Lived experiences of the psychotherapeutic process in Psychoanalysis and Psychoanalytic Psychotherapy

CliniPinel

2009/2010

Authors:

Rui Aragão Oliveira; Hugo Senra; Carlos Amaral Dias; Conceição Oliveira; Cristina Nunes; Luís Loureiro; Sandra Oliveira

With financial support from the International Psychoanalytical Association

Index

Introduction

Recent studies on the subjective experiences of the processes of psychoanalytically-based psychotherapy have demonstrated new and important developments for both clinical practice and the elaboration and discussion of theoretical conceptualizations (Bateman & Fonagy, 2004; Sandell at al., 2002, Stoker & Zevalkink, 2002; Wallerstein, 1994).

Due to its complexity, however, the subject of study in psychoanalytic theory has always proved to be difficult in terms of its systematic evaluation. Freud proposed a specific method of investigation by taking into account the difficulties that this new subject of study (the unconscious) raised. For Freud, however, the question of the validity of therapeutic intervention was always a concern he took upon himself in his research (Freud, 1938).

Due to its intrinsic wealth, the clinical method has led to extraordinary developments in understanding the dynamics of the mental world. It placed the study of the unconscious and unconscious processes as the main subject of its work. On the other hand, methodological procedures of quasi-experimental nature, themselves also with increasingly complex operational structures, have made an important contribution, even though mostly from a semiological-descriptive perspective. These procedures, however, have undoubtedly supported the development of psychoanalytic science and therapeutic technique (Fonagy & Baruch, 1990, Bateman & Fonagy, 1999; Fonagy, 2000; Fotopoulou et al., 2008). In fact, although they have been regarded as controversial in the psychoanalytic community, it is undeniable that we have been witnessing a proliferation of studies with results concerning the effectiveness and efficiency of the psychotherapeutic process (Wallesrtein, 1994, Sandell et al., 2002; Zevalnink & Stoker, 2002; Bateman & Fonagy, 2004) and with consequences not only crucial for psychoanalytic theory and clinical technique, but also for public health programs (Roth & Parry, 1997; R. Sandell et al., 2000; Leichsenring, 2005; Lazar, Sandell and Grant, 2006).

The important and historic work of Glen Gabbard et al. (1997) on the economic impact of psychotherapy, where he demonstrates how it contributes to cost reduction in treatments for people with severe mental disorders and contributes towards a significant decrease in absenteeism in this population, revived the importance of the subject-matter, inside and outside the psychoanalytic world and emphasized the need to deepen scientific knowledge about the psychotherapeutic process.

In the last decade, various and significant publications have been discussing both the specificities of the psychoanalytic psychotherapy process and the outcomes in population groups with well-defined symptomatology, which range from panic disorders (Milrod et al, 2007) and their comparison with other therapeutic approaches (Leichsenring et al, 2009), to groups of patients with depressive syndromes and anxiety disorders (Fonagy, Roth, Higgitt, 2005). Falk Leichsenring (2005, 2008, 2009) is particularly well-known for his meticulous scientific reviews on the results of psychoanalytic psychotherapy by repeatedly trying to highlight the contribution of this psychotherapeutic approach. His meta-analysis has begun by initially highlighting the paucity of rigorous studies on the subject, but has also expanded on the difficulties of their implementation (lack of evaluation methodologies that allow intercomparative studies, divergent understanding of what psychoanalytic psychotherapy claims to be, absence of complementary data which are essential in devising methodological procedures, or the existence of small studies with controlled trials have, for instance, been some of the most severe criticisms Leichsenring points out). However, he also stresses the differentiation of long-term psychoanalytic psychotherapy in what both its outcome and the patients' long-term stabilization are concerned, confirming that this psychotherapeutic approach clearly stands out amongst others, as for instance in the treatment of severe chronic patients.

Moreover, studies on the effectiveness of long-term psychoanalytic psychotherapy have been assumed as a research subject in itself (of Maat, 2009), focusing on theoretical reflection on the specifics attained by the psychoanalytic method (Kächele & Fonagy, 2009).

The aforementioned difficulties inherent to the main subject of work of psychoanalytic psychotherapy - namely, unconscious processes in the dynamics of mental life - meant that for quite a while studies on the effectiveness or ineffectiveness of psychotherapy included these processes in reviews or in incoherent evaluations. This was due to the fact that they were conducted under ideal conditions, where the description of semiologically descriptive frames prevailed and where the evaluation focused almost exclusively on symptoms, thus ending up bearing little resemblance to today's clinical private practice. These studies result from experimental approaches and refer to research conditions where variables are highly controlled, the results are predictable and the conditions in which psychotherapy occurs almost impossible (if not at all possible), lagging behind the characteristics of clinical reality.

On the other hand, naturalistic studies about the psychotherapeutic process have been developed. These have been contextualized in terms of effectiveness, i.e., the ability of the method to promote desired outcomes, highlighting the positive effects on patients, and sometimes blending them with the assessment of symptoms.

Finally, studies on efficiency deal with the therapeutic process as a subject-matter, focusing on the competence to produce results with minimum expenditure of resources and efforts. These studies therefore seek to examine what undergoes transformation and how that change organizes and develops.

The synthesis of these three components indisputably falls short of being excessively reductionistic and would probably be worthy of greater and more focused attention. However, it allows us to introduce central issues to the field of research in psychoanalysis and psychoanalytic psychotherapy, which we subsequently seek to develop.

I. From the object of clinical work and study to the studied objects in clinical and empirical research

We believe we cannot carry out good research, regardless of the method one uses, without being clear about two basic and fundamental questions: what is the subject of investigation? (What do we want to know?); and which method do we intend to use? (How are we going to try to know?)

If our subject is the unconscious (and unconscious processes), the question is bound to become particularly difficult. By casting a quick glance at the evolution of the 'unconscious' as a concept and the implications of this transformation in the specifics of clinical work and research of psychoanalysis, one quickly becomes aware of the complexities and difficulties we are facing.

Initially inscribed in Freud's first topology of the psyche, the unconscious was basically everything that lies outside the field of the conscious and its dynamism was very different from the one we now find in current conceptualization. Freud's first contacts with Charcot's clinical practice and his latter discovery of the talking cure, led him to clearly discern the phenomenon of hysteria and its mental world and to give particular attention to the phenomenon of "selective" unconscious memory. The veracity of remembered facts as recalled and reported by the patient became less of a focus, and the reason why and how they were recalled took on greater importance. Consequently, it was now possible to see beyond the scenario which was explicitly presented by the symptoms and to seek to achieve meaning and sense almost always unknown to the subject himself. The unconscious is thus formed by repressed contents which were inaccessible to the conscious due to the effect of repression, an essentially unconscious process.

Even in those early days psychoanalysis was already introducing a crucial problem for scientific investigation and empirical methodologies: the relationship between symptom and meaning. Moreover, we must bear in mind that the symptom can in fact change, disappear and transform itself, but the unconscious problem can remain, and diverse substitute symptoms can emerge. As a matter of fact, the disappearance of symptoms, which usually has defensive value, may even aggravate a patient's condition in some circumstances. As a result, the nosographic classifications of psychiatry as criteria for evaluating the psychotherapeutic process

have in fact an extremely limited importance in psychoanalysis and psychoanalytic psychotherapy.

As an example, there are even some cases of therapeutic success where the presenting symptoms do not undergo much change, but where they not only show some signs of improvement in some other parameters in terms of suffering, but also benefit from not deteriorating too much. This way they are protected from continuing a true and much more serious 'psychiatric path'.

Later on, with the evolution of psychoanalytic knowledge and the broadening of clinical experience, the conceptualization of the dynamics of the mental world and unconscious processes would become more complex and suffer inevitable evolutionary transformations.

In the second Freudian topographic scheme, which in reality had been gradually developed in Freud's work even before it was presented in the famous paper *The Ego and the Id* in 1923, the unconscious dynamics of the psyche is now considerably amplified by the idea that it would work as a structure in which various elements dynamically interact with each other. The unconscious ceases to have a special and unique position and begins to qualify as Id, but also as Ego and Superego. It is now acknowledged as a system with its own characteristics, where the absence of denial and doubt, as well as timelessness, are drawn attention to. The expression of symptoms and its associated behavior refer not only to aspects of the unconscious world, but primarily to conscious and unconscious relational patterns of the inner world. It is moreover not always easy to describe its dynamics without reducing and disregarding it. The implications for psychotherapeutic technique are tremendous, especially in the conceptualization of healing, illness and mental health, and also for the aims established in the therapeutic context, where the mere reduction of presenting symptoms is no longer the goal or even the privileged object of psychoanalytic work.

A few years later, Freud once more ends up introducing further modifications to the concept of the unconscious with his paper ***Splitting of the Ego in the Process of Defense*** (1938/1940), even though he had been very attentive to the contributions of his colleagues (namely Ferenzi's and Klein's). This new

conceptualisation of the unconscious would be considered the third Freud's model of the mind by N. Marucco (1978) or by E. Raggio (1989).

Freud (1938/1940) describes a particular situation in which the Ego's confrontation with a traumatic reality causes it to become ambivalent when faced with both pressure from the demanding instinct it seeks to satisfy and from some imminent danger. This situation drives the Ego towards behaving in a complex duplicity: on the one hand, it partly relinquishes the satisfaction of the drives, but on the other hand it rejects reality by unconsciously calling upon omnipotent parts which are able to thus reject the traumatic perception (see e.g. the excellent and recent texts organized by BOKANOWSKI, & Lewkowicz, 2009). And while Klein views the process of splitting as parts of the Ego being unconsciously placed in the most significant relationships, mainly through the projective identification mechanism, be it communicational or pathological, Freud presents us with a particular dimension of unconscious processes which is also made up of parts resulting from a withdrawal of meaning, via the splitting of the ego and followed by the mechanisms of denial. This process ends with an appeal to an omnipotent belief, which is marked by a narcissistic wound. We are now faced with an unconscious, which is also split and has its own recording and returning procedures. This new realisation draws our attention to the fact that objectivity and subjectivity are constituted both symmetrically and simultaneously in the development process of the Self. In his work "Psychic Retreats", John Steiner (1993) shows us the implications of all this for understanding pathological psychic organizations and for clinically approaching them.

Due to the more or less acknowledged negligence of the assessment of unconscious themes, it is thus easy to understand how the research on the psychotherapeutic process is faced with enormous difficulties and how strangely limited many of its reached conclusions must be.

A profound reflection on the specific problem of research on the effectiveness and efficiency of psychotherapy therefore becomes essential because of the complexity inherent in the primary subject of study, where the reduction of symptoms, changes in the patient's behavior and actions, changes of internal

versus external relational patterns, the manifestations of paranoid-schizoid anxieties or the power of the functioning ego have sometimes clearly been disparate and not always easy to integrate.

It does not seem viable to simply ignore these considerations and to come up with simplifications which would be subject to methods inherent in other branches of science: the events can certainly "relate", but do not exactly have to "correlate" with statistical meaning; they are presented in specific situations as being displaced and do not intersect, even though they belong to the same mental world!

If we try to accumulate data in a sterile and incomprehensible manner by merely copying the study of other fields of science and focusing on the idealization of methodology, we will almost certainly be conjuring up Paulo Cesar Sandler's naive realist (2003) who stems from the traditional empirical scientist (as if studying and understanding the actions of mankind could be summed up by simply adding all their synaptic connections to the smallest detail). This way we would surely be dealing with schizoid phenomena, which would be utterly devoid of human uniqueness. On the other hand, we would certainly be bound to be confronted with the naïve idealist, who feels protected by his belief that the "bosom" (the "being", in adulthood) is simply what he believes it should be (just like the naive analyst may simply believe that the best clinic is in actual fact his own "clinical practice") if we were to do without any methodological reflection which would allow for constant questioning and improvement and help us to humbly acknowledge our ignorance. We would thus undoubtedly be preoccupied with mere clinical practice, hating and refusing to look outwards, to non-success, to frustration and to thinking.

Juan Pablo Jiménez (2009) takes us back to the particular craftsmanship of the analyst, who will only use limited amounts of material and theoretical and practical instruments to create his work and use heterogeneous information which he accumulated in his training years and clinical experience and that he will be creatively adapting to each case (Jiménez, 2009, pp.11). Persistent comparison of something that is inscribed in constant dynamism indeed requires a deep reflection on the methods of validation.

The question of how to validate psychotherapeutic work had always been a concern for Freud and the psychoanalytic community at large. In his paper "Constructions in Analysis" (1937) he clearly expressed these concerns and pointed out how the exercise of constant validation of interpretative construction was always in his mind, as opposed to suggestion (associated with infantilization and the devaluation of reflective capacity) or active techniques. Interpretation is a gift the patient subsequently validates through the changes and constructions he is able to formulate. We see ourselves moving from a psychoanalytic model based on archeology - the search for hidden truth - to an architectural model (Jimenez, 2009), where new constructions, creativity and mental flexibility gain ground. The reconstruction of the past is only a preliminary and always incomplete objective which is followed by the construction of new and different narratives. Validation thus not only springs from the return of the repressed, but ultimately from transformation, change, progress, creativity and growth.

The problem with much of the research on the effectiveness of psychoanalytic psychotherapy is the belief that its efficacy depends on objectives or improvements.

But if we consider these reflections, can we then ask: What objectives and what improvements? Improvements seem in fact unlikely to be merely validated by symptom reduction (as previously argued!). And objectives seem to change during the psychotherapeutic process, as a consequence of evolution itself. The vast majority of patients do not have precise objectives: they want to get to know and understand themselves, to feel that they can change a few recurring patterns and feel free from a painful past they see as a burden by gaining creative ability to allow them to get greater satisfaction in their contact with reality.

For the analyst, the objectives are almost always decrease mental rigidity, increase intrapsychic flexibility and diminish the use of less primitive mental mechanisms. Both improvements and objectives bring up complex questions with regard to their validation.

Some scholars seek to correct this by combining instruments for assessing symptoms with the patients’ and/or the therapists’ opinions - but this problem is

not a simple one because the unconscious reasons underlying their answers are immeasurable (to look for the best answer to suit and gratify the analyst or to avoid questioning the time and money one has spent; the analyst's answer also contains many variables which are difficult to work with - hence the need of supervision).

This confusion of voices has sometimes led to major misunderstandings and misperceptions of the studied phenomena.

II. The study of the psychotherapeutic process in psychoanalysis and psychoanalytic psychotherapy

In an important and illuminating text, Daniel Widlocher (2003) distinguished between research ***in*** psychoanalysis / psychoanalytic psychotherapy and research ***on*** psychoanalysis / psychoanalytic psychotherapy. Research ***in*** psychoanalysis / psychoanalytic psychotherapy is any work that seeks to better understand what happens during treatment (understanding the therapeutic process) and can only be performed by specialists / trained clinicians. Research ***on*** psychoanalysis / psychoanalytic psychotherapy is any approach coming from outside the process (working on therapeutic indications, results, therapeutic technique, etc.) and can be done by someone mastering evaluative techniques and who works closely with the psychoanalyst. Indeed, they are not the same thing; they are related with each other and we believe that they both benefit from each other, but they are also very different.

If we take a look at the papers that were written about the study of the therapeutic process (F. Leichsenring 2005; S. Jung, L. Ng, C. Eizirik, 2007; Falkenström F., J. Grant, J. Broberg, R. Sandell, 2007; of Mat, 2009), we can easily confirm how little investment of time and effort this subject received in a consistently inattentive way during the course of the first half of the twentieth century. Until around 1960, research was mostly made up of mere statistical data; its results were categorized into different classes of patients and their evolution reported in an almost rudimentary way.

More complex evaluation methods would soon follow. These were studied in depth and were inscribed in a comprehensive and well devised conceptual knowledge, favouring longitudinal designs which actively seeked to address the process of change, with before and after treatment application of instruments which sought to achieve an expression of greater objectivity with regard to more reliable predictors of the therapeutic success. Their aim was to effectively enhance the therapeutic process.

Later, during the 80's and 90's, procedures were developed which meticulously analyzed the psychological structure of the patient. They aimed at describing and evaluating processes of structural change which went alongside the development of the psychotherapeutic process where the approach of the therapeutic relationship was gaining new importance as a tool to be operationalized.

However, more comprehensive and thorough follow-up studies on the process of therapeutic change began to take place in the beginning of the 21st century, where the effects of the longevity and intensity of psychotherapy were also drawn attention to.

In fact, research on long-term psychoanalytic psychotherapy is rare, even though it has been systematically introduced and prized by the Menninger Project (Wallerstein, 1999). One of the obvious arguments relates to the fact that it is extremely difficult to integrate methodological principles which are commonly used for measuring therapeutic efficacy in shorter interventions, in themselves limited to the temporal dimensions of the researchers themselves. The latter, as Falkenström well claims (2007), make use of operating procedures which are limiting in psychoanalytic contexts (control groups, randomization of population groups, standardized treatment approaches in accordance with treatment manuals, etc.). More recently and alongside naturalist studies, other groups of researchers have have been managing to bring fundamental dimensions to the analytical clinic (the examples of STOPPER Project in Sweden (R. Sandell & al., 2000, 2006), or OPD Task Force, 2008, nowadays on a worldwide scale), and have greatly contributed to the deepening of the therapeutic process, and the controversial

discussion between psychotherapy and psychoanalysis (H. Kächele, 2010). In addition to the mere symptom removal, they have been highlighting the differences which were observed a long time after the treatment of psychoanalyzed patients, as they seem more able to consciously or unconsciously continue something inherent in the therapeutic process even years after its conclusion. Falkenström (2007) advances the hypothesis that patients who have undergone psychoanalysis develop a more discernible analytical internal function than the ones subject to psychotherapy. In other words, they unconsciously continue the therapeutic work of transformation and mental development by themselves even after the end of the therapeutic encounter. This process is usually understood as the product of unconscious identification processes with the analytic function of the psychoanalyst and it can even be considered as a criterion for establishing the end of therapy.

This process of internalizing the analytic function has itself been much discussed and interpreted in multiple and sometimes even contradictory ways (in the extreme, Kohut argued that this should not even exist, and that a "cured" patient should not need to have the ability to self-analyse). But even if we agree on the importance of this capability as a fundamental criterion for the end of the therapeutic process (in clear opposition to Kohut), we can not ignore the fact that the implementation and evaluation of this ability is extraordinarily complex and very controversial (Wallerstein, 1999; Kantrowitz, 1990).

A study conducted by the German Psychoanalytic Association contends, for example, that patients who underwent psychoanalysis, in which the attendance of weekly sessions is more frequent, develop a capacity for self-analysis which is different from the one developed by those subject to psychotherapy (Leuzinger-Bohleber, 2003). However, the data on which this position is based requires even greater consistency (Falkenström, 2007).

The Swedish study STOPP, comprehensive and ambitious in longevity, has been favoring quantitative methodology. Many of its topics are investigated through self-completed questionnaires and scales, which is clearly limited. Despite highlighting important aspects, they do not at all seem to be able to get in touch

with crucial aspects in psychoanalytic therapy. These quantitative studies are perhaps more useful to point toward dimensions that qualitative studies should investigate by developing their own, albeit rigorous, methodologies.

The use of more elaborate methodologies has been taking on a more and more central role in psychoanalytically-based research (Jung, Nunes & Eizirik, 2007) in a crescendo of creativity and scientific enrichment. These methodologies resort to a number of interviews (Moustakas, 1994), an approach that allows access to the analysis of unconscious material through the processes of transference and countertransference, whereby the subjects, without any sort of restriction, not only draw attention to the representations of their satisfaction and gains regarding their treatment, but also emphasize the changes and their impact on multiple areas of their lives. Moreover, both their satisfaction and the therapeutic relationship have become key points in psychoanalytically-based research.

It is within this frame of reference that the research work presented hereafter is established. It attempts to contribute to the deepening of knowledge about personal experience following psychoanalysis or psychoanalytic psychotherapy by both analyzing and understanding the main features of a larger post-therapeutic psychological development and studying the influence of intensity and longevity factors of the therapeutic process.

Empirical study

Lived experiences of the psychotherapeutic process

Before we address the summary record of the proceedings, we believe it may be useful to summarize the general objectives of this research project, which can be found in Table 1.

Table 1 - Overview of the project

Project title	**Experiences of the psychotherapeutic process**
General Objectives	Understanding the lived experience of patients who have undergone processes of psychoanalytic psychotherapy or psychoanalysis.
Specific Objectives	• Analyze and understand the motives that led them to seek treatment; exploration of how they experienced the various phases of the process; exploration of the changes they experienced during the process and after it ended; and their experience of the relationship with the psychotherapist. • To study the influence of the factors "intensity of the treatment sessions" and "longevity of the psychotherapeutic process". • Compare possible differences between patients undergoing Psychoanalytic Psychotherapy vs Psychoanalysis.
Methodology	Exploratory Study using Qualitative Analysis methodology by resorting to questionnaires and/or interviews
Sample	Convenience sampling based on patients who have undergone psychoanalytic psychotherapy or psychoanalysis in private practice within CliniPinel and whose therapeutic process has been terminated by mutual agreement for at least 1 year.

Methodological Procedures

The performed procedures were essentially organized into 5 parts: 1) Building up a bibliography; 2) Sample selection; 3) Designing a questionnaire to be filled in by the therapist; 4) Designing the interview script/questionnaire; and 5) Sample collection.

Bibliographic Collection

The bibliographic collection of articles and references related to the theme focused on two basic areas, namely research on psychotherapy/psychoanalysis, and the use of qualitative analysis methods (phenomenological) in the study of issues related to psychotherapy. Record and file review was done through the use of bibliography management software *EndNote*.

Sample Selection

The sample selection process at CliniPinel, a private clinic of psychoanalysis, psychoanalytic psychotherapy and psychiatry located in Lisbon, began after a first team meeting. Here, the therapists were notified of both the general purpose of the study and the procedure that ought to be followed when selecting their patients. They were also asked to consult their records in order to choose among those psychotherapy and/or psychoanalysis patients who had ended therapy by mutual agreement (with clinical psychotherapeutic discharge) at least one year before.

At this same meeting, the general contact procedure with patients was also discussed. It was decided that these would first be contacted by their therapists (in an attempt to inquire about their interest in participating in the study). If so, they would subsequently be contacted by an independent investigator (the grantee) who would ask them about their preferred method of data collection, so as to fully protect the identity of therapists and/or patients.

Following this meeting, the therapists received a letter which was sent round in the clinic. It not only informed them of the purpose of the research but also invited them to participate in the study. By this time, the questionnaire that was to be filled in by each therapist (Appendix B) was already available. It had been designed to collect both demographic data about the therapists and data about those patients who had agreed to participate in the research study.

It should also be mentioned that all the therapists from this clinic have undergone solid training in psychoanalysis or psychoanalytic psychotherapy, which includes personal psychoanalytic experience, regular supervision and

frequent clinical practice in psychoanalysis and/or psychoanalytic psychotherapy. This data will be adequately presented in its own section.

Conception of the Questionnaire to be filled in by the Therapist

The questionnaire to be filled in by clinicians (Appendix B) consisted of: 1) data on the Psychotherapist/Psychoanalyst, 2) Contact Procedure with the patient, and 3) data on the patient.

The first section – Data on the Psychotherapist/Psychoanalyst – consists of a set of questions on sociodemographic data which aimed for a thorough description of the sample of therapists. Its construction was based on a questionnaire developed for this purpose. For this reason, the authors removed some questions in order to simplify the questionnaire and adapt it to the population it was aimed at, namely, Psychoanalytic Psychotherapists and Psychoanalysts. The questions of the final version include data such as age, gender, degree, year of completion of undergraduate degree, the university where they graduated, higher degrees, training location in psychotherapy and/or psychoanalysis, the context of professional practice, years of clinical practice, frequency of clinical practice, frequency of supervision and attendance (past or present) of personal psychotherapy.

The second section - Contact Procedure with Patients -, consists of a table with information that adequately explains the criteria for patient selection and suggests a general procedure guide the therapists should follow when engaging in their first telephone contact with their patients. Thus, therapists were instructed to contact patients who had undergone psychoanalytic psychotherapy or psychoanalysis and whose therapy had been ended by mutual agreement at least 1 year before. Concerning the telephone conversation, it was suggested that patients should first be informed that the clinic would be conducting a research study on the patients' experience of the psychotherapeutic process and that if they agreed to participate in it, an independent researcher might contact them later on about it. At that moment they would be filled in about the study in more detail and would be

sent a questionnaire. The therapists were also instructed to tell their patients about the anonymous nature of their participation.

And finally, the third section - Data on Patients – consists of a set of forms which the therapists filled in with information about those patients they had formerly contacted and who then agreed to participate in the research. Each patient was asked their name (for further contact), sex, age, type of psychotherapeutic intervention (face to face psychotherapy/psychoanalysis), the beginning and end of therapy, frequency of weekly sessions, plus a field for notes and comments that clinicians might want to add.

Conception of Questionnaire/Interview Guide for Patients

After long reflection by the team on the appropriateness of the methods to the set targets, we chose to follow the methodological recommendations of the Consensual Qualitative Research (CQR) method (Hill et al., 2005; Hill, Thompson, & Williams, 1997). Contrary to some phenomenological approaches which discourage the consultation of literature on the grounds that it might subsequently influence data analysis, this approach argues that consulting literature on the subject does not necessarily have a negative influence, since it facilitates the exploration of little studied areas within a certain theme, it assists the development of new ways of examining old topics and ultimately allows the research topics to be better defined and the interview protocol/questionnaire to be better designed. With this in mind, in order to understand the kind of issues/areas that were addressed, we looked into papers about research on the efficacy of psychotherapy where a qualitative methodology had been used for the analysis of patient interviews (Leuzinger-Bohleber, Stuhrast, Ruger, & Beutel, 2003; Falkenström Grant, Broberg, Sandell &, 2007; Jung, Nunes, & Eizirik, 2007). What followed was an initial draft containing questions that might be asked. This draft was subsequently discussed and modified as a team by considering the areas we decided to focus on (grounds for seeking therapy, self-observed changes during and after the process, choosing a striking episode which happend during the course

of therapy, the termination of psychotherapy, the relationship with the therapist and an open question designed to encourage patients to share issues which they did not address but felt might be important). This was the process whereby the final interview protocol/questionnaire (Appendix C) was ultimately conceived.

Two versions of the protocol were thus made: a first one to be applied in interviews (Appendix D) and second one in Word format (Appendix E) to be sent by electronic mail. We chose to design the questionnaire in Word format as opposed to using an online questionnaire for several reasons, namely: 1) it would allow patients to save their text as they wrote it and the software also allowed them to save their text in case of power failure; 2) it would allow to answer the questionnaire gradually in case there was no time or willingness to do it all at once; and 3) it would allow the option to restore ("undo") written information in the event of it being accidentally erased .

Process of gathering a Sample of Patients

As soon as the researcher had access to the questionnaires filled out by therapists, he inserted the demographic data of the therapists into a database. Then he proceeded to contact those patients who had agreed to participate in the study by telephone. The conversation with these patients was based on the following telephone protocol: "Good morning/afternoon. Am I speaking with Mr. X / Ms. X? My name is Daniel Gomes and I am contacting you regarding a research study which is being conducted by CliniPinel. I believe you have already been contacted by us and had agreed to participate in our study. I am calling to know if you still want to take part in it and if you are willing to answer a questionnaire by email, by post or if you would prefer to come for a personal interview."

If they chose to participate via e-mail, they were asked to provide their e-mail address and they would then be sent an email (Appendix F) containing the questionnaire attached in Word format (Appendix E) together with instructions for its completion and return. Alternatively, had they chosen to be interviewed, they were asked about which times they had available so that they could attend the interview at the clinic. After that, a final contact was made to schedule the

interview. They were also informed that the interview would be recorded on audio tape for transcription purposes and that anonymity and confidentiality would be preserved. Finally, if they chose to answer by post, they were asked to supply their correct address so that the questionnaire could be sent to them in due time.

In case they were indecisive, they were sent the questionnaire by e-mail so that they could make their decision about which method they preferred. After having had a look at the questions and having decided on the preferred method, they were contacted again after some time.

In those situations in which, despite the positive response and interest shown by patients, no response was obtained, a second contact was made by email about 1.5 months later; in a final stage, 2.5 months after the first contact, the researcher made a final telephone conversation, where he reminded patients of the study and how important it would be for them to cooperate.

General Statistics of Contacts with Patients and Collected Data

Characterization of the participating therapists

Results of the Therapist Questionnaires

Out of the 17 psychotherapists and psychoanalysts who were contacted for the study, only five questionnaires were filled out and handed in by therapists (four females and one male). These mentioned a total set of 21 patients who were registered as having agreed to take part in the research.

Summary of therapist data:

	A	B	C	D	E
Age	38	41	50	49	36
Education	Degree in Psychology (15 years ago); PhD in Clinical Psychology	Degree in Psychology (18 years ago); PhD in Clinical Psychology	Degree in Psychology (26 years ago); Postgraduate degree in Clinical Psychology	Degree in Psychology (26 years ago); Masters in Clinical Psychology	Degree in Psychology (14 years ago);
Member of the	Since 2007	Since 2001	Since 2002	Since 2001	Since 2002

Portuguese Association of Psychoanalysis					
More than 50% in private clinical practice	yes	yes	yes	yes	yes
Total number of years of regular clinical institutional/private practice	0/6	6/17	10/18	7/10	0/13
Frequency of clinical practice	More than 6 patients a week	More than 6 patients a week	More than 6 patients a week	More than 6 patients a week	More than 6 patients a week
Private individual supervision	yes	yes	yes	yes	yes + group
Personal psychotherapeutic process	Psychoanalysis	Psychoanalysis and Psychodrama	Psychoanalysis	Psychoanalysis and Group analysis	Psychoanalysis and Psychodrama

Contacts and Patient Data

Of the 21 referred patients, 19 were contacted by telephone and one participant was sent an email because he was living abroad. It was not possible to get in touch with the last one. Whenever the call was sent to voicemail, the researcher left a message where he identified himself, explained the purpose of the call and left his telephone contacts and e-mail address.

Obtained Responses

Characterization of the participants

Of the 21 subjects who agreed to participate when they were contacted by telephone, only data from 13 participants was in fact collected: 10 men and three women (two of the latter ones attended a personal interview which was recorded and one chose to send her replies by letter). Their main characteristics are described as follows:

Age	Gender	Psychoanalytical Psychotherapy or Psychoanalysis	Duration of the treatment	Weekly attendance
44	F	Psych. Psychotherapy	4 years	2x
41	F	Psych. Psychotherapy	1 year + 5 months	1x
43	M	Psych. Psychotherapy	1 year + 10 months	1x
29	F	Psychoanalysis	3 years	2x
35	F	Psychoanalysis	3 years	2x
37	F	Psychoanalysis	3 years	2x
40	M	Psych. Psychotherapy	3 years	2x
63	F	Psych. Psychotherapy	4 years	1x
56	F	Psych. Psychotherapy	2 years	1x
38	F	Psych. Psychotherapy	1 year + 8 months	1x
35	F	Psychoanalysis	3 years	2x
49	F	Psych. Psychotherapy	1 year + 8 months	1x
29	M	Psychoanalysis	7 years	3x

The table above thus shows us that at the time of the evaluation interviews, the ages of the subjects ranged between 29 and 63 years, mostly between 35 and 45 years. Of the 13 subjects, 5 underwent psychoanalytic treatment and mostly attended sessions twice a week. Only one patient mentioned having attended psychoanalytic sessions three times a week. The remaining eight mentioned undergoing psychoanalytic psychotherapy, which is a shorter treatment on average. The duration of the therapies varied from 1 year and 5 months to 7 years.

1. Methodology of the Analysis of Collected Information

All the assembled information was gathered through the conducting of interviews whose handling is based on a model of a qualitative analysis. Giorgi's Interpretative Phenomenological Analysis (1997, 2003) and Bardin's Content Analysis and data coding (2008) were specifically the two chosen methods. Consequently, we proceeded to perform the organization process and content analysis by following the methodological steps described hereafter:

a) Detailed reading of the interview transcripts so as to progressively register the more relevant and indicative information contained in the subjects' responses;

b) Organization of the interview questions into three thematic groups according to the timing of question and answer (if they occurred before, during or after therapy);

c) Construction of a table for registering the content and for handling and operating the codification of the answers;

d) Definition and characterization of content indicators which are organized into categories/groups allowing each type of response to be incorporated. In this step, it is important to know if the subject's answer refers to more subjective contents, such as internal or relational conflicts, feelings towards themselves or feelings relating to therapy or the therapist, feelings of anxiety, among others, or whether it refers to more objective and specific contents such as physical or psychological symptoms, direct actions or interference directed to the subject by external agents, etc. We shall discuss in more detail how we organized this work further on;

e) Definition of subgroups for specific topics addressed by the subjects by respecting the nature of the response, ie, by proceeding to a subsequent encoding and in an open way. In this step, we describe and frame the subjects' responses according to the meaning of the words they used to answer the questions and not according to pre-established categories;

f) Description of the answers in order to characterize the type of content that emerged from each group of answers (and from each question) and in order to analyze the frequency of specific content within the same questions (eg.

the frequency of a particular reason for seeking help or of a particular feeling towards the therapist or therapy).

We shall now describe in detail how the methodological steps described above were put into operation.

Considering the structure of the questionnaire we applied to the subjects, we chose to separate the questions into three large groups in terms of the analysis of the content of the interviews:

- The first group concerns the content which relates to the period before psychotherapy or psychoanalysis and points at the reasons which led the subjects to ask for help. This analysis group was termed Pre-Therapy Phase;
- The second group refers to the contents which relate to the period between the beginning and termination of psychotherapy or psychoanalysis, therefore focusing on the period of the treatment itself. This group was termed Peri-Therapeutic Phase;
- The third group concerns contents which relate to the subject's post-treatment experiences, i.e. their self-perceptions after the psychotherapeutic or psychoanalytic process. For this reason, we termed this analysis group Post-Therapeutic.

I – Pre-Therapeutic phase - Reasons for seeking therapeutic help

The pre-therapeutic phase is composed of the answers to the first question of the interview protocol. This question may bring the following aspects to the subject's mind: the nature of the psychological distress (mental pain) which motivated him to seek help, the way he perceived his suffering (in view of the symptom or mental conflict), and also the initial expectations regarding change and transformation of those aspects that felt likely to be changed. For the analysis of the answers to this question, which is related to the reasons for seeking therapeutic help, we applied codes to the following themes:

- Answers in which he voiced objective, internal reasons (psychological or somatic symptoms) or external reasons (when the subject attributes his decision to attend a session to the advice of others);
- Answers in which he voiced subjective and conflictual reasons. Among the subjective reasons, we contemplated the subject's internal and external conflicts or his relational conflicts. The first ones only concern the reasons associated with the subject's dissatisfaction with aspects regarding himself, such as his mental resources, his feelings, his memories and his acceptance of his own "I". We consider those answers referring to external or relational conflicts to be those which indicate the subject's feelings of dissatisfaction and/or conflict with someone else and how he relates to them (and/or they to him);
- Answers in which the subject relates internal subjective reasons to relational ones;
- Answers in which the subject relates objective reasons to subjective reasons;
- Defensive and/or avoidant answers, whenever they are vague, unclear or with little content;
- Lack of response - total avoidance;
- Other answers that do not fit into any of the above categories, but that are susceptible of being described and analysed (free content analysis).

II – Peri-Therapeutic Phase

We assigned the peri-therapeutic phase to the subjects' answers to questions 2, 3, 4 and 6 of the protocol of the interview. They address the following issues: the changes the subject observed about himself during therapy (question 2); a striking episode the subject recalls as having occurred during therapy (question 3); the way he perceived the relationship with her therapist (question 6); and the way he experienced the termination of the therapeutic process (question 4). On a mental level, these questions may suggest the following aspects to the subject: experiences arising from the therapeutic process; feelings which came up during the same

period towards himself, the therapist and therapy; self-awareness of the changes which ocurred during the therapeutic process; the kind of changes/transformations the subject underwent during therapy; the internalization of the therapeutic function; the quality of the internalization of the object therapist; the quality of the internalization of the therapeutic space; anxieties and feelings arising from the therapeutic experience during and at the time of its termination (separation anxiety), among others.

For question 2, we followed a similar content encoding model we applied on the group of answers of the pre-therapeutic phase. Thus, we tried to group the answers according to the type of change the subjects voiced: changes on an objective and concrete level (concrete situations of the subject's life and/or changes in the type or frequency of the symptoms) or on a subjective and conflictual level (whether it be changes relating to internal conflicts or conflicts with external objects). The coding criteria for this group of answers are the same as those previously defined for the pre-therapeutic phase.

For question 3 we did not define any coding criteria other than a free analysis of the answers as well as a diversified description and analysis of each of these answers.

For question 6 we also chose a predominantly free and open content analysis, without any pre-established categories. However, the analysis of the answers progressively allowed for a retrospective encoding in accordance with the feelings that the subjects gradually verbalized about their therapist. As a result, we were able to classify these answers as indicative of the verbalization of positive, negative or ambivalent feelings about the therapist. Within this classification, we were able to find feelings of a more personal nature (more related to social and love relationships or friendships and suggesting that the therapist was perceived as a friend or a family member) and of a more therapeutic nature (more related to experiences arising from the therapeutic relationship and suggesting that the therapist was seen as someone who had a therapeutic and transforming function). Futhermore, we were also able to find answers that allowed us to characterise the

quality of the internalisation of the object therapist and whether or not there were feelings which hinted at the idealisation of the therapist.

Finally, for question 4, which referred to the experience of ending the therapeutic process, we chose an open analysis model. Nevertheless, we identified certain themes that could be analyzed retrospectively, as was the case of question 6. Accordingly, we were able to describe the kind of feelings that this experience brought up in the subjects, as well as the quality of the internalisation of the therapeutic space and the anxieties arising from the therapeutic experience, during and at the time of its termination (separation anxiety, when these were verbalised.)

III - Post-Therapeutic Phase

We consider that the answers to question 5, which inquires about the changes which were experienced after the termination of the therapeutic process, place the subject in a post-therapeutic period. As a result, it is a question which can bring up the following aspects for the subject: contact with the changes which ocurred during and after the therapeutic process; how the subject experienced this same process (feelings about the therapeutic space); the quality of the internalization of the therapeutic (or analytical) function; the quality of the integration of changes/transformations which were produced in the course of the therapeutic process; self-awareness of changes/transformations which the subject experienced following the therapeutic process: the feeling of satisfaction towards these changes (if any). In addition to a diversified description and analysis of all the answers (exploration of the content) given by the subjects, we used a content analysis scheme which was similar to the one we chose for question 2 of the peri-therapeutic phase. Hence, we classified the answers according to the type of change the subjects verbalized, i.e. whether the changes are objective (symptoms) or subjective/conflictual. Another aspect we analyzed was the existence or non-existence of associations between changes relating to internal conflicts and changes relating to conflicts with external objects. Besides these aspects, we also

analyzed the answers which might suggest judgements about the aspects this question might potentially rise, as mentioned earlier.

2. Results

2.1. Outcomes Analysis – content analysis

The first step towards the operationalization and conclusion of the analysis of the content which emerged out of the conducted interviews consisted of the construction of a table designed to register this same content (Annex G). On this table we organized the information we had gathered in each interview according to the three phases of the therapeutic process. At this point in time we had already coded and classified this information according to previously defined criteria. Throughout the table we can observe several examples which illustrate the criteria for the encoding of information (eg. which sentence of the subject exemplifies why it was coded into a certain category). Hereafter we will proceed with the description and the characterization of the contents which were recorded and analyzed in each interview and in line with the data from the table.

2.1.1. Pre-therapeutic phase

After a content analysis of the subjects' answers to the question concerning the pre-therapeutic period (see table of contents), we can observe the following:
The subjects' answers revealed both objective and concrete reasons for seeking therapeutic help (symptoms, signs, others) and subjective and conflictual reasons (internal and external conflicts).

Of the total of subjects (n = 13), only 5 verbalized subjective/conflictual reasons; only two subjects verbalized objective reasons and 6 subjects reported both (objective and subjective reasons). Among the total number of answers, we registered 11 answers which mentioned subjective reasons (internal conflicts and relational conflicts and/or with external objects) and nine answers where objective reasons were pointed out (symptoms and third-party suggestion). With regard to

objective and concrete reasons, it was observed that only one subject claimed to have had objective external reasons, which came down to a third-party suggestion. The remaining nine subjects who presented objective reasons reported symptomatic complaints. Among the latter ones, several symptoms were mentioned, the most frequent one being depression (7 references), sleep disturbances (3 references) and feelings of anguish and anger (2 references). The other symptoms, such as phobias, somatic complaints, fear of being alone, depressive mood and sadness, feelings of emptiness, suicidal ideation, among others, only showed up once throughout the total sample.

As for subjective and conflicual reasons, we would like to point out that 6 references were made about internal mental conflicts and 8 references were made to conflicts with external and relational objects. Among the subjective reasons, which related to intra-psychic conflicts (internal), the subjects approached topics such as: dissatisfaction with oneself and/or with their mental resources; feelings of insecurity; fear of abandonment; painful memories; need for better self-knowledge; and need to know more about their own childhood. Among these reasons (n = 6), those which were registered as having the highest number of references were dissatisfaction with oneself (4 answers) and dissatisfaction with their own mental resources (2 answers).

With regard to reasons related to relational conflicts (n = 8), the reasons which were found in the answers were: dissatisfaction with the relationship with a partner (love relationships) and/or family (namely father and/or mother), dissatisfaction with relationships at work; conflicts with others in general - constant need of approval by others, among other situations. The two most frequent answers were dissatisfaction with love relationships and parental relationships (father, mother), followed by dissatisfaction with relationships at work. There was also a subject who mentioned objective, concrete reasons together with conflictual reasons, revealing that he was aware that his symptoms of anxiety and depression were related to his dissatisfaction with the love relationship he had at the time.

Finally, it should be noted that there were five answers that we can consider to be of the more defensive type, because they contain few elements of analysis and/or because they are vague.

2.1.2. Peri-stage therapy

The interview questions that correspond to the peri-phase therapy are, as we have seen, those which lead the subjects to evoke changes they experienced during therapy, to remember a striking episode (that occurred during therapy) or the way they felt about both the therapist and the termination of therapy. We will now proceed with a descriptive analysis and characterization of the content of the subjects' answers to each of these questions. Subsequently, we will characterise the contents referring to this phase in a broader way.

Question 2. - Changes experienced by the subject:

The subjects' answers to this question revealed changes they experienced during the therapeutic process on two different levels: on an objective and concrete level, referring to changes at symptom level and in terms of the subject's daily life and on a subjective and conflictual level, referring to changes with regard to internal/intra-psychic conflicts and external/ relational conflicts.

Of the total subjects (n = 13), 9 expressed experiencing changes merely on a subjective/conflictual (internal and external) level. Among the remaining 4 subjects, 3 of them mentioned objective changes, not only pointing out improvements in terms of symptoms, but also changes on a subjective/conflictual level. One subject did not voice any kind of change. We therefore have 9 subjects who only verbalized changes on a merely subjective/conflictual level, 3 subjects who verbalized mixed changes, i.e. of objective nature (symptoms) and subjective/conflictual (internal and relational conflicts) nature and one subject who did not report feeling any change. Nevertheless, we would like to point out that almost all subjects (n = 12) reported changes on a subjective/conflictual level, of which 2 only reported having internal conflicts (mentioning positive changes in terms of self-confidence, awareness of self and of conflicts and of their mental

resources for dealing with anguish and conflict); 2 other subjects verbalized changes concerning only external/relational conflicts (mentioning positive changes concerning their understanding of others and of their relationships with parental figures); and 8 subjects verbalized changes they experienced on both a subjective and a conflictual level (intra-psychic and relational conflicts). Among the changes concerning a subjective/conflictual internal level, we draw attention to the following contents: a new feeling of "I"; positive changes in terms of self-confidence, self-acceptance, self-esteem and/or less self-blame - changes which reflect a transformation in terms of libidinal investment (between internal and external); increased self-awareness of internal conflicts inherent in psychological distress; and greater satisfaction with internal resources in terms of flexibility, capacity to handle anguish, problem solving and coping with negative feelings. Overall, we observe a distinctly higher frequency of responses which mention changes in terms of libidinal investment and self-acceptance (n = 5).

Regarding the responses indicating changes on a conflict external/relational level, we observed the following contents: changes perceived as being positive in their relationship with parental figures or in love relationships (the most frequent answer, with n = 4); changes in terms of libidinal investment (taking better care of themselves in relation to others), changes in terms of understanding others and relationships in general; and one subject mentioned painful feelings associated with the passage from face-to-face therapy to the couch (transferential aspects concerning the experience of the therapeutic relationship).

We also identified three responses more defensive in nature, where the subjects addressed a topic in a vague manner, using generic or inaccurate examples to describe their feelings. Moreover, we registered an answer where the subject did not report any change and therefore it was not possible to classify it.

Question 3. – A striking episode during therapy:

As we can see on the contents table displaying the subjects' answers, the topics they mentioned were very diverse. Most of the subjects (n = 7) chose episodes related to internal changes operated during the therapeutic relationship,

such as: closer and deeper contact with the internal world (self-knowledge), changes which each conflict, (external and internal) operated on the subject, newly-found perspectives about themselves and their relational world; personal gain on an internal and a relational level. In all of these answers the subjects directly associated the positive changes they experienced in their internal and relational world with the therapeutic process. It should be noted that one subject mentioned the importance of a particular intervention of their therapist (an interpretation) to achieve new meaning and perspective about their anxieties and conflicts.

About half of the subjects (n = 6), also voiced certain feelings towards the therapist and incorporated positive and negative transferential content. The subjects mentioned: feelings of personal exposure; feeling understood and accepted by the therapist; seeing the therapist as a teacher who taught them to think about themselves on their own (analytic function of the mind); and seeing the therapist as someone who helped them find new meanings for themselves and for their relationships.

Furthermore, two subjects reported non-therapeutic episodes which were not directly linked to therapy: a subject mentioned a time when his son fell ill, and another subject reported getting drunk after a session. Two other subjects did not answer this question.

Question 6. - Relationship with the therapist:

Even though the subjects verbalized their subjective experience of how they felt about their therapist in answer to this question, we were able to find common denominators in the content they brought up. Considering that what was being dealt with here, namely, the verbalization of affects towards the therapist, we coded these answers in terms of the verbalisation of positive, negative or ambivalent affects. As we also found allusions to how the subjects internalized the imago of the therapist, we coded contents in terms of the quality of this internalization, namely as it being a good object, a bad object, an ambivalent object

of or an idealized object. As mentioned before, the examples supporting the choice of the type of coding for each answer are listed on the contents table (Annex G).

With regard to the outcomes, we can mention some of the affects which were verbalized by the subjects, such as: "loving", "helped to grow"; "was a milestone in my life"; "was important, powerful..."; " part of me ";" friend "; "was understanding";" sometimes annoyed me..."; "I did not like having to pay for sessions I did not attend."

In general, it can be said that most of the subjects verbalized positive and not negative affects (n=9). Of the 13 analyzed responses, 4 expressed affective ambivalence in relation to both therapist and therapy. In these cases, some affects we found were: "I felt good, but sometimes it annoyed me when she looked at the clock" and "disappointment, insecurity, anger"; "helped me understand and find myself" and "at the beginning she seemed to be a cold person". We would like to point out that in this group of answers the type of affect which were chosen were more of a personal level than a therapeutic level.

Among the answers where positive affects were verbalized, we found 10 answers where the subjects mentioned affects of a more therapeutic type (understanding, reassuring, it helped me to understand and find myself) and 8 answers which were more personal (loving, friend). In total (if we consider both positive and negative affects), we found 5 answers in which the subjects only mentioned personal affects about their therapist; 3 answers in which the subjects only verbalized affects relating to the therapeutic process (the affects of a therapeutic type); and 5 subjects with answers of both types.

As for the internalization of the therapist, we found 4 answers alluding to an internalization of the therapist as a good object; 4 answers alluding to an internalization of the therapist as an ambivalent object; and 5 answers alluding to an internalization of the therapist as a good idealized object.

Question 4. - Completion of therapy - experiences:

Considering that this question potentially reminded the subjects of anxieties around separation and how their separation from their therapists was adressed, we paid

particular attention to both the verbalization and the non-verbalization of feelings with regard to these experiences. After analyzing the answers, only 3 subjects reported having had feelings which were directly related to separation from their therapist (separation anxiety). In this group, the feelings which were verbalized were feelings of abandonment, sadness, difficulties in dealing with the last day and sense of loss.

More than half of the subjects (n=6) expressed positive affects regarding their experience of the termination of therapy. The following affects were mentioned: satisfaction with the achieved objective; satisfaction with achieved changes; satisfaction with the help given by the therapist; the fact that they could continue their lives in a more satisfactory way without resorting to the therapist's help; improvements in symptoms (n=1); appreciation of newly achieved internal resources. However, there was also another type of response: one subject avoided talking about this subject; another subject verbalized negative feelings regarding both therapy and therapist; and 2 subjects reported feeling that the work had remained unfinished.

Finally, it should be noted that one subject expressed feeling that the therapy had not ended, as it is a process that will be continued on its own without the physical presence of the therapist, the experience of terminating therapy thus evoking the concept of internalization of the analytic function.

2.1.3. Post-treatment phase

Question 5 - Changes felt after therapy:

As mentioned earlier, for the analysis of the answers to this question we choose the following coding: changes which were experienced subjective and relationally (or in terms of conflict with external and relational objects); subjective and internally experienced changes (in terms of intra-psychic conflicts); and objectively felt changes, in terms of improvement of initial symptoms. In addition to this coding, we will proceed to describing the type of answers in terms of how they verbalized their therapeutic experiences.

In a first analysis, we would like to emphasize that we found a general trend in the subjects' answers: they generally expressed being satisfied with the therapeutic process and established direct and indirect connections between the reasons that led them to ask for help and the changes they felt after therapy. Here we come across situations where there is only an increased satisfaction with internal and/or relational resources, or even at symptom level, as well as other situations in which the subjects mention changes in subjective areas (internal and relational) which evoke conflicts that had not been verbalized as initial reasons for seeking therapeutic help.

With the exception of two subjects who mentioned experiencing only one type of change, the other subjects mentioned experiencing several types of changes after therapy. In the first case, there was a subject who only mentioned subjective internal changes and another one who mentioned purely objective changes, focusing on experienced improvement of symptoms. In the second case (most answers), all subjects reported subjective internal changes (changes in internal mental resources) as well as relational changes (changes in terms of relationships with someone external to the subject). There were also 3 subjects who added feeling that their symptoms had improved (objective changes) to this kind of changes. Among the answers indicating changes at symptom level, we found direct links to the symptoms which were initially reported (like the reasons for seeking help), such as sadness, anxiety, depression, etc.

With regard to the more subjective changes (internal and relational), those which were mentioned the most were: greater satisfaction with internal resources, such as the ability to think about their own feelings and anxieties; self-awareness and self-esteem; increased contact with the inner world; and greater satisfaction with relational resources, in terms of the distance from or closeness to parental figures and partners. It should be noted that this data seems to be consistent with the results of Question 3 from Phase 2. In addition to these facts, it seems relevant to highlight that there were 4 answers which mentioned the existence of a relationship between subjective internal changes and subjective relational changes

and, in some cases, even between these changes and the improvement of symptoms.

Another fact that should be pointed out is the fact that there were answers which also addressed other themes, such as the satisfaction with therapy, satisfaction with the therapist and his interpretations and the feeling that changes were operated little by little.

2.1.4. General considerations:

After having layed out and analysed the results of our study, we can draw some conclusions from the assessment of the content of the three phases as a whole. We shall briefly present some aspects which stand out from a more global perspective of the emerging content of the interviews. Subsequently, and in another chapter of this paper, we shall discuss these findings in greater depth by linking them with the state of the art and the theoretical framework.

Overall, considering the contents mentioned by the subjects in the three phases of the questionnaire, we can observe some general tendencies and some common denominators in the themes which have emerged. As to the reasons for seeking help, which have to do with the subjects' psychological distress or mental pain, we would like to point out that there is clearly a general tendency over the course of therapy towards focusing more on their internal and relational world and less on the symptoms. Among the contents which concern subjective reasons (internal and relational) and which bring up the subject's internal and relational conflicts, we can also observe a positive development, which reflects itself in the subjects' degree of satisfaction and in the way they focused on those contents, indicating that they are discovering new themes during the therapeutic process. These changes were further underlined in the answers to question 3 concerning a striking episode, where the subjects generally valued the therapist's intervention and the transformations they experienced in the course of therapy. Another fact that confirms this evolution is the tendency of some subjects to go further by associating internal (intrapsychic) changes with both relational changes and conflicts with others.

With regard to the lived experience of therapy, its termination and the relationship with the therapist, the contents emerging from these answers seem to indicate a general tendency towards overestimating the role of the therapist and of therapy as a space for change, understanding and feelings of comfort. The feelings which were expressed about the therapist also follow these tendencies, as we can observe a considerable number of answers where a benign quality is attached to the imago of the therapist. Nevertheless, we also observed that a considerable amount of benign internalisations of the therapist by the subjects tends to be strikingly accompanied by some sort of idealization, or a tendency towards idealization, or overvaluation of the therapist's image.

3. **Conclusions**

The attempt to fathom the experiential process of those subjects undergoing a process of psychoanalytic psychotherapy or psychoanalysis emerges as a complex task in both its conceptualization and methodological resources.

In this study we sought to differentiate the phenomena of mental functioning inherent in the search for psychotherapeutic treatment and in the exploration of changes during the course of the process and also the perceptions of the relationship with the psychotherapist.

The methodological procedures which were designed deserve special reference and attention as they assisted in preserving not only neutrality and privacy, but also the most genuine and personal involvement of the subjects.

We believe that this concern reflected itself in the considerable amount of answers which were given by the previously contacted subjects, with a level of response exceeding 60% (13 answers in 21 subjects who were contacted).

On the whole, we draw attention to an evident internalization of the focus on the reasons for seeking psychotherapy, which seems to accompany the evolution of the process. Several subjects mention the fact that they keep discovering new themes during therapy, which seems to demand an effort in terms of the re-framing of the initially proposed objectives. The mere description of symptoms and their prevalence, although initially important, seems to become progressively diluted, except perhaps when the pain is associated with a major stiffening of the symptom.

These changes, which are perceived by the subjects, have two important and fundamental consequences: they are likely to spring from the process of change which is induced by therapy - and we could almost paradoxically propose that the subjects' revision of the motives which lead them to seek therapy could be viewed as a criterion for its efficacy; another important aspect arising from this premise are the methodological implications we should seriously consider and which require deeper reflection.

There also seems to be a natural expansion of the subject's awareness of resources which allows him to be more able to express the whole process of transformation he experienced in a clearer and more complete manner.

The representation of the therapist, which is to some extent identified with an agent of change, also appears to be present whenever the subjects talk about their transformations in a more intense and deep way.

Furthermore, we would like to stress the importance of the experience of separation, where the influence of the idealization of the therapist, on the one hand, or its denial on the other, seem to take on a particularly prominent place which is able to produce strong and intense anxieties. These should deserve special attention in any psychotherapeutic process.

Finally, considering the objectives that had been proposed for this research, where a collection of interviews with a considerably larger number of subjects was to be expected, it is not immediately possible to study the influence of factors such as the intensity of treatment sessions and/or the longevity of the psychotherapeutic process, nor is it possible to compare patients undergoing psychoanalytic psychotherapy and psychoanalysis. Nevertheless, we believe that the methodology we used may allow for a more profound reflection on these subjects should the sample be more comprehensive.

References

Amadei, G., & Landoni, G. (n.d.). Measuring clinical assessments with an empirical intrument: a pilot study by the Milanese Psychoanalysis Centre (Publication. Retrieved 12 March 2009, from IPA Research Database: http://www.ipa.org.uk/research/pdf/amadei.pdf

Aragão Oliveira, Rui (2008) Repetir acidentalmente ou acidentar-se repetidamente. Revista Portuguesa de Psicanálise, 2008, 28(2), 105-112.

Bardin, L. (2008). *Análise de Conteúdo*. 4ª.Ed. Lisboa: Edições 70.

Blatt, S. J., & Shahar, G. (2004). Psychoanalysis - with whom, for what, and how? Comparisons with Psychotherapy. Journal of the American Psychoanalytic Association, 52(2), 393-447.

Brockmann, J., Schlüter, T., & Eckert, J. (n.d.). Frankfurt – Hamburg long-term psychotherapy study: Process and outcome of psychoanalytically oriented therapy and behavior therapy – a study from private practices (Publication. Retrieved 12 March 2009, from IPA Research Database: http://www.ipa.org.uk/research/pdf/brockmann_odr.pdf

Bokanowski, T.; Lewkowicz, S. (2009) On Freud's "Spliting of the ego in the process of defence". Karnac, London.

Cogan, R. (2007). Therapeutic Aims and Outcomes of Psychoanalysis [Electronic Version]. *Psychoanalytic Psychology*, *24*, 193–207. Retrieved 12 March 2009 from http://www.ipa.org.uk/research/pdf/cogan.pdf.

de Maat, Saskia; Jonghe, Frans de; Schoevers, R.; Dekker, J. (2009) The effectiveness of long-term psychoanalytic therapy: a systematic review of emprirical studies. Harv. Rev. Psychiatry, February 2009, Vol. 17, nº 1, 1-23.

Falkenström, F., Grant, J., Broberg, J., & Sandell, R. (2007). Self-analysis and post-termination improvement after psychoanalysis and long-term psychotherapy. *Journal Of The American Psychoanalytic Association*, *55*(2), 629-674.

Fonagy, P., Roth, A., & Higgitt, A. (2005). The outcome of psychodynamic psychotherapy for psychological disorders. *Clinical Neuroscience Research*, *4*(5-6), 367-377.

Fonagy, P.; Kächele, H. (2009) Psychoanalysis and other long-term dynamic psychotherapies. In M.G. Gelder, J.J. Lopez-Ibor and N. Andreasen (eds) New Oxford Textbook of Psychiatry. Second Edition. Oxford, Oxford University Press 2009, vol. 2, pp 1337-1349.

Freedman, N., Hoffenberg, J. D., Vorus, N., & Frosch, A. (1999). The Effectiveness Of Psychoanalytic Psychotherapy: The Role Of Treatment Duration, Frequency Of Sessions, And The Therapeutic Relationship. *Journal of the American Psychoanalytic Association*, *47*(3), 741-772.

Freud, S. (1937) Constructions in analysis. Standard Edition, 23: 255-269. London: Hogarth Press, 2001.

Freud, S. (1940[1938]) Splitting of the ego in the process of defence. Standard Edition, 23: 271-278. London: Hogarth Press, 2001.

Gallegos, N. (2005). Client Perspectives on what Contributes to Symptom Relief in Psychotherapy: A Qualitative Outcome Study. *Journal of Humanistic Psychology, 45*(3), 355-382.

Giorgi, A. (1992). Description versus interpretation: Competing alternative strategies for qualitative research. *Journal of Phenomenological Psychology, 23*(2), 119-135.

Giorgi, A., & Giorgi, B. (2003). Phenomenology. In J. Smith, Qualitative psychology: a practical guide to research methods (Vols. 25-50, pp. 25-50). London: Sage.

Giorgi, A. (1997). The theory, practice, and evaluation of the phenomenological method as a qualitative research. *Journal of Phenomenological Psychology*, Vol. 28 Issue 2, p235, 26p.

Giorgi, A. (2000). Concerning the Application of Phenomenology to Caring Research. *Scandinavian Journal of Caring Sciences, 14*(1), 11.

Giorgi, A. (2002). The Question of Validity in Qualitative Research. *Journal of Phenomenological Psychology, 33*(1), 1-18.

Giorgi, A. (2004). A Way to Overcome the Methodological Vicissitudes Involved in Researching Subjectivity. *Journal of Phenomenological Psychology, 35*(1), 1-25.

Giorgi, A., & Gallegos, N. (2005). Living Through Some Positive Experiences of Psychotherapy. *Journal of Phenomenological Psychology, 36,* 195-218.

Giorgi, A. (2006). Concerning Variations in the Application of the Phenomenological Method. *Humanistic Psychologist, 34*(4), 305-319.

Giorgi, A. (2008). Concerning a Serious Misunderstanding of the Essence of the Phenomenological Method in Psychology. *Journal of Phenomenological Psychology, 39*(1), 33-58.

Gomes, D. R. P. (2008). *Countertransference Questionnaire: Desenvolvimento da Versão Portuguesa do Instrumento.* Unpublished Masters Dissertation, Instituto Superior de Psicologia Aplicada, Lisboa, Portugal.

Groenewald, T. (2004). A Phenomenological Research Design Illustrated [Electronic Version]. *International Journal of Qualitative Methods, 3 (1),* 1-26. Retrieved 10 March 2009 from http://www.ualberta.ca/~iiqm/backissues/3_1/pdf/groenewald.pdf.

Hill, C. E., & Knox, S. (2009). Processing the therapeutic relationship. *Psychotherapy Research, 19*(1), 13 - 29.

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual Qualitative Research: An Update. *Journal of Counseling Psychology, 52*(2), 196-205.

Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A Guide to Conducting Consensual Qualitative Research. *The Counseling Psychologist, 25*(4), 517-572.

Ingram, D. H. (1992). The Psychoanalyst's Experience of Intimacy with the Patient. *Journal of the American Academy of Psychoanalysis, 20*(3), 413-422.

Jiménez, J.P. (2009) Grasping psychoanalysts' practice in its own merits. Keynote Lecture. 46th Congress of the International Psychoanalytical Association. Chicago, 29 July – 1 August 2009.

Jung, S. I., Fillippon, A. P. M., Nunes, M. L. T., & Eizirik, C. L. (2006). História recente e perspectivas atuais da pesquisa de resultados em psicoterapia psicanalítica de longa duração. *Revista de Psiquiatria do Rio Grande do Sul, 28*, 298-312.

Jung, S. I., Nunes, L. T., & Eizirik, C. L. (2007). Avaliação de resultados da psicoterapia psicanalítica. *Revista de Psiquiatria do Rio Grande do Sul, 29*, 184-196.

Kächele, H. (2009) Psychoanalytic controversies psychotherapy: discussion. Inter. J. Psycho (2010) 91: 35-43.

Kantrowitz, J.; Katz, A.L.; Paolitto, F. (1990) Follow-up of psychoanalysis five to ten years after termination: II development of the self-analytic function. Journal of the American Psychoanalytic Association 38: 637-654.

Kernberg, O. F. (2004). Rewards, Dangers, Findings, and Attitudes in Psychoanalytic Research. *Canadian Journal of Psychoanalysis, 12*(2), 178-194.

Lazar, A.; Sandell, R.; Grant, J. (2006) Do psychoanalytic treatment have positive effects on health and health care utilization? Further findings of the Stockholm Outcome of the Psychotherapy and Psychoanalysis Project (STOPPP). Psychotherapy Research, January 2006; 16(1): 51-66.

Leichsenring, F. (2005). Are psychodynamic and psychoanalytic therapies effective?: A review of empirical data. *International Journal of Psycho-Analysis, 86*(3), 841-868.

Leichsenring, F., Biskup, J., Kreische, R., & Staats, H. (2005). The Göttingen study of psychoanalytic therapy: First results. *International Journal of Psycho-Analysis, 86*(2), 433-455.

Leichsenring, F., Rabung, S. (2008) Effectiveness of Long-term Psychodynamic Psychotherapy: a meta-analysis. JAMA, October 1, 2008—Vol 300, No. 13, 1551-1565.

Leichsenring F, Salzer S, Jaeger U, Kächele H, Kreische R, Leweke F, Rüger U, Winkelbach C, Leibing E: Shortterm (2009) Psychodynamic psychotherapy and cognitive-behavioral therapy in generalized anxiety disorder: a randomized, controlled trial. Am J Psychiatry 2009; 166:875–881.

Leuzinger-Bohleber, M., Stuhrast, U., Rüger, B., & Beutel, M. (2003). How to study the 'quality of psychoanalytic treatments' and their long-term effects on patient's well-being: A representative, multi-perspective follow-up study. *International Journal of Psycho-Analysis, 84*(2), 263-290.

Loureiro, L. M. D. J. (2002). Orientações Teórico-Metodológicas para a Aplicação do Método Fenomenológico na Investigação em Enfermagem. *Revista Referência*(8), 5-16.

Loureiro, L. M. d. J. (2006). Adequação e Rigor na Investigação Fenomenológica em Enfermagem - Crítica, Estratégias e Possibilidades. *Revista Referência, II* (2), 21-32.

Luborsky, L. (2001). The Meaning of Empirically Supported Treatment Research for Psychoanalytic and Other Long-Term Therapies. *Psychoanalytic Dialogues, 11*(4), 583-604.

Marucco, N. C. (1978) Narcisismo, escisión del yo y Edipo. Rev. De Psicoanalisis, XXV, 2.

Midgley, N., Target, M., & Smith, J. (2006). The outcome of child psychoanalysis from the patient's point of view: A qualitative analysis of a long-term follow-up study. *Psychology and Psychotherapy: Theory, Research and Practice, 79*, 257-269.

Milrod, B. et al. (2007) A randomized controlled clinical trial of psychoanalytic psychotherapy for panic disorder. American Journal of Psychiatry, 164(2): 265-272.

Moreira, V. (2004). O método fenomenológico de Merleau-Ponty como ferramenta crítica na pesquisa em psicopatologia. *Psicologia: Reflexão e Crítica*, *17*, 447-456.

Moustakas, C. (1994). *Phenomenological Research Methods*. Thousand Oaks: Sage Publications.

OPD Task Force (ed.) (2008) Operationalized Psychodynamic Diagnosis OPD-2: Manual of diagnosis and treatment planning. Hogrefe & Huber Publishers, Washington, USA.

Raggio, E. G. (1989) Sobre la escisión del yo: reflexiones sobre una tercera tópica freudiana. Revista de Psicoanálisis, vol. 46 (2-3), 1989, 348-359.

Rascón, S. R., Corona, P. C., Lartigue, T., Rios, J. M., & Garza, D. L. (2005). A successful trial utilizing the Leuzinger-Bohleber methodology for evaluation of psychoanalytic treatment: Preliminary report. *International Journal of Psycho-Analysis, 86*(5), 1425-1440.

Sandler, Paulo Cesar (2003) O projecto científico de Freud em perigo, um século depois? In André Green (org.) Psicanálise Conteporânea. Imago editora, pp. 217-242.

Sandell, R. (2001). Can Psychoanalysis become Empirically Supported? *International Forum of Psychoanalysis, 10*(3-4), 184-190.

Sandell, R., Blomberg, J., Lazar, A., Carlsson, J., Broberg, J., & Schubert, J. (2000). Varieties of Long-Term Outcome Among Patients in Psychoanalysis and Long-Term Psychotherapy: A Review of Findings in the Stockholm Outcome of Psychoanalysis and Psychotherapy Project (Stoppp). *International Journal of Psycho-Analysis, 81*(5), 921-942.

Sandell, R., Lazar, A., Grant, J., Carlsson, J., Schubert, J., & Broberg, J. (2006). Therapist attitudes and patient outcomes. III. A latent class analysis of therapists. *Psychology And Psychotherapy, 79*(Pt 4), 629-647.

Sebek, M. (2001). Varieties of Long-Term Outcome Among Patients in Psychoanalysis and Long-Term Psychotherapy (Vol. 82, pp. 205-210).

Sousa, D. (2006). Investigação em Psicoterapia: Contexto, questões e controvérsias. Possíveis Contributos da Perspectiva Fenomenológico-Existential. *Análise Psicológica, 3*(XXIV), 373-382.

Sousa, D. (2008). From Monet's paintings to Margaret's Ducks: Divagations on phenomenological research. *Existential Analysis, 19*(1), 143-155.

Steiner, J. (1993) Refúgios psíquicos: organizações patológicas em pacientes psicóticos, neuróticos e fronteiriços. Imago editora, Rio de Janeiro, 1997.

Szecsödy, I. (1999). How can we end psychoanalysis - and still have a follow-up of it? *Scandinavian Psychoanalytic Review*, *22*(1), 48-66.

VandenBos, G. R. (2007). *APA Dictionary of Psychology* (1st ed.). Washington, DC: American Psychological Association.

Wallerstein, R. S. (2003). Psychoanalytic Therapy Research: Its Coming of Age. *Psychoanalytic Inquiry, 23*(2), 375-404.

Wallerstein, R. S., & Fonagy, P. (1999). Psychoanalytic Research and the IPA: History, Present Status and Future Potential. *International Journal of Psycho-Analysis*, *80*(1), 91-109.

Wilczek, A., Barber, J. P., Gustavsson, J. P., Åsberg, M., & Weinryb, R. M. (2004). Change After Long-Term Psychoanalytic Psychotherapy. *Journal of the American Psychoanalytic Association*, *52*(4), 1163-1184.

Appendix A - List of collected bibliography

Amadei, G., & Landoni, G. (n.d.). Measuring clinical assessments with an empirical intrument: a pilot study by the Milanese Psychoanalysis Centre (Publication. Retrieved 12 March 2009, from IPA Research Database: http://www.ipa.org.uk/research/pdf/amadei.pdf

Aragão Oliveira, Rui (2008) Repetir acidentalmente ou acidentar-se repetidamente. Revista Portuguesa de Psicanálise, 2008, 28(2), 105-112.

Blatt, S. J., & Shahar, G. (2004). Psychoanalysis - with whom, for what, and how? Comparisons with Psychotherapy. Journal of the American Psychoanalytic Association, 52(2), 393-447.

Brockmann, J., Schlüter, T., & Eckert, J. (n.d.). Frankfurt – Hamburg long-term psychotherapy study: Process and outcome of psychoanalytically oriented therapy and behavior therapy – a study from private practices (Publication. Retrieved 12 March 2009, from IPA Research Database: http://www.ipa.org.uk/research/pdf/brockmann_odr.pdf

Cogan, R. (2007). Therapeutic Aims and Outcomes of Psychoanalysis [Electronic Version]. *Psychoanalytic Psychology*, *24*, 193–207. Retrieved 12 March 2009 from http://www.ipa.org.uk/research/pdf/cogan.pdf.

Falkenström, F., Grant, J., Broberg, J., & Sandell, R. (2007). Self-analysis and post-termination improvement after psychoanalysis and long-term psychotherapy. *Journal Of The American Psychoanalytic Association, 55*(2), 629-674.

Fonagy, P., Roth, A., & Higgitt, A. (2005). The outcome of psychodynamic psychotherapy for psychological disorders. *Clinical Neuroscience Research, 4*(5-6), 367-377.

Freedman, N., Hoffenberg, J. D., Vorus, N., & Frosch, A. (1999). The Effectiveness Of Psychoanalytic Psychotherapy: The Role Of Treatment Duration, Frequency Of Sessions, And The Therapeutic Relationship. *Journal of the American Psychoanalytic Association, 47*(3), 741-772.

Gallegos, N. (2005). Client Perspectives on what Contributes to Symptom Relief in Psychotherapy: A Qualitative Outcome Study. *Journal of Humanistic Psychology, 45*(3), 355-382.

Giorgi, A. (1992). Description versus interpretation: Competing alternative strategies for qualitative research. *Journal of Phenomenological Psychology*, *23*(2), 119-135.

Giorgi, A. (2000). Concerning the Application of Phenomenology to Caring Research. *Scandinavian Journal of Caring Sciences, 14*(1), 11.

Giorgi, A. (2002). The Question of Validity in Qualitative Research. *Journal of Phenomenological Psychology*, *33*(1), 1-18.

Giorgi, A. (2004). A Way to Overcome the Methodological Vicissitudes Involved in Researching Subjectivity. *Journal of Phenomenological Psychology*, *35*(1), 1-25.

Giorgi, A. (2006). Concerning Variations in the Application of the Phenomenological Method. *Humanistic Psychologist, 34*(4), 305-319.

Giorgi, A. (2008). Concerning a Serious Misunderstanding of the Essence of the Phenomenological Method in Psychology. *Journal of Phenomenological Psychology, 39*(1), 33-58.

Giorgi, A., & Gallegos, N. (2005). Living Through Some Positive Experiences of Psychotherapy. *Journal of Phenomenological Psychology, 36*, 195-218.

Giorgi, A., & Gallegos, N. (2005). Living through some positive experiences of psychotherapy. *Journal of Phenomenological Psychology, 36*(2), 195-218.

Gomes, D. R. P. (2008). *Countertransference Questionnaire: Desenvolvimento da Versão Portuguesa do Instrumento.* Unpublished Masters Dissertation, Instituto Superior de Psicologia Aplicada, Lisboa, Portugal.

Groenewald, T. (2004). A Phenomenological Research Design Illustrated [Electronic Version]. *International Journal of Qualitative Methods, 3 (1),* 1-26. Retrieved 10 March 2009 from http://www.ualberta.ca/~iiqm/backissues/3_1/pdf/groenewald.pdf.

Hill, C. E., & Knox, S. (2009). Processing the therapeutic relationship. *Psychotherapy Research, 19*(1), 13 - 29.

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual Qualitative Research: An Update. *Journal of Counseling Psychology, 52*(2), 196-205.

Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A Guide to Conducting Consensual Qualitative Research. *The Counseling Psychologist, 25*(4), 517-572.

Ingram, D. H. (1992). The Psychoanalyst's Experience of Intimacy with the Patient. *Journal of the American Academy of Psychoanalysis, 20*(3), 413-422.

Jung, S. I., Fillippon, A. P. M., Nunes, M. L. T., & Eizirik, C. L. (2006). História recente e perspectivas atuais da pesquisa de resultados em psicoterapia psicanalítica de longa duração. *Revista de Psiquiatria do Rio Grande do Sul, 28,* 298-312.

Jung, S. I., Nunes, L. T., & Eizirik, C. L. (2007). Avaliação de resultados da psicoterapia psicanalítica. *Revista de Psiquiatria do Rio Grande do Sul, 29,* 184-196.

Kernberg, O. F. (2004). Rewards, Dangers, Findings, and Attitudes in Psychoanalytic Research. *Canadian Journal of Psychoanalysis, 12*(2), 178-194.

Leichsenring, F. (2005). Are psychodynamic and psychoanalytic therapies effective?: A review of empirical data. *International Journal of Psycho-Analysis, 86*(3), 841-868.

Leichsenring, F., Biskup, J., Kreische, R., & Staats, H. (2005). The Göttingen study of psychoanalytic therapy: First results. *International Journal of Psycho-Analysis, 86*(2), 433-455.

Leuzinger-Bohleber, M., Stuhrast, U., Rüger, B., & Beutel, M. (2003). How to study the 'quality of psychoanalytic treatments' and their long-term effects on patient's well-being: A representative, multi-perspective follow-up study. *International Journal of Psycho-Analysis, 84*(2), 263-290.

Loureiro, L. M. d. J. (2002). Orientações Teórico-Metodológicas para a Aplicação do Método Fenomenológico na Investigação em Enfermagem. *Revista Referência*(8), 5-16.

Loureiro, L. M. d. J. (2006). Adequação e Rigor na Investigação Fenomenológica em Enfermagem - Crítica, Estratégias e Possibilidades. *Revista Referência, II* (2), 21-32.

Luborsky, L. (2001). The Meaning of Empirically Supported Treatment Research for Psychoanalytic and Other Long-Term Therapies. *Psychoanalytic Dialogues, 11*(4), 583-604.

Midgley, N., Target, M., & Smith, J. (2006). The outcome of child psychoanalysis from the patient's point of view: A qualitative analysis of a long-term follow-up study. *Psychology and Psychotherapy: Theory, Research and Practice, 79,* 257-269.

Moreira, V. (2004). O método fenomenológico de Merleau-Ponty como ferramenta crítica na pesquisa em psicopatologia. *Psicologia: Reflexão e Crítica, 17,* 447-456.

Moustakas, C. (1994). *Phenomenological Research Methods*. Thousand Oaks: Sage Publications.

Rascón, S. R., Corona, P. C., Lartigue, T., Rios, J. M., & Garza, D. L. (2005). A successful trial utilizing the Leuzinger-Bohleber methodology for evaluation of psychoanalytic treatment: Preliminary report. *International Journal of Psycho-Analysis, 86*(5), 1425-1440.

Sandler, P. C. (2003) O projecto científico de Freud em perigo, um século depois? In André Green (org.) Psicanálise Contemporânea. Imago editora, Rio de Janeiro, 217-242.

Sandell, R. (2001). Can Psychoanalysis become Empirically Supported? *International Forum of Psychoanalysis, 10*(3-4), 184-190.

Sandell, R., Blomberg, J., Lazar, A., Carlsson, J., Broberg, J., & Schubert, J. (2000). Varieties of Long-Term Outcome Among Patients in Psychoanalysis and Long-Term Psychotherapy: A Review of Findings in the Stockholm Outcome of Psychoanalysis and Psychotherapy Project (Stoppp). *International Journal of Psycho-Analysis, 81*(5), 921-942.

Sandell, R., Lazar, A., Grant, J., Carlsson, J., Schubert, J., & Broberg, J. (2006). Therapist attitudes and patient outcomes. III. A latent class analysis of therapists. *Psychology And Psychotherapy, 79*(Pt 4), 629-647.

Sebek, M. (2001). Varieties of Long-Term Outcome Among Patients in Psychoanalysis and Long-Term Psychotherapy (Vol. 82, pp. 205-210).

Sousa, D. (2006). Investigação em Psicoterapia: Contexto, questões e controvérsias. Possíveis Contributos da Perspectiva Fenomenológico-Existential. *Análise Psicológica, 3*(XXIV), 373-382.

Sousa, D. (2008). From Monet's paintings to Margaret's Ducks: Divagations on phenomenological research. *Existential Analysis*, *19*(1), 143-155.

Steiner, J. (1993) Psychic retreats: pathological organizations in psychotic, neurotic and borderline patients. The New Library of Psychoanalysis, London.

Szecsödy, I. (1999). How can we end psychoanalysis - and still have a follow-up of it? *Scandinavian Psychoanalytic Review, 22*(1), 48-66.

VandenBos, G. R. (2007). *APA Dictionary of Psychology* (1st ed.). Washington, DC: American Psychological Association.

Wallerstein, R. S. (2003). Psychoanalytic Therapy Research: Its Coming of Age. *Psychoanalytic Inquiry, 23*(2), 375-404.

Wallerstein, R. S., & Fonagy, P. (1999). Psychoanalytic Research and the IPA: History, Present Status and Future Potential. *International Journal of Psycho-Analysis, 80*(1), 91-109.

Wilczek, A., Barber, J. P., Gustavsson, J. P., Åsberg, M., & Weinryb, R. M. (2004). Change After Long-Term Psychoanalytic Psychotherapy. *Journal of the American Psychoanalytic Association, 52*(4), 1163-1184.

Appendix C - Questionnaire to be filled out by the Clinician

cliniPinel
Clínica de Psiquiatria, Psicoterapia e Psicanálise
Professor Doutor Carlos Amaral Dias

Data on the Psychotherapist/Psychoanalyst			
Age:			
Gender:	☐ Male	☐ Female	
Degree in			
Year of Award			
Awarding Body			

What is the Highest Academic Qualification you possess?	
☐ Degree (pre-Bologna)	☐ Masters (pre-Bologna)
☐ Degree (Bologna)	☐ PhD
☐ Post Graduation	☐ Others _____
☐ Integrated Masters (Bologna)	

Where did you do your training in Pychoanalytic Psicotherapy and/or Psychoanalysis?	**Date of the beginning of the training**
☐ Portuguese Society of Psychoanalysis	
☐ Portuguese Association of Psychoanalitic Psychotherapy	
☐ Portuguese Society of Psychoanalitic Psychotherapy	
☐ Portuguese Association of Psychoanalysis and Psychoanalitic Psychotherapy	
☐ Others. Which one?	

In which context do you spend the most part (50%) of your professional time?
☐ Private Practice
☐ Institutional Practice
☐ Training
☐ Comunity Intervention Project
☐ Other(s) – Which ones? _____

Total number of years in regular clinical pratice:	_____
If possible, specify: Institutional: _____ Private: _____	

What is the frequency of your clinical practice
☐ Up to three patients a week
☐ Between three to six patients a week
☐ More than six patients a week

Do you attend supervision in your clinical parctice?	☐ Yes	☐ No
If yes, indicate the type of supervision you attend:		
☐ Institutional	☐ Individual	☐ Group
☐ Private	☐ Individual	☐ Group

Are you or have you undergone personal psychotherapeutic process?	☐ Sim	☐ Não
If yes, indicate the type(s) of psicotherapy(ies):		
☐ Psichoanalysis	☐ Existential Psychotherapy	
☐ Psicanalytic Psychotherapy	☐ Cognitive-Behavioural Psychotherapy	
☐ Brief Psychotherapy	☐ Psychodrama	
☐ Counselling	☐ Groupanalysis	
	☐ Other(s). Which ones? _____	

Contact Process with Patients

The patients to be contacted should have the following characteristics:

- To have undergone a process of Psychonanalytic Psychotherapy or Psychonalysis with you;
- The process must have ended by mutual agreement;
- The process must have terminated at least 1 year ago;
- The the process need not necessarily have taken place at CliniPinel.

The telephone contact with the patient by the therapist should address the following points:

- To inform them that CliniPinel is carrying out a research study about the lived experience of psycotherapeutic processes from the patients' point of view, in an attempt to understand a little explored area: the patients' perspective of their psychotherapy.
- To enquire about their availability to participate in the study, informing them that if they agree to participate, they will be contacted by phone by an external researcher (without any kind of contact with the psychotherapist) who will send them a questionnaire following this phone contact.
- To emphasize that all the information ou data which are obtained in the course of the estudy will be duly protected in terms of their confidentiality and anonymity, including the psychotherapists who will have no access to them.

Patient Data

Use the following forms to register data and therapeutic details from patients you have already contacted and showed interest in participating in the present study.
Do not forget that these patients should have terminated the psychotherapeutic/psychoanalytic process by mutual agreement and that therapy should have terminated at least 1 year ago.

Name				
Gender	☐ Male	☐ Female	**Age**	
Telephone/Mobile number				
Type of Intervention		☐ Psychoanalytic Psychotherapy		☐ Psychonalysis
Date of the Beginning of therapy				
Date of the Termination of therapy				
Frequency of Sessions a week				
Notes/Comments You believe to be relevant.				

Name				
Gender	☐ Male	**Gender**	☐ Male	**Gender**
Telephone/Mobile number				
Type of Intervention		☐ Psychoanalytic Psychotherapy		**Type of Intervention**
Date of the Beginning of therapy				
Date of the Termination of therapy				
Frequency of Sessions a week				
Notes/Comments You believe to be relevant.				

Name				
Gender	☐ Male	**Gender**	☐ Male	**Gender**
Telephone/Mobile number				

Type of Intervention	□ Psychoanalytic Psychotherapy	**Type of Intervention**
Date of the Beginning of therapy		
Date of the Termination of therapy		
Frequency of Sessions a week		
Notes/Comments You believe to be relevant.		

Name				
Gender	□ Male	**Gender**	□ Male	**Gender**
Telephone/Mobile number				
Type of Intervention		□ Psychoanalytic Psychotherapy		**Type of Intervention**
Date of the Beginning of therapy				
Date of the Termination of therapy				
Frequency of Sessions a week				
Notes/Comments You believe to be relevant.				

Name				
Gender	□ Male	**Gender**	□ Male	**Gender**
Telephone/Mobile number				
Type of Intervention		□ Psychoanalytic Psychotherapy		**Type of Intervention**
Date of the Beginning of therapy				
Date of the Termination of therapy				
Frequency of Sessions a week				
Notes/Comments You believe to be relevant.				

1. Do you recall the main motivations or reasons which led you to seek psychotherapeutic help? Try to describe them.

2. What are the main changes you observed in the course of psychotherapy? If possible, give a few examples of some of these changes.

3. If you had to choose one moment/episode which happened during the course of therapy and which you consider being extremely important or meaningful to you, which episode comes to mind? Try to describe this episode, even if it seems irrelevant, and explain in what way it was meaningful and important to you.

4. How did you experience the termination of your therapy? What significant thoughts, feelings or episodes do you recall from this time?

5. At times, patients notice changes in the way they behave and relate to others after terminating their psychotherapeutic processes. These changes are often not visible to those around them. If this is the case with you, what kind of changes in yourself or in the way you handle situations in your daily life do you believe to be associated with the therapeutic process? If possible, include some examples.

6. Is it possible for you to describe the way you felt and/or feel about your psychotherapist? How did you experience your relationship with him/her throughout the therapeutic process?

7. If you wish to share some thoughts which you believe could contribute to a better understanding of your therapeutic process (and which were not addressed in this questionnaire), you can do so here**:**

Clinipinel/ IPA Research

Interview | Date: | Code: |

Age:____

Gender: M ___ | F ___

Date of the Beginning of Therapy:
Date of the Termination of Therapy:
Availability to be contacted again: Yes ____ | No ____

1. **Do you recall the main motivations or reasons which led you to seek psychotherapeutic help? Try to describe them.**

2. **What are the main changes you obsereved in the course of psychotherapy? If possible, give a few examples of some of these changes.**

3. **If you had to choose one moment/episode which happened during therapy and which you consider being extremely important or meaningful to you, which episode comes to mind? Try to describe this episode, even if it seems irrelevant, and explain in what way it was meaningful and important to you.**

4. **How did you experience the termination of your therapy? What significant thoughts, feelings or episodes do you recall from this time?**

5. **At times, patients notice changes in the way they behave and relate to others after terminating their psychotherapeutic processes. These changes are often not visible to those around them. If this is the case with you, what kind of changes in yourself or in the way you handle situations in your daily life do you believe to be associated with the therapeutic process? If possible, include some examples.**

6. **Is it possible for you to describe the way you felt and/or feel about your psychotherapist? How did you experience your relationship with him/her throughout the therapeutic process?**

7. **If you wish to share some thoughts which you believe could contribute to a better understanding of your therapeutic process (and which were not addressed in this questionnaire), you can do so here:**

Appendix E - Questionnaire sent by Email (WinWord format)

cliniPinel
Clínica de Psiquiatria, Psicoterapia e Psicanálise
Professor Doutor Carlos Amaral Dias

CliniPinel has sought to emphasize the importance of developing studies concerning the many facets of the psychotherapeutic process by seeking to clarify some of the experiences and processes inherent in their participants so as to expand the understanding of areas which remain unexplored.

Presently, we are conducting a study which is funded by the International Psychoanalytical Association (http://www.ipa.org.uk). The aim of this study focuses on the exploration and understanding of the many experiences that psychoanalytic psychotherapy or psychoanalysis patients go through in order to reach a better understanding of the psychotherapeutic process.

Your collaboration in this research is of extraordinary importance. Thank you for your willingness to take part in it.

All personal information you may disclose in this study will be adequately safeguarded by ethical principles and confidentiality. To this end, the data you might send will be solely accessed by an independent researcher who will replace any personal references by codes, so as to preserve anonymity (yours and of people you might mention).

The Questionnaire consists of seven open questions concerning your psychotherapeutic process. We ask you to try to answer all the listed questions by exploring and clarifying all the possible details.

By answering and returning this questionnaire, you are automatically acknowledging being aware of the objectives of this study and that you wish to take part in it.

Any doubts or questions regarding the study can be addressed to the researcher (Mr. Daniel Gomes) through his mobile phone (917 676 764) or via e-mail (danielgomes@gmail.com).

Please indicate (with an X in the underligned area) if you are available for further contacts, in case it is necessary to complement the study with more details.

- Yes ____ | No ____

Demographic Data of the Participant

Age:____

Gender: M ___ | F ___

Date of the Beginning of Therapy:
Date of the Termination of Therapy:

General instructions for completing the questionnaire

Please answer the following questions in a spontaneous manner and as faithfully as possible to your feelings and thoughts about your psychotherapeutic process. We would like to call your attention to the fact that there is no limited space for your answers. The way the questions are laid out (one per page) serves a purely organizational purpose and you may therefore write freely. However, please be careful and save your file as you answer the questions so you will not lose information in case there is some computer malfunction.

Do you recall the main motivations or reasons which led you to seek psychotherapeutic help? Try to describe them.

What are the main changes you observed in the course of psychotherapy? If possible, give a few examples of some of these changes.

If you had to choose one moment/episode which happened during therapy and which you consider being extremely important or meaningful to you, which episode comes to mind? Try to describe this episode, even if it seems irrelevant, and explain in what way it was meaningful and important to you.

How did you experience the termination of your therapy. What significant thoughts, feelings or episodes do you recall from this time?

At times, patients notice changes in the way they behave and relate to others after terminating their psychotherapeutic processes. These changes are often not visible to those around them. If this is the case with you, what kind of changes in yourself or in the way you handle situations in your daily life do you believe to be associated with the therapeutic process? If possible, include some examples.

Is it possible for you to describe the way you felt and/or feel about your psychotherapist? How did you experience your relationship with him/her throughout the therapeutic process?

If you wish to share some thoughts which you believe could contribute to a better understanding of your therapeutic process (and which were not addressed in this questionnaire), you can do so here.

Appendix F - E-mail form sent to the participants who provided their e-mail

Good morning,

Thank you for agreeing to participate in our research.

As agreed in our telephone conversation, I am attaching the questionnaire about the experience of the psychotherapeutic process.

If you prefer to be interviewed in person, please contact me so that we can make an appointment.

Should you wish to answer the questionnaire by e-mail, download the attachment to a folder on your computer and open it. Once the questionnaire is in WinWord format (.doc), you may begin to write and save the contents. Once you have completed it, please forward your version to the email address below.

In case you require any further clarification, please contact me via this email (danielgomes@gmail.com) or the mobile phone 917 676 764.

Yours sincerely,

Daniel Gomes

--
Daniel R. P. Gomes
danielgomes@gmail.com
(+351)917676764

Attached annex:

Clinipinel-IPA – Patient Questionnaire.doc
49K View as HTML Open as a Google document Download

APPENDIX G

TABLES FOR CONTENT ANALYSIS

Patients	**Phase 1 - Pre-therapeutic**
	1. Reasons for seeking therapeutic help
F1	Attribution of reasons to internal objective causes (symptoms); Objective/concrete reasons – Focused on symptoms: psychosomatic, sadness, sleep disorders, fear of being alone; Absence of verbalization of reasons relating to internal conflicts and/or conflicts with external objects.
F2	Attribution of reasons to internal objective causes (symptoms); Objective/concrete reasons – Focused on symptoms: Depression; Absence of verbalization of reasons relating to internal conflicts and/or conflicts with external objects.
F3	Attribution of reasons to internal objective causes (symptoms) and to internal subjective causes (internal conflicts and/or conflicts with external objects); Objective/concrete reasons – Symptoms: Depression; feeling of emptiness; Subjective and relational reasons – Internal conflicts: dissatisfaction with oneself. Conflicts with external objects: dissatisfaction with the relationship with his/her husband; dissatisfaction with the professional situation.
F4	Attribution of reasons to internal objective causes (symptoms) and to internal subjective causes (internal conflicts and/or conflicts with external objects); Objective/concrete reasons – Symptoms: Depression; Subjective and relational reasons – Conflicts with external objects: dissatisfaction with the professional situation.
F5	Attribution of reasons to internal objective causes (symptoms) and to internal subjective causes (internal conflicts and/or conflicts with external objects); Objective/concrete reasons – Symptoms: Depression; sleep disorders; anger; anguish; school failure; Subjective reasons – Internal conflicts: dissatisfaction with oneself and with internal resources (capacity to organize oneself and to fulfill commitments).

F6	Avoidant answer, with vague information; Attribution of reasons to internal subjective causes (internal conflicts and conflicts with external objects); Subjective reasons – Internal conflicts: dissatisfaction with oneself. Conflicts with external figures: permanent need of the other's approval.
F7	Attribution of reasons to internal objective causes (symptoms) and to internal subjective reasons (internal conflicts and conflicts with external objects); Objective/concrete reasons – Symptoms: Depression; separation anxiety; Subjective reasons – Internal conflicts: feelings of insecurity; fear of abandonment; painful memories. Conflicts with external figures: unsatisfactory love relationship; difficulties in communicating with the partner.
F8	Avoidant answer; Attribution of reasons to internal subjective causes (internal conflicts and conflicts with external objects) and to external objective causes (by suggestion of another person); Subjective reasons – Conflicts with external figures: relationship with a work partner.
F9	Avoidant answer – Avoidant type; Attribution of reasons to internal subjective causes (internal conflicts and conflicts with external objects) Subjective and internal reasons: need to know oneself better and to understand one's childhood better.
F10	Attribution of reasons to internal objective reasons (symptoms) and to internal subjective causes (internal conflicts and conflicts with external objects); Objective/concrete reasons – Symptoms: Depression; panic attacks; anxiety attacks; sleep disorders; phobias; Subjective reasons – Conflicts with external figures: unsatisfactory love relationship; difficulties in communicating with the partner; professional problems. Relates objective reasons with subjective reasons.
M1	Avoidant and vague answer; Attribution of reasons to internal subjective causes (internal conflicts and conflicts with external objects) Subjective reasons – Internal conflicts: vague feeling of unhappiness and non-acceptance of oneself.

M2	Attribution of reasons to internal objective causes (symptoms) and to internal subjective causes (internal conflicts and conflicts with external objects); Objective/concrete reasons – Symptoms: Depression; suicidal ideation; Subjective reasons – Conflicts with external figures: breakup of an unsatisfactory love relationship; domestic violence.
M3	Avoidant answer; Attribution of reasons to internal subjective causes (internal conflicts and conflicts with external objects) Subjective reasons – Conflicts with external figures: unspecified relational problems.

Patients	**Phase 2.1 - Peri-therapeutic**	
	2. Observed changes	**3. Striking episode**
F1	Objective level (symptoms): not mentioned; Subjective and conflictual level: Conflicts with external objects: changes in the relationship with the mother (cutting the "umbilical cord"); improvement in the relationship with others ("not to constantly please others") Internal conflicts: feeling of a new "I" – structural change.	Contact with the internal world (childhood); Understanding feelings and anguish (new meanings); Transformation of the meaning of parental figures (new perspective, less idealized); Feeling of personal exposure; Associates internal gains with relational gains.
F2	Objective level (symptoms): not mentioned; Subjective and conflictual level: Conflicts with external objects: changes felt as positive ones ("I don't want to always be the one who pleases others") and new feelings which were experienced in relation to others (also felt as being positive); Internal conflicts: increased confidence and self-esteem; less culpability.	Emphasizes the importance of an interpretation from the analyst: finding of new meanings for an anxiety-provoking situation related to conflicts with a work colleague. Points out the help the analyst gave him/her in finding this new meaning.
F3	Avoidant answer; Objective level (symptoms): less sad; Subjective and conflictual level:	Avoidant answer, without verbalizing any episode which is directly related to the therapeutic experience; Verbalizes an episode external to therapy (the son's illness) and which has definitely affected him/her.

	Conflicts with external objects: not mentioned; Internal conflicts: higher self-confidence; feels that he/she has not changed and that it is his/her own fault, because he/she did not have the courage to change more – self-conscious of the conflict.	
F4	Objective level (symptoms): not mentioned; Subjective and conflictual level: Conflicts with external objects: better understanding of others; improvement in the relationship with the mother.	Changes in the relationship with mother; General personal gains – less conflicts with others; Highlights the importance of an interpretation from the analyst;
F5	Objective level (symptoms): not mentioned; Subjective and conflictual level: Conflicts with external objects: sees changes with regard to the relationships with her parents and her boyfriend as something positive; Internal conflicts: better acceptance of oneself; more satisfied with internal resources.	Episode related to the relationship with oneself and her internal resources: dealing with feelings of guilt; better self-acceptance and increased ability to think about herself.
F6	Avoidant answer; Questions the existence of changes; Objective level (symptoms): bodily changes – slimmer; Subjective and conflictual level: Conflicts with external objects: increased awareness of own reactions with regard to others. Internal conflicts: not mentioned.	Did not answer.
F7	Objective level (symptoms): symptom relief; Subjective and conflictual level: Conflicts with external objects: increased satisfaction with relational resources; Internal conflicts: increased confidence and self-esteem; more able to deal with situations of loss; more flexible with herself; increased satisfaction with her internal resources. Readjusting anguish.	Episode related with the experience of being understood and cared about by the therapist.

F8	Avoidant answer; Mentions feelings of complete passivity in the therapeutic relationship ("I just listened"); Objective level (symptoms): Not mentioned; Subjective and conflictual level: not mentioned.	Avoidant answer; Talks about extra-therapeutic episodes with concrete attachment ("after the session I got very drunk").
F9	Objective level (symptoms): not mentioned; Subjective and conflictual level: Conflicts with external objects: changes experienced as positive with regard to the act of blaming others ("before I used to put all the blame on others"); Internal conflicts: better self-knowledge; increased self-esteem; satisfaction with regard to the ability to understand herself better.	Mentions the fact that she felt that the therapist was like a teacher who taught her to think about herself on her own – analytic function.
F10	Objective level (symptoms): not mentioned; Subjective and conflictual level: Conflicts with external objects: moving form face-to-face to the couch experienced as a painful change; Internal conflicts: better able to analyse problems; increased satisfaction overall with regard to own internal skills.	Mentions something she found out about herself – trying to seduce people and associating that with her moving to the couch.
M1	Avoidant answer, vague; Objective level (symptoms): not mentioned; Subjective and conflictual level: Conflicts with external objects: not mentioned; Internal conflicts: increased self-knowledge and satisfaction with internal resources.	Did not answer.
M2	Objective level (symptoms): not mentioned; Subjective and conflictual level: Conflicts with external objects: changes experienced as positive with regard to the relationship with parental figures (father); overcoming painful feelings when talking about her painful past.	Satisfied with the help from the analyst with giving her anguish new meanings.

	Internal conflicts: Increased self-esteem; better able to elaborate on negative feelings. Partly associates changes with regard to relational and internal resources.	
M3	Objective level (symptoms): not mentioned; Subjective and conflictual level: Conflicts with external objects: changes experienced as positive with regard to the relationship with parental figures and others in general; Internal conflicts: Increased self-confidence; Associates gains with internal resources to gains in terms of relationships.	Mentions a dream which was interpreted and which helped him understand one part of himself better, seeing it as an internal gain for him.

Patients	**Phase 2.2 - Peri-therapeutic (continuation)**	
	4. Relationship with the Therapist	**5. Termination of the therapy – lived experiences**
F1	Verbalization of positive personal and therapeutic affects (“affection”; “helped grow”; “was a milestone in my life”); Internalization of the therapist as a good internal object (“is part of me”).	Ambivalent feelings (“duality: feeling of accomplishing a set goal and feeling of lack”); Feeling positive about being able to continue his/her life without needing to look for further help; Verbalizes separation anxiety about the termination of the therapeutic process.
F2	Verbalization of positive personal affects (“important, strong, affection, respect”) and of therapeutic affects (“he never made me feel bad about my feelings”); Idealization of the therapist (“he was perfect”). Internalization of the therapist as a good internal object;	Low response when touching upon the subject of separation anxiety, avoids the subject; Centres his/her experiences on the improvement of symptoms; Feels that the process is left unfinished.

F3	Verbalization of positive personal affects (“friendship”) and therapeutic affects (“understanding”); Internalization of the therapist as a good internal object; Idealization of the therapist.	Low response with regard to separation anxiety; Feels that the process is left unfinished: has to interrupt his/her therapy because of financial reasons, but feels he/she will come back.
F4	Verbalization of positive personal affects (“friendship”) and no therapeutic expression of affects; Internalization of the therapist as a good internal object;	Does not verbalize any separation anxiety; Feelings of empathy towards the analyst.
F5	Verbalization of positive affects of a more therapeutic nature (“understanding; reassurance; tranquilizing, satisfied, finished stage”); Internalization of the therapist as a good internal object; Some idealization of the therapist (“I was fascinated to hear him”).	Feeling of general satisfaction with achieved goals, values the internal resources he/she gained; Does not verbalize any separation anxiety.
F6	Verbalization of ambivalent affects (“sometimes I felt good, other times it annoyed me when she took another look at her watch”); Verbalizes negative feelings about himself/herself such as disappointment, insecurity, anger and sadness.	Does not verbalize any separation anxiety; Verbalizes negative feelings regarding the therapeutic experience (“it was a relief”.
F7	Verbalization of positive affects of the therapeutic type (“trust, tranquility”); Internalization of the therapist as a good internal object.	Does not verbalize any separation anxiety; Avoidant; Positive feelings (vague) related with the termination of therapy.
F8	Verbalization of positive affects of the therapeutic type (“the one who listens and does not criticize”); Idealization of the therapist (“he was a university lecturer”).	Associates the end of the therapy with the end of a society – attributes positive feelings.
F9	Verbalization of positive personal affects (“it was a relationship as the one you have with a teacher”); Verbalizes some ambivalence (“it would have been easier and more empathic if I had not moved to the couch”); Some idealization of the therapist (“teacher”).	Verbalizes separation anxiety regarding the end of the therapeutic process, even though he/she points out having been able to deal with it through therapy; Feels that the process continues without the therapist, feels autonomous; Satisfied with the termination of therapy.

F10	Verbalization of ambivalent affects: positive of the therapeutic kind ("empathy); and negative ("I did not like having to pay for missed sessions and having a fixed time for the sessions");	Separation anxiety: feeling sad and difficulty in dealing with the last day.
M1	Verbalization of positive personal affects ("friend") and of therapeutic affects ("trust");	Separation anxiety: feelings of sadness and loss.
M2	Verbalization of ambivalent affects: positive at therapeutic level ("helped me understand and find myself"); negative at personal level ("at the beginning he/she seemed like a cold person") and also positive at personal level ("almost friendship)" ;	Does not verbalize any separation anxiety; Verbalizes initial fears and feeling grateful to the therapist for having helped him solve his problems.
M3	Verbalization of positive personal affects ("huge patience; tolerance, feelings of gratitude and affection"); Idealization of the therapist ("was exceptional").	Verbalizes being aware of what led him to interrupt therapy and associates it with his internal and relational conflicts.

Patients	**Phase 3 - Post-therapeutic**
	6. Termination of the therapy – felt changes
F1	Subjective relational changes: feels more distant from other people, but with gains in terms of his/her closeness to them; Subjective internal individual changes: more able to defend him/herself against problems; increased self-confidence. Reveals being more in touch with his inner world.
F2	Subjective relational changes: does not idealize the external world anymore; redimensioning of the relationships with others; Subjective internal and individual changes: feels more independent; Global feeling of satisfaction with therapy.

F3	Subjective relational changes: feels better about being closer to his family; Subjective internal individual changes: improvement in terms of internal resources ("more tolerant");
F4	Objective changes / symptoms: improvement in terms of symptoms; Subjective relational changes: satisfactory changes in the relationship with the mother; Subjective internal individual changes: better internal resources (handles negative feelings better).
F5	Objective changes / symptoms: improvement in terms of symptoms (less depressed); Subjective relational changes: feels more distant/separated from the parental figures; higher self-awareness of his/her emotional relationships; Subjective internal individual changes: higher self-conscience; Associates internal gains with relational gains.
F6	Subjective internal individual changes: focused on the gains in terms of mental skills and resources – "ease my need of control"; mentions more concern about own body ("I take better care of myself").
F7	Subjective relational changes: generally feels more confident in her relationships with others. Subjective internal individual changes: more assertive and clearer in her communication with others; feels that her expectations are more adjusted to other people's reality; Associates internal with relational gains.
F8	Objective changes / symptoms: improvement in terms of symptoms (focused on the symptoms) Avoidant; does not verbalize any changes which may have been experienced as positive or significant.
F9	Mentions that her changes occurred in a progressive way; Subjective relational changes: satisfactory changes regarding the kind of relationship she establishes with others ("I changed the way I relate to others"); Subjective internal individual changes: calmer and more able to understand situations with more self-control and changes in her "I" ("I

	changed the way I am"); Associates internal gains with relational gains.
F10	Subjective relational changes: feels more confident in her relationship with others in general. Subjective internal individual changes: feels more confident about herself; feels better about herself; calmer; Associates internal gains with relational gains.
M1	Avoidant answer, vague. Subjective relational changes: better equipped to deal with others. Subjective internal individual changes: higher self-consciousness; more conscious of his/her problems and improved resources to deal with them.
M2	Subjective relational changes: feels he/she gets more out of his/her relationships. Subjective internal individual changes: feelings of re-finding him/herself and recovery of inner peace;
M3	Objective changes / symptoms: improvement in terms of symptoms (does not specify); Subjective relational changes: feels more secure in emotional and work relationships; Subjective internal individual changes: feels better about him/herself ("less explosive");