symptom measures (Blatt & Auerbach, 2003; Wallerstein, 1998).

Some approaches include for example, the Karolinska Psychodynamic Profile developed by Weinryb and Rössel (1991), the Scales of Psychological Capacities by Wallerstein (1988) et al., the concept of reflective functioning (RF) by Fonagy and Target (1997), the Analytic Process Scale (Scharf, Waldron, Firestein, Goldberger, Burton, 2004), or the Psychotherapy Process Q-sort (PQS) by Jones (2000). Some of these instruments were developed with the intention of providing a "common metric" for conducting comparative analyses of psychotherapy processes across different types of psychotherapy (e.g. between Cognitive Behavioral and Interpersonal psychotherapy), whereas others do not consider and therefore do not analyze therapeutic foci and their change, considering only change implicitly defined as an abatement or eradication of pathology. This definition is, however, conceptually problematic when it comes to measuring change in the context of psychodynamic therapy.

When analyzing psychodynamic therapy, follow-up studies (Leuzinger- Bohleber, 2002; Pfeffer, 1959; Schlesinger & Robbins, 1975) have repeatedly shown that patients remain susceptible with respect to their central conflicts for a long time after successful courses of therapy and that they transiently react in a neurotic manner when conflict-laden topics are touched upon. What is fundamentally changed is rather the patients' ability to deal with such situations in a regulatory fashion. These observations suggest that changes within psychoanalytic treatment should be conceptualized as changes in dealing with conflictual tendencies and vulnerabilities rather than their elimination (Grande, et al, 2009).

Initial findings with OPD diagnosis under psychotherapeutic treatments did not show massive change (e.g. cessation of conflicts, marked increase of structural level). The Heidelberg study group started to employ the logic of focus-related restructuring (Grande et al., 2000; Grande et al., 2001). For this purpose OPD foci from the relationship, conflict and structure axes are defined and assessed as to the intensity of the therapeutic processing, their coming into awareness, the responsibility being taken for them, and their possible integration. In the year 2000, Rudolf, Grande, and Oberbracht, developed the Heidelberg Structural[4] Change Scale (HSCS),an instrument capable of measuring therapy-based changes in dealing with individually defined problem areas (Grande, Rudolf, Oberbracht, & Pauli-Magnus, 2003; Rudolf et al., 2000).Change is understood as a re-structuration in the sense of "a progressive integration of specific problematic areas which are essential to the patient's psychodynamics" (Grande, Rudolf, Oberbracht, Jakobsen &Keller, 2004, p. 46). The term "re-structuration" not only refers to a change in structure, but also to a demonstrable transformation in the organization of the whole personality, that is, encompassing all the OPD axes.

This scale was constructed following the Assimilation of Problematic Experiences Scale (APES), developed by Stiles, Meshot, Anderson, and Sloan (1992), in which assimilation refers to the process whereby difficult experiences are acquired, integrated, and reformulated. The construction of the Heidelbreg Structural Change Scale was done looking to adapt it to the demands of psychoanalytic treatments (Rudolf, Grande & Oberbracht, 2000).

Until now the Heidelberg Structural Change Scale (HSCS) has been used through specific interviews with the goal of evaluating the level of foci integration. Through this procedure findings have shown that the level of foci integration correlates with the outcome measured by the treating professionals (Grande, Rudolf, Oberbracht et al., 2000). When studying the patient's follow-up after six months and after three years, findings show that those who had good results in the Heidelberg Structural Change Scaleat the end of their psychotherapies attained more substantial changes in the central aspects of their lives.

Despite these important results, this instrument has not been used to study in-session moments, as change episodes, which is why it would be interesting to see on a moment-to-moment basis how foci change in terms of their level of integration (structural change[5]) and how this relates to subjective change. Studying foci and specifically foci integration in change

[4]Given the similar- sounding terms "structure" and "structural change", it is necessary to clearly distinguish between the two: Whereas "structure" in the OPD refers to psychological capacities or deficits, "structural changw" in the context of the psychoanalytic discussion denotes a basic form of personality modification with respect to relationship patterns, unconscious conflicts, and patients' structural features in the sense of the OPD.

episodes has even more clinical importance, since therapists have to learn to respond to the patient knowing when and how to deliver an intervention and for this reason, they have to be connected to patients' core dynamics and characteristics, to therapeutic progress and to the material brought by the patient (Stiles, Honos-Webb & Surko, 1998; Llewelyn & Hardy, 2001).

4.2. Tracking Foci in the therapeutic process

The problem focus serves as a guide for the content of the therapist's interventions. There is now a convincing body of empirical evidence indicating that the therapist's ability to track a problem focus consistently is associated with positive treatment outcome (Crits-Christoph, Cooper, & Luborsky, 1988; Messer, Tishby, & Spillman, 1992; Piper et al., 1993; Silberschatz, Fretter, & Curtis, 1986). Although there is no evidence that a precisely formulated problem focus, per se, directly contributes to a positive treatment outcome, common sense dictates that a more precisely formulated problem is easier to track. In any event, it is not known how consistently therapists can stay focused on the story content of a problem formulation, even when the precision of the formulation is enhanced by research procedures. The available evidence does not indicate that therapists do a satisfactory job of tracking a problem focus (Crits-Christoph et al., 1988).

Concerning the process of finding a focus, maximizing the collaborative and creative nature of the exploration is helpful. That is, out of an often seemingly chaotic mass of impressions, events, and painful feelings, a pattern begins to emerge and to be noted aloud. Associations and other patient's responses either enrich and intensify the attraction of mutual attention to this pattern, or they do not, and attention shifts back to a more openly exploring mode, with approaches toward other possibly troubled dimensions of functioning. The responsibility for describing the problem rests with the patient, aided by the therapist's interest in detail and by his or her observation of patterns that echo each other (Thayer, 1986; Thöma & Kächele, 1985).

It is clear that during brief psychodynamic psychotherapies, a circumscribed focus or problem, either unconscious or preconscious, gradually emerges through comprehension or understanding, in virtue of the interpretative work and inherent integration that unravels during the process. The focus is discovered by first exploring the patient's responses to a

[5]This thesis will refer to a "change in the level of integration of foci" to refer to the "structural change" measured

recent stress or precipitating event. The particular patient's response provides the clue as to the patient's habitual character style and typical mode of defense and adaptation. When the recent event is understood in terms of its specific and unique meaning to the patient, the therapist can gradually attain a deeper understanding of those weaknesses in the patient's character structure that have resulted in the present vulnerability to psychological disequilibrium following the recent stress (Chernus, 1983). Thus a main characteristic of psychodynamic psychotherapy is the exploration and continued work on a problem area that was not previously and consciously accessible to the patient.

Although there are varied systems that conceptualize and decant in focus operationalizations, there are few studies that measure them during the therapeutic process with a micro-analytical approach (that is to say in segments of sessions). Hence the importance of studying the OPD focus during episodes of change in psychotherapeutic processes, and in this way, reporting how they behave during the process, and their relation to the patient's change. Also, very few studies investigate the precision of the work between the therapist and the patient in relation to the focus established for the patient.

In summary, by virtue of the emergence of brief dynamic psychotherapies, therapy focus has acquired a central role in their study. In generic terms, focus emerges from the interaction between the patient and the therapist, changes along the therapeutic process and can even be thought of as a mechanism of change. The focus conceptualizations have varied over time, and in some cases operationalizations have been developed to facilitate their identification. Despite being diverse, these can be grouped into those referring to intrapsychic conflicts and those referring to dysfunctional relational patterns. They can also be classified according to whether the focus representation is monoschematic or multischematic.

For focus identification, a psychodynamic formulation must emerge from a proper diagnosis. Despite the system variety, only the Operationalized Psychodynamic Diagnosis System (OPD) allows for a multi schematic foci formulation. This formulation is used to guide therapist intervention and therefore leads to therapy planning, even though OPD assumes that foci may change as the therapeutic process unfolds. Therapeutic foci can be formulated on the basis of OPD diagnosis of relational patterns (Focus on Axes 2), inner conflicts (Focus on Axes 3) and structural vulnerabilities (Focus on Axes 4). OPD Foci are also thought to be related, nevertheless few investigations confirm this relational hypothesis.

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by the Heidelberg Structural Change Scale, in order to avoid confusions with the term "structural"

When considering the psychotherapy process research reflections about the study of relevant episodes within the session and throughout the process, it can be expected that foci may evolve, transform, or change. No studies have been found that look at foci, their relation and trajectory during the therapeutic process and not even their change during relevant episodes. Specifically when considering psychodynamic process, change can be understood beyond symptomatic reduction. From this perspective the aim of therapy is the achievement of structural change, conceived as a complex change in the intrapsychic matrix that underlines symptoms and maladaptive behavior. The pressing need to prove benefits of dynamic psychotherapy have intensified the development of instruments measuring structural change, as the Heidelberg Structural Change Scale (HSCS). This instrument has not been used to study in session moments such as the change episodes. It would be relevant to observe in a moment to moment basis how foci change in their level of integration and how they are related to change.

III. OBJECTIVES

General Objective

To determine the presence of therapeutic foci, their level of integration, and their relationship to the subjective change in four brief successful psychodynamic therapies.

Specific Objectives

1. To determine the types of Foci and their relationship in episodes of change, and throughout therapeutic processes.

2. To establish the relationship among types of Foci, and the patient's subjective change throughout the therapeutic process.

3. To establish the relationship among types of Foci and their integration levels, in episodes of change and throughout the therapeutic process.

4. To establish the relationship between the integration level of Foci and the level of subjective change of the patient in episodes of change, and throughout the therapeutic process.

IV. HYPOTHESIS

The hypothesis will include directionality for the variables since there is enough theoretical and empirical background for some of the objectives. However, there is not enough background to hypothesize for other objectives. Therefore, research questions were formulated or in other cases general a hypothesis in need to be explored was formulated.

Regarding the types of foci and their relationship, one hypothesis refers to the presence of the relational pattern focus, which is expected to be more present than the other foci throughout the whole process.

Also, an inverse relationship is expected between the presence of the conflict focus (axes 3) and the presence of the structure focus (axes 4). When the conflict focus (axes 3) is specifically more present, the structure focus (axes 4) will diminish. Therefore, the question arises whether this inverse relationship will remain the same during the different phases of the process (initial, middle and final phase) or if there will be differences among them.

On the other hand, when examining the therapeutic process, the question will investigate whether there will be a phase of the process with more presence of any foci in particular.

Thus, it is hypothesized that the conflict focus (axes 3) will increase its presence throughout the process (initial, middle and final phase), whereas the structure focus (axes 4) will diminish during the therapeutic process.

Regarding the relationship of foci with subjective change more specific questions arise, such as “will there be a relationship between the presence of a focus and the level of subjective change through the different phases of the process?”.

First, it is expected that the level of integration will not increase lineally but irregularly in a positive direction when examining the foci throughout the process.

Furthermore, another question arises such as "will there be a relationship between the presence of a focus and the level of integration throughout the different phases of the process?”.

Secondly, for the relationship between the level of integration and subjective change to exist, the hypothesis will specifically address that the highest levels of integration will be in direct relationship to higher levels of subjective change.

Also, this positive relationship between both the level of integration and the subjective change will consistently remain the same during the different phases of the therapeutic process.

V. METHODOLOGY

For this study a *multiple single subject* design was used seeking to establish the presence of therapeutic foci, their integration level, and their relationship to subjective change throughout four successful brief psychodynamic therapies. Thus, through observation and systematic evaluation repeated over time (Chassan, 1979), this study provides a basis for the generation and generalization of scientific knowledge about psychotherapy.

5.1. Participants

Four psychotherapeutic processes of brief psychodynamic modality were selected from a database that gathered the documentation on of fourteen individual psychotherapeutic records from different theoretical orientations -recollected during FONDECYT 1030482 and 1060768 projects, conducted between the years 2003-2007, and funded by the Chilean National Fund for Science and Technology (FONDECYT)-. The four processes depended on forms of consent that authorized the use of such records for research purposes not limited to the particular project in which they were conducted. Access to this database was provided by Professor Mariane Krause as the researcher in charge of the projects in which these psychotherapies were registered. Furthermore, authorization for the use of these data for the present thesis was granted by the Ethics Committee from Pontificia Universidad Católica de Chile.

All four therapies were conducted in Chile, and had no more than twenty five sessions, performed on a weekly basis, using a "face to face" method. As it can be observed in Table 2, the patients in all four therapies were females who were seeking help at several mental health care centers as outpatients due to various reasons for consultation (see detail in Table 2). However, all of the females manifested depressive symptoms (according to the psychiatrist's diagnosis). The therapists were four psychiatrists and psychoanalysts, with at least twenty-years of experience but none of them were familiar with the OPD system when performing the psychotherapies.

Furthermore, change episodes identification and demarcation were carried out during the execution of the above mentioned FONDECYT projects. The author of this thesis actively participated throughout the entire process as a research assistant. For this reason, although the four therapies had already demarcated episodes, they were reviewed again, and demarcations were confirmed for this thesis. Since episodes are the unit of analysis in which

this thesis is based on, it is relevant to explain the detailed procedure of demarcation (see procedure), nonetheless considering them as part of the sample, and not as results. It should be pointed out that all sessions were transcribed according to the Mergenthaler and Gril (1995) transcription rules.

Taking into consideration the information given above, this study counted with a total of seventy episodes of change, extracted from eighty psychotherapy sessions (see Table 2). All psychotherapeutic processes were considered successful, according to the initial and to the final application of the Outcome Questionnaire OQ-45.2 (OQ-45.2, Lambert, et al., 1996), and all of them showed a statistically significant change (more information is given using the instruments).

Table 2.

Participants' Description

Therapy	Age	Occupation	Marital Status	Patients' Reasons for Consultation	Change episodes	Sessions
1	29	Med. Tech.	Married	Anxiety stemming from separation	10	22
2	38	Economics	Separated	Grief from separation Psychiatrist told her.	14	18
3	43	School Vice-principal	Married	History of attempt of suicide	24	21
4	42	Housewife	Married	Derivated from daughters' psychologist. Difficulties with husband.	22	19
Total					70	80

Finally, although it can be considered as a result itself, a summary of the identified OPD foci for each patients will be shown (see Table 3)since it is important to consider all of the patients with their individual characteristics. Focus identification will be later explained in the procedure in more detail.

Table 3.

*Foci Identification for each therapy**

Therapy	Conflicts Focus (Axis 3)	Structural Vulnerabilities Focus (Axis 4)
1	Desire for care vs. autarchy Submission vs. control Rather active	Object perception Self-regulation Moderate-Low (2.5)
2	Dependence vs. autonomy Submission vs. control Rather passive	Object perception Self-regulation Bonding (internal objects) Moderate-Low (2.5)
3	Conflicts of self-value Submission vs. control Rather passive	Self-regulation Bonding (internal and external objects) Moderate-Low (2.5)
4	Conflicts of self-value Desire for care vs. autarchy Rather active	Object perception Self and object regulation Moderate (2)

* Relational pattern focus couldn't be summarized, but each patient had a relational formulation

5.2. Instruments

Generic Change Indicators (GChIs)

Generic Change Indicators (Krause et al., 2007) correspond to a list of change indicators (see Annex 1), which are generic in the sense that they can be applied for therapy evaluation independent of its theoretical focus. In addition, they offer information on change contents and, inasmuch as they are hierarchically organized, they allow for the distinction between basic and advanced changes; therefore, they allow to evaluate both therapeutic evolution and results, when globally considered. The GChIs have been validated empirically using qualitative and quantitative methods (Krause, 2005, Krause, et al., 2007). It is considered that the approximate average of change moments by session corresponds to 0.8 (Krause, et al., 2007; Krause, et. al., 2008). For a change moment to be considered as such, it should satisfy the following criteria: (i) a theoretical correspondence with change indicators should exist, (ii) change should occur during session, (iii) change must be a novel fact, (iv) there should not exist evidence contradicting said change, and (v) it should be supported by patient's nonverbal

behavior.

For illustration purposes, the following examples of change indicators are provided:

Indicator 5: Questioning of habitual understanding, behavior and emotions.

P: *"perhaps he feels abandoned and – and he – don't know – expresses it this way – in this aggressive way-".*

Indicator 8: Discovery of new aspects of self.

P: *"Perhaps, and I attribute it to him - perhaps I am more formal than him, I do not know, perhaps it can be, can be, yes, I didn't looked it from that point of view".*

Indicator 12: Reconceptualization of problems or symptoms.

P: *"and my mother ´give me a little kiss - ay - ay I love you - ay tell me that you love me – give me a kiss too´ that is - she wants me to be like her - that - - that I have found now- she wants me to be like her".*

Operationalized Psychodynamic Diagnosis (OPD-2)

As mentioned in the background, Operationalyzed Psychodynamic Diagnosis (OPD, Task Force, 2001) is a diagnosis system that proposes an articulated integration of fundamental dimensions, in a diagnostic formulation oriented to therapeutic indication. It consists of five axes: Axis 1, Illness experience and prerequisites for treatment; Axis 2, interpersonal relationships; Axis 3, Conflict; Axis 4, Structure; and Axis 5, Mental and psychosomatic disorders (here CIE or DSM diagnosis can be used). It includes: (a) an inventory organized in four dynamic axes, and a descriptive syndromic one; (b) a training and clinical application manual; and (c) response forms for each axis, for an easier and more reliable application.

In its second version (OPD-2, Task Force, 2008), the instrument adds guidance for defining the therapeutic focus, treatment strategies, and the monitoring of the therapy process. Studies have shown that among the 30 potential problems (see Annex 2), there is a maximum of five central foci that should be identified for each patient; axis 2, which refers to dysfunctional relational patterns, should be one of them. The others should be chosen from axis 3, referring to conflicts, and axis 4, referring to structural vulnerabilities. This selection may lean towards conflicts or structural vulnerabilities depending on the structure severity (structural impairment) (Grande, et al. 2004).

Relational Pattern Focus (Axis 2)

This axis identifies dysfunctional relational pattern. This pattern includes behavior and interpersonal positions taken by the patient as well as his objectives in the relational

constellation. The specific quality of these positions and their associated relational behavior are described for each patient by a 30-item list. Thus, a maximum of 3 items for each interpersonal position must be chosen.

Inner Conflicts Focus (Axis 3)

For this axis the manual describe the following types of conflict: *dependency versus autonomy, submission versus control, need for care versus self-sufficiency, self-esteem conflict, superego and guilt conflict, oedipal-sexual conflict* and *identity conflict*.

The manual describes criteria for the elaboration of these conflicts in the following areas: partner selection, attachment behavior/family life, family of origin, behavior in the vocational/professional sphere, behavior in the socio-cultural environment, and finally illness behavior. For this thesis the raters (see procedure section) are instructed to indicate which two are the most important conflicts for the particular patient and whether they correspond to an active or passive mode.

Structure Vulnerabilities Focus *(*Axis 4)

The patient's level of functioning and integration is assessed on the basis of the structural capacities and vulnerabilities displayed in terms of six dimensions. These dimensions record capacities for *self-awareness, self-regulation, defense, object awareness, communication,* and *attachment conflict*. They are used to assess the patient's level of integration using the ratings "well-integrated", "moderately well-integrated", "poorly-integrated", and "disintegrated". The rating criteria for all dimensions are defined in the manual. Each of the six dimensions has a number of subdimensions identifying the various aspects of the superordinate structural capacity in question. For example, the *capacity for self-regulation* dimension encompasses the subdimensions tolerance of affects, regulation of self-esteem, regulation of impulses, and anticipation (Rudolf, Oberbracht & Grande 1998).

Raters (see procedure) were asked to identify up to three structural dimensions that they considered to be the patient’s focus. Also, they had to rate the global level of the structure.

Heidelberg Structural Change Scale (HSCS)

The Heidelberg Structural Change Scale (Rudolf, Grande & Oberbracht, 2000) was used to identify the way in which patients dealt with the selected OPD Foci already identified for them. The method used by the Heidelberg Structural Change Scale was based on the Assimilation Model developed by Stiles, Meshot, Anderson and Sloan (1992). In order to

evaluate how the OPD foci evolved through the therapeutic process, seven stages (see Annex 3) were developed. Each stage marked a therapeutically significant step, beginning with increasing awareness of a previously unperceived problem area, extending to the therapeutic working through associated aspects and experiences, and then to subsequent basic changes in both the patient's experience and specific external behavior.

Foci Presence Scale (FPS)

This instrument was developed for this thesis (Dagnino & de la Parra, 2010). Its objective is to measure the degree of presence of a focus in a given verbal interaction between patient and therapist in segments of psychotherapy sessions (see Annex 4). For its application it requires the OPD Foci to be already formulated for a particular patient. With the transcription of therapy segments, raters must identify through the patient and the therapist verbal interaction whether there is an OPD Foci being treated and if it is not present, the raters must thematically describe the segment (score 0: Absence of foci). If they identify that the OPD Foci are being treated, they must score the degree from 1: vague reference, 2: knowledge and exploration of focus or 3: work on focus.

Outcome Questionnaire (OQ-45.2)

The Outcome Questionnaire (OQ-45.2) is a self-report questionnaire for the evaluation of therapeutic outcomes. It was developed by Lambert, et al. (1996) and validated for the Chilean population by Von Bergen y De la Parra (2000). It consists of 45 items grouped in three subscales: *symptoms*, specifically anxious and depressive (SD), *interpersonal relations* (IR) and *social role*(RS), the sum of these scales renders a total score (T).

A high total score, indicates that the patient reports a high discomfort with his/her quality of life, specifically in some of the areas contained in the scale or together with the presence of symptoms. The interpretation of the results is based on cutoff index dividing the functional population from the dysfunctional population (PC = 73), and a reliable index of change that allows to determine whether the changes of the patient during treatment are statistically significant (ICC = 17) (Jacobson & Truax, 1991). According to this instrument all processes were considered successful since they show a difference between the initial and final scores that is larger than 17 (reliable change index).

5.3. Procedure

The procedure consisted of three stages (see Figure 1). The first stage was carried out before the beginning of the present doctoral thesis (as mentioned in the previous section). This stage consisted in the demarcation of change episodes, which were revised and confirmed by the author as previously mentioned. The second stage consisted in the identification of the OPD foci and in the third and final stage the level of foci presence and the level of integration of these were assessed in each change episode.

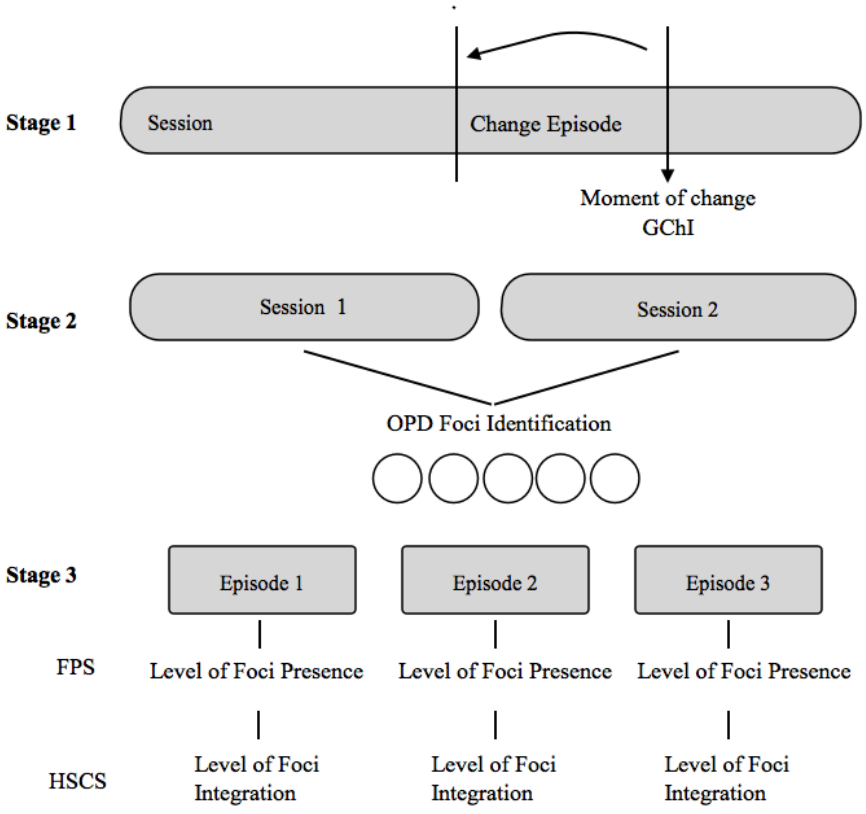

Figure 1. Stages of the Procedure

First stage:

It is important to mention that the first stage of the procedure was previously carried out by both the author and the FONDECYT team under the direction of Prof. Mariane Krause. For the purposes of this thesis the author once more revised the change episodes previously demarcated; there was no need to make adjustments.

The procedure for change episode demarcations consists of the identification of a

change moment. In order to do this each therapy was observed in situations by two independent trained members of the research team, who coded the identified change moments based on the GChIs (Annex 1). At the end of each session the raters compared their codes, searching for an agreement. When an agreement did not take place, the entire team thoroughly reviewed the sessions' videotapes and transcripts until a consensus was reached. The process of intersubjective of validation (Hill, et al.,1997) was used to come up to a consensus by the entire team.

The following criteria had to be present to define a change moment:

1. Theoretical correspondence: Change observed coincided with the contents of one of the GChIs.
2. Verifiability: Change must have been observed in the session as it took place. If the changes took place outside the session, these changes had to be mentioned during a specific session and explicitly related to the therapy.
3. Novelty: The specific content of that change was present for the first time in therapy.
4. Consistency: The change observed corresponded with the nonverbal behavior and was not denied or contradicted in the same session or later in therapy (Krause et al., 2007).

Once the change moments were identified (constituting the end of the change episode), the precedent interactions were observed and the beginning of the episode was indexed at the beginning of the conversation related to the subject over which the change occurred (for more information regarding this procedure see Krause et al, 2007).

Second and Third Stages:

Both for the focalization (second stage) and for the determination of the integration level of foci (third stage), two group of judges were used consisting of three members in each group (2001). The members underwent one hundred hours of theoretical and practical training and, in turn, the method was applied to the clinical interviews. All six judges were psychotherapists of different orientations; three of them were psychodynamic, one cognitive-behavioral and two systemic. Additionally, all of them had at least ten years of clinical experience. Their expertise was significant considering that other studies suggest that only two or three years are needed to accomplish an acceptable degree of reliability on the OPD system(Stasch, Cierpka, Hillenbrand & Schmal, 2002). The six judges were divided into two groups of three judges each. The first group, Judges A, participated in the second stage and the second group, Judges B, took part in the third stage of the procedure.

The second stage was subdivided into two moments. The first moment consisted of the re-training of all the judges. (Judges A and B) in the OPD system which included a revision of the OPD axes, codification of an interview's foci(video and transcript) and a posterior group analysis. A modification of the 'Heidelberg foci list' was used, since the scale suitability with all different axes has been shown in other studies (Grande et al., 1997). However, the list was adapted for the identification of the OPD foci of this thesis, giving emphasis to a more rigorous justification of foci selection. Subsequently, judges made a second independent coding, and had group discussions to clarify doubts. During this process, a reliability analysis was performed for the judges A. Once a satisfactory reliability was attained, the second stage started. In this stage each judge of group A received videos and transcriptions of the first two interviews of each of the four therapies constituting the sample, along with the Heidelberg Foci list.

As for the reliability of the OPD Foci Identification, a weighted kappa (Fleiss, 1971) was estimated for the specific identification of Focus 2 (relational pattern), Focus 3 (conflict) and Focus 4 (structural vulnerabilities). Specifically for the reliability of Focus 2, a thematic grouping was done (see more in data analysis). As observed in Table Nº4, the interrater reliability kappas for Focus 2 show a range from .35 to .6 which can be considered as fair and good (Fleiss, 1981; Cichetti, 1994). For Focus 3 range was .66 to 1, and for Focus 4 range was .76 to 1, which is respectively considered as good and excellent, especially considering the large number of potentially selectable foci. These figures are acceptable (Fleiss, 1981; Cichetti, 1994).

Table 4.

Mean agreement of Foci Identification for the three judges (Judges A) in each Therapy (K_w)

Therapies	Relational Pattern Focus (Axis 2)*	Conflict Focus (Axis 3)**	Structure Vulnerabilities Focus (Axis 4)***
Therapy 1	.502	.83	.83
Therapy 2	.43	.66	.76
Therapy 3	.6	1	.83
Therapy 4	.35	1	1

* Considering the four quadratics themes
** Considering principal and secondary conflict
*** Considering all the structural foci

Third stage: Upon collection of the identified foci for each patient from Judges A group, the author proceeded to format unification and foci re-edition, including vignettes for patients or descriptions justifying the foci election. This procedure was performed because material that is closer to a clinical situation renders greater interrater agreement (Berns, 2001). Additionally, more information on OPD was included. For example, for conflicts selected as foci, a general description, as well as passive and active modes descriptions were added. Regarding focal structural vulnerabilities, a description of their expression in the integration/disintegration continuum was also added.

The document with the edited foci was delivered to each member of Judges B group, together with the first psychotherapy session (video and transcript) of a given patient, as well as the transcripts of each change episode. The transcripts were delivered in a different order as identified in the process, so judges were not knowledgeable of the therapeutic moment in which they took place.

In this third stage, the same method as with group A was applied. A training and a pilot application were performed, during which the manual of the Heidelberg Restructuration scale (Rost, Dagnino, 2009) was read. A therapy that did not pertain to the current thesis sample was coded. Through the pilot application two issues were evident. The first issue was the presence of more than one type of focus in each episode, at the expense of the present study's objectives. Given this situation, the author together with Dr. Guillermo de la Parra, developed an instrument to allow for the examination of the relative presence of each focus in the analyzed session segments. This new instrument was named Foci Presence Scale (FPS, Dagnino & de la Parra, 2010) (Annex 4), which will be described in the next section. The second issue was the impossibility of specifically identifying an integration level for each of the focus prescribed for the patient. It was only possible to establish a global level of integration for the whole episode, but not for each particular focus. This issue was expected due to the fact that the foci integration level (HSCS) has been applied on interviews specifically made for its evaluation and not in real therapy sessions, not to mention just a segment of the session. Since segments are smaller, the possibility of identifying the integration level for each focus decreases. Nevertheless, this fact did not jeopardize the study's main objectives (especially when considering the FPS instrument created for the determination of the degree of foci presence). It was then decided to use it under this format.

As it has been previously mentioned each judge from Judges B group received the first session and the episodes, chronologically scrambled, and labeled with letters of the alphabet, so no information about their temporal location was provided. Together with these materials,

the judges received a template for the identification of the type of focus and its degree of presence (FPS) in each episode, and also for the identification of foci integration level (Heidelberg Structural Change Scale, HSCS) in each episode.

Regarding the identification of foci presence through the Foci Presence Scale, FPS, reliability was measured using the single Intra Class Correlation Coefficient (ICC_s, Shrout & Fleiss, 1979), since the variables are continuous (see Table Nº5). For Focus 2 (relational pattern) ICC_s ranges from .57 to .80, according to Fleiss (1981)[6] they can be considered as fair to excellent. For Focus 3 (conflict) and Focus 4 (structure) ICC_s ranges from .75 to .91 and from .72 to .82 respectively (see Table 5), both of them showing therefore excellent reliability (Fleiss, 1981).

Table 5.

Mean agreement of Degree of Presence for each foci for the three judges (Judges B) in each Therapy (ICC_s)

Therapies	Relational Pattern Focus (Axis 2)	Conflict Focus (Axis 3)	Structure Vulnerabilities Focus (Axis 4)
Therapy 1	.51	.84	.74
Therapy 2	.77	.91	.76
Therapy 3	.60	.81	.72
Therapy 4	.80	.75	.82

For the identification of Foci Integration (Heidelberg Structural Change Scale, HSCS), a mean agreement was once more calculated using ICC_s (See Table Nº6).In this case for Focus 2 (relational pattern) reliability ranges from .68 to .80, for Focus 3 (conflict) from .72 to .80, considered in both cases good to excellent reliability. Finally for Focus 4 (structure) reliability ranges from .54 to .65, considered as fair to good reliability (Fleiss, 1981).

Table 6.

Mean agreement on the Level of Foci Integration for each episode for the three judges (Judges B) in each Therapy (ICC_s)

Therapies	Relational Pattern Focus (Axis 2)	Conflict Focus (Axis 3)	Structure Vulnerabilities Focus (Axis 4)

[6]According to Fleiss (1981), ICCs greater than .74 are considered excellent; from .60 to .74, good; from .40 to .59, fair; and less than .40, poor.

Therapy 1	.73	.80	.62
Therapy 2	.68	.76	.65
Therapy 3	.78	.80	.54
Therapy 4	.80	.72	.60

5.4. Data analysis

For the utilization of the Foci Integration variable (HSCS), this was transformed to an ordinal scale from 1 a 19 (e.g. 1= 1, 1+ =2, 2- =3….). Therefore, both the Generic Change Indicators (GChI) and Foci Integration (HSCS) scoring ranges from 1 to 19.

To assess variables in the time dimension, two approximations were used. For some calculations, episode number was considered and for others, the process was divided into three stages (beginning, middle and final) considering the number of episodes of a therapy and dividing it by three (see Table 7).

Table 7.

Episode frequency per Phase of the Psychotherapeutic Process.

	Phase 1	Phase 2	Phase 3
Therapy 1	3	3	4
Therapy 2	5	4	5
Therapy 3	8	8	8
Therapy 4	8	7	7

Regarding the foci, five therapeutic foci were identified for each of the four therapeutic processes (Relational Pattern, Conflict and Structure). In order to observe the evolution of the therapeutic process, the presence of both conflicts was averaged whenever more than two conflicts appeared. The same function was applied for the structural foci whenever more than two appeared. This method allowed for the compensation of the "small n" in the analysis performance.

The degree of presence for some types of foci was considered as a continuous variable for some analyses (levels 0 to 3) whereas for other analyses, the degree of presence was dichotomized as high presence (levels 2 and 3) or low presence (levels 0 and 1).

When the dependent variable was dichotomous, Generalized Estimation Equations were used. The presence of multiple observations for each subject (e.g. the existence of repeated measures) allowed to model the probability of obtaining the dependent measure.

To account for the objectives, a first approach consisted of performing descriptive analyses, such as the frequency and the correlation analyses for continuous variables such as the foci integration level. Subsequently, the ANOVAs of multiple measures was used and multiple regressions were computed in order to determine principal and interaction effects over the Presence of Focus, the Generic Change Indicators and the Foci Integration Level. When the dependent variable was dichotomous, Generalized Estimation Equations were used (given the presence of multiple observations for each subjective. the existence or repeated measures) which allowed to model the probability of obtaining the dependent measure.

VI. RESULTS

The results have been organized in descriptive results of foci types, their level of presence, their level of integration, and their subjective change. The corresponding results to each specific objective will also be shown.

1. Descriptive

1.1. Type of Foci

Regarding the first result for the identification of the OPD foci in change episodes, the judges identified in absolutely all the episodes at least one focus(≥1 score on the Foci Presence Scale), Table8 shows the frequency of episodes per each focus. The results show that in 57 of the 70 episodes, the relational pattern focus (axis 2) was identified, in 66 of the 70 episodes, the conflict focus (axis 3) was identified, and in 67 of the 70 episodes, the structural vulnerabilities focus (axis 4) were identified.

Table 8.

Frequency of OPD Foci Identification in change episodes(N=70)

Foci	Identified	
	f	%
Relational Pattern focus (axes 2)	57	81.4
Conflict focus (axes 3)	66	94.3
Structural focus (axes 4)	67	95.7

1.2. Foci Presence

Addressing the specific presence of the foci, the relational pattern focus (axis 2) appears more frequently with an average of 1.34. The conflict focus is present (axis 3) with an average of 1.06. The structural focus (axis 4) is present with an average of 0.98.

The following figures show the level of presence of each foci throughout the entire therapy process as well as the differentiation for each therapy. The temporal axis is the episode number. Figure 2 shows the evolution of the level of presence of the relational pattern focus (axis 2) , Figure 3 shows the evolution of the level of presence of conflict focus (axis 3) and Figure 4 shows the evolution of the level of presence of the structural vulnerabilities focus (axis 4).

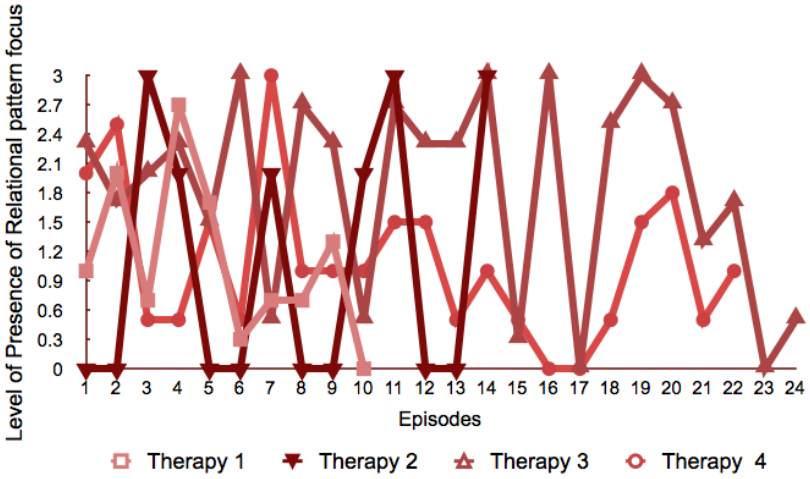

Figure2. Level of Presence of the relational pattern focus (axis 2)for each psychotherapy through the change episodes.

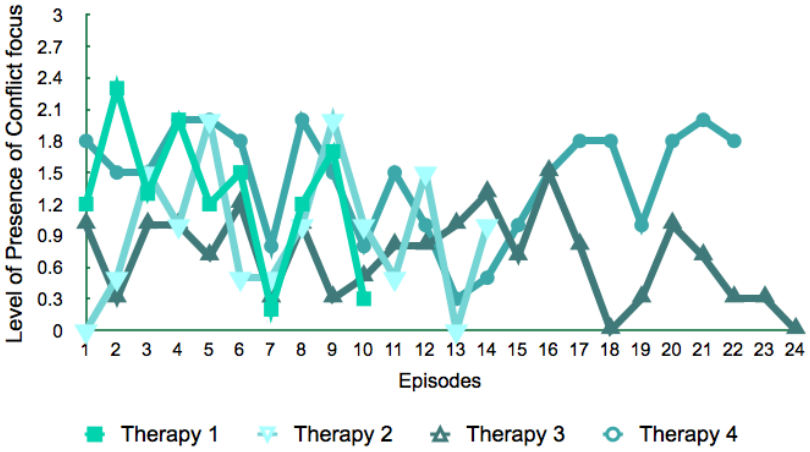

Figure 3. Level of Presence of the conflict focus (axis 3)for each psychotherapy through the change episodes.

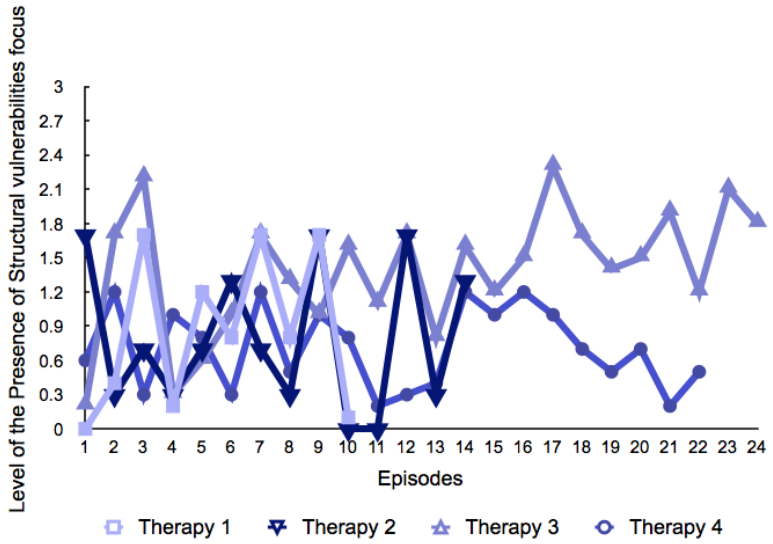

Figure 4. Level of Presence of the structural vulnerabilities focus (axis 4) for each psychotherapy through the change episodes.

It can be observed that the therapeutic process shows an irregular trajectory with increases and decreases in the level of presence of each focus for every therapy. Overall, the relational pattern focus (axis 2) shows more variability during the process, in that it presents extreme levels (0 and 3). This result is not the same when examining the conflict focus (axis 3) and the structural vulnerabilities (axis 4).

Considering the average of each focus regarding their level of presence, the evolution looks like Figure 5. Descriptively, the interpersonal pattern focus (axis 2) and the conflict focus (axis 3) show a tendency to diminish towards the end of the process. Instead, the structural vulnerability focus (axis 4) tends to increase near the final phase of the process.

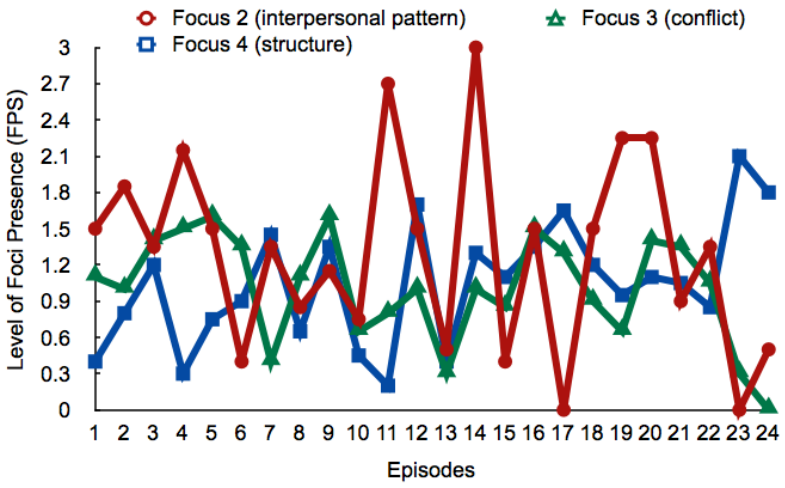

Figure 5. It shows the average of the level of Presence for each of the focus: the relational pattern focus (axis 2), the conflict focus (axis 3) and the structural focus (axis 4) for all psychotherapies through the episodes.

1.3. Foci Integration Level

For the level of Foci Integration (HSCS) Figure 6 shows an improvement in the level of Foci Integration throughout the process.

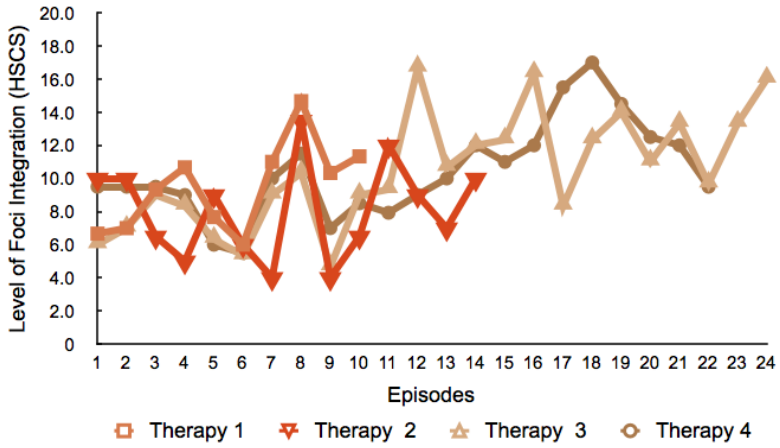

Figure 6. It shows the evolution of the Level of Integration of Foci (HSCS) for each therapy throughout the therapeutic process (episodes).

2. Results about the relation of the variables in study

To account for the results, the objectives of the thesis are used as a comprehensive guide.

2.1. Type of Foci and Level of Presence

To determine the presence of foci in the different phases of psychotherapy, analyzed therapies were divided into three phases: the initial phase, the middle phase and the final phase. Marginally significant differences were observed among them when considering the level of foci presence (χ^2 (2 *df*)= 5.83, *p*= 0.054). More foci presence was observed during the middle phase of the therapeutic process when comparing it to the final phase (*b*= 0.202, *p*=.110) (See Table 9 and Figure 7)

Table 9.

Repeated Measures ANOVA for level of foci presence by phases of the process.

Parameter	β	Wald chi-square test	Sig.	95 % CI Low	95 % CI High
(Intersection)	1.321	571.445	.000	1.213	1.430
Initial Phase	0.139	0.951	.329	-0.140	0.417
Middle Phase	0.202	2.559	.110	-0.045	0.449
Final Phase	0[(a)]	-	-	-	-

Note: Dependent Variable; FociLevel Presence.

CI: Confidence Interval.

[e]Established in 0 since this parameter is redundant

*p< 0.05; **p< 0.01; ***p< 0.001.

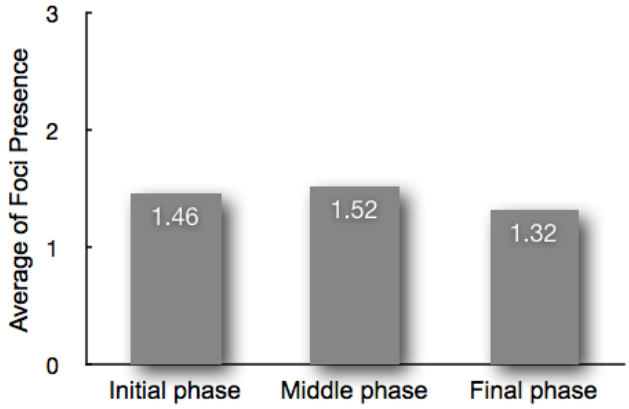

Figure7. Average presence of foci in general considering the different phases of the process.

However, the distinction among the types of foci, and independently from the phase of the psychotherapy, statistical differences were observed regarding the level of presence of the three foci (F(1,207) = 4.348, p < .005). Specifically, the relational pattern focus (axis 2) has a higher level of presence than the structural vulnerability focus (axis 4) (p< .005*)* (See Table 10and Figure8)

Table10.

Repeated Measures ANOVA for level of foci presence by type of foci (focus 2: relational pattern; focus 3: conflict focus and focus 4: structural vulnerabilities focus).

Parameter	β	t	Sig.	95 % CI Low	95 % CI High
Intersection	0.975397	10.495	.000	0.792172	1.158621
Focus 2	0.367460	2.796	.006	0.108342	0.626579
Focus 3	0.07694	.586	.559	-0.182134	0.336103
Focus 4	0[(a)]				

Note: Dependent Variable; Level of Foci Presence.

CI: Confidence Interval.

[a]Established in 0 since this parameter is redundant

*p< 0.05; **p< 0.01; ***p< 0.001.

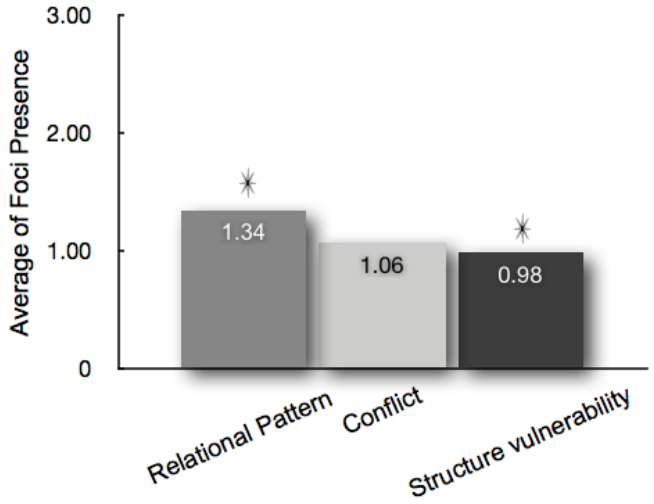

Figure 8. Average of Foci Presence for each focus

When analyzing the interaction among the phases of the process and the type of focus, results showed that there was a statistically significant interaction (χ^2 (3 *df*)= 370.68, $p \leq$ .001).

Specifically (see Table11) during the middle phase, the conflict focus (axis 3) was more present than during the final and middle phases (p=.001) (see Figure 9).

Table11.

Repeated Measures ANOVA for the interaction of psychotherapeutic phase (phase 1: initial; phase 2: middle and phase 3: final) with type of focus (focus 2: relational pattern; focus 3: conflict focus and focus 4: structural vulnerabilities focus) in terms of the level of foci presence.

				95 % CI	
Parameter	β	Wald chi-square test	Sig.	Low	High
(Intersection)	1.537	64.506	.000	1.162	1.912
[phase=1] * [focus=2]	-0.123	1.314	.252	-0.334	0.087
[phase=1] * [focus=3]	0.068	0.015	.902	-1.014	1.150
[phase=1] * [focus=4]	-0.177	0.561	.454	-0.642	0.287
[phase=2] * [focus=2]	-0.138	0.450	.502	-0.541	0.265
[phase=2] * [focus=3]	0.073	0.036	.850	-0.681	0.827
[phase=2] * [focus=4]	0.023	0.470	.493	-0.042	0.088
[phase=3] * [focus=2]	-0.299	4.801	.028	-0.566	-0.032
[phase=3] * [focus=3]	-0.347	0.586	.444	-1.237	0.542
[phase=3] * [focus=4]	0[(a)]				

Note: Dependent Variable; Level of Foci Presence.

CI: Confidence Interval.

[a]Established in 0 since this parameter is redundant

*p< 0.05; **p< 0.01; ***p< 0.001.

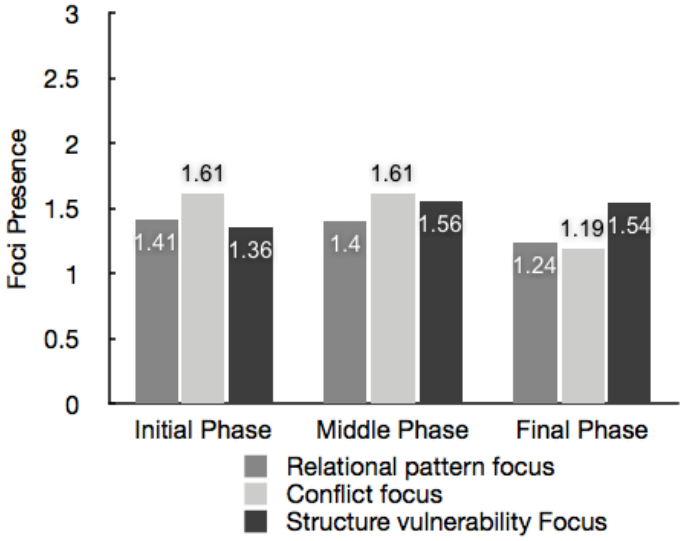

Figure 9. Average of the level of presence for each focus in the different phases of the psychotherapeutic process.

To evaluate the probability of the high presence of a focus during the different phases of the process, the variable level of presence was dichotomized in "high presence" (level 2 or 3) or "low presence" (absence level or level 1). A Generalized Estimation Equation analysis was made for dichotomy dependent variables. Three models were adjusted, one for each focus taking as dependent variable the probability of the high presence of a focus and as the independent variable the therapeutic phase of the process.

In the case of the probability of the relational pattern focus (axis 2), the model globally showed significant differences (χ^2(2 *df*)= 6.74, $p \leq .005$). Specifically, the probability that the relational pattern focus (axis 2) was "highly present" was more evident during the initial phase than in the final phase (p=.023) (see Table 12). For the probability of the presence of conflict focus (axis 3) the global model shows that there are no significant differences (χ^2 (2 *df*)= 5.02, p= .081) among phases. Finally, in the case of the probability of the presence of the structure vulnerabilities (axis 4) the model showed that there were significant differences (χ^2 (2 *df*)= 28.62, $p \leq .001$). Specifically, it was more probable that the structural vulnerabilities focus became more present during the final phase than in the initial phase (p<.000) (see Table12) (*seeFigure10).*

Table12.

Generalized Estimation Equation analysis for the probability of high presence of relational pattern focus (axis 2), conflict focus (axis 3) and structural vulnerabilities (axis 4), according to the different phases of the psychotherapeutic process.

Parameter	β	Wald chi-square test	Sig.	OR	95% CI	
					Low	High
DV: Prob. Focus 2						
(Intersection)	-0.782	3.959	.047	0.458	0.212	0.988
[initial phase]	1.225	4.694	.03	3.403	1.124	1.302
[middle phase]	0.79	2.611	.106	2.203	0.845	5.743
[final phase]	0[(a)]	.	.	.	.	.
DV: Prob. Focus 3						
(Intersection)	-0.720	1.795	.180	0.487	0.170	1.395
[initial phase]	0.516	2.731	.098	1.675	0.908	3.088

[middle phase]	-0.079	0.344	.715	0.924	0.605	1.411
[final phase]	0[(a)]	.	.	.	.	.
DV: Prob. Focus 4						
(Intersection)	-0.364	0.656	.418	0.695	0.288	1.677
[initial phase]	-1.293	23.651	.000	0.274	0.163	0.462
[middle phase]	-0.756	2.505	.114	0.469	0.184	1.198
[final phase]	0[(a)]	.	.	.	.	.

DV: Dependent Variable

CI: Confidence Interval.

[a]Established in 0 since this parameter is redundant

*p< 0.05; **p< 0.01; ***p< 0.001.

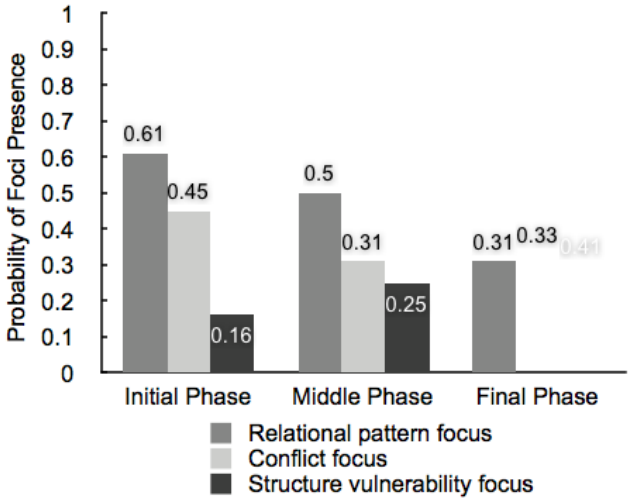

Figure 10. Probability of high presence of relational pattern focus (axis 2), conflict focus (axis 3) and structural vulnerabilities (axis 4), according to the different phases of the psychotherapeutic process.

To establish the relationships among the three focus in change episodes, a Pearson correlation analysis was performed, considering the foci presence variable as a continuous variable (0 to 3). The results showed only an inverse significant relationship between the presence of conflict focus and the presence of structural vulnerability focus (see Table 13).

Table13.

Correlation among the presence of the relational pattern focus (axis 2),the conflict focus (axis 3) and the structural vulnerabilities (axis 4).

Correlation between foci	Focus 2	Focus 3	Focus 4
Relational pattern focus (axis 2)	1	.014	-0.036
Conflict focus (axis 3)		1	-.286*
Structural vulnerabilities focus (axis 4)			1

*p< 0.05; **p< 0.01; ***p< 0.001.

These results showed that there was a higher presence on the conflict focus (axis 3) in change episodes and a lower presence in the structural vulnerabilities focus (axis 4). To illustrate this relationship between these two foci, a clinical vignette was chosen. This is a vignette of Therapy Nº4. In this example the presence of the conflict focus was coded by the raters as 1 (vague reference to focus), and the presence of the structure vulnerabilities was coded as 3 (work on the foci).

Therapist: *This may sound like criticism to you....(he shows her the physical posture)*

Patient: *Yes, maybe, it bothers me, but at this time I am worried about what we talked about my mother, having that baby without knowing she was pregnant, that is odd, I didn't realize that at that moment* (patient was 12 years old at that moment)

Therapist: *So, these things we talk about turn into criticism.*

Patient: But these are the things that are happening to me all the time. I am not giving importance to things. With some things I cannot tell the difference between reality and fantasy, and I am afraid of that.

Therapist: *So, when you are here and finding out more things or just talking, it's confusing to you.*

Therapist: *So, you feel that by coming to therapy and talking about these things will be confusing and you will miss everything that is good.*

Patient: *Yes, because thinking about them will get me confused.* (she talks about how important it is to read and to be in the fantasy world).

Therapist: *So, you are telling me that this is survival.*

When examining the relationship among the three foci but throughout the psychotherapeutic process, only one significant correlation was found. Specifically, it corresponded to an inverse significant relationship between the conflict focus (axis 3) and the structural vulnerability focus (axis 4) during the initial phase of the process. In other words, only during the initial phase a high presence of the conflict focus related significantly to a lower presence of the structural vulnerability focus and vice versa.

Table14.

Correlation between presence of relational pattern focus (axis 2), conflict focus (axis 3) and structural vulnerabilities (axis 4) in each phase of the psychotherapeutic process.

	Initial phase	Middle phase	Final phase
Focus 2[a] – Focus 3[b]	0.028	-0.047	-0.028
Focus 2 – Focus 4[c]	0.082	0.013	-0.128
Focus 3 – Focus 4	-0.416*	-0.301	-0.073

[a]Focus 2: relational pattern focus

[b] Focus 3: conflict

[c] Focus 4: structural vulnerabilities

*p< 0.05; **p < 0.01; ***p < 0.001.

2.2. Foci and Subjective Change

To establish the relationship among types of foci and the subjective change throughout the psychotherapeutic process, a repeated measures analysis of variance was performed. This analysis was done for each of the focus, considering the variable level of presence dichotomized in "high presence" (level 2 or 3) or "low presence" (absence level or level 1).

For the relational pattern focus (axis 2) regarding principal effects, the ANOVAs showed significant differences (χ^2 (3*df*)= 176.234, $p \leq .001$). Specifically, when comparing the phases (initial, middle and final) in each level of the variable "high presence" and "low presence", results showed that (see Table15) when the relational pattern focus is highly present, the initial phase presented generic change indicators significantly lower (p<0,001) than the final fase, which in turn presented generic change indicators significantly lower than the middle phase (p<0,001).

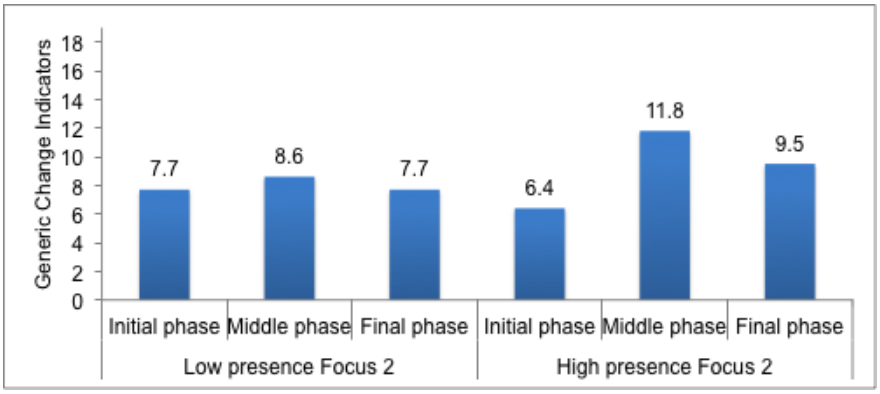

Figure11. Interaction of Phase in every level of the variable Presence dichotomized in "high presence" and "low presence" for the relational pattern focus (axis 2), for the Generic Change Indicators.

With respect to the conflict focus (axis 3) at the level of principal effects, the ANOVAs showed statistical differences (χ^2 (3 *df*)= 30.96, $p \leq .001$). Specifically, when comparing the phases, results showed (see Table 15) that when conflict focus was highly present, the initial phase presented generic change indicators lower (p<0,001) than the final phase. The middle phase did not present differences from the other phases.

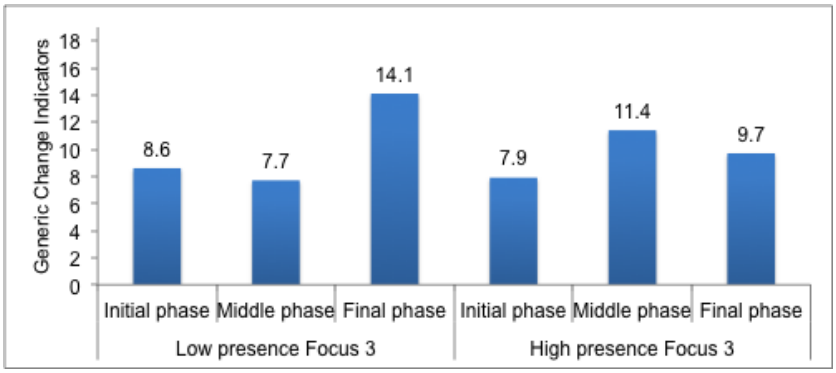

Figure12. Interaction of Phase in every level of the variable Presence dichotomized in "high presence" and "low presence" for the conflict focus (axis 3), for the Generic Change Indicators.

Finally, for the structure vulnerabilities focus (axis 4) at the level of principal effects, ANOVAs showed statistically significant differences (χ^2 (3 *df*)= 357.035, $p \leq .001$). Specifically, when comparing the phases, results showed (see Table 15) that when the structure vulnerabilities focus was highly present there were no differences in the level of change indicators during each phase.

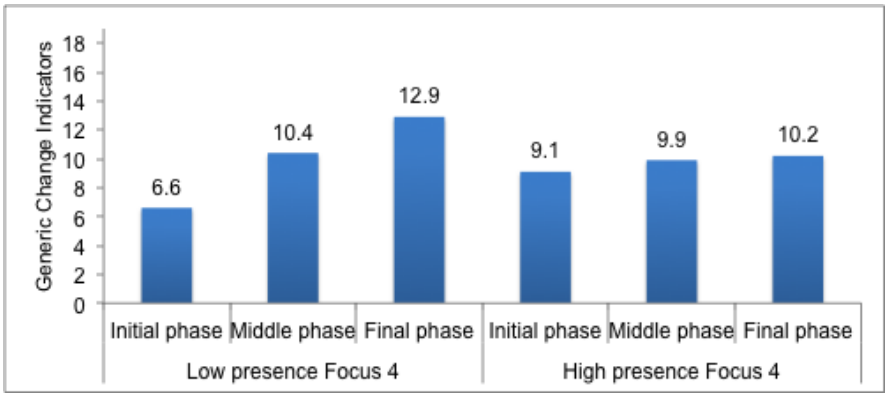

Figure 13. Interaction of Phase in every level of the variable Presence dichotomized in "high presence" and "low presence" for the structural vulnerabilities focus (axis 4), for the Generic Change Indicators.

Table15.

Repeated Measures ANOVA for the variable foci presence dichotomized in "high presence" and "low presence" for each type of foci (focus 2: relational pattern; focus 3: conflict focus and focus 4: structural vulnerabilities focus) in interaction with phases of psychotherapy for the level of Generic Change Indicators.

				95% CI	
Parameter	β	Wald chi-square test	Sig.	Low	High
High presence Focus 2					
(Intersection)	9.516	127.664	.000	7.865	11.167
[Focus 2=0] [phase=1]	-1.742	1.558	.212	-4.478	.993
[Focus 2=0] [phase=2]	-1.046	.309	.578	-4.736	2.643
[Focus 2=0] [phase=3]	3.497	15.146	.000	1.736	5.259
[Focus 2=1] [phase=1]	-3.059	18.895	.000	-4.438	-1.680
[Focus 2=1] [phase=2]	2.360	44.701	.000	1.668	3.052
[Focus 2=1] [phase=3]	0(a)	.	.	.	.
High presence Focus 3					
(Intersection)	9.707	4.046	.000	6.701	12.714
[Focus 3=0] [phase=1]	-1.069	1.034	.309	-3.130	1.034
[Focus 3=0] [phase=2]	-1.920	1.964	.161	-4.604	1.964
[Focus 3=0] [phase=3]	4.400	6.380	.012	.995	6.380

[Focus 3=1] [phase=1]	-1.778	1.335	.001	-2.862	1.335
[Focus 3=1] [phase=2]	1.705	.348	.555	-3.956	.348
[Focus 3=1] [phase=3]	0(a)	.	.	.	.
High presence Focus 4					
(Intersection)	1.252	59.562	.000	7.648	12.855
[Focus 4=0] [phase=1]	-3.614	1.409	.001	-5.809	-1.418
[Focus 4=0] [phase=2]	.162	.013	.908	-2.583	2.907
[Focus 4=0] [phase=3]	2.646	2.449	.118	-.668	5.961
[Focus 4=1] [phase=1]	-1.120	1.091	.296	-3.221	.981
[Focus 4=1] [phase=2]	-2.610	.226	.635	-1.338	.816
[Focus 4=1] [phase=3]	0(a)	.	.	.	.

Dependent variable: Generic Change Indicators
Model 1: (Intersection), Focus 2* Phase, Model 2: (Intersection), Focus 3* Phase, Model 3: (Intersection), Focus 4* Phase
[a]Established in 0 since this parameter is redundant
*p< 0.05; **p< 0.01; ***p< 0.001.

2.3. Foci and Level of Integration

To establish the relationship among types of foci and the levels of integration, in change episodes, the Heidelberg Structural Change Scale was used (HSCS).

First of all, the levels of integration were analyzed through the different phases of the process, independently of what focus was present. Statiscal significant differences were found regarding the level of foci integration and the phases of psychotherapy (F(2,56.6)=10,329, p<.000). Specifically, (see Table16) the level of foci integration was significantly lower during the initial phase when compared to both the middle phase (p=.000) and the final phase (p=.004) (see Figure14).

Table16.

Repeated Measures ANOVA for the variable foci integration level in relation with the therapeutic phases

				95 % CI	
Parameter	β	t	Sig.	Low	High
Intersection	10.313677	20.730	.000	9.319495	11.307858
Initial phase	-2.248168	-3.359	.001	-3.584191	-.912146

Middle phase	.453303	.693	.491	-.855459	1.762065
Final phase	-	-	-	-	-

Note: Dependent Variable; Level of foci integration (HSCS).

CI: Confidence Interval.

*p< 0.05; **p< 0.01; ***p< 0.001.

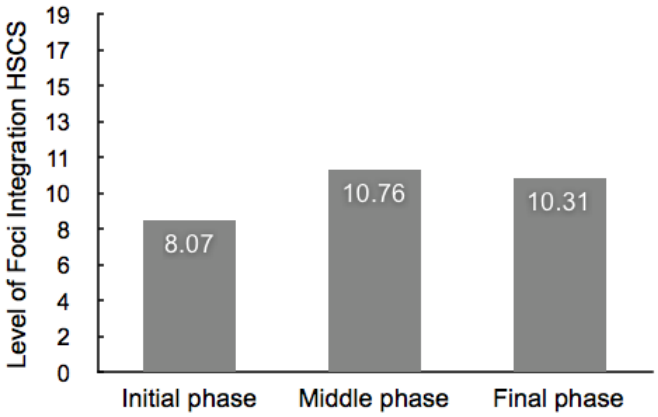

Figure 14. Average of level of foci integration for each phase of psychotherapy

The results showed that the level of foci integration was significantly different during the Phases of the process. When the variable of the foci presence degree was included, a significant relationship was observed between this variable and the level of foci integration depending on the phase of the process ($F(3,157) = 4.737$, $p < .005$). Specifically (see Table17),in change episodes of the initial phase and as the level of foci presence increased, the level of integration decreased (p=.032). On the other hand, in the change episodes of the middle phase and as the level of foci presence increased, the level of integration increased (p=.021) (see Figure15).

Table 17.

Generalized Estimation Equation analysis for the interaction of phase of the psychotherapeutic process and level of foci presence.

				95 % CI	
Parameter	β	t	Sig.	Low	High
(Intersection)	9.62	25.25	.000	8.86	10.37
[initial phase] * level of foci presence	-.7005	-2.15	.032	-1.34	-.059

[middle phase] * level of foci presence	.761	2.33	.021	.117	1.406
[final phase] * level of foci presence	.239	.655	.51[illegible]	-.481	.959

Dependent variable: Level of Foci Integration (HSCS)

CI: confidence interval

[a]Established in 0 since this parameter is redundant

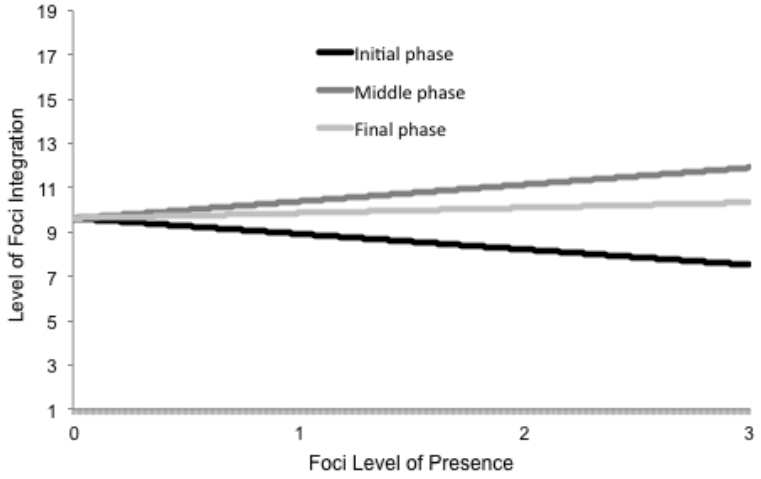

Figure 15. Interaction of the level of foci integration and the degree of foci presence for each phase of the psychotherapeutic process.-

To establish the relationship between the presence of types of foci and the level of integration of the foci, a repeated measures analysis of variance was made. This analysis was done for each of the focus, considering the variable level of presence dichotomized in "high presence" (level 2 or 3) or "low presence" (absence level or level 1).

For the relational pattern focus (axis 2) regarding principal effects the ANOVA did not show significant differences (χ^2 (2 *df*)= 1.239, p = .538).

With respect to the conflict focus (axes 3) ANOVA showed (see Table 18) significant differences (χ^2 (3 *df*)= 3392.7, $p \leq .001$). Specifically, when this focus had a "high presence", the initial phase presented a significative lower level of integration than the middle phase, and the middle phase was significatively higher in the level of integration than the final phase (p=.023).

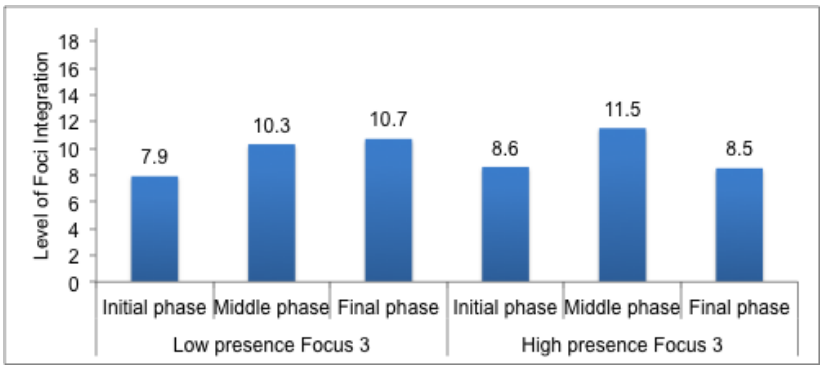

Figure16. Interaction of Phase in every level of the variable Presence, dichotomized in "high presence" and "low presence" for the conflict focus (axis 3), for the level of foci integration.

When examining the structural vulnerabilities focus (axis 4), principal effects of ANOVA presented statistical differences (χ^2 (3 *df*)= 618.286, $p \leq .001$). Specifically, when comparing the phases inside each level of presence, the structural vulnerabilities focus high presence had a higher level of integration during the initial phase than during the final phase (p=.000). On the other hand, when this focus was highly present during the middle phase, its level of integration was higher than during the final phase (p=.000).

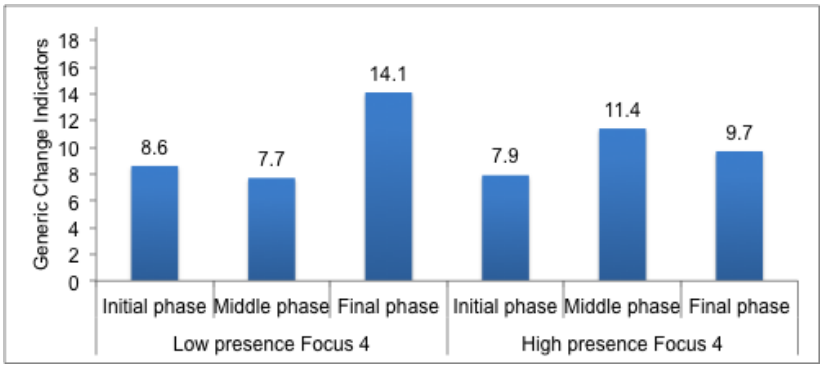

Figure17. Interaction of Phase in every level of the variable Presence, dichotomized in "high presence" and "low presence" for the structural vulnerability focus (axis 4), for the level of foci integration.

Table18.

Repeated Measures ANOVA for the variable foci presence dichotomized in "high presence" and "low presence" for each type of foci (focus 2: relational pattern; focus 3: conflict focus and focus 4: structural vulnerabilities focus) in interaction with phases of psychotherapy for the level of foci integration

				95% CI	
Parameter	β	Wald chi-squared	Sig.	Low	High
High presence Focus 3					
(Intersection)	8.562	73.591	.000	739.616	37001.015
[Focus 3=0] [phase=1]	-.593	.439	.508	.095	3.196
[Focus 3=0] [phase=2]	1.834	15.500	.000	2.511	15.589
[Focus 3=0] [phase=3]	2.142	8.162	.004	1.959	37.054
[Focus 3=1] [phase=1]	.043	.003	.959	.205	5.305
[Focus 3=1] [phase=2]	2.974	5.167	.023	1.506	254.361
[Focus 3=1] [phase=3]	0(a)	.	.	.	.
High presence Focus 4					
(Intersection)	6.957	54.633	.000	166.036	6645.767
[Focus 4=0] [phase=1]	5.655	75.314	.000	79.646	1024.289
[Focus 4=0] [phase=2]	1.881	2.236	.135	.557	77.284
[Focus 4=0] [phase=3]	.242	.043	.836	.129	12.595
[Focus 4=1] [phase=1]	6.730	159.205	.000	294.405	2382.492
[Focus 4=1] [phase=2]	5.666	24.277	.000	30.325	2750.194
[Focus 4=1] [phase=3]	0(a)	.	.	.	.

Dependent variable: Level of Foci Integration

Model 1: (Intersection), Focus 2* Phase, Model 2: (Intersection), Focus 3* Phase, Model 3: (Intersection), Focus 4* Phase

[a]Established in 0 since this parameter is redundant

*p< 0.05; **p< 0.01; ***p< 0.001.

2.4. Level of Foci integration and Subjective Change

To establish the relationship between the level of foci integration (Heidelberg Structural Change Scale) and the level of subjective change (Generic Change Indicators) a regression analysis was developed considering the level of change indicators as a predictor

variable. The results indicated that the level of foci integration predicted the level of generic change indicators ($F(1,67)=19,28$, $p<.001$) (see Figure 18). Specifically, an increase in the level of foci integration produced an increase of 0.55 points on the level of generic change indicators (β = 0,55, $p<.001$, 95% IC [0,30, 0,80]).

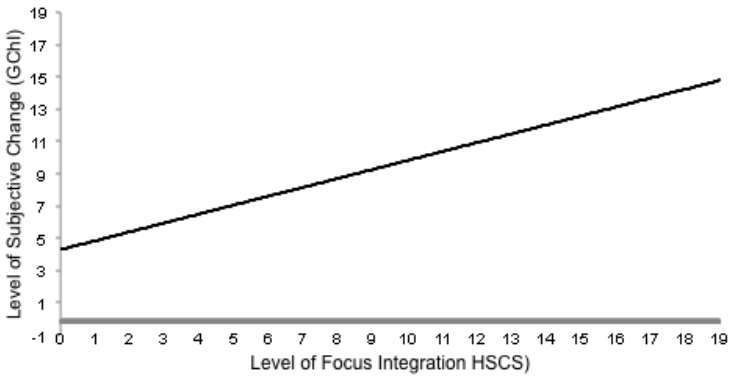

Figure 18. Estimated score for the generic change indicators as function of the foci level of integration.

With respect to the relationship between the level of foci integration and the level of generic change indicators during the different phases of the process, signficative differences were found ($F(2,65)=6.341$, $p<0,05$). Specifically, (see Figure 19) generic change indicators did not vary during the initial phase as the function of the level of foci integration (p=.070). However, it significantly varied during the middle and final phases ($p<0,01$). Beginning with the middle phase and as the process developed, the relationship between both measures was higher (see Table19).

Table 19.

Estimated score for the generic change indicators as function of the foci level of integration for each phase of the therapeutic process.

				95 % CI	
Parameter	β	t	Sig.	Low	High
Intersection	7.57	4.952	.000	1.626	4.519
Initial phase	-3.761	-3.533	.001	-1.63	-5.88
Middle phase	-1.44	-1.477	.144	.507	-3.39
Final phase	0(a)				

Dependent variable: Level of Subjective Change

[a]Established in 0 since this parameter is redundant

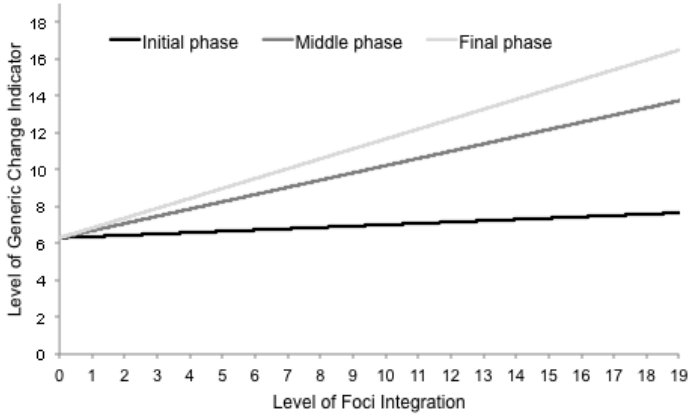

Figure19. Estimated score for the generic change indicators as function of the foci level of integration for each therapeutic phase.

VII. CONCLUSION AND DISCUSSION

Nowadays focus constitutes a central and defining aspect for the therapeutic work in the clinical practice, and, particularly for the brief psychotherapy model. This study searched for the foci presence, their level of integration and their relationship with the subjective change throughout the four brief and successful psychodynamic therapies.

Of the multiple systems that accomplished the challenge of operationalizing the foci, this study used the Operationalyzed Psychodynamic Diagnosis System (OPD-2) since it fulfilled the requirement to consider the relational aspect and the inner conflicts as part of the foci in a multiesquematic way, including the structural aspect. Therefore, the analyses were done with this definition of foci, considering a focus on relational patterns, a focus on inner conflicts and a focus on structural vulnerabilities.

The foci were identified in change episodes of the analyzed therapies and their differential presence was established through the different phases of the therapeutic process. The first important finding was that the OPD foci were identified in all change episodes. This confirmed the fact that this system was able to describe what was really happening between the patient and the therapist, even in small segments as the change episodes. Furthermore, as these were psychotherapies performed by a therapist without training in OPD, the ability to identify the OPD foci implied that the problematic areas defined by this system were really what the therapist and the patient needed to work on.

In general terms, the foci presence concentrated more on the middle phase of psychotherapy in comparison to the initial and final phases of the process. This result coincided with what several authors (Gennaro, Gonzalez, Méndez, Riveiro & Salvatore, 2011; Salvatore, Gelo, Genaro, Manzo, & Al-Raroideh, 2010) have referred to as the phenomenon of the U-shaped trajectory of the therapeutic process. They have proposed that the result may reflect a part of the psychotherapy when the therapeutic work was more intense. Maybe this U-shaped trajectory could be better understood as an indirect effect of what Kiesler (1983) referred to as the role of successful therapists who applied a systematic pressure on relevant patients' issues. This pressure had to be gentle during the initial phase of psychotherapy in order to create a solid and stable working bond between the patient and the therapist. It must become intense during the middle phase and it should turn gentle again during the final phase when the patient has experienced change (Strong & Clairbon, 1982; Tracey, 1986).

When considering the relative presence of the different foci on the phases of the therapeutic process, the focus on the dysfunctional relational patterns had more presence during the initial phase, which was concordant with the patients in the study due to the fact that all of them had a dysfunctional relationship theme as a therapeutic complaint. This complaint would have been more present at the beginning of the process. In the case of an inner conflict focus its presence was stable during the phases of the process showing no difference among them. Instead, the structural vulnerabilities focus showed that its presence increased through the process and it was higher during the final phase. This increase in the high presence of the structural vulnerabilities focus was not expected. Actually, the work on the structural vulnerabilities was expected to occur more at the beginning of the process giving way to the work on the conflict issues (OPD, 2008). As Rudolf and Grande (2006) referred to, the foci constitute a gestalt among the relational aspects, the internal conflicts and the structural vulnerabilities. Thus, the results throughout the phases of the therapeutic process, the foci were always compounded by these three dimensions but the shaping gestalt varies from phase to phase in relation to which dimension stood as a figure. Likewise, it was possible to conclude that what stood as a figure of therapeutic foci during the initial phase were the relational patterns. The structural vulnerabilities stood as a figure during the final phase. The unexpected appearance of the structural vulnerabilities during the final phase of the process could be understood by the characteristic of the patients used in this study. All the patients had a middle level of structural vulnerability, which suggested that their vulnerabilities were not an impediment for the work on other foci during the initial phase of psychotherapy. The hypothesis that the work on the structural vulnerabilities would occur with more frequency at the beginning of the therapy made sense for patients with lower structural vulnerabilities, where no distinct conflicts were identifiable (OPD Task Force, 2008).

Regarding the relationship among the types of foci and their subjective change, a possible association was explored between the presence of the foci and the level of the generic change indicator. At this point it is relevant to point out that the subjective change implies cognitions about the view of the self and others in the world. Having this in mind, it was found out that during the middle phase the presence of the relational pattern focus and the conflict focus were related to higher levels of subjective change. On an average, the generic change indicators were related to the presence of the relational pattern focus and the conflict focus corresponded to a middle level which indicated an increased permeability towards new understandings. With respect to the structural vulnerability focus, its presence did not show a

relationship with the generic change indicators. The association between the two dimensions of foci related to the relational patterns and patients' conflicts resulted in changes that went from the discovery of new aspects of themselves to the transformation of values and emotions in relation with the self and others. As far as the structural vulnerabilities focus was concerned, no relationship was found. This difference with the other foci could be explained due to the presence of work on the structural vulnerabilities, namely, the focalization on cognitive functions, metacognition, emotional regulation, etc., did not reflect necessary changes on subjective theories, even though changes on these psyquic functions could constitute the foundations for the transformations on interpersonal and conflict thematic axis (Grande, 2003).

Another aspect explored in this study was the relationship among types of foci and their level of integration. In general terms, the level of integration or foci assimilation by the patient, increased from the initial to the middle phase of the psychotherapy, staying at the same level when advancing in the process from the middle to the final phase. Specifically, and considering the general presence of the foci, the initial phase showed that the high presence of the foci was associated with lower integration. Instead, during the middle phase, the high presence of the foci was associated with a higher level of assimilation. First, the fact that the general foci presence was associated with a high and a low integration meant that the evaluation of the level of integration was not directly associated with the foci presence. Therefore, this result was not a methodological artifact. Secondly, the negative relationship during the initial phase between the level of presence and the level of integration, was probably due to the intense therapeutic work on the patients' problematic areas. It is then possible to assume that the positive relationship between the level of integration and the focus theme during the middle phase, corresponded to the "successful" work done during the initial phase.

When considering each of the foci in particular, a higher presence of conflict focus during the middle phase was associated with higher levels of integration or assimilation. On the other hand, the presence of the structure vulnerability focus became evident during the initial and the middle phase of psychotherapy as well as a higher association with the level of integration, when compared to the final phase. As it has been referred to before, the structure focus presence was higher during the final phase; so, both results probably corresponded to the fact that the more integrated aspects of the structure related to the less vulnerable structural theme which was a necessary condition for the therapeutic work on the other foci.

The decrease on the level of integration or assimilation towards the final phase could reflect the work on the most vulnerable aspects of the structure.

Also, regarding the foci integration level but exploring its association with the subjective change, the results showed a direct relationship between them. This outcome was true for the general foci and for the foci throughout the phases of the psychotherapeutic process. Consequently, the higher the level of foci integration, the higher was the level of subjective change, and it could be inferred that this relation was stronger towards the end of the process. This result was relevant for this thesis, since it validated the idea that the foci assimilation and the work are important measures of therapeutic change. Since the presence of foci was not enough reason to discuss in the evolution of the therapeutic work, auxiliary observations were needed in order to qualify for the foci presence in the therapeutic discourse. Also, the high relationship between generic change indicators evolution and foci integration level provided validation for both change models. Although both models come from different theoretical definitions (Subjective Theory and Assimilation Model), they both support the idea that change is composed of successive transformations, and that occur hierarquically. Because these models are highly correlated, they seem to evaluate and highlight similar aspects of the therapeutic process. The higher the change in the level where the patient integrates her/his problematic areas (foci integration), the highest the change on the subjective patterns of interpretation and explanation (subjective change). These commonalities allude to a capacity, an aspect of the patient's comprehension considered as fundamental for change. Therefore, the integration model and the model of subjective change are crucial for the patient to accomplish strategic and adaptive self-knowledge (Dagnino, et al, 2012). This idea seems to be similar to what Wampold and colleagues (2007) refer to as an "insight", understood as a common factor implying a functional understanding of conflicts, complaints or disorder, which is essential for the therapeutic process and common to all theoretical orientations. This "insight" can be understood as mindedness (Silver, 1983) defined as: "The patient's desire to learn the possible meanings and causes of his internal and external experiences as well as the patient's ability to look inwards to psychical factors rather than only outwards to environmental factors....[and] to potentially conceptualize the relationship among thoughts, feelings, and actions" (p. 516)".

Until now, the emphasis of the conclusions has been on the possibility to identify the foci OPD in every change episode in the investigated psychotherapies and also, that they have an evolution in the different phases of the process which is associated with the level of integration and the level of subjective change. In spite of this, the different dimensions that

formed the focus showed specific behaviors through psychotherapies and in their relation with the process of change and of assimilation.

On one hand, the relational pattern focus showed a higher presence than the other foci in the whole process. And when examining it through the different phases, the relational patterns focus had a higher probability of presence during the initial phase, a presence that diminished at the end of the process. On the other hand, the high presence of the relational patterns focus was related to a higher subjective change specifically during the middle phase of the psychotherapeutic process. Instead no relationship was found between the high presence of this focus and its level of integration during the different phases of the process.

The conflict focus was more present during the middle phase of the process than during the final phase. Its presence was complementary to the presence of the structural focus, meaning that the higher the presence on the structural focus, the lower the presence on the structural focus, especially during the initial phase. The high presence of the conflict focus during the initial phase was related to a lower subjective change, but when relating it to the level of integration, the high presence of the conflict focus showed higher levels of integration during the middle phase.

Finally, the structural focus showed the lowest presence throughout the whole process when compared with the other foci. However, the probability of its higher presence was observed during the final phase of the process. There was no relationship between the high presence of the structural focus and the subjective change. Instead, its relationship with the level of integration showed that its high presence was related to higher levels of integration during the initial phase which diminished toward the end of the process.

Altogether, the results of this thesis showed research and clinical scopes. First, these scopes give empirical validation to the OPD system which identified the foci .In turn, these foci were ascertained in brief dynamic therapies. The therapists performing these therapies were neither familiar with the OPD system at the time of developing the processes nor did they use it as a guide for the therapeutic interventions. The relevancy of such facts was one of the objectives of the OPD-2(2008) fulfilling the need to study the system praxis validation. Additionally, the OPD foci in this study were identified by raters of different theoretical orientations which shows that despite the fact that the OPD system is psychodynamic, there is a high adherence to the description of the patient's problematic issues closer to the clinical practice approach rather than following theoretical models.

With respect to research, it should be noted that since the first manual of the OPD system was published (OPD-1, 1996), OPD has further developed from a diagnostic system

into a structuring and planning tool for practical therapeutic work (OPD-2, 2008). Rudolph et al. have taken an important step in this direction by developing and using this system as a measure outcome, concentrating their research in measures (Heidelberg Structural Change Scale) done during the initial and later phases of the therapy or with interviews specially meant to access to the level of integration (Grande et al., 2001; Grande et al., 2003; Rudolf et al., 2001). Following this line of research, this thesis has advanced through a methodological proposal and with results that accounted for the OPD foci, specifically showing how the OPD foci developed and transformed during the psychotherapeutic process. An important and specific contribution to this study was the development of the Foci Presence Scale (Dagnino & de la Parra, 2010). This instrument allowed to identify the foci in segments' transcriptions. On one hand, this device was relevant for the enrichment of psychotherapeutic research and on the other hand, it was relevant for both the clinical practice and training purposes. By fostering close attention not only to the whole session, but also to the presence of the foci in relevant segments, the practitioners gained a "royal road" to though as to how psychotherapy works on patients' problematics (Lepper, 2009). Furthermore, as Greenson (1967) stated, the quality of the therapist intervention is an essential element, so long as the therapist knows what to say to the patient, when and how to formulate interventions in a helpful way.

However, an important aspect of the problematic that inspired this study was the relationship between the focalization and its association with the development of brief psychotherapy. The results confronted us with the question about how foci would develop in unlimited dynamic psychotherapies. For example, Thöma &Kächele (1988)considered the interactionally formed focus to be the axis of the analytic process, and thus conceptualized psychoanalytic therapy as an "ongoing, temporally unlimited focal therapy with a changing focus"(p. 460). In unlimited psychotherapy, the work on the structural vulnerabilities focus could be more emergent during the process.

Another aspect of the results was the discovery of the relationship of more work on the structure vulnerabilities focus towards the end of the process. Grande, et al. (2004)stated that when the structural vulnerabilities were identified, the therapist had to temporally position himself/herself as an auxiliary aspect especially during the initial phases. By doing so, the therapist stimulated and stabilized the structural development of the patient. The therapist had to do within the necessary timeframe in order to guide the therapeutic work to the acknowledgment of conflicts. As is has been discussed in this chapter, an explanation for this result could be that patients in this study had a middle level of structure vulnerabilities, which might explain for the reason for the therapeutic work to be centered at the beginning and

middle phases in the relational pattern focus and the conflict focus, and specifically when the conflict focus became assimilated, the structure arose to be worked on during the final phase.

However, in this study research the foci presence was defined by their exploration and the work on them during the therapeutic session. In this line of study and considering what Grande, et al., (2004) referred to, questions must be asked of whether this focus on the structural vulnerabilities during the initial phase might be related to the observation of an implicit aspect, that is, in the interventions the therapist performed with the other foci. Therefore, for example, the implication might be that during the initial phase of the psychotherapy, the work on structure focus corresponded to an offer of the structural way of thinking (e.g. an auxiliary aspect) allowing the exploration and work on the relational pattern and the conflict focus. Consequently, there would be a need to develop an observational device to study the place where the therapists' interventions would be present on foci work.

All the results of this thesis were based on the change episodes selected in these successful psychotherapeutic processes. This homogeneity allowed to conclude about certain commonalities of the foci, their level of integration and their evolution during the process. However, because of this characteristic, it was not possible to draw conclusions about the specificity that the foci had in change episodes or in successful therapies because no observations were made on other segments of the process that would function as control segments (e.g. stuck episodes) or in unsuccessful therapies. Also, considering the patient and how all the samples had a middle level of structural dimension, questions arose at how these foci would behave on patients with high or low structure diagnosis.

In the future, it would not only be interesting to identify the foci in patients with a different structural level, in segments associated with or without change, but also to study how the presence and the integration of the foci relate to the outcome measures such as the patient's general wellbeing, his/her reduction of symptoms, his/her improvement on interpersonal relationships, or in social roles which could be measured by the Outcome Questionnaire (OQ-45.2, Lambert, et al., 1996). It would also be interesting, for both the theory and the clinical practice, to analyze the association that the presence and the integration of the foci might have during the different phases of the process with other elements that have shown their relevance as change factor such as the course of the bond between the patient and the therapist.

In sum, let us remember that focalization, on one hand arises from the need to abbreviate the therapeutic processes, as a way to provide psychotherapy to people from different socioeconomic levels. On the other hand, psychotherapies tend to be brief even in

private practice. The results of this thesis, with its achievements and limitations, reveal the importance to continue studying the therapeutic focus from a process view, since the need to focalize and intervene over the focalization at the present time is a central aspect to develop an effective psychotherapeutic intervention. This line of research not only provides more knowledge to validating psychotherapy as an effective tool, but also it helps to develop practical orientations in practice.

VIII. REFERENCES

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Erklärung gemäß § 8 Abs. 1 Buchst. b) und c) der Promotionsordnung der Fakultät für Verhaltens- und Empirische Kulturwissenschaften

Promotionsausschuss der Fakultät für Verhaltens- und Empirische Kulturwissenschaften der Ruprecht-Karls-Universität Heidelberg
Doctoral Committee of the Faculty of Behavioural and Cultural Studies, of Heidelberg University

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Declaration in accordance to § 8 (1) b) and § 8 (1) c) of the doctoral degree regulation of Heidelberg University, Faculty of Behavioural and Cultural Studies

Ich erkläre, dass ich die vorgelegte Dissertation selbstständig angefertigt, nur die angegebenen Hilfsmittel benutzt und die Zitate gekennzeichnet habe.

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Vorname Nachname Paula Andrea Dagnino Robles

Datum, Unterschrift July 31th 2015 

IX. ANNEX

Annex 1.

Hierarchy of Generic Change Indicators (listed in ascending order) (*Krause, et. al, 2007)*

Level	**Indicators**
I. Initial consolidation of the structure of the therapeutic relationship.	1. Acceptance of the existence of a problem 2. Acceptance of his/her limits and of the need for help. 3. Acceptance of the therapist as a competent professional. 4. Expression of hope 5. Questioning of habitual understanding, behavior and emotions. 6. Expression of the need for change. 7. Recognition of his/her own participation in the problems.
II. Increase in permeability towards new understandings.	8. Discovery of new aspects of self. 9. Manifestations of new behaviors and emotions. 10. Appearance of feeling of competence. 11. Establishment of new connections. 12. Reconceptualization of problems and/or symptoms. 13. Transformation of valorizations and emotions in relation to self or others.
III. Construction and consolidation of a new understanding.	14. Creation of subjective construct of self through the interconnection of personal aspects and aspects of the surroundings, including problems and symptoms. 15. Founding of the subjective constructs in own biography. 16. Autonomous comprehension and use of the context of psychological meaning. 17. Acknowledgment of help received. 18. Decreased asymmetry between patient and therapist. 19. Constructions of a biographically grounded subjective theory of self and others and of the relationship with surroundings.

Note. Taken from Altimir et al. (2010)

Annex 2.

OPD Potential Foci

The three dynamic axes of the multiaxial system of operationalized psychodynamic diagnosis that become foci

Axis II—interpersonal relationships

Perspective A: the patient´s experience Patient experiences himself/herself as …
Patient experiences others as …
Perspective B: the experience of others (also the investigator)
Others experience the patient as …
Others experience themselves as …

Relationship dynamic formulation how the patient again and again experiences others how the patients react to what they experience offer of relationship the patient makes to others (unconsciously) with the reactions which answers the patient induces in others (unconsciously) that way how the patient experiences when others react as induced

Axis III—conflict Repetitive-dysfunctional conflicts

1. Individuation versus dependency
2. Submission versus control
3. Need for care versus self-sufficiency
4. Self-worth conflict
5. Guilt conflict
6. Oedipal conflict
7. Identity conflict

Mode of processing main conflict

Axis IV—structure

1a. Self-perception
1b. Object perception
2a. Self-regulation
2b. Regulation of object-relationship
3a. Internal communication
3b. Communication with the external world
4a. Attachment capacity: internal objects
4b. Attachment capacity: external objects
5. Structure in total

Annex 3.

Levels of Foci Integration (HSCS).

Stages		Excerpt from the manual
1. ***Focus problem warded off***	**exact** **1** **match** **1+** **tendency↓**	The problem is completely unconscious; experiences connected with it are evaded; problematic behavior is ego-syntonic; the patient has "no problems" with the critical area
2. ***Unwanted preoccupation with the focus***	**tendency↑** **2-** **exact** **2** **match** **2+** **tendency↓**	Unpleasant feelings and thoughts in connection with the problem area can no longer be immediately rejected; but preoccupation with the problem is reluctant; external confrontations with the problem take place but are rejected as disturbances; no realisation that the problems might be associated with the patient's own person
3. ***Vague awareness of the focus***	**Tendency↑** **3-** **exact** **3** **match** **3+** **tendency↓**	Patient notices/suspects the existence of a problem that is part of him/herself and cannot simply be rejected; in the course of repetition the problem takes on a continuing existence; negative affects originate from the tension between the insistent nature of the problem and the patient's defensive/aversive attitude
4. ***Acceptance and exploration of the focus***	**tendency↑** **4-** **exact** **4** **match** **4+** **tendency↓**	The problem starts to take on a new shape in the patient's consciousness; incipient indications of an active, "head-on" preoccupation with it; the problem can now be formulated as an "assignment" and hence be made the subject of therapeutic work; destructive, rejecting responses may interfere with this attitude but can no longer undermine it altogether

Annex 4

Foci Presence Scale (FPS)

Dagnino, P. & de la Parra, G. (2010)

(based on the Heidelberg Structural Change Scale (Rudolf et al., 2000)

This scale allows us to describe the degree of foci presence in segments of psychotherapy. Alludes to an OPD-based foci definition and considers the foci as co-constructed between therapist and patient and is therefore a product of the dyad work.

Instructions: The evaluator must base his observation on the verbal interaction between therapist and patient during the segment of psychotherapy and must codify the level of presence of foci in each segment scoring the type of focus that the participants refer to. For this, the rater must consider the focus that has been established for the patient in particular. It is worth pointing out, that in one segment, several foci can be worked but at different levels so it is necessary to establish the level of presence for each of them (scoring the number of focus in the boxes on the right, e.g. on structure there may be three established focus for the patient, each of them will have a number that must be written on the box). In the case of Level 0, it can happen that patient and therapist are working on a topic that does not belong to the foci described for that patient, so if this level is scored, a small description of the talked theme must be written.

Rater: ____ ____ (First letter of mothers' and fathers' name)

Segment:____

Level 0 Absence of work on the focus	Patient and Therapist do not refer to OPD focus. If the rater perceives that the focus is being acted (and not explicitly formulated) you must consider this level.			
Level 1 Vague reference to focus	Any of the participants refers vaguely the focus, that is to say that the rater has to be more inferential or go to higher levels of abstraction to deduce the focus, since this is not so evident. For example, in case of conflict focus the allusive theme is seen on third parties or in case of structural focus there is an unspecific reinforcement of structural themes.	**Foci**		
		Relational Pattern	**Conflict**	**Structure**
		☐	☐ ☐	☐ ☐ ☐
Level 2 Foci acknowledge and exploration	The focus is suggested explicitly, either by the patient or the therapist exclusively. The other dyad member acknowledges it but does not work on it. The other member of the dyad is able to recognize it but there is no work on it. Example, even though the therapists' discourse goes around the foci, the patient is only able to say, "yes, yes, it can be like that".	☐	☐ ☐	☐ ☐ ☐
Level 3 Work on the foci	Patient and Therapist refer to foci and their discourse goes around it, clearly both are working on it.	☐	☐ ☐	☐ ☐ ☐