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Research on the countertransference and the tree of clinical decisions of the therapist, applying DLA

A systematic study of the patient's and therapist's style

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Summary

DLA is a method designed for the analysis of erogeneities and defenses from the Freudian perspective. Three tools for the investigation of the erogeneities (in the levels of narration, phrase and words) and two other instruments for the analysis of the defenses (in the levels of narration, phrase and words) were developed. The paper has three goals: 1. to show the usefulness of the method for the research of the styles of the patient and specially of the therapist, 2. to test the value of the method for researching the countertransference and the tree of clinical decisions of the therapist, 3. to decide if some proposals concerning a) the expression of the positive or negative position of the patient in front of the therapeutic work, and b) the best complementarities between the styles of patient and therapist, are correct. The patient's and therapist's styles and its best complementarities, the tree of clinical decisions of the therapist and the countertransference are studied in four cases. The paper concludes that: 1. DLA is a useful method for the research of the styles of patient and therapist; 2. The method allows to describe with precision the features of the pertinent and non pertinent strategies of the therapist and its changes, and also permits to infer the countertransferential processes; 3. The present research can show the utility of the description of the manifestations of the collaborative position of the patient in front of the therapeutic work (the contribution of the patient to the therapeutic alliance); but this investigation cannot decide whether the proposal concerning the good complementarities between patient and analyst styles is correct or not. The results of this research suggest that concerning this question more sophisticated studies, taking into account different levels of the discourse, need to be developed.

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As early as the beginning of the '70 David Liberman (1970) developed a description of the styles of the patient and the analyst, based on the psychoanalytic theory of the libidinal drives (sexuality) and of the defense. Each patient was conceived by the author as a combination of styles, with the prevalence (transitory or lasting) of one of them. Besides, using his description of the styles, Liberman presented his theory concerning the manifestation of the positive or negative position of the patient in front of the therapeutic work. Liberman studied too the best complementarity between the styles of patient and analyst. Some of Liberman's description was excessively intuitive in some aspects, specially concerning the influence of the defense in each style. His analyses of the cases were not systematic; nevertheless, he showed the impressive possibilities that his incipient method had. Liberman used the term "style" referring not only to the theoretical field (the language expressing certain erogeneicity, etc.), but also to an empirical one, which corresponds to the features of the combination of various classes of languages (theoretically speaking) in a concrete discourse.

Since the mid 70's I have tried to refine and to operationalize more carefully this method (Maldavsky, 1976, 1980, 1986, 1990, 1992, 1995a, 1995b, 1997, 1998b, 1999, 2002, 2003, 2004a, Maldavsky et al., 2000). I developed five tools to make up the method which allows to investigate the discourse as an expression of the erogeneicity and the defense. I called the method David Liberman algorithm (DLA).

In this paper I have three goals: 1. to show the usefulness of the method for the research of the styles of the patient and specially of the therapist, 2. to test the value of the method for the research of the countertransference and the tree of clinical decisions of the therapist, 3. to decide if some Liberman's proposals concerning a) the expression of the positive or negative position of the patient in front of the therapeutic work, and b) the best complementarities between the styles of patient and therapist, are correct.

I. The method (DLA)

I. 1. General presentation

Freud (1916-17) states that understanding each clinical case implies that the therapist and the researcher take into account the specific libidinal fixation and the defense. In each patient a combinatory between some sexual fixation and some defenses determines the singular clinical problem. A method that detects erogeneicities and defenses in the discourse of the patient can be useful in the therapeutic process and outcomes of research. David Liberman algorithm was designed for the research of the discourse from this Freudian perspective. The method has a strong theoretical argumentation, explaining why several erogeneicities and defenses were considered the most important, and what the criteria for the operationalization of both variables were (Maldavsky, 2003)*. DLA

* The operationalization concerns first to the main variable (erogeneicity), because defense is, after Freud (1915c), a specific destiny for sexual drives. The operationalization of sexual Trieben is centered in Freudian concept of "experiences of pleasure" and "experiences of pain" (Freud, 1950a). Both experiences are the bridge between sexuality and representational world, including

specially the language (preconscious representations). Three component intervene in the experience of pleasure and of pain: 1) affection, 2) perception, 3) motricity. For each sexual drive, those three component has specific features. DLA method is based on a description of the types of affection, motricity and perception corresponding in the ego to each specific erogeneicity. For example, for LI the corresponding motricity tended to inner alteration (i.e. self soothing procedures), for O2, the corresponding motricity tended to express affection, for A2 the motricity tended to grasp and dominate the object, etc. Those descriptions of the specific features of the components of the experiences for each eroticism derivated from the research on clinic experience and/or from the child or adult observation (Maldavsky, 1980, 1986, 1990, 1995a, 1995b, 1997, 1998a, 1998b, 1999).

Besides, various reliability and validity tests of DLA were developed:

Overview of validity and reliability tests

| I. Validity | II. Reliability |
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| <p>I.a. <u>Contrasts with studies using other instruments</u> Maldavsky, 1998b, 2001a, 2001b, 2003a Maldavsky, Tebaldi, Cusien, Groisman, Pereyra, 2001 Maldavsky, Alvarez, Neves, Roitman, Tate de Stanley, 2003b Goldberg, 2002</p> | <p>II. a. <u>Of the tools for studying the erogeneicity</u> <u>Interjudge reliability</u> Maldavsky, 1998b Maldavsky <u>et al.</u>, 2000 Maldavsky, Alvarez, Neves, Roitman, Tate de Stanley, 2003a, 2003b Maldavsky, Aguirre, Iusim, Legaspi, Rodríguez, 2003 <u>Repetition of the application of a DLA tool to other fragments of the same treatment</u> Maldavsky <u>et al.</u>, 2000 Kazez, 2002 Romano, Maldavsky, 2004 <u>Contrasts between two or more DLA tools</u> Alvarez, Maldavsky, Neves, Roitman, Tate de Stanley, 2004 Buceta, Alvarez, Cantis, de Durán, García Grigera, Maldavsky, 2004 Maldavsky, 2002a, 2002b, 2002d, 2002e, 2003a, 2004c Maldavsky y Almasia, 2002 Maldavsky, Alvarez, Neves, Roitman, Tate de Stanley, 2003a, 2003b Maldavsky, Aguirre, Iusim, Legaspi, Rodríguez, 2003 Maldavsky, Aguirre, Iusim, Legaspi, Rodriguez Caló, Tate de Stanley, 2004 Romano, Maldavsky, 2004</p> |

allows to investigate erogeneities and defenses in three levels: narration, phrase, words. The inventory of erogeneities includes: IL (intrasomatic libido), O1 (primary oral), O2 (secondary oral sadistic), A1 (primary anal sadistic), A2 (secondary anal sadistic), UPH (urethral phallic) and GPH (genital phallic)**. The inventory of the defenses included main and complementary ones. The main are: creativity or sublimation, 2. repression, 3. disavowal, 4. forclusion of the reality and the judges, 5. forclusion of the affection. Complementary defenses are identification, projection, isolation, undoing, etc. The defenses can have a normal or a pathological use, and can reach three different states: successful, failed or both. All the defenses are conceived as drive destinies (Freud, 1915c).

I. 2. Detection of the erogeneities

Narrative analysis. DLA differentiates five scenes in the narrative. Two of them are states; the other three, transformations. The narration contains 1) an initial state of unstable equilibrium, broken by 2) a first transformation, corresponding to the rise of the desire. This moment is followed by 3) a second transformation, the attempt to consummate the desire, and finally 4) a third one, that includes the consequence of this attempt. This is followed by 5) the final state. Two states (one initial and another final) and three transformations form the matrix of narrative sequences. This formal structure acquires specific qualifications for each language of eroticism. These qualifications imply that the "actants" (types of characters), affects, actions, ideal, group representation, temporal and spatial conception, has a high grade of

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| <p><u>I.b. Contrasts with clinical research</u> Maldavsky, 1999, 2003b, 2003c Almasia, 2001 Maldavsky y Almasia, 2002 Maldavsky y Truscello de Manson, 2002 Kazez, 2002 Alvarez, 2001</p> | <p><u>II. b. Of the instruments for studying the defense</u> <u>Interjudge reliability</u> Maldavsky, 1998b, 1999 <u>Repetition of the application of a DLA tool to other fragments of the same treatment</u> Maldavsky <i>et al.</i>, 2000 Romano, Maldavsky, 2004 <u>Contrasts between two or more DLA tools</u> Alvarez, Maldavsky, Neves, Roitman, Tate de Stanley, 2004 Buceta, Alvarez, Cantis, de Durán, García Grigera, Maldavsky, 2004 Kazez, 2002 Maldavsky 2002c, 2002d Maldavsky, Alvarez, Neves, Roitman, Tate de Stanley, 2003a, 2003b Maldavsky y Almasia, 2002 Maldavsky, Cusien, Roitman, Tate de Stanley, 2003 Romano, Maldavsky, 2004</p> |
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** Freud (1930a) stressed that he preferred to use "voluptuosiness" for indicating the organic basis of sexuality. I employ "erogeneity" in the same way. The inventory of erogeneities is basically the same exposed by Abraham (1924) and Freud (1932). According Freudian (and Abraham) proposals, a specific libidinal fixation has efficacy in each clinical structure (i.e. A2 in obsessional neuroses). IL was not described by Abraham. Freud (1926) mentioned it when stated that in the first moment of the life libidinal components were fixed to inner organs, specially lung and heart. Libidinal fixation in IL has its efficacy in psychosomatic diseases, additions, etc.

definition. Among the "actants", those of model, subject, double and assistant can be distinguished. Eventually, object of desire and rival also appear. In the real facts the researcher can find suppressions, redundancies, permutations, condensations (Maldavsky, 2003). This tool allows to infer extratransferential conflicts of the patient.

Words analysis. The systematization of narrative brought a basic contribution to gather the words taking into account sexual categories. For example, in the narrative belonging to A2 eroticism, the scene of a solemn public oath in an institutional context, allows to include in the corresponding file of the dictionary terms as "duty", "tradition", "moral", "study" and others which express the attempt to dominate and control the reality (including the internal one) by the means of a knowledge of concrete facts. It is possible to add also "clean", "library" and many other words.

In DLA a dictionary, a computational program that allows to investigate word networks is available. The dictionary consists of seven files, one for each language of eroticism. In each file there are units made up of: 1) fragments of words, 2) words, 3) groups of words. The totality of the files includes about 620.000 words, belonging to 5.000 radicals approximately. Many words have a multiple erogenous sense. Therefore, it could happen that the meaning detected by the program corresponds to more than one language of eroticism. The researcher can use the program for two types of study: the automatic and the interactive one. This tool allows to 1) contrast its results with the ones of narration and phrase analysis, 2) construct predictive statements, 3) detect some scenes not expressed in narrative and phrase levels.

Grid for the narration analysis

| Eroticism Scene | Genital phallic | Urethral phallic | Secondary anal sadistic | Primary anal sadistic | Secondary oral sadistic | Primary oral | Intrasomatic |
|--|---|---|---|--|---|--|---|
| Initial state | Aesthetic harmony | Routine | Hierarchic order | Natural legal balance | Paradise | Cognitive peace | Balance between tensions |
| First transformation: arousal of the wish | Wish for aesthetic completeness | Ambitious wish | Wish to dominate an object in the frame of a public oath | Wish for revenge | Temptation Expiation | Abstract cognitive wish | Speculative wish |
| Second transformation: the attempt to realize the wish | Reception of a gift | Encounter with the mark of paternity in the depth of the object | Knowledge that the object remains attached to corrupt subjects | Revenge | Sin Reparation | Access to the truth | Pleasure gained by an organic intrusion |
| Third transformation: consequence of the attempt to realize the wish | Pregnancy Aesthetic disorganization | Adventure defiance | Moral acceptance because of its virtue social condemnation and moral expulsion | Consagrator as a leader Motility impotence, feeling of being in jail and humiliation | Expulsion from Paradise Absolution and love acceptance | Consagrator because of his/her geniality Loss of lucidity and functioning at the service of the other subject's cognitive pleasure | Organic euphoria Asthenia |
| Final state | Shared harmony Constant feelings of disgust | Adventure Pessimistic routine | Moral peace Moral torture | Evocation of a heroic past Return to natural peace Unending resentment | Vale of tears Recovery of Paradise | Pleasure in revelation Loss of essence | Balance between the tensions without loss of energy Constant tension or constant asthenia |

Phrases analysis. The grid of the narration also allows to systematize other kind of emergence of the scene, displayed in the present discourse of the speaker. The scene not narrated but displayed in the present can be studied as a group of phrases. For example, accusation and insult are phrases that correspond to the scene of the essay to consummate the desire of vengeance (A1); doubts is a phrase that expresses a dysphoric resolution of the scene belonging to the narration of A2, and objection corresponds to the scene of standing in the position of the rival in the scene of the arousal of the desire in the same A2, exaggerations and dramatizations are phrases that correspond to the attempt to consummate the wish of receiving a gift in GPH scenes, etc. Two kind of analysis are possible: the paradigmatic (that allows to infer the categorical system of the speaker) and the syntagmatic one (that allows to investigate his dynamic processes). This third tool is specially useful for the analysis of the relationship between patient and analyst within the session.

I. 3. Detection of the defenses

Narrative analysis. If certain scene allows to infer a specific eroticism, certain position of the speaker in the scene he/she describes allows to detect 1) a specific defense and 2) a specific state of it. DLA has a) a description of the features of each position that the speaker can occupy in the narration, and b) a sequence of instructions useful for the investigation of the type of the defense and its state. This tool allows to detect just the main defenses. For example, in A1 the speaker can appear as a hero, as the subject of a secret aim of revenge, but he can also set himself as a victim of alien abuse, or as an instrument (assistant) employed by an unjust protagonist that will despise him afterwards. In the first situation, the dominant defense is the successful disavowal, as results in defiant characteropathies, and in the second one (the patient as a victim of abuses or as an instrument, afterwards rejected, that the main character employs in the frame of a desire of revenge) prevails disavowal too, but as a failed defense.

Phrases and words analysis. If phrases and words allow to detect the erogeneity, rhetorical studies (mostly focused in the syntagmatic analysis) allow to infer the defense displayed during the session. DLA contains a) a systematization of the resources (rhetoric figures, argumentation) expressing some defense and its state, and b) a sequence of instructions allowing to detect how to decide what defense and which state of it appears. This tool allows to detect the main and the complementary defenses. For example, from the perspective of argumentation, an accusation during the session against the therapist accompanied by concrete references to supposed specific situations is usually an evidence of disavowal, and an accusation during the session against an ambiguous superior power (god, the President, etc) accompanied by equally ambiguous references to supposed specific situations is usually an evidence of forclusion of the reality and the judges.

II. Patient's and therapist's styles, tree of clinical decisions and countertransference research

II. 1. Analysis of the patient-therapist relationship

Liberman (1970) stated that the collaborative position of the patient in front of the therapeutic work is expressed in his/her unconscious ratification of the pertinent interventions and his/her not deliberated rectifications of the not pertinent interventions of the therapist. Inversely, the negative position of the patient in front of the therapeutic work is expressed as unconscious rectifications of the pertinent clinical interventions and as not deliberated ratification of the not pertinent ones.

Besides, Liberman (1970) considered that each discursive style of the patient has an optimum complementary style of the therapist. Liberman stated that, when an analyst turns in emphatically to the patient and has a comprehension of his psychic processes, this fact is evidenced in interpretations with a complementary style of the patient's one. Here is the list of therapist's optimum complementarities that Liberman thought for each style of the patient, with some additions that belong to me:

| | | | | | | | |
|---------|----|-----|----|----|----|-----|-----|
| Patient | IL | O1 | O2 | A1 | A2 | UPH | GPH |
| Analyst | O2 | GPH | A2 | A2 | A1 | O1 | O1 |

Liberman justified his proposal stating that in what I called GPH there are frequently redundant dramatizations and syntactic and semantic proliferation without synthesis, while in O1 the tendency to the abstraction and the lack of commitment in a concrete scene prevails. This last style gives to the first one its optimal complement, while leading to detect the common in the redundancy, and substituting a pathogenic defense (repression) by another one, more benign. In the same way, GPH is the complement to O1. Similar argumentation leads to justify the other complementarities among the styles. Concerning O2, the optimal complement is A2, because the first one puts the emphasis in the feeling against the thought according to rules that the second one emphasizes. A1 also defies the thought, putting the accent in alloplastic action; so, its best complement is again A2. About this last one, that gives importance to thought instead of decision and action, its optimal complement is A1. For IL, that gives attention to corporal processes with no affective qualification, its optimal complement is O2. At last, UPH has the same rank of essential redundancy as GPH, and its complement is O1.

II. 2. Researching the countertransference and the tree of clinical decisions of the therapist

Freud (1910d) defined the countertransference as the affective resistential reaction of the therapist depending on his own unconscious conflicts and influenced by the patient manifestations. Racker's perspective (1960) considered countertransference not only as a resistance but also as a necessary way for understanding and dealing with important conflicts of the patient. So, the capacity of the therapist to maintain his clinical goal including his own perturbing feelings is a central contribution to remove the obstacles appearing during the treatment. It is useful to think the countertransferential problem in the light of a complementary serie in which both factors (therapist conflicts and influence of patient manifestations) have its relative importance.

Hayes (2004) stressed the lack of systematic research on countertransference, specially taking into account the clinical material itself. The study of the countertransference in each clinical situation implies the research of the discourse of both participant, patient and therapist. The analysis of the patient's discourse informs about his concrete style, belonging to his libidinal fixation and defenses, specially those displayed during the session. From the therapist discourse (phrases and words studies), the researcher infers which the clinical style is. Each therapist style contains different strategies, composed by some interventions with an introductory or complementary value and others with a main value. The style of each analyst with his patient can be formalized as a specific combination among strategies, that is, among introductory, main and complementary interventions. Two kinds of questions are relevant: 1) concerning the combination among introductory, complementary and main interventions, 2) concerning the continuity or the change in the main interventions during the session. Sometimes a contradiction between two introductory interventions, or two complementary ones, or between an introductory and a main or a complementary or between a main and a complementary intervention can be detected. Sometimes the orientation of the main interventions changes. Those modifications of the orientation can be a consequence of a rectification of a partially erroneous clinical way or can be an effect of the changes in the patient's discourse obtained by pertinent previous interventions. If the change implies a clinical reorientation, it is possible to study the tree of decision of the therapist in terms of different strategies: the failed and the successful ones. This kind of description (including the research of the patient's discourse as an expression of his erogeneities and defenses and the research of the style of his therapist) allows to investigate too the countertransference. Usually this type of study requires, as a complement, that the therapist gives some additional information about his perturbing feelings during the session. If not, countertransferential feelings can be inferred mostly by a combination of the research on the inadequacy of therapist's interventions and on the features of the patient's style.

III. Clinical studies

I want to present four cases so as to study different types of countertransferential obstacles; 1) erotic, 2) hostile, 3) feeling of being invaded, 4) somnolent. In the four studies I'll describe and analyze briefly the main features of the discourse of the patient as a complement of the more careful investigation of the discourse of the therapist. The study of the patient's discourse requires the use of the five tools (three for detecting the eroticism and two for researching the defenses) of DLA. Instead, the study of the therapist discourse needs just two of those tools. Usually, the therapist doesn't do narration, but phrases. So, the tools for the analysis of the phrases and for the analysis of words are recommended. The results of those four brief clinical expositions will be used to discuss some Liberman's proposal on the collaborative position of the patient to the therapeutic alliance and on the stylistic complementarities during the session (part IV).

III.1. Therapist I: Defense against the lasting erotic countertransference

Clinical material. In her four session María (22) exposed her trouble with a mother's figure that induced her to do a sacrifice; so, the mother exhibited herself and reinforced her vanity using the patient, her daughter. Mother's argument included the exhortation to resign her own things in benefit of poor people, and the patient, after following these precepts, suffered an impotent and vindictive anger, uncontrollable. She narrated various anecdotes of her infancy in where this sequence were evident. She claimed that her mother interfered the patient's wishes of exhibition. But during the session Marias's style of narration included mostly dramatizations, exaggerations, which increased proportionally with her anger against her mother.

In the beginning the therapist tended to emphasize the weight of feelings, specially sadness, in the patient. The patient answered him with an increase in her hostility (not against the therapist) and displayed recurrent interrupted dramatizations. Then the therapist showed his doubts and disorientation and remained silent. After a pause, the patient gave new illustrative anecdotes and commentaries and the therapist changed his orientation: took other of the options existent in his repertory: emphasized the confusions generated in the patient by her mother's discourse and stressed the relative place of the patient in her relationship. So, the patient started to think, to extract conclusions and to develop more coherent dramatizations.

The hard moment to overcome was when the therapist tended to emphasize affective states; for the patient he turned himself an allied or a representant of her mother. When the therapist used other option contained in his repertory (stressing the relative position of the patient in her relationship with her mother) the patient quickly found the way to move forward in her therapeutic work.

Analysis. In the narration level Maria described scenes in where, from her perspective, her mother used O2 (references to the affects) at the service of GPH (brightness, exhibition). Listening her mother, in the patient herself A1 developed. This vindictive wish increased her own disposition to an exhibitionist dramatization (GPH) as an instrument to achieve the vengeance. In the phrase level, A2 (narration of concrete facts, concrete reflections) and GPH (exaggerations and specially dramatizations) are prevalent. The first one was a way to display the second one, which becomes relevant. Therefore, she developed in session a histrionic and exhibitionist presentation of the facts. In the patient successful disavowal corresponded to A1, but repression (corresponding to A2 and specially GPH) prevailed. Those defense failed (i.e., disorganization of the dramatization, impossibility to put in order her thinking). In the repertory of analyst's resources O2, A2, UPH and GPH had a great incidence. The first two were prevalent, specially the first one (O2) in the beginning of the session. When he changed his strategy, A2 prevailed.

In different papers (Maldavsky, 2002; Maldavsky, Alvarez, Neves, Roitman, Tate de Stanley, 2003a, 2003b) we focused on a part of the forth session of this treatment, and detected two fragments (A and B), with different narration. In the first fragment the therapist developed two strategies, both the two first steps having the same character: 1) accompanying the patient's discourse, 2) preparatory

indication of the main intervention. The difference between the strategies appears when the therapist made the main intervention. In the strategy I included in his tree of decisions the therapist privileged affective states, as is inherent to O2. In the strategy II, he paid attention to thought processes, the order of the relations, etc. (A2). In return, in Fragment B the therapist used just the strategy II.

Tree of decisions of therapist I

| Sequence of interventions in Fragment A | |
|---|--|
| Sequence of interventions in Strategy I | Sequence of interventions in Strategy II |
| 1) UPH (accompanying, introductory intervention) | 1) UPH (accompanying, introductory intervention) |
| 2) A2 (indication, introductory intervention) | 2) A2 (indication, introductory intervention) |
| 3) O2 (main intervention) | 4) A2 (main intervention) |
| 4) A2/UPH (doubts and disorientation): dysphonic result | 4) A2: euphoric result |
| Logical dominance: O2/A2/UPH | Logical dominance: A2/UPH |

| Sequence of interventions in Fragment B |
|--|
| 1) UPH (accompanying, introductory intervention) |
| 2) A2 (indication, introductory intervention) |
| 3) A2 (main intervention) |
| 4) A2 euphoric result |
| Logical dominance: A2/UPH, coincident with Strategy II |

After trying this, we analyzed these two fragments with the computerized program. So, we had these results concerning the words' level (only main positions):

| Fragment A | |
|---------------|---------------|
| Strategy I | Strategy II |
| 1. A2 30.24% | 1. UPH 29.46% |
| 2. O2 23.81% | 2. A2 21.17% |
| 3. GPH 15.87% | 3. GPH 19.88% |
| 4. UPH 15.12% | 4. O2 19.33% |

| Fragment B |
|---------------|
| 1) UPH 30.50% |
| 2) A2 23.30% |
| 3) GPH 17.79% |
| 4) O2 12.71% |

We concluded that the results of the analysis of phrases and word networks are alike, especially concerning the relevance of O2 in strategy I, that didn't prevail in strategy II. After that, we evaluated the analyst's interventions clinically. We concluded that strategy I was non pertinent, and that strategy II was pertinent. Strategy I increased patient's resistance, while the strategy II contributed to the creation and reinforcement of the therapeutic alliance and allowed the patient to extract some conclusions. So, we formulated a hypothesis about the therapist's strategy I. We stated that, partially influenced by the patient's exhibitionist discourse with an underlying vindictive desire, the therapist tried to defend himself against a perturbing erotic countertransference.

The next step was to study the therapist's discourse in 20 sessions of the first year of treatment with the computerized program (dictionary). The computerized analysis detected this prevalences in the word networks: 1. A2, 2. O2, 3. GPH, 4; UPH or 1. O2, 2. A2, 3. UPH, 4. GPH.

On both occasions, O2 had strong relevance. In consequence, we presumed that 1) if in these sessions the coincidence between the results of the analysis of words and phrases were maintained (therefore in the level of phrases had relevance the ones that express O2), and 2) if the therapist's interventions were still not pertinent, so 3) the therapists continued suffering the effects of the defense against his erotic countertransference.

So, we took a new step. With another team of collaborators (Maldavsky, Aguirre, Iusim, Legaspi, Rodríguez Calo, 2003, Maldavsky, Aguirre, Iusim, Legaspi, Rodríguez Caló, Tate de Stanley, 2004) we studied the therapist's discourse in a session some months later. We noted that 1) the results of the words and the phrases analysis still coincide, 2) analyst's interventions where O2 had relevance were not pertinent, 3) at the end of the hour the therapist recorded an unusual commentary: he said that in this session he felt less erotical countertransference...

It's possible to add that, in the fourth session, in the Fragment A and B previously mentioned, the strategy I (failed) of the therapist included a 20% of his interventions, and the strategy II (successful) the other 80%. In the latter session studied, 100% of the therapist's interventions were unsuccessful.

III. 2. Therapist II: Two first sessions

I want to study and compare the interventions of the same therapist with two different patients in the first session. In both some partial countertransferential interferences, with different features, appeared.

III. 2.1. Transitory expression of the countertransferential hate

Clinical material. Belisario (45) began the first session of his treatment saying that he became choleric too fast. He suffered from a great irritability, either in his family or in his job. He could not bear someone criticizing or contradicting him. While discussing with him, his wife had a violent crisis, took a seat and ejected it. He used to speak with his wife, but now he didn't tolerate to be questioned by her, he didn't tolerate to be fucked. In his job he obtained recently a better position, but he could not bear being rectified.

During those initial cathartic discourse of Belisario, the therapist accompanied ("mhm") his narration and asked him some questions aiming to obtain more information. But in this moment he changed: he stated that

Belisario said that he didn't tolerate anything, but he felt anxiety. The patient interrupted him: he was afraid he was an unsuccessful professional. But immediately he recovered his cathartic style adding a dramatization of a discussion with his wife. In his dramatization he included into another, where he referred to his own violent commentary to those marital interchange. Then the therapist asked him if he felt himself choleric, and the patient said no. The therapist asked him if he suffered because he felt that his wife criticized him and he said yes.

Then the therapist stressed that the moment when the patient said "I can't tolerate it" was posterior to another moment in which he suffered from his special sensibility to the alien disapprobation. He added that the patient had a great self-exigence. Belisario agreed and began to narrate episodes connected with his problem, including a car accident tendency. The therapist's interventions became more extended. He connected the narration of the patient with some feelings, beliefs and reactions. His main interventions were introduced with some preparatory ones, with a cautious approach character. The patient added more examples (recent or past scenes of his life) concerning the same problems.

Commenting on this first session, the therapist said that he felt anxious because of the violent tendencies (inner session or in his social milieu) of Belisario. Some unstoppable violent episode of the patient could ruin the professional prestige of the therapist.

Analysis. Belisario's narrations combined basically two languages of the eroticism: 1) O2 (the loss of affective connection with his wife), 2) A1 (the feeling of being fucked). In the level of phrases, 1) IL (cathartic discourses), 2) GPH (dramatizations, exaggerations), 3) UPH (interrupted sentences), and 4) O2 (reproach) prevailed. GPH and UPH were complementary languages, and O2 and IL, the two main ones. In the beginning IL prevailed; after that O2 was dominant.

In the narration level, the patient had a dysphonic position: he was in a vale of tears (O2) and he suffered the humiliation of the others (A1). In the first language his defensive mechanism (disavowal) was unsuccessful and Belisario reacted with an impatient attack. The same occurred with A1: he reacted with violence when he felt a humiliated state. In both languages he passed from the state to a kind of action that increased his unpleasant feelings. This fact was an expression of a more unsuccessful condition of the same defense (disavowal): from the perspective of the patient's ego, the reality and the superego rejected returned.

The analysis of the phrases shows that the scenes displayed during the session were the dysphoric ones too. For UPH (self interruptions), the scene corresponds to an interfered ambitious advance; for GPH, it corresponds to an impossibility of showing an aesthetic harmony (using dramatizations). Concerning IL, the scene corresponds to a tendency to eliminate the tensions via an impossible discharge (cathartic discourse), which paradoxically left the patient more exhausted. And concerning O2, the scene corresponds to the laments (vale of tears). Those scenes are indicatives of the failure of the corresponding defense: repression (for UPH and GPH languages), disavowal (for O2) and forclusion of the affect (for IL).

In the second part of the session, in the narration level IL had a dysphoric result (car accidents), corresponding to the failure of the forclusion of the affection, but this language (and the corresponding defense) disappeared from the phrase level and was replaced by A2, in a euphoric version (narration of concrete facts). Besides, in the level of the phrase the function of UPH (accompanying) changed, and, concerning GPH, the dramatizations diminished, but not the exaggerations. Nevertheless, the main position of O2 corresponds to a dysphoric scene (self reproach).

The therapist began accompanying patient discourse (“mhm”) and asking some questions with the aim of receiving information. But almost immediately he changed and focused his interventions on the affect of the patient. That is, in the beginning his resources belonged specially to UPH (“mhm”), to the usual states of the patient (O2) and to A2 (request of information), with the prevalence of UPH. But then he switched to O2 (emphasizing the importance of the affections). Doing so, he tried to diminish not only the cathartic discourse of the patient, expressing IL, but also the forclusion of the affect. The change of the patient discourse was a consequence of the insistence of the therapeutic interventions in the same way (the therapist gave him three similar interventions). When Belisario changed to the prevalence of O2, the therapist emphasized A2. As a complement, he used UPH for approaching to the references to some violent tendency of the patient.

From the perspective of therapeutic interventions the session has three parts: 1) introductory moment (“mhm”, information request), 2) reference to the affects of the patient, 3) interpretations. The changes in the type of the main interventions depended on the modifications occurred in the patient’s discourse, and not on the substitution of an erroneous strategy for the pertinent one. Besides, the second and the third parts of the clinical strategy of the therapist had two sectors: a) the introductory and b) the main ones. Both introductory sectors can be studied more carefully.

The analysis of the words of therapist in each moment shows these figures: Fragment 1: UPH 28.57%; O2 22.58%; A2 21.50%; Fragment 2: O2 24.22%, UPH 21.85%, A2 20.50%, GPH 17.82%, Fragment 3: A2 27.37%, UPH 22.80%; O2 21.35%.

Introductory sectors of the therapist interventions require a more careful study. The first intervention of the therapist in Fragment 2 was illustrative. The therapist stated that Belisario said that the patient didn’t tolerate anything, but he suffers from anxiety. This intervention initiated the second moment in the clinical strategy that finished achieving the therapeutic goal: the discourse of the patient became less cathartic and the therapist could speak about the self-exigence of the patient, etc. Nevertheless, the first intervention of the therapist (“you said that you don’t support, but...”, etc) not only stressed the question of the affectivity of the patient but also contained an objection, a phrase-structure that expressed a criticism, an opposition to the alien opinion. And the patient said previously that he didn’t bear that someone criticized him. The statement of the therapist was double: 1) the main sector was devoted to the affects of the patient (O2), 2) the less important sector, which functioned just as an introduction to the main part, was the objection. And that less important sector could be seen as a provocation by the patient. The posterior two introductory interventions of the therapist centered in the affectivity of the patient didn’t

contain this kind of phrase structure. It is possible to infer that this type of intervention (objections) was an expression of the rebellion and the defiant position of the therapist against the violence of the patient. After this moment, specially in Fragment 3, the therapist found other resources (UPH) to approach (cautiously) to this problematic reaction of the patient. Possibly the hate of the therapist (partially awoken by the discourse of the patient) was an additional factor that could increase his anxiety during the session, when he supposed that the patient could become violent and prejudices his professional prestige.

Sequence in the therapist's decisions

| | | |
|--|---|---|
| 1. Accompanying (UPH) | } | Introductory |
| 2. Demanding information (A2) | | |
| 3. Objection (A2). Introductory intervention | } | First main intervention. Aim: to diminish cathartic discourse of the patient Result: successful |
| 4. Stressing the affects (O2). Main intervention | | |
| 5. Cautious approach to certain themes (UPH). Introductory intervention | } | Second main intervention Aim: to introduce rationality in the affective world of the patient Result: successful |
| 6. Describing and thinking (A2). Main intervention | | |

In this case, the main component of the sequence of the interventions of the therapist had only one great branch, with inner changes. His main interventions were pertinent. But the introductions to the two main interventions contained different options (both linked with the virulence of the patient speaking and listening), one of them (A2) less pertinent.

Tree of decisions of the Introductory of the main interventions in Therapist II

| | |
|--------------|-----------------------|
| Strategy I | Strategy II |
| A2 Objection | UPH Cautious approach |

These less pertinent introductory sector to the main intervention (corresponding to the Strategy I) risked to awake a virulent reaction of the patient. That is, in those pertinent global clinical strategy, one detail could lead to an unexpected result. This detail operates as a possible self-sabotage of the therapist effort (Buceta, Alvarez, Cantis, de Durán, García Grigera, Maldavsky, 2004).

III. 2.2. Defense against a transitory countertransferential feeling of being invaded

Clinical material. Jacinta (42) opened her first session asking "Where shall I begin?" laughing. She added that she had thought during all the day. Then, designing the therapist by his name, she asked him if she could call him familiarly. The therapist agreed. Jacinta said that she had done a therapy previously with interruptions. She had some things there a little bit misplaced.

She needed to review what happened with the men, and also the problems with her parents and a new job project. She said that she didn't know how to begin, as if she never were done... She felt strange the situation. The therapist, who had accompanied the discourse of the patient with some "mhm", asked then "why". The patient answered that she had obtained recently some achievements, but she thought that it was convenient doing... "Then, I don't know", said.

The therapist enumerates the three problems mentioned by Jacinta (job, parents, men) and asked her what her election was. She chose the theme of the job. For several years she had worked as an educational supervisor in national schools and she had the option to obtain the same position in the private ones. The therapist asked her if both positions were reciprocally excluding. As a consequence of the insistence of the therapist, Jacinta answered that if she had the new position she had to resign the former one. She was afraid that something could disturb her during the test for the new job. She asked herself why she wanted to leave the state position. There she felt herself calm, but she knew that she had to change. The therapist asked her if she was afraid and she agreed. Then the therapist gave the first interpretation: the patient was afraid that her anxiety was superior to her wishes. The patient agreed. She added that her present job was a few meters away from her house (and the therapist stressed this phrase of the patient). She narrated that she was a single woman, living at her parent's home. She had bought an apartment for herself, but she had sold it and her parents moved to another house. Now, she didn't tolerate remaining too much time in the house of her parents. She didn't have there her own space. Her father occupied the room that she had previously. The therapist interpreted that the question of the job was the scenario where she displayed something that had a common denominator with the other themes: a conflict between the new, unknown, linked with the adventure and the ambition, and the safety, where the surprise had no place. He connected this conflict with the fact that her anxiety could be superior to her wishes.

The patient answered referring that in certain moments she felt herself tied, walking without clarity. In some moments she couldn't be aggressive with the others, and then she suffered in her body: she had pain in her head, or vomits, etc. Those episodes appear especially in her job, each year more frequently. Commenting on this first session the therapist said that in the beginning he was afraid that the patient advanced invasively in her search for contact with him. When the session was displayed, this feeling disappeared.

Analysis. The analysis of the narration level of Jacinta indicated the relevance of five languages: 1) O2, 2) UPH, 3) A2, 4) A1, 5) GPH. In the narration level, the majority of the session was occupied by the prevalence of O2 and specially UPH. O2 was expressed in the patient's references to the attachment to her parents and specially in her statement that she still didn't have a space in her parent's house (↓ loss of paradise). UPH was expressed in the patient's tendency to remain in the routine as opposite to the adventure. Remaining in the routine was a way to maintain the illusory paradise-like state. The prize was the repression of ambitious wishes. If the patient kept the illusion of being in a paradise-like state, the disavowal was prevalent, and the repression of the ambitious wishes was the condition to achieve those aims. In

this case, both defenses (repression and disavowal) were successful. A third language, A2, was expressed in the fragment linked with her works at the school (with the corresponding social contract, the relevance of the traditional known, etc). This narration had an euphoric version corresponding to a normal defense. But when the patient consulted, she felt that she loss this paradise-like state, and that she had some unrepressed ambitious wishes. So, repression and disavowal failed. She consulted when her defensive system changed. In the last part of the session other two languages prevailed: 1) A1, 2) GPH. The scene of feeling herself tied corresponded to a dysphoric version of A1, and the vomits, etc, to a dysphoric version of GPH. Feeling herself tied expressed too that disavowal was unsuccessful, and her somatic manifestation were manifestations of the failure of the repression.

In the level of the phrase analysis, the session had three moments with changing prevalences. In the first one, UPH (excessive approaching) and GPH (seductive attitude: calling the therapist by his name, etc.) prevailed, with the prevalence of the first one. In the second moment UPH (disorientation) was dominant, accompanied by A2 (indecisions and doubts). In the third moment the description and the narration of concrete situations (A2) prevailed.

In the first moment the scene corresponding GPH had a transitory euphoric condition, but not for UPH (the excessive approach left the patient without orientation). Very fast the patient entered in some dysphoric scenes: the disorientation (which interfered ambitious advances) and immediately the doubts (which interfered the achievements of domination and control using concrete knowledge). In the third moment the patient combined the narration of a concrete problem (her decision on the change of work) with the tendency to stress the hierarchic difference between the two positions, when the therapist asked her whether she could or couldn't maintain both ("or... or..").

Finally, she understood what her therapist meant and answered that she had to choose between the two working positions. All those phrases belonged to A2, but the type of phrase that she initially could not express was the one demanding a decision. In the fourth moment narrations and description of concrete situations and problems corresponded to a scene of achievement of wishes of domination and control of the reality using the concrete knowledge.

The initial therapist's interventions corresponded to UPH (contact), but very fast he changed to A2 (why) and then to a combination between A2 (what theme the patient chose) and O1 (gathering different themes: men, job, etc. in the same group, that is, different ways among whose the patient have to choose). The next interventions of the therapist were centered in A2 (had the patient to decide between the two jobs: either... or..?). Then the therapist asked (just one intervention) about the feelings of the patient (O2) and immediately he offered his first interpretation: the conflict between wishes and anxiety (A2). The subsequent interpretations of the therapist joined A2 (insisting in the opposition between wishes and anxiety) and O1 (gathering the three themes introduced by the patient before).

Sequence in the therapist decisions

| | | | |
|------|--|-----------------------|---|
| I. | 1. Contact (UPH) | } Introductory | Aim: contact |
| II. | 2. why (A2) | Main | Introductory Aim: request of information |
| | 3. you must to decide the theme (A2) abstract phrase (O1) | Main Complementary | |
| | 4. do you need to chose between the two jobs? (A2) | Main | Result: sucessful |
| III. | 1. references to patient feeling (O2) | | First main intervention Aim: to reach attunement Result: successful |
| | 2. description of the patient conflict (A2) | Main | |
| | 3. gathering themes (O1) | Complementary | Second main intervention Aim: to obtain the first changes in the patient defenses Result: sucessful |

Possibly, when the therapist changed from the first intervention (contact, mhm) to the “why” he could liberate himself from his troubling countertransferential feelings of being invaded . With this patient the therapist had just one branch in his strategy, changing his type of interventions when the patient modified her discourse.

From the perspective of therapeutic interventions the session had three parts: 1) introductory moment (yes, mhm), whose therapist’s words wasn’t analyzed by the program, 2) request of information, 3) brief reference to the affection and first interpretations, concerning wishes and anxieties.

The analysis of the words of the therapist with the computerized program shows these figures. Fragment 1: unanalyzable because of the absence of significative words, Fragment 2: A2 44.36%; UPH 19.90%; O2 14.70%, Fragment 3: UPH 30.22%; A2 26.50%; O2 21%.

It is possible to note that the results of word analysis of the therapist coincide with the results of analysis of his phrases. The relevance of UPH in the third fragment of therapist discourse depended on the theme he focused

III. 2. 3. Similarities and differences among therapist’s interventions

Comparing the style of the therapist with Belisario and Jacinta, some similarities were evident, specially the emphasis in the effort for attunement and after that in generalizations and explanations. Nevertheless, with Belisario this kind of interventions was more extended than those with Jacinta. But the active interventions with Jacinta (asking about feeling, interpretations) began earlier than with Belisario. In the initial moment the accompanying phrases of the therapist with Belisario contrasted with the contact phrases used with Jacinta. With Jacinta the therapist used too some phrases that expressed a further grade of abstraction (gathering different themes taking into account some nuclear features in common) than with Belisario. With him, the therapist just generalized a situation (A2), but did not gather several of them in the same

group (O1). With Belisario the therapist had to intersperse a more extended resources (three interventions) aiming to obtain empathy, while with Jacinta these resource (corresponding to O2) involved just one intervention.

| | With Belisario | With Jacinta |
|-----|--|------------------------|
| O1 | None | Complementary value |
| O2 | Three interventions | One intervention |
| A2 | Extended explanations and argumentations | Short statements |
| UPH | Accompanying | Accompanying / Contact |

Studying the whole session with the computerized program we can detect a great difference between percentages of words exchanged by the therapist with each patient. The proportion between Belisario's and his therapist's words is 10 for the first and 4 for the second. Instead, the proportion between Jacinta's and her therapist's words is 10 for the first and just 2,4 for the second.

The difficulties for the attunement between Belisario and his therapist depended on the defenses of the patient against his affection and also on the hostility that awoke in the therapist and whose manifestation appears just in some little details, and not in his global strategy. The question of the attunement with Jacinta was quickly solved by the therapist. But perhaps the interventions used with her, shorter than those used with Belisario, and the very brief interventions concerning her affection, depended on the therapist' initial anxiety of being invaded by the patient. In the same way, the major effort of the therapist with Belisario depended too on the countertransference difficulties with the patient. The therapist had two branches (strategies) of introductory interventions with Belisario, and just one with Jacinta. It is possible to see the major difficulties that the therapist had with Belisario comparing with Jacinta's first session. Those differences depended on the type of erogeneities and specially main defenses in both patients: failed disavowal and foreclosure of the affection in Belisario and failed repression in Jacinta.

III. 3. Therapist III: Defense against lasting somnolence in the countertransference

Clinical material. Lucrecia (49) began her treatment three years ago. Four years before starting the sessions her mother had died, after five years of almost vegetative life. Lucrecia was devoted to take care of her. She was the unique descendent of her parents. Unmarried, she lived with her father. Her parents had another baby, who died a few days after the delivery. The mother waited three years after deciding to try again to have a baby, Lucrecia. The patient remembered that the Sundays, the family used to visit the grave of her sister.

The first session after the summer holidays, Lucrecia presented a poor discourse, interfered by persistent silences. She just answered to the therapist questions referring to her somnolence and her tendency to sleep. Her first phrase was that she suffered the somnolence but she could tolerate it. After a moment she described a scene in which she went to the bed and tried not to sleep. She lied down in the opposite side, like when her mother was ill and she cared her, fighting against her somnolence. And, like in those period, now she

couldn't resist and felt asleep. Answering the continuous questions asked by her therapist, she narrated some episodes of her daily life: medicaments, project of visiting the cemetery, shopping in the supermarket, etc. The therapist oscillated between two kind of interventions: 1) referred to the mourning state of the patient, 2) asking insistently on what, how and when some details of the daily life of the patient occurred. During an extended part of the session, the second type of interventions prevailed. Then the therapist came back to the episode in which the patient slept in the opposite way. She interpreted it as an evocation of the moment when her parents were alive and the mother was ill. The patient answered that the birthday of her mother was near. The therapist came back to the relief and the guilt of the patient when the mother died. The therapist added that in that moment the patient asked herself why continuing alive, and that in this question there was a reference to her vitality. The patient said that she did want and did not want that her mother died, and that she didn't tolerate the situation of taking care of her, neither physic nor spiritually. Then she commented that she wanted to celebrate her own birthday, instead her father objected to her decisions. The therapist centered her interventions on the wish of the patient for celebrate the own, and to rescue herself from the situation of lost, in the endogamic links. Commenting on this session, the therapist said that during some extended moments she suffered too from different degrees of somnolence. This feeling disappeared in the last part of the session.

Analysis. In the level of narration Lucrecia had various languages intervening: 1) IL (references to her medicine, to her somnolence, to the care of her mother, etc.), 2) O2 (projects of going to the cemetery, evocation of her mother's death), 3) A2 (the scene in which she tried to resist her somnolence and to control herself) and 4) GPH (celebration of her birthday). Among these, during a great part of the session the first prevailed. In the last part of the session that prevalence changed: O2 acquired more weight and finally GPH was the most important.

The session had two moments. 1) When the patient had to describe her holidays, she entered in a half mutism. She answered briefly to the insistent questions of the therapist and added just little anecdotes. Her discourse becomes more and more disconnected from her affectivity, and the therapist oscillated between repeating the previous procedure (insistent questions) and accepting (yes, sure, etc) the patient's superficiality. Some interventions of the therapist stressed the relevance of the mourning state of the patient, but Lucrecia answered referring to banal anecdotes, and the analyst insisted with questions demanding information, etc. 2) In the last part of the session the therapist recovered her main orientation and stressed the relevance of the nostalgic wishes of the patient. Then the patient changed, evoked the period of her mother's death and her own feelings and finally referred to her own anniversary and to her wish to celebrate it.

It is possible to infer that in the patient two main languages and two defenses are combined: 1) O2 and IL, and 2) the disavowal of the death of her mother and the forclusion of the affection, respectively. The disavowal of the object loss was the central defense, and the forclusion of the affection was its complement. But at the beginning of the session the forclusion of the affection prevailed, and, when this defense was removed, emerged the main

mechanism, the disavowal. During the session the main clinical problem for the therapist was to remove the forclusion of the affection. Dealing with the disavowal didn't demand to her the same effort. The forclusion of the affection left the patient in a somnolent state. In the first part of the session, she tried to fight against this position using A2. The scene in which she slept in the opposite way is illustrative. The oppositionist condition is inherent to the characters belonging A2, trying to dominate the world and themselves. But the patient opositive effort failed and the tendency to remain asleep (IL) triumphed. Then, the patient occupied the position of her mother. In the second part of the session, O2 (evocation of her mother illness and death and of her own feelings in this period) was the main language. Finally, in the patient's narration GPH prevailed (references to her birthday celebration).

The same occurred in the level of the phrases. IL, O2, A2, UPH and GPH were the more frequent. UPH and GPH were complementaries, and initially IL prevailed. The first answer of the patient (she suffered the somnolence, but she could tolerate it) was illustrative. The main sector corresponds to IL, and its complement ("but", etc.) belongs to A2. That is, the opposition against somnolence using (to no avail) A2 appears too in the level of the phrase. This type of combination between phrase-structures was the most relevant during the extended first moment of the session. In a second part of the session, O2 acquired more relevance in phrase level, with the complement of GPH (dramatizations) and UPH (interrupted sentences).

In the first part of the session, the therapist insistent resources, centered too in A2, failed to obtain clinical changes. But when the therapist changed her strategy and used O2, she reached some modifications in the discourse of the patient: Lucrecia shifted to a prevalent use of this language (O2). In this moment the therapist resorted back to her A2 and the patient answered using GPH.

The clinical tree of decisions of the therapist had two branches. In the first part of the session, A2 prevailed, and was unsuccessful. At this moment UPH had some importance: the therapist insisted asking when and eventually where the fact narrated by the patient occurred. Also GPH was evident, when the therapist asked how the patient had reached a certain idea, or how she felt. In the last part of the session the therapist changed her strategy: she abandoned temporarily A2 interventions and gave relevance to O2 and, when the patient used too this language, in the therapist prevailed again A2. This second strategy included the use of two languages, depending on the changes in the patient: 1) O2, 2) A2. And this strategy reached the clinical aims.

The analysis with the computerized program of the words integrating the interventions of the therapist shows these figures:

| Strategy I | |
|------------|--------|
| 1. A2 | 28.24% |
| 2. GPH | 21.88% |
| 3. UPH | 21.29% |
| 4. O2 | 16.67% |

| Strategy II | |
|-------------|--------|
| 1. O2 | 31.43% |
| 2. A2 | 23.23% |
| 3. UPH | 21.36% |
| 4. GPH | 14.32% |

This result coincides with those corresponding to the analysis of the phrase of the therapist in both strategies. The increase of O2 in the second

strategy, and the diminution of GPH and A2, the most important in the first strategy, was very clear.

Tree of decisions of Therapist III

Strategy I

A2 Main intervention
UPH Complement
GPH Complement

Main goal: to rescue the patient from her somnolence

Result: dysphoric, including the increasing of countertransferential somnolence

Strategy II

O2 First main intervention

A2 Second main intervention

Main goal: to rescue patient and therapist from their somnolence and to recover the interchange of affects and thinking

Result: euphoric: the somnolence disappears in patient and therapist, and feeling and thinking were the center of both discourses

It is interesting to note that when the therapist fought infructuously with the somnolence of the patient and her own using A2, she occupied in the scene the same position as the patient who tried to maintain her mother alive and eventually fell asleep. Both, patient and therapist, occupied respectively an unsuccessful opposite position surpassed by their impotent somnolence (Stanley, Cusien, Truscello de Manson, Garzoli, Roitman, Maldavsky, Bodni, 2004).

It's possible to add that in the session the 60% of the therapist's interventions belongs to Strategy I, and the other 40%, to the strategy II. In the extended first part of the session, a 5% of pertinent therapist's interventions were disconfirmed by the patient.

IV. Findings

1. DLA and the analysis of the styles of patient and analyst

The analysis of the four cases shows the utility of DLA for the research of the styles of patient and analyst. In each style some languages of the eroticism are combined and recombined. Some languages of the patient can have a complementary function and, after a clinical intervention, switch to the main position, etc. Those changes lead to infer the modifications in the defensive system of the patient. Besides, the method allows to detect what the complementary and the main languages in the therapist interventions and its changes were, that is, the style of the therapist, conceived as one or more strategies, pertinent or not. DLA allows to investigate too little changes in the complementary languages of the therapist.

Tools of DLA were used differently in some analysis. Specially the computerized dictionary had relevance in constructing a doble conditional predictive statement referred to Maria's therapist research.

2. DLA, countertransference and attunement research

Countertransference can be better investigated if the researcher has some information about the feelings of the therapist during the session.

Combining this information with the analysis of the discourse of patient and therapist, the researcher can infer the wishes and specially the defenses of the therapist, both conceived as transitory obstacles in the clinical work.

In the three therapists, the countertransferential affects are the same as those more conflictive in the corresponding patient. In therapist I, the GPH wishes (with an underlying defiant aim of vengeance) was the same as his patient's. In therapist II, a provocative hate was experimented too (and first) by the first patient. Possibly the style of therapist II with his second patient (who did an initial excessive approach) depended on the fact that he had a tendency to react in the same way, that he substituted by the opposite one. Besides, those two cases shows that the same therapist has different transitory countertransferential obstacles depending on the specific style of the patient. In therapist III, the somnolence of the therapist coincided with that of the patient.

Therapist identification with the patient allows him to reach empathy, but implies the risk that both enter in a symmetric escalation (either erotic, violent, invasive, or somnolent). Sometimes the therapist's non pertinent interventions depend on his/her defense against some wishes and feelings (therapist I and III, and partially II, with the second patient), or are a direct expression of them (therapist II with the first patient). If the non pertinent interventions were a defense against the feeling and wishes of the therapist (and the defense was oriented by the aim of preserving the clinical work), the patient could recognize this effort, with a certain independence of the specific features of the interventions.

The same type of clinical intervention could have different value taking into account the style of the patient. For example, the emphasis on the affective state of the patient increased the resistance of María, and diminished the clinical obstacles of Belisario and Lucrecia. In these two last patients the efficacy of that kind of intervention depended on the fact that the patients had a forclusion (more or less vigorous) of the affection, and the interventions of both therapists contributed to remove this pathological mechanism.

The difficulties for the attunement between therapist II and Belisario depended on defenses of the patient against his affection and also on the hostility that awoke in the therapist, whose manifestations appears just in some little details, and not in his global strategy. The difficulties in the attunement of therapist III also depended on the attack of the patient against her own feelings (forclusion of the affection). But the disorientation of therapist I depended more on his difficulties for dealing with his own feelings than on the patient aggressivity or seductive attitude. It is possible to infer that while in therapist II and III countertransferential obstacles were the effect of the defensive system of the patient, in therapist I his own psychic features and formation had a certain influence on his countertransferential difficulties. The previously mentioned complementary series between patient and therapist contributions on the countertransferential obstacles can be clearly seen. Nevertheless, in the four cases, the countertransferential obstacles depended on an identification of the therapist with his/her patient and maintained the clinical situation trapped in the inner conflictive world of the patient.

3. Position of the patient in front of the therapeutic work

Therapist's I and III had two strategies of intervention, one of them failed and the other one successful. In the fourth session, Therapist I was oriented positively by the patient to change to other strategy, more pertinent. In consequence, in this session just the 20% of his interventions were not pertinent. In the latter session the 100% of his interventions were erroneous. He couldn't reorient himself listening the discourse of the patient, and insistently used O2. Therapist III gave a 60% of erroneous interventions. In the extended first part of the session, a 5% of her interventions were pertinent, but the patient disconfirmed them. In the second part of the session, the patient answered positively when the therapist gave the same type of interventions. Therapist II had only one strategy, successful, and he needed to stress differently certain proposals with Belisario and Jacinta's.

It's possible to present a range among the four treatment, taking into account both participants, patient and therapist. In one extreme, Maria and Lucrecia and their corresponding therapists, in the other one, Belisario and Jacinta and their therapist. In the fifth session studied Maria's therapist was reoriented positively for the patient, when he had an erroneous strategy, but in the second session studied he insisted in the same strategy, that was equally erroneous. Lucrecia's therapist was reoriented negatively when she had a pertinent strategy, and then she confused her way. Finally the therapist recovered her pertinent orientation and the patient agreed with her. In the other extreme, the therapist had some minor difficulties for maintaining his orientation with Belisario, and almost no difficulties with Jacinta. Belisario's discourse revealed some insistence in the cathartic discourse, although the therapist pertinent interventions. Besides, the therapist had a non pertinent introductory intervention. But viewing his strategy as a whole, the therapist had pertinent interventions.

In this two extremis, the successful and the failed ones, both participants of the therapeutic relationship had different weight. When the strategy I of therapist I failed, Maria gave new associations that reoriented positively the clinical work. When therapist II included an introductory objection in his first clinical intervention, the patient answered to the best part of this intervention, and not to the worst. Those two interactive scenes are evidence of the collaborative position of the patients. But when the therapist II asked on the affection (O2) of Belisario, the patient answered with an insistence in his cathartic style (IL). The therapist needed three interventions in the same way to reach a positive result. This kind of answer placed Belisario in a more resistant position in front of the therapeutic work. When therapist III tried to introduce O2 in her interventions during the extended first part of the session, the patient asked using a more monotone and banal discourse. This kind of answer can be considered as an evidence of a poor collaborative position of the patient with the therapeutic work. Just in the last part of the session the patient admitted that the therapist used O2 successfully.

Maria's therapists had great difficulties for reaching a pertinent strategy. Lucrecia's therapist had too difficulties, specially for maintaining her orientation. Belisario's and Jacinta's therapist had almost no difficulties for reaching a pertinent orientation.

In consequence, a complementary serie can be constructed taking into account the influence of both participants in reaching a pertinent clinical

orientation. But both therapists of one extreme (Maria's and Lucrecia's) had to protect the therapeutic relationship against their countertransference, and the patients seemed to valorate positively those efforts. In consequence, the research of the therapeutic alliance has to take into account not only the pertinence of the clinical orientation created by both participants but also the effort of the therapist for preserving the clinical project from the risk of the invasion by countertransferential irruptions.

It is possible to conclude that clinical description of Liberman on the manifestations of the positive or negative contribution of the patient in front of the psychotherapeutic work (therapeutic alliance) can be useful. But perhaps this proposal can be enriched taking into account how the patient answer when the therapist (immersed in her/his struggle against the countertransference) gave erroneous interventions.

4. Best stylistic complementarities between patient and therapist

Therapist I had unsuccessful interventions when prevailing O2 in his strategy and reached good results when A2 was dominant. This second style is the best complement of O2 and A1, the pathologic combinatory suffered by the patient, disguised with GPH appearance. Therapist II obtained a good result using O2 when Belisario was in the worst defensive moment, attacking his affects and using cathartic discourse (IL). When the patient changed to the prevalence of O2, the therapist changed too, using successfully A2. The same therapist used successfully A2 mixed with O1 when in the patient prevailed UPH. Therapist III failed in her strategy using A2 when in the patient prevailed IL, and finally arrived at the best complementary style, in which O2 was dominant.

This summary of the stylistic interaction among patients and therapists seemed to give a certain support to Liberman's proposal concerning the best stylistic complementarities. But the clinical facts are more complex. The previous description of the stylistic interaction in the sessions analyzed was oversimplified, and didn't take into account that in each patient's discourse different styles coexisted. For example, in the patient of therapist I, O2 and A1 were detected almost exclusively in the level of the narration, but not in the phrase and the word levels, where A2 and GPH prevailed. A2, as an optimum complementary style in the analyst, is a useful answer (Liberman dixit) just to O2 and A1, but not to the styles detected in the level of the phrase and of the words. Similarly, each analyst intervention contains more than one language, and I ignore which of them is determinant in provoking the answer of the patient.

V. Discussion

Subjective variable of the therapist. The main therapist variables influencing on the efficacy of treatment are 1) type of interventions, 2) therapeutic style. Style of the therapist includes the question on her/his subjectivity. In this paper I focused subjectivity from the Freudian perspective, including the participation of the eroticism of the therapist, combined with sublimatory, creative or eventually repressive mechanisms. Two aspects of the subjectivity of the therapist were studied: 1) his style (considered as an ensemble of interventions combining different manifestations of the therapist's erogeneities), 2) his/her inferred

countertransference and the position she/he had on it. This type of research can be combined with the ones centered on the type of technical interventions of the therapist. Maria's cases was studied simultaneously by another team (Avila Espada et al., 2004), focusing precisely technical interventions of her therapist. First findings of both research (stressing the importance of countertransference) were coincident.

Components of therapeutic alliance. Which components participate in the therapeutic alliance are theme of research. In this investigation I detected that not only the contribution of both participants for reaching a pertinent clinical orientation, but also the efforts of the therapist for preserving the treatment from disruption of countertransference answers has relevance. This second aspect can be seen as a component of the personal compromise of the therapist in the treatment.

Stylistic complementariness. Concerning the problem of stylistic complementarities between patient and therapist, it's not enough the Libermanian proposal, that took into account only one eroticism in each participant. The reality shows that in the clinical interchange more than one erogeneity participates in the patient's and therapist's discourse. Possibly the best complementary style of the therapist fits well with the style that contains the main defense of the patient, and we have to be prepared to detect that some interventions allow just to reach a partial change in the defensive system, perhaps in a secondary defense (like projection) but not in the central one. Possibly, we can detect how the therapist corrects himself changing some partial aspects of his strategy, substituting one introductory (or complementary) intervention by another one, more adequate, but not the main one. And DLA allows to detect this permanent process of self rectification.

So, this investigation can just give a partial support to Liberman's proposal concerning stylistic complementarities. Instead, it opens the possibility to design a more sophisticated research, taking into account the various levels of analysis of the discourse, to eventually decide whether or not Liberman proposal are correct.

Research on defense. A underlying utilization of DLA method for the analysis of patient's discourse can be noted. DLA allows to detect not only erogeneities and defenses and its variations but also what the state of those defenses was (successful, failed, etc.). It's not usual a method that gives this kind of results. Freud stressed that the problem was less the defense than its state; hysterical symptoms, for example, depends on a failure of repression, the invasion of psychotic ego by hallucinations depends on a failure of foreclosure of the reality and the ideal, etc.

VI. Conclusions

1. DLA is a useful method for the research of the styles of patient and therapist.
2. The method allows to describe with precision the features of the pertinent and not pertinent strategies of the therapist and its changes, and also permits to infer the countertransference processes.
3. The present research can show the utility of Liberman description of the manifestations of the collaborative position of the patient in front of the therapeutic work (the contribution of the patient to the therapeutic

alliance), and adds a complementary feature, about how the patient answer to erroneous clinic interventions dues to the defense of the therapist against a perturbing countertransference.

However, the present investigation cannot decide whether Liberman's proposal concerning the good complementarities between patient and analyst styles is correct or not. The results of this research suggest that concerning this question more sophisticate studies, taking into account different levels of the discourse, need to be developed.

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