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AN ANALYSIS OF AN ADOLESCENT'S PSYCHODYNAMIC PSYCHOTHERAPY PROCESS: A SINGLE-CASE STUDY

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An Analysis of An Adolescent's Psychodynamic Psychotherapy Process: A Single-Case Study

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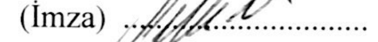
Jüri Üyeleri : Dr. Öğretim Üyesi Sibel Halfon (İmza) 
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ABSTRACT

Adolescence is a complex and challenging period in human life. In order to understand the underlying dynamics of an adolescent, this work studies the specific themes in the course of a psychodynamic psychotherapy process with an adolescent. The data of this study is comprised of 43 fully transcribed sessions with a 17-year-old female adolescent in Turkey. The transcripts of each session were evaluated by two separate groups of raters on 4 main categories which are affect, psychosexual theme, defenses and therapeutic relationship. Specifically; one group of raters were asked to evaluate the predominant Psychosexual Theme (oral, anal, oedipal) in the session, the Here-and-Now Defensiveness of the client, and the level of Defense Mechanisms (projection, splitting, acting out, dissociation, denial) in the session. The other group of raters were asked to evaluate the therapeutic relationship variables; Affect (aggression, fear, envy, guilt, shame, sadness) of the client during the session and Therapeutic Alliance variable. The data was analyzed using time-series analyses; ARIMA modelling and cross-correlation analysis. The results indicated that negative affects except hidden sadness shows a decreasing trend in time. The level of separation, defensiveness and therapeutic alliance variables shows a significant relationship with affects.

Keywords: Adolescent, separation-individualization, single case, cross-correlation, time series, affect, defenses, therapeutic alliance

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ÖZET

Ergenlik, insan yaşamındaki karmaşık ve zorlayıcı bir süreçtir. Bu çalışma, bir ergenin davranışlarının altında yatan dinamikleri anlamak için, bir ergen ile psikodinamik yaklaşımla yürütülen bir psikoterapi sürecindeki belirli temaları incelemektedir. Bu çalışmanın verileri, Türkiye'de 17 yaşında kadın bir ergenle yapılan 43 seansın verilerinden oluşmaktadır. Her seansın transkriptleri, duygu, psikoseksüel tema, savunma mekanizmaları ve terapötik ilişki olmak üzere 4 ana kategoride iki ayrı grup tarafından değerlendirilmiştir. Çalışmada, bir grup değerlendiriciden hastanın seans sırasında, kullandığı baskın Psikoseksüel temasını (oral, anal, oidipal), Şimdi ve Burada Savunmacılığını ve Savunma Mekanizmalarını (yansıtma, bölme, eyleme dökme, ayrışma, inkar) değerlendirmeleri istendi. Diğer gruplardan ise Duygu (öfke, korku, kıskançlık, suçluluk, utanç, üzüntü) düzeyini ve Terapötik ilişki değişkenlerini değerlendirmeleri istendi. Veriler zaman serisi analizleri, ARIMA modellemesi ve çapraz korelasyon analizi kullanılarak analiz edildi. Sonuçlar, örtük üzüntü dışındaki olumsuz etkilerin zaman içinde azalan bir eğilim gösterdiğini göstermiştir. Ayrışma düzeyi, savunmacılık ve terapötik ittifak değişkenlerinin düzeyi, etkiler ile arasında anlamlı bir ilişki göstermektedir.

Anahtar Kelimeler: Ergen, ayrışma-bireyselleşme, vaka çalışması, çapraz korelasyon, zaman serileri, defanslar, savunmalar, terapötik ittifak

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CHAPTER I

INTRODUCTION

Is there a simple way to describe adolescence? As Anna Freud (1958) said, "Once we accept for adolescence disharmony within the psychic structure as our basic fact, understanding becomes easier" (p. 275). The complexity of the adolescence period stems from the nature of this period, in which the individual faces all phases of the childhood developmental problems, while making new adjustments to the past fundamental conflicts (Josselyn, 1971). Therefore, due to the difficulty of the adolescence period, it is a very valid research area in both clinical and theoretical fields. In order to understand the underlying dynamics of an adolescent, this thesis studies the specific themes in the course of psychodynamic psychotherapy with an adolescent.

The adolescence was first addressed in the psychoanalytic literature by Sigmund Freud in the *Three Essays on Sexuality* (Freud, 1905), where puberty is seen as a period during which the infantile sexual life transforms into adult sexuality. Although Sigmund Freud had mentioned adolescence in his works, Anna Freud was the first one who drew attention to the details of its dynamics. The reason for Anna Freud's specific focus on this period was her belief that while analytical thinking was being formed, the adolescence period had been neglected (A. Freud, 1958). To outline this special period, she indicated the differences between the childhood and adolescence periods by labeling adolescence as "by its nature an interruption of peaceful growth" (A. Freud, 1958, p. 267).

After Anna Freud paved the way, Blos became one of the most prominent scientists in the adolescence literature with his book *On Adolescence* (1962; Holder, 2005). Blos, (1967) considered adolescence as a second individuation phase following Mahler's theory of separation individuation. He also assumed that adolescence is a second chance for the individual to find out healthier resolutions for infantile conflicts. In parallel with Blos, Josselyn (1971) suggested

that Mahler's separation-individualization phase reappears during the adolescence.

During the so-called second individualization process, adolescents suffer from various internal conflicts. While such internal conflicts and the struggles of transitioning to adulthood and leaving the childhood behind takes place, arguably the most commonly observed and suffered emotional state of the adolescents is the depressive state. Indeed, research shows that depression is a very common affective state for the adolescents, and it is encountered at a universal level. According to the World Health Organization (WHO) data of 2000 and 2012, among the many mental health problems during adolescence, adolescents most commonly go through depression (World Health Organization, 2014).

Adolescence depression is therefore elaborated widely in the literature by many researchers (e.g. Blos, 1962; Josselyn, 1971; Milne & Lancaster, 2001; Nolen-Hoeksema & Girgus, 1994). Among them, Josselyn (1971) formulated the adolescent depression through her study. She explains the common type of depression during adolescence as characterized by feelings of emptiness and depersonalization. Additionally, she observed that adolescents, who repeatedly have experienced defeat, also suffer from depression that eventually leads to committing suicide in some cases.

As outlined above, depression in adolescents is widely encountered, and thus, commonly studied. However, these studies usually focus on the prevalence and etiology, rather than the subjective experience. In-depth single case studies that offer an understanding of the underlying dynamics of adolescents suffering from depression are not as commonly available in the literature. In this light, this study investigates the psychodynamic psychotherapy process of a 17 years old female adolescent who is suffering from major depression. Taking this case, the study explored the affects, defenses and psychosexual themes as well as the characteristics of the therapeutic relationship that are believed to define the psychodynamic process with an adolescent.

1.1. Psychoanalytic Literature Regarding Adolescence

1.1.1. Classical Point of View on Adolescence

The adolescence period, which also maintains physical changes called puberty, was first emphasized in the psychoanalytic literature in Sigmund Freud's work titled, *Three Essays on Sexuality* (Freud, 1905). He illustrated the "detachment from parental authority" as "one of the most painful, psychical achievements of the pubertal period" (p.226). In his work, he claimed that the sexual impulses which were latent during the childhood, are expected to commence in time, in conjunction with the maturation process of puberty. By claiming this, Freud opposed the existing common perception at the time regarding the first manifestation of the sexual impulse; which was the belief that sexual impulse was nonexistent during the childhood (Freud, 1905). Instead, Freud introduced the concept of infantile sexuality that retreats into a dormant phase as the oedipal period ends. So, adolescence from Freud's perspective is not the first encounter with sexuality, but a revival of the infantile sexuality with all the unresolved issues with adult genital sexuality as its final destination.

Following Freud's work in 1905, adolescence was instead seen as a transformation process. In other words, adolescence was conceptualized as a phase between the adult sexual life and the infantile sexual life, rather than being seen as the beginning of adult sexual life. According to Freud (1905), sexual impulses exist from the very beginning of life. To elaborate on this, he describes that the infant's sexual needs are based on the satisfaction of a biologically pre-determined erogenous zone. In the first year of the infant, the libido is positioned in the infant's mouth. Thus the infantile satisfaction is derived from sucking, biting and breast feeding. After this stage, the libido shifts towards the anal during the period of 1-3 years of age and the anus becomes the erogenous zone (Freud, 1905). The infant fulfils pleasure through defecating, as being able to do so in all places and at all times is very rewarding for the infant. The anal stage is followed by the phallic stage during 3-5 years of age, where the child's attention is focused

in the genitals (Freud, 1905). The child derives pleasure through masturbation, but the infantile sexuality at this period is different from the adult sexuality. These erogenous zones transform into the genital zones during the adolescence (Freud, 1905). In the adolescence period, the infantile sexuality goes through the changes which result in the final shape of adult sexuality.

In terms of Freud's instinct theory, latency is a stage of quiescence, where the child seems to be not under the pressure of the instinctual drive (Freud, 1905). Gradually, as the child moves towards puberty, the primitive energy is increased during the puberty phase (Brafman, 2000). Additionally, the aggression, pre-genital impulses and oedipal fantasies resurface; and the castration anxiety in boys and penis envy in girls are, once again, moved to the core of the character (Freud, 1905).

Building on Sigmund Freud's work, Anna Freud was the first one who specifically underlined the importance of the adolescence period, and presented the first contributions on adolescence in the field of analytical thinking (A. Freud, 1958). The motivation of this neglect is that, psychoanalytical thinking declined the idea of the puberty as the beginning of sexual life as Freud (1905) indicated. Anna Freud also indicated that the significant pre-genital phases of sexuality and development are passed through, and the distinctive instincts are developed and actualized not only in puberty, but also before the puberty.

Besides the psychological changes during the puberty, Anna Freud (1966) pointed out the imbalance in the psychic equilibrium in an adolescent's life. In order to understand the puberty period, she suggested that the ego state in early childhood needs to be understood (A. Freud, 1966). Throughout infancy, the struggle between ego and the id has its particular state. Regarding id, the instinctual desires have specific features that characterize the oral, anal and phallic stages. On the other hand, the ego is in the course of formation; it is weak and immature while facing these instinctual desires during infancy (A. Freud, 1966). In later life, the instinctual desires are faced with a more or less rigid ego; in contrast, during the infancy the ego is weak and cannot resist the conflict (A. Freud, 1966).

Thus, as the conflict continues, the ego finds a way to delay the undeniable desires of id. In order to resist the unfulfilled desires of id, the ego uses the defensive methods to bear the anxiety. When the *modus vivendi* has been compromised between the id and the ego, both of them hold on it after that (A. Freud, 1966). After the phallic stage, there is the latency phase, which can be considered as a temporary break from the struggle between the id and the ego. The latency period is seen important in terms of ego distinction from the id and ego autonomy (Blos, 1971). Ego autonomy is referred as the ego function as thinking, memory, capability to make distinction among real world and fantasy, and consciousness (Blos, 1971). If these capabilities were not developed during the latency, then the latency period can be seen inconclusive or inadequate (Blos, 1971). Blos (1971) believed that several conflicts in early adolescence were due to these developmental problems.

Also, the importance of "early adolescence" is stressed by Anna Freud as well. She indicated that before the puberty begins and the latency period ends, there is an interval stage, which she called "pre-puberty" (A. Freud, 1966). Throughout this period, only the quantifiable changes have been monitored in terms of increasing instinctual energy (A. Freud, 1966). This quantitative change in instinctual life is not limited to sexual life. Both the libidinal energy and aggression are intensified. In addition to that, the oral, anal and oedipal fantasies appear again, which were suppressed during the latency phase.

The ego organization in the pre-puberty duration is harsh and firmly strengthened opposing to the infancy phase, in which the ego is undeveloped and vulnerable under the pressure of the id (A. Freud, 1966). Specifically, the ego is capable of revolting to the external world during the early childhood and while doing so, aligns with the id in order to satisfy the instinctual desires. Meanwhile, the ego during the puberty cannot ally with the id, due to the struggle with the superego (A. Freud, 1966). In order to protect its own reality, the ego uses various defenses against instincts that are coming from the id (A. Freud, 1966).

The uncomfortable experiences of the pre-puberty phase correspond to the different periods in the struggle between the id and the ego in early childhood such as oral, anal or oedipal phases (A. Freud, 1966). Additionally, Josselyn (1971) noted that during the adolescence, the individual faces all aspects of the childhood problems, so that s/he can make new adjustments to the past fundamental conflicts.

Further, qualitative changes in instinctual energy accompany the physical changes that take place during puberty (A. Freud, 1966). The instinctual energy, which is indistinguishable in the early stages, changes its direction with the increase in the genital instincts (A. Freud, 1966). In other words, the libidinal energy is withdrawn from the pre-genital impulses and instead focused on the genital impulses during the adolescence. This would mean that the previous pre-genital impulses take a back seat in favor of genitality during the puberty. The function of the libido at puberty is not decreasing the conflict between id and the ego, but is rather increasing it (A. Freud, 1966).

The conflict may result in two opposite ways according to Anna Freud (1966). First possibility is that the id may surpass the ego and the formerly developed character would be changed without a trace. The other possibility meanwhile is that the ego may overcome, and the character formed during the latency would be permanent (Sandler, 1983). If the latter happens, the id instincts of the adolescent are limited to the instinctual life of a child (A. Freud, 1966). Therefore, the ego should adapt and stretch itself to the new demands of the id; otherwise a premature personality organization continues and accordingly, the emotional life remains dull (Spiegel, 1951).

Although the classical point of view indicated that adolescence period is a mere duplication of the oedipal period, as stated previously, Spiegel (1951) contradicts with the idea. He claimed that adolescence is a unique period where the instinctual desires find their sufficient way for discharging the pressure (Spiegel, 1951). The difference during this period in comparison to previous periods is that the adolescent has the means and necessary genital capacity to discharge his/her sexuality. He argued that although the full extent of this change

to adolescence is not known yet, this period is a new phase in itself and should not be considered as a repetition of other periods (Spiegel, 1951).

The role of regenerated oedipal phase is not maintained in the same form as described by Freud for infancy (Spiegel, 1951). The adolescent is initially faced with the Oedipus complex, but this phenomenon is later reduced slowly. Parental image replacements are increasingly selected among those who have less similar traits with the original parent representations (Spiegel, 1951).

1.1.2. Object Relational Point of View on Adolescence

In addition to the Freudian point of view, Mahler explored the development and difficulties in the early stages of childhood. In terms of intricacies of the development process, she stressed the effect of severe symbiotic interference in the development process (Mitchell & Black, 1995). She claimed that the developmental process has two opposite edges which are the "the consciousness of self and the absorption without awareness of self" (Mahler, 1972, p.487). He states that a person may not necessarily remain at the either edge of the spectrum; a person can move between these two opposing polarities simply and concurrently, either effortlessly or with difficulty. This process therefore is a never-ending process; it can easily become restarted in different phases of the life. Although this progression changes from one person to another or in time, the main intrapsychic achievements during the infancy do not change (Mahler, 1972).

Mahler (1972) portrays development as a process of separation and individuation. Based on her observations, she subdivided this process into four sub-phases which are named as; *differentiation/hatching, practicing, rapprochement,* and *object constancy* (Mahler, 1972).

Additionally, she also acknowledged that there are the predecessors of the aforementioned differentiation phase - such as the *autistic shell*; which is a phase without any object, and the *symbiotic phase*; which is a pre-object phase. This objectless period which maintains these two phases, was Mahler's (1972) reframing of Freud's "primary narcissism" phase (Mitchell and Black, 1995). The

first months of the infancy constitute the *symbiotic phase*. Mahler (1972) stated that the young infant breaks out of an *autistic shell*, and then participates into the initial human relations, which is called *normal symbiosis*. At the beginning of the symbiotic phase, infant has an internal focus, and in time, he/she gains perceptions which are concentrated on the outer world. In this phase, the infant is highly focused on the mother figure (Mahler, 1972).

As the time passes, this attention on the symbiotic orbit is combined with the infant's memories shaped from the experiences of his/her mother's good and bad memories; which are formed by receiving attention from the mother, which is the good experience; and the end of mother's attention at that time span, which constitutes the bad experience (Mahler, 1972).

In the first sub-phase of the separation-individuation, *hatching*, the attention is outwardly directed, and the insurance comes from looking back to the mother as a source of self-positioning (as cited in Mitchell & Black, 1995). When the infant has adequately individuated to recognize the mother, then s/he starts to explore the faces of the others from a distance or a close scope, and turns with surprise or anxiety to his/her mother.

The *hatching* sub-phase overlaps with the *practicing* sub-phase, as the infant has the ability to move away from the mother through the improved locomotive capabilities (Mitchell & Black, 1995). This *practicing* period of the infant, which is titled after the infant's practicing activities on the environment, takes place during 7 to 17 months of age, approximately. In this period, a different pattern of relationship with the mother is observed (Mahler, 1972). The infant's attention shifts from the mother to the inanimate objects. These objects are the toys or any object that the mother hands to the infant. The infant experiences these objects through his/her sense organs. One of such objects becomes the "transitional object" for the infant in later as Winnicott (1953) mentioned. With the assurance that is received from this transitional object, the infant enhances his/her relationship with the outside world in addition to his/her relationship with the mother.

However, as the infant explores the outside world, s/he gets excited with his/her new abilities and gets filled with a sense of omnipotence, notwithstanding the desire for the psychical connect with her mother (Mitchell & Black, 1995). Thus, during the hatching period the mother is seen as a secure base by the infant, and s/he can easily crawl back to the mother, to fulfill his/her emotional needs (Mahler, 1972). Mahler (1972) indicated that infants in the practicing phase have intense episodes of excitements. However, this excitement subsides when they realize that the mother is not present in the room. During such periods, their attention to the outside world decreases; and they withdraw themselves from the outside world and become preoccupied with their own internal world.

At around 16 to 25 months, the child's locomotion ability increases; and s/he becomes more aware of the outer world (Mitchell & Black, 1995). This duration is called the *rapprochement* sub-phase of separation-individuation by Mahler (1972). With increased mobility, the child experiences separation anxiety, due to the psychical separateness from the symbiotic relationship with the mother (Mahler, 1972). The formerly brave child in the practicing phase may become uncertain at this stage, and desires his/her mother nearby mostly while navigating these new experiences, in order to adapt to this new situation where he/she is separate from the mother. The child wants and wishes to share with her mother all the new capabilities and skills gained through these experiences.

The possible complication in this period is that the mother might misinterpret the genuine progressive necessity of the child as regressive, and thus correspond to such behaviors with intolerance or by remaining inaccessible (Mitchell & Black, 1995). When the child is faced with these reactions due to the mother's misinterpretation, the child may feel the fear of abandonment. The child at this period has not yet developed the psychic capacity to act as an autonomous agent, and therefore, showcases "mood predisposition," which is based on the child's perception of mother's lack of acceptance and emotional understanding at the rapprochement period. This contributes to a tendency of depression at the child's part (Mahler, 1966).

During rapprochement, the infant's interaction type with his/her mother goes through an important change. At the earlier phases, the child contacts his/her mother and renews a sense of security through physical contact at certain intervals to recharge his/her emotional reserves, later to return to explorations of the world to be excited and absorbed in such efforts (Mahler 1972). However, in this new phase, the frequency of the child's need for contact intensifies, and the child looks to continuously be in contact with the mother as well as other familiar adults around him/her at a more developed level of symbolization (Mahler, 1972).

Rapprochement sub-phase is critical since the individuation of the child progresses fast during this period; and eventually s/he develops a sufficient level of awareness of his/her separateness from the mother. In order to resist this separateness, the child uses various defense mechanisms (Mahler, 1972). Although the child's desire is to maintain the symbiotic unit, s/he can no longer participate in the illusion of mother's omnipotence. Eventually, the toddler understands that s/he and her/his mother each are different individuals and accordingly, they have separate internal lives (Mahler, 1972). Therefore, as hard as it is for him/her self, the child must give up his/her own omnipotence, which takes place through intense fighting with the mother and to a lesser degree, with the father (Mahler 1972). This is called the "rapprochement crisis" by Mahler (1972).

At the beginning of the third year, the mother's involvement in the child's world aids the comprehensive processes happening in the child's thinking process, testing of reality and coping skills. At that point, it is assumed that the child has started developing emotional *object constancy* (Mahler, 1974).

Mahler's separation-individuation process is likened to the adolescence period by many analysts (Blos, 1967; Josselyn, 1971, Sandler, 1983). Specifically, they suggest that the sub-phases of the separation-individuation process as defined by Mahler are somewhat similar with the processes that the adolescent experiences with his/her external world.

In line with this point of view, Blos (1967) acknowledged that the adolescence period is a second individualization period. He suggested that both periods have similarities in terms of the weakness of the personality and the transitions that the psychic structure goes through (Blos, 1967).

In Mahler's theory, the periods of "autistic phase" and the "symbiotic phase" takes place prior to hatching. Likewise, the adolescent experiences the similar patterns of going through phases prior to hatching. The autistic phase of the adolescent is hard to detect. Josselyn (1971) notes that it is indeed very tough to detect the autistic phase, though it can be easily observed during serious psychotic collapses. During several instances, the adolescent displays lack of awareness of the external world and of him or herself. Additionally, the adolescent is also prone to feelings of emptiness and to experiencing difficulty in relating to him/her self or to others. The adolescent behaves mechanically without displaying real emotions, besides a rage-like expression which is similar to an uneasy newborn's reactions (Josselyn, 1971).

Next, in congruence with Mahler's symbiotic orbit, an adolescent's relationships with friends can be regarded as symbiotic, resembling fusions (Josselyn, 1971). These relationships are formed in a way that adolescents cannot exist as distinct individuals who are apart from one another. As can be expected from a symbiotic-like relationship, they look, act and relate as if they are one person. It seems as if one of them cannot exist without the other. This symbiotic-like relationship is not exclusive to partners of same sex or age; it may be formed with anyone older or younger, same-sex or opposite sex (Josselyn, 1971).

Also, Blos (1967) believed that Mahler's hatching from the symbiotic relationship in infancy is similar with the adolescence. Like the infant, adolescents also loosen their ties with their parents, and reduce their family dependencies in order to become individuals themselves in the adult world (Blos, 1967). The adolescent is often trying to figure out his/her "ego ideal" with a desire to be different from his/her childhood. S/he has a desire to become more independent and accordingly is embarrassed of being dependent, and s/he pursues friendships who are different from the ones s/he loved before (Josselyn, 1971).

Adolescents' withdrawal from their dependence is also acknowledged by Anna Freud, who pointed to adolescents' objections to intimacy with their parents (Sandler, 1983). She elaborates that this defense is rooted in their desire to become an adult and the desire to continue their childhood at the same time, which causes an internal conflict and this conflict is at the core of the adolescent's inner world (Sandler, 1983).

The ego conflicts that are visible in various reactions and feelings such as acting out, absence of purpose and meaning, procrastination, and moodiness, are commonly seen as signs of a defect in the detachment from internal objects, and therefore represent a defect of individualization itself (Blos, 1967). The desire for individualization can be seen in the adolescent's rejection of her/his family ties and her/his avoidance of the painful detachment practice (Blos, 1967). This duration is temporary and delays are "self-liquidating." During this avoidance duration, the adolescent goes to extremes such as running away, leaving school, using drugs, in order to separate from childhood dependencies (Blos, 1967). The struggle of separation individualization is in accordance with the adolescence period.

On the other hand, Schafer (1973) has taken an opposing view to Blos' view of the parallel positions between the separation-individuation in childhood and adolescence. He indicated that individuation does not take place solely by moving away from the relations to childhood objects, given that the very existence of objects is the sign that individuation has already taken place, no matter how the relations to objects may be unsteady (Schafer, 1973). The reason for this acceptance is that individuation is key for letting go of childhood relations and only someone who has gone through such a process can accomplish this.

Winnicott (1965) provides a different point of view which is based on the environmental factors on the development. Winnicott's (1965) developmental point of view proposes that failures and collapses happen when the environment fails to respond to the child's emotional needs in an emphatic way. In line with his theory of development, he emphasizes the importance of the environmental factors that may shape internal dynamics of adolescence. Winnicott suggested the

re-adaptation to the reality since the weak self needs dependency. However, in one of his writings, Winnicott (1971) makes a statement that is visibly in contrast to his prior statements, in which he indicated that "…In the total unconscious fantasy belonging to growth at puberty and in adolescence, there is the death of someone" (p. 196). This argument supports the proposition that adolescence encompasses a re-experiencing of the oedipal phase, where the infant wants to take the position of his/her same sex parent (Tamir, 2014).

Similar with Anna Freud, Winnicott (1965) indicated that adolescents' conflicts are parallel to the problems they faced during childhood. According to Winnicott (1965), the adolescent experiences isolation and depression due to the detachment from their primary objects. This isolation is due to their need of shaping their own identity and shaping his/her genuineness. But at the same time they need social attachments to find a commonality with the other people, to feel like s/he is like the others. Thus, they are "social isolaters" (cited in Tamir, 2014).

1.1.3. Recent Psychodynamic Studies on Adolescence

Latest studies have focused on evidence based rationalizations of the psychotherapy researches, as a response to the belief that psychodynamic literature is lacking empirically supported studies (Kazdin, 2009). In order to address this gap, some studies have explored the efficiency of psychodynamic psychotherapies for adolescents (e.g. Tishby, Raitchick, & Shefler, 2007; Tonge, Pullen, Hughes & Beafoy, 2009). Although the small sample size made it harder to generalise their results, smaller samples have allowed for understanding the nature of change (Midgley & Kenendy, 2011).

In this light, Tishby et al. (2007) studied the changes in interpersonal conflicts among adolescents, which was conducted with ten adolescents between 15 and 18 years of age, who have gone through a one-year psychodynamic psychotherapy process. They assessed the result using the Core Conflictual Relationship Theme (CCRT), (Luborsky and Crits-Cristoph, 1990). The results have shown that as time passed by, the adolescents have become less angry and

confrontational in their relationship with their parents. Meanwhile, their relationship with the therapist have changed from asking to be understood and helped, to being understood and developing a more separate relationship.

Additionally, Tonge et al. (2009) studied the effectiveness of psychodynamic psychotherapy on adolescents who have serious mental illnesses. The study was conducted with 40 adolescents who were aged between 12 to 18 years, who have received psychodynamic psychotherapy once or twice per week. Their results have shown that these adolescents who received psychodynamic psychotherapy had a decrease in their clinical symptoms and social problems, compared to the selected control group. The efficiency of the therapy was based on the initial level of psychopathology, and a "floor effect" was noticed.

While visibly more research is available today on the effectiveness of psychodynamic psychotherapies for adolescents with different psychopathologies (e.g. Fonagy et al., 2002), lesser studies have focused on the process of psychotherapy, or worked on the associations between the outcomes and the treatment processes employed (Midgley, Ansaldo, Target, 2014). One of the notable studies among the latter group is the IMPACT (Improving Mood with Psychoanalytic and Cognitive Therapies) study (Goodyer et al., 2011). This study is qualitative, longitudinal research, which takes the view of the adolescents, parents and therapists in examining the adolescents' depression. The study compares three psychotherapy interventions; namely, Short Term Psychoanalytic Psychotherapy (STPP), Cognitive Behaviour Therapy (CBT) and Specialist Clinical Care (SCC), in order to treat moderate to severe depression in adolescents. Although it is an ongoing study, the preliminary findings revealed that all three different therapeutic interventions have resulted in decreasing the depressive symptoms. One year after the end of interventions, all three different types treatments were indicated as similarly effective in terms of reducing depressive symptoms, with similar total costs.

1.1.4. Adolescence from Attachment Theory Perspective

Another essential dimension one must consider when trying to understand the dynamic of adolescence is attachment. Bowlby (1958) explains the theory of attachment as a survival-centered, fundamentally biological desire that infants have, where they seek the closeness of caregivers. While receiving care from their caregivers repeatedly, the infants cultivate representations of relational patterns where they see themselves as worthy of care, which is readily provided by the attachment figure (Bowlby, 1969).

Ainsworth (1989) indicated that the attachment relationship formed with parents, is not a relationship that is limited in the childhood period, but also during adolescence and adulthood; whereby the attachment relationship established with the parents have influences on the individual’s all established lifelong relationships. In other words, the first close relationships provide a foundation on which all interpersonal relationships established in life are formed on. The first relationship representations, which are considered as internally processed models, define whether the individual feels safe or in fear during his/her relationships with others and whether the individual considers him/herself worthy of others’ love (Ainsworth, 1989). Also, Ainsworth and her colleagues (1978), studied the non-verbal reactions of the infants when they faced with “unexpected situations” for themselves, such as separating and reuniting with their mothers. This study revealed three types of attachment styles for this age group; namely secure, ambivalent and avoidant.

According to Kerns and Stevens (1996), an explanation for the significance of the first attachment relationships in adolescence is that interpersonal development has an accumulation from the past; what happened in infancy affects childhood and what happens in childhood affects adolescence (Steinberg, 2001). Many studies that worked on this proposition have come up with results where infant with insecure attachment styles, later go on to have more inclination for psychological and social troubles during the adolescence period (Buist et al, 2004; Nickerson, 2002).

These models define the sum of beliefs and expectations that individuals have and also utilize, in developing close relationships with others. According to Attachment Theory, the individuals who were insecurely attached to their parents during their infancy have a negative model in their adolescence, while individuals with secure attachments in infancy have a more positive and healthy internal model during adolescence. (Kobak & Sceery, 1988).

In a more recent study made by Zimmermann (2004), it was observed that the adolescents who have secure attachment representations, can have more emotionally close relationships and develop a friendship understanding that is more sensitive. In addition to that, adolescents who experience problems in their friendships carry risks with regards to having negative experiences such as violence, academic failure, concern, depression and loneliness (Ooi et al., 2006).

The adolescence period has a special importance with reference to the theory of attachment, since the individual's own evaluation of the attachment organization that has been formed in infancy takes place during adolescence (Steinberg, 2001). Additionally, with the changes that take place in cognitive functioning, the individual can make a better differentiation between self and the others, as well as between attachment figures in multiple relationships. This development leads the adolescent to review his/her attachment with the parents and to recognize their positive and negative aspects (Allen & Land, 2008). Thus, as in the classical Oedipus complex and object relational configurations, adolescence might be a repetition of the old patterns in terms of attachment as well as a window of opportunity to reflect upon and transform them.

1.2.Psyches of Adolescents

1.2.1. Affect in Adolescence

A critical aspect in the evaluation of personality in the adolescence phase is the affect regulation (Hauser & Schmidt, 1991). Many healthy adolescents go through various range of affects and develop the ability during later stages of

adolescence to modulate emotional states. On the other hand, many distressed young people demonstrate problems in their ability to live, understand and regulate other's emotional states (Ammaniti, Fontana, & Nicolais, 2015).

Aggression in the raw form is a typical feature of adolescence (Blos, 1967). While the adolescents are going through the detachment from the primary objects, an item of early object relations emerges as ambivalence (Blos, 1967). In the framing of an adolescent, it is visible how the instinctual drives are defused. Thus aggression manifests in general during the adolescence (Blos, 1967).

It is stated by Sagan (1954) and later echoed by Parman (2003), that adolescence period means sorrow. It is the sorrow of what is lost and what will never come back again. Some of the before mentioned losses entail childhood, bisexuality and the loss of intense relationship with the parents. Therefore, this period is a type of mourning process. The adolescent body has physically changed and the bisexual period has ended. Also the intense, almost symbiotic relationship with the mother should be let go, as well as the childhood objects, which leads to a process of exploring new objects (Parman, 2003). This is why the dominant sentiment of this period is one of sorrow and the process itself is one of mourning (Parman, 2003).

Other affects that are observed during the adolescent period are guilt and shame. Shame is initially mentioned in the psychoanalytic literature in reference to the adolescence period (Parman, 2003). Guilt is a product of the super ego and shame is a product of the ego ideal. While there is no individual responsibility in shame, there is the violation of a moral law depending on the individual's will (Parman, 2003). The passing from shame to guilt happens through passing from the ideas of contamination and spoiling to moral flaw and offense consciousness (Parman, 2003). Shame can be manifested in the narcissistic context, while on the other hand guilt maintains the view from another person and the wrongness of the existence of an action or a thought. In addition to the self-worth, guilt makes a reference to the self-identity. During the adolescence, the rephrasing of the super ego and the ego ideal result in self confusion, aggression, narcissism and hopelessness (Parman, 2003).

Also Kaufman (1989) indicated that shame is an underlying reason for syndromes that are commonly seen during adolescence such as eating disorders, impulsivity and depression, identity confusion, and acting out (Kaufman, 1989). These triggers might also come in the form of physical changes which can happen out of the adolescent's control and also in a short period of time (Anastasopoulos, 1997). The increase in the sexual drive during this period also brings an anxiety along with itself, one in which the adolescent both wishes to display, while feeling unsure of doing so due to inadequacy, which again triggers shame (Anastasopoulos, 1997). Lastly, the adolescent's boosted self, accompanied by a sense of weakness and identity confusion might be the cause for feelings of shame (Anastasopoulos, 1997).

1.2.2. Defense Mechanisms in Adolescence

Sigmund Freud identified the term *defense* in his 1894 publication titled "The Neuro-Psychoses of Defense," and associated psychopathology with utilization of certain defensive mechanisms. Following Freud's introduction of the defense notion, Anna Freud detailed the defense mechanisms and provided classifications for these mechanisms. Regarding the trigger of defense mechanisms, in addition to the *instinctual anxiety* and *superego anxiety* identified by Freud, she added *objective anxiety* that is aroused by the real external world (A. Freud, 1936). Contributions of ego psychology to the notion of defense also include the association of defense mechanisms not only with psychopathology, but also with healthy, adaptive functioning (Gerö, 1951; Hartmann, Kris, & Loewenstein, 1946).

While the classical point of view stressed that the defenses are an intra-psychic process and have a role in decreasing the level of tension which is caused by the id, the relational perspective elaborates the use of defense mechanism as in the relational context. Based on this perspective, the mechanisms protect the individual from the external world, or the individual protects him/herself against the negative emotions caused by the external world, or from the feared social

consequence of a desire through relational means and the individual controls the relationship along with the self (Stolorow & Lachmann, 1980, as cited in Cavdar & Fisek, 2017). In other words, the genuine relationship is considered as a part of the defense description (Cavdar & Fisek, 2017).

In general, defense mechanisms are seen as unconscious reactions to internal and external conflict or triggers (Perry et al., 1998; Perry, 2014). Thus, they cause a broad range of emotional phenomena both in an adaptive and a pathological way (Perry, 2014). As the adolescence period is a conflictual period due to the psychical changes, it is important to understand the dynamics of the defense mechanisms.

As outlined above in the previous sections, adolescence is seen an important period since the oedipal conflicts have been reactivated and reprocessed within this period. Bronstein and Flanders (1998) indicated that those who cannot integrate the earlier splitting ego, or in other words, those who cannot reach depressive position and struggle the paranoid–schizoid position in Kleinian terms might experience a collapse in the adolescence (Bronstein & Flanders, 1998). Those adolescents who have not integrated the early split ego parts use extreme projective identification, which drives the adolescent's terror of being like the same sex parent and the adolescent's inability of maintaining a sense of self (Bronstein & Flanders, 1998). This might be endorsing the denial of own gender identity or attacking the body. Also, this might trigger delusional fantasies of being attacked by others too (Bronstein &Flanders, 1998). Early splitting defenses may also cause a kind of a manic denial of the reality and support a fantasy of idealization which might have magical solutions to his/her problems (Bronstein & Flanders, 1998). This can also be seen in the transference dynamic in the therapeutic situation.

Additionally, it may be assumed that the adolescent's defense mechanisms are activated against the incestuous fantasies of the oedipal period (Spiegel, 1951). The significant amounts libido that is directed to object, is shifted to narcissistic libido and to the sense of loneliness, which takes place when the adolescent moves apart from the infancy objects (Spiegel, 1951).

However, the defense mechanisms which are useful in childhood are no longer sufficient and they lose their power in adolescence. Josselyn (1971) describes it with an analogy of "as if a person must take off all his clothes before he dressed in a new grab, he must change from the skin out" (p. 21). He claimed that in the process of re-dressing, the adolescent goes through different processes such as sometimes changing only part of his/her dresses, sometimes deciding not change the clothes of the past by believing that they are sufficient, and, sometimes re-dressing under the covering of the outside appearances of the old, for defensive purposes (Josselyn, 1971).

This re-dressing process is mostly not understood by the grown-ups. While the adolescent is re-dressing, his/her internal conflicts are visible during periods of nakedness (Josselyn, 1971). Although the adolescence period is seen as regression by some analysts (e.g. Geleered, 1961), Josselyn (1971) believed that this is an effort to find a new way of mastery, not a getaway from a new conflict.

As the adolescent is not having childhood defenses and adjustments, s/he wants to determine what kind of a person s/he currently is; not just who s/he will become in the future (Josselyn, 1971). This process is similar to the separation-individuation process that s/he encountered during about the age of two years (Mahler, 1972). Thus, to create a new identity, he uses similar instruments that he used when s/he was a toddler (Blos, 1967). However, using the same techniques when s/he had used before cannot be described as a regression (Josselyn, 1971).

The perceived imbalance for the adolescents is not a simple indecision but rather it is a cause of intense experiencing style. They experience their feelings in an extreme intense way (Josselyn, 1971). Thus, whatever they found meaningful they respond to it with a huge intensity (Josselyn, 1971). For instance, if they like being lonely, then they become a loner. This intense responsiveness to the stimuli can easily be changed in time when a new stimulus comes into their attention (Josselyn, 1971).

Also, Anna Freud (1966) indicated that the adolescents regularly behave at the extremes, by noting that "…they make the most passionate love relations, only to break them off as abruptly as they began them. They may be inconsiderate, but

can also be touchy. They can be lightheartedly optimistic, but very pessimistic…" (p.103). Based on Anna Freud's description, it can be noted that the adolescent responds to each stimulus with complete emotionality or with total repression (Josselyn, 1971).

Josselyn (1971) indicated that the adolescent's suppression of his/her emotions is usually misinterpreted. When adolescents are suppressing their emotions, they are in fact denying their needs and desires and their defense of such a behavior is very apparent. Josselyn assumes that when aggressive adolescents acting in suppressive ways, they are mostly disguising their true desires to be accepted by others and of being cared (Josselyn, 1971).

The ego of the adolescent constructs a defense of hiding the emotions that he/she feels to his/her parents, and thereby showing the opposite of what he/she truly feels (A. Freud, 1958). The resulting aggressiveness that is shown to the parents is initially a defense against object love; but these are later felt too unbearable to the ego and are moved away in their own right (A. Freud, 1958). One way this phenomenon takes place is through projection; whereby the aforementioned aggressive feelings are attributed to the parents, who the adolescent perceives as oppressors. In Anna Freud's (1958) clinical situation, the aggression is first observed as the doubtfulness of the adolescent and after, with the increase of projections, it appears as paranoia (A. Freud, 1958).

Another way this phenomenon takes place is when the aggression turns against the self instead of to the external objects (A. Freud, 1958). During these occasions the internally directed aggression leads to depression and tendencies of inflicting self-harm, escalating towards suicidal inclinations in some cases (A. Freud, 1958).

In addition to all the above mentioned defenses, acting out is the most typical adolescent defense mechanism (Blos, 1963). According to Blos, acting out works in support of regulating anxiety, which guards the psychic structure in opposition to conflictual tension; whereby such a conflict can be seen between the external world and the ego. In addition to that, acting out that works in favor of

the ego, that protects the psychic mechanism against tension, causing from structural inadequacy or breakdown.

1.2.3. Object Relations in Adolescence

Another crucial aspect of the psychic world of the adolescent could be reflected upon via the quality of its object relations. In psychoanalytic theory, object relations refer to the mental representations of the early relationships with others. These self and object representations form specific configurations and guide future behavior.

According to Mahler's (1972) separation individuation process, as the infant passes through the autistic shell period which is objectless and the symbiotic phase which is a pre-object period, the internal object relations are formed as the infant is able to differentiate self and the other object. It is indicated by Blos (1967) that adolescence period is a reanimation of the separation individuation process, and in order to develop new object relations, the adolescent has to isolate him/herself from the primary object relations (Blos, 1967). Hence, a sense of loneliness prevails as the adolescent moves away from the infancy objects (Spiegel, 1951), and the boundary between the self and the object for the adolescent gets blurrier and more permeable compared to latency and adulthood periods. Furthermore, when the separate existence of the self is the case, as the subjective omnipotence is broken the internal world is dominated by merged versus rejecting or unattainable object images and omnipotent dual unity versus totally weak self images.

On the other hand, adolescence is also an opportunity for change in terms of the self-object configurations. As the turmoil of adolescence prevails, both the boundary between self and object and integration of good and bad aspects of the representations, once again, becomes an issue of concern. From the Kleinian perspective, this period can be considered as the regressions to the paranoid schizoid position, in which the good and the bad are split from each other and the self and the object are merged (Klein ,1958).

During the adolescence period, the individual tries to move away from the internal objects, because s/he experiences dependency and the object necessity as a narcissistic threat, and perceives the feeling of dependency as submission (Spiegel, 1951). The fear of dependency is an important aspect that is more dangerous than hatred; because hatred makes maintaining the boundaries easier for the individual and allows him/herself to impose the independency (Spiegel, 1951). However, the object relations may challenge the narcissistic balance of the adolescent. Therefore, the adolescent reduces his/her relationship with the object and turns towards himself/herself. The adolescent withdraws a significant amount of libido that is directed to object to self as narcissistic libido (Spiegel, 1951).

1.2.4. Psychopathology in Adolescence

Adolescence period is seen like a borderline state in terms of the characteristics it displays. As mentioned in the previous sections, the adolescent struggles in the separation-individualization process (Brown, 1993). A crisis can occur such as when the adolescent wishes to become an independent adult, while simultaneously having a desire to continue dependency with his/her parents. Because of this struggle, some borderline functioning is observed in the adolescent psyche (Brown, 1993).

Kernberg's (1975) description of the borderline organization and the description of adolescence's features have similarities. Kernberg, (1967) a contemporary psychoanalyst, has worked on borderline personality extensively and provides a model based on borderline personality disorders. His belief is that it is critical to understand the psychological structures that lies underneath the personality disorders. Thus according to him, the borderline level of organization has the following features: *a) non specific manifestations of ego weakness (poor affect tolerance, impulse control, subliminatory capacity); b) primitive defenses, including splitting; c) identity diffusion; d) intact reality testing but a propensity to shift toward dreamlike thinking, and; e) pathological internalized object*

relationship (Kernberg, 1967, p. 648). These features can be detected in the adolescents.

Still, it cannot be argued that the adolescent psyche has a borderline functioning solely based on these features that form the borderline level of organization. Instead, adolescence could be considered as a period where any absence in the capacity for separation-individualization could come up (Brown, 1993). Obviously, there are some adolescents who have borderline personality organizations, but their internal chaos is long-lasting and they cannot have stable relationships (Brown, 1993).

Laufer and Laufer (1984) suggests that the adulthood psychopathology is rooted in a breakdown experienced in the adolescent period. According to Laufer and Laufer (1984), the breakdown is the adolescent's denial of the sexually active new body and the physical changes in his/her body. The breakdown is seen as a defense mechanism that is the denial of the reality, and the introjection of this causes serious adult psychopathologies. In general, Laufer and Laufer (1984) sees adulthood as a developmental process and the stop of this project is called a breakdown, which is creating a psychopathology. The aim of the developmental process in the adolescence is formation of the gender identity in an unchangeable and permanent manner.

According to Barett (2008), adolescence is a period where a specific form of loneliness is experienced which is different from depression, but one that could mistakenly be diagnosed as so. This feeling stems from the object loss caused by the less tight main libidinal object ties. This feeling of loneliness is rooted in the adolescent's yearning to transfer love to new adult relationships from that primary object, and yet such relationships are not present for the adolescent. Therefore, this feeling is not based on the fear of loss of love from the primary object (Barett, 2008).

The adolescent in this situation may be led to extensively immerse him/herself in cigarettes, food, alcohol or internet. Such over indulgences are "orally based regressive attempt to "take in" and "expel out," preserving the felt

"lost" object and converting the loneliness into elation" which can be considered as manic defenses (Barett, 2008, p. 111).

Also, Josselyn (1971) indicated that the common emotional condition for adolescence is depression. This depression might be permanent or temporary; however, when it is a permanent emotional state, then it becomes a sign for intervention. According to the traditional psychoanalytic point of view, depression is aggression turned inwards; in other words, aggression directed to self. However, this dynamic might not fully capture the meaning of depression in the adolescence (Josselyn, 1971).

Several factors are accounted for depression in the adolescence period; such as problems in the separation individuation process (Blos, 1967) and insecure attachment styles (Armsden, McCauley, Greenberg, Burke, & Mitchell, 1990). Problems in the separation-individuation process and problems faced in the formation of a new identity may sometimes cause depressive symptoms on the adolescent (Christenson & Wilson, 1985). As the adolescent moves into an autonomous state, their ties with family grow weaker and other individuals become more important in the adolescent's life, to fulfill their attachment needs. However, the adolescent's capability to mitigate such changes are very much linked with their attachments to the primary caregiver (Milne & Lancaster, 2001). If the adolescent has a deep and insecure attachment with the primary caregiver, separation process will be problematic (Quadrio & Levy, 1988). The research indicated that securely attached individuals have lower levels of stress (Kobak and Sceery, 1988). Also, Armsden, et al. (1990) explored the peer and parent attachment during adolescence. Their studies have shown that adolescents who are suffering from depression have more insecure attachments with their parents, in comparison to the control groups. Furthermore, Milne and Lancaster's (2001) work on female adolescent's depression predictors indicated that adolescent depression could be predicted by the low level of care received from mother, high level of dependency feelings, failing own self expectations and insecure attachment to caregivers.

In his studies Josselyn (1971) revealed different sources of the adolescence depression. The first type of depression in adolescents is the feeling of emptiness and the absence of self-definition; in other words, depersonalization. This type of depression could be perceived as a psychotic state if it were to happen in adulthood. The adolescent suffers from having no feelings; s/he feels emptiness. However, it does not mean that s/he does not have feelings, but rather s/he feels unsure about how to make sense of and elaborate on them as well as what actions s/he should take including how to share these feeling with other people.

As s/he does not know how to handle his/her feelings, it might be preferable to deny them. The resulting feeling of emptiness goes along with some level of anxiety in some cases (Josselyn, 1971). This mood state looks like a grief process. The adolescent has lost his/her part of the self. S/he no longer has her/his childhood identity and at first, s/he has not had an adult personality (Josselyn, 1971).

Meanwhile, the other kind of the adolescent depression is observed in adolescents who repeatedly have experienced defeat according to Josselyn (1971). Such defeats are the results from past experiences that always yield similar outcomes; and despite the individual's efforts they were too strong to overcome. They think they are beaten by life and the simple way to deal with it is by escaping it (Josselyn, 1971). Unfortunately, this group of adolescents are the ones who are most likely to commit suicide, since they experience that they were beaten by life, and committing suicide is a way out from their defeated life (Josselyn, 1971). Combined with the absence or loss of a meaningful close relationship, offsetting the failures faced in life becomes tougher for such adolescents. Researchers who are exploring the antecedents of the adolescent suicide found losing a significant relationship, long term difficulties and escalation of the problems as the main drivers of suicidal behavior (Teicher & Jacobs, 1966).

Additionally, narcissistic vulnerability is one of the aspects at the forefront in adolescence depression (Anastasopoulos, 2007). Adolescents are exposed to internal and external demands, in addition to losing parental security and

developing outward relations (Anastasopoulos, 2007). Also, in this period, the parents are either directly or indirectly, and intentionally or unconsciously are inclined to venerate their children with their own narcissistic expectations, and as a result, push their children to always accomplish more (Anastasopoulos, 2007). Coupled with the internal conflicts and the physical changes, the pressure that the adolescents face from their environment may lead them to experience narcissistic vulnerability, which eventually ends in feelings of depression.

In the depressed adolescent, there is a link between the disorganized self-identity and the early representations of self, which is a critical component in the quality of the ego ideal while it is being shaped (Anastasopoulos, 2007). In line with this, Anthony (1970) classifies two types of adolescent depressions: First, the depression is caused mostly due to the pre-oedipal psychopathology which is a conflict between the ego and the ego ideal and these struggles have vital effects on self-esteem, inadequacy, feelings of shame, weakness and narcissistic object reactions, and dependency (Anthony, 1970). The second type of the depression is rooted in the oedipal phase, in which the guilt and moral issues are linked to punishing the superego and introverted aggression (Anthony, 1970).

In order to have a broader perspective in terms of how adolescents experience depression, Dundon (2006) conducted a meta-analysis which covers six qualitative studies that were published till 2004. The results of this study acknowledged that the adolescents base their depression on a number of stressful life events such as poverty, parental psychopathologies, and problems with peers; which are outlined as the risk factors that cause depression in adolescents.

As a part of broad study named IMPACT, Midgley, Parkinson, Holmes, Stapley, Eatough and Target (2017) have conducted a sub exploratory study, namely; IMPACT-ME, which aimed to explore the underlying mechanisms regarding adolescent depression, who are aged between 11 to 17. The researchers have worked on gaining an understanding from the view of the adolescents themselves, by conducting semi-structured interviews. Their results outlined three themes; whereby the first one was providing meaning to experiences, as this was seen as a critical factor to establish a sense of order and re-create a sense of

identity for the adolescent going through depression. Their second theme, which was on rejection, victimisation and stress which the adolescents attributed for their depression, aligns with Dundon's (2006) meta-analysis. Their third theme meanwhile suggests how adolescents viewed depression as initiated by an internal factor, which leads to self-blaming themselves for being depressed, despite going through a number of stressful experiences.

CHAPTER II

CURRENT STUDY

2.1. Scope of the Current Study

On the basis of the literature presented above, this study aims to explore the internal world of an adolescent by tapping into the subjective experience to better understand the dynamics of adolescence, namely predominant affect, defense, separation-individuation process and other relational aspects. Taking all these aspects of psyche into consideration, it was considered that a long-term psychodynamic psychotherapy relationship is the best setting where conscious and unconscious dynamics could be observed in-depth. Specifically, because a long term therapeutic relationship provides a deep emotional bond that activates strong affect, thus defenses, as well as unresolved relational issues.

Instead of analyzing multiple cases, the single case designs or in other words, intra-subject designs, allow us to figure out what is happening in the psychotherapy process. Although single case designs are not powerful in terms of predicting causal relationship and generalizability, it has several benefits of deducing numerous observations from the same client (Pole & Jones, 1998). Thus, with time-series analysis, it is possible to provide a causal association between observations representing one group of variables and observations of another group of variables (Kivlighan, Multon & Patton, 2000). Hence, single-case process analysis allows us to show the degree of change in the client's affect and used defense mechanisms, as well as showing when that variation happened relative to changes in here and now variables.

Several dynamics were chosen to reach this aim, which are psychosexual theme, affect, defense and relationship. Predominant *psychosexual theme* of the session was planned to be examined since the classical psychoanalytic literature focuses on the re-activation of unresolved dynamic from oral, anal, and especially

oedipal phases of psychosexual development. The *affect* of the adolescent was selected as another dimension of observation, since the affective processes in adolescence shed light on the subjective experience. Additionally, as the literature suggests that adolescents tend to hide their feelings (Josselyn, 1971), probably even from themselves, this study will include both the manifest and hidden forms of affect. Again, on the basis of literature aggression, fear, envy, guilt, shame and sadness were selected as the affects to be observed and noted. Next main focus of in-depth investigation is the *defenses*, both in terms of intensity and mechanism. To identify the use of defense mechanism projection, acting out, denial, splitting, and dissociation were selected, since literature indicates a predominance of these mechanisms during adolescence. Further, in order to capture immediate and relational nature of defense that is not covered by the intrapsychic mechanisms, here-and-now defensiveness of the client was also included in observations. The last aspect to be considered in this study is the relationship. Especially based on Mahler's (1972) perspective, separation-individuation is a crucial aspect to be investigated, since it is expected to be relationally re-enacted. Further, in order to obtain a clearer picture of the relational context in which separation-individuation dynamic will be revealed, transference, countertransference and alliance are included as further areas of observation.

Further, since adolescence is defined as a period of sudden shifts and fast change, this study adopted a process approach. Instead of a cross-sectional method, all aspects listed above will be longitudinally observed and documented over the entire period of psychotherapy.

As this study is the first study to examine an adolescent's subjective experiences in-depth within a relational context, it is designed as a descriptive study. A specific hypothesis was not formulated prior to the work. The aim of this study is to systematically study and describe certain characteristics of an adolescent's psyche as they unfold in a deep relationship.

2.2. Method

2.2.1. Data

The data of this study is comprised of 43 fully transcribed sessions of a psychodynamic psychotherapy with a 17-year-old female adolescent in Turkey. The sessions were audio recorded with the permission of the client and her parents, to be utilized for research purposes. The sessions were recorded for an ongoing research project in the Istanbul Bilgi University Psychological Counseling Center. The data was shared by the author with the consent of the primary researcher and the second advisor of the thesis.

Client. Ms. H was a 17 years old female client who started psychotherapy with the complaints of depressive symptoms, visual hallucinations, and a desire to quit school. She had enuresis until she was 8 years old and she was putting on diapers on herself. In addition to her depressive symptoms, she only occasionally had fantasies of committing suicide. Her visual hallucinations are seldom observed, but none occurred in therapy. In addition to the psychodynamic psychotherapy sessions, she had been seeing the psychiatrist of the same Center. She was diagnosed with major depression, and prescribed with anti-depressants.

She lost her mother's mother when she was 9 years old. During this period, she was left alone at home, as everyone else in the family left home to go to their village. As a 9-year-old, she struggled while being alone at home, and was able to receive help from the neighbors sometimes. Her complaints started after her grandfather died when she was 14 years old, and later her mother moved to the grandmother's house for the duration of that summer. During this period, she stayed with her father and brother. Still, she was left alone at home again during the first week of mourning after grandfather's death.

She came from a religious family with a low socio-economic background. She lives with her mother, father, and younger brother. Her mother and father sells vegetables in the local bazaar and her brother works as an assistant in a firm.

During the psychotherapy sessions, she covered her head with headscarf, and later opened her head again.

Her relationship with her mother during the psychotherapy process is like a symbiotic relationship. Instead of going to school, she rather prefers to stay at home near her mother. When she was a child, she acted like a mother to her mother. Her relationship with her father is based on fear. She kept away from her father and was unable to act genuinely near him.

Therapist. The therapist of Ms. H was a clinical psychology trainee at İstanbul Bilgi University, Turkey. She was conducting psychodynamic psychotherapy and was supervised throughout the psychotherapy process. Psychotherapy sessions were finalized as the therapist's internship period ended.

Sessions. There are 43 sessions in this study. The first two sessions were omitted based on how the content of the sessions were structured and reported as intake sessions by the therapist. The session number 6 was not included in this study since they are family sessions. The last session is also not included in this study since it is a structured termination session. There are two missing records in this study due to the technical problems of the audio record. Thus, the total number of 43 sessions were analyzed in this study. The process was forcedly terminated due to therapist permanently moving to another country.

2.2.2 Instruments

The variables in this study were formed under 4 main categories which are Affect, Psychosexual Theme, Defense (defense mechanisms and here-and-now defensiveness) and Therapeutic Relationship (level of separation between the therapist and the client, therapeutic alliance, transference and countertransference). These variables were observed and rated by trained raters using a coding manual prepared by the researcher (see Appendix A). The details of the training and coding process are explained in the Procedure section. The definition and the properties of each variable were presented below.

Affect. In order to depict the affect of the client, aggression, fear, envy, guilt, shame and sadness were selected and the coding system was created on the basis of The Analytic Process Scale Coding Manual (Scharf, Waldron, Firestein, Goldberger & Burton, 2010) and clinical observations. Each affect was evaluated with regards to the intensity of the feeling observed or sensed by clinical intuition during the session. Highest score (4) indicates strong degree of the mentioned feeling; whereas lower score (0) indicates no such feelings being observed in the session. In addition to the score of intensity, for each affect, raters were asked to note down whether the affect was Manifest or Hidden. When the client explicitly displays and/or talks about a certain affect, they mark it as “Manifest”. When the client does not directly display or verbalize the affect (due to defensive omission or distortion), but the existence of the affect is strongly sensed by clinical intuition, they marked it as “Hidden.” The inter rater agreement of the pilot data is .71.

The scoring system detailed below has been directly adopted from Scharf et al. (2000, p. 5-30).

AGGRESSION: Client speaks about, manifests or show indications of assertive, aggressive, hostile feelings, fantasies, activities, or memories. Following themes will be included: aggressive, competitive, angry, attack, assault, hostility, derogation, criticism, meanness, opposition.

Score 0: In cases where no hostile feelings or actions are displayed or mentioned by the client.

Score 2: In cases where the client mentions or displays a moderate degree of assertive, aggressive or hostile feelings or actions. The client should be moderately emotionally involved in aggressive expressions or actions.

Score 4: In cases where a strong degree of assertive and hostile feelings or actions are mentioned or displayed by the client. The client should be strongly emotionally involved in aggressive expressions or actions.

FEAR: Client perceives a threat to personal well-being. The perceived threat being either a feeling, fantasy or memory of the client. Fear, dread, horror, terror themes will be included.

Score 0: Instances where nothing about fear, dread, horror or terror feelings, fantasies or memories are displayed or mentioned by the client.

Score 2: Instances where the client mentions or displays about moderate degree of fear, dread, horror or terror feelings, fantasies or memories. The client should be moderately emotionally involved in fear related expressions or actions.

Score 4: Instances where a strong degree of fear, dread, horror or terror feelings, fantasies or memories are displayed or mentioned by the client. The client should be strongly emotionally involved in fear related expressions or actions strongly.

ENVY: Client speaks about or displays negative feelings towards something desirable and yet unattainable to her/him, often having desires to take away or spoil others possessions. Following themes will be included: destroying the good, devaluing the good, grudge, devouring the other off something, ill will, malice.

Score 0: Situations where feelings or memories of envy are not displayed or mentioned at all by the client.

Score 2: Situations where the client mentions or displays a moderate degree of feelings or memories of envy. The client should be moderately emotionally involved in envy expressions or actions.

Score 4: Situations where a strong degree of feelings or memories of envy are mentioned or displayed by the client. The client should be strongly emotionally involved in envy expressions or actions.

GUILT: Client speaks about or manifests guilt over a real or fantasied, past or present action. Following themes will be included: right, wrong, crime, fault, being punished or abused, responsibility, sin, immoral, deserving the bad.

Score 0: In cases where the client does not display or make reference to anything about feelings or memories of guilt.

Score 2: In cases where a moderate degree of feelings or memories of guilt are mentioned or displayed by the client. The client should be reasonably emotionally involved in guilt expressions or actions.

Score 4: In cases where the client mentions or displays a strong degree of feelings or memories of guilt. The client should be strongly emotionally involved in guilt expressions or actions.

SHAME: Client speaks about or manifests shame over the perception or treatment of self, by him/herself or others. Defective self, flawed self, humiliation, degradation, embarrassment, ridicule, disgrace, fantasies of disappearing will be included.

Score 0: Instances where nothing about feelings or memories of shame are mentioned or displayed by the client.

Score 2: Instances where the client mentions or displays a moderate degree of feelings or memories of shame. The client should be moderately emotionally involved in shame expressions or actions sensibly.

Score 4: Instances where the client mentions or displays a strong degree of feelings or memories of shame. The client should be strongly emotionally involved in shame expressions or actions.

SADNESS: Clients speaks about or manifests emotional pain. Following themes will be included: feelings of loss, despair, grief, crying, sorrow.

Score 0: Situations where no display or mention of feelings or memories of sadness come from the client.

Score 2: Situations where the client mentions or displays a moderate degree of feelings or memories of sadness. The client should be reasonably emotionally involved in sad associated expressions or actions.

Score 4: Situations where a strong degree of feelings or memories are displayed or mentioned by the client. The client should be strongly emotionally involved in sad associated expressions or actions.

Following the definition and scoring of each affect, the manual includes the following instruction:

Further mark as,

Manifest: predominantly explicit during the session

Hidden: predominantly implicit during the session; sensed by clinical intuition

Psychosexual theme. In order to identify the predominant psychosexual theme, raters were asked to evaluate each session in terms of psychosexual stages –oral, anal and oedipal- and select the one that best describes the issues discussed in the session. In order to identify the keywords for each theme, Kulosh and Mayman's (1993 p. 293) psychosexual theme descriptions, presented below, were used to operationalize psychosexual stages.

ORAL: Client specifically speaks about oral issues; suck in, eat, binge, swallow, take in, absorb, drink, gulp, wash dawn, consume, ingest, devour, soak up, bite, purge, chew.

ANAL: Client particularly speaks about anal issues; hold, keep, tight, rigid, order, clean, stubborn, solid, resolute, intractable, tenacity, obstinacy, discharge, evict, mess, dirt, annul, force out, drive out, explode, garbage, debris, shit.

OEDIPAL: Client specifically speaks about oedipal issues; genitals, castration, jealousy, comparison, fear of punishment, genital intercourse, gender-based comparisons, penis envy, and pregnancy.

Defense. Two measures regarding defense was used. The first one, Here-and-Now Defensiveness captures the intensity of the defensiveness at the here-and-now, regardless of the specific aim and effort involved. The second measure, Defense Mechanisms Rating Scale is employed to be able to depict what types of mechanisms were operating.

Here-and-Now Defensiveness was measured using a coding system developed by Cavdar and Fisek (2017**.** This measure allows for all verbal or nonverbal behavior of the client to be rated on a scale, given that it indicates defensiveness at the here-and-now. The scale was designed as a 5-point scale. As suggested by the authors of the code, raters were asked to focus on the here and now, and ignore the accounts of past behaviors of the client.

The scoring system presented below has been directly adopted from Cavdar (2014, p. 136-139).

Score 0: Not defensive at all

The client is not currently defensive. Talks and acts freely or just gives an account or answers a question. The content of the speech may include accounts of defenses, but the client is not currently defensive.

Score 1: Slightly defensive

The client is slightly defensive at the here & now. However, she has partial awareness of herself being defensive and/or there is something else going on, although she cannot acknowledge it.

Score 2: Moderately Defensive

The client is moderately defensive at the here & now. There is little or no awareness of herself being defensive and/or there is something else going on. Her efforts and responses are more resistant to becoming conscious.

Score 3: Very Defensive

The client is very defensive at the here & now. There is no awareness of herself being defensive and/or there is something else going on. Her efforts and responses are more rigid and resistant to becoming conscious.

Score 4: Extremely defensive

The client's defensive efforts distort the perception of reality and/or her relationship with the analyst. There is no awareness. Her efforts and responses are extremely rigid and resistant to becoming conscious.

Defense mechanisms were assessed using The Defense Mechanism Rating Scale (DMRS; Perry, 1990). It is an observer rated scale that assesses 27 defense

mechanisms. There are both quantitative and qualitative scoring methods in the scale. In the quantitative method, the raters were asked to record the number of times each defense is used and then each defense is weighted according to their level in an overall hierarchy of defenses. On the other hand, in the qualitative method of scoring, raters were asked to assess each defense mechanism on a three-point scale where 0 refers to not using, 1 refers to probably using and 2 refers to definitely using the defense. For to the purposes of the study, only 5 defense mechanisms that are projection, acting out, denial, splitting, and dissociation were assessed. The qualitative scoring method was used. The descriptions and the related themes are explained in the coding guide (Appendix A).

Therapeutic relationship. This section was composed of 4 aspects that are; the level of separation between the therapist and the client, therapeutic alliance, transference and countertransference variables.

Separation. This measure is developed for the purposes of this study to be able to depict the level of separation between the client and the therapist. It is designed as a 5-point observer rating scale. The scale is prepared to ordinally represent the developmental phases as symbiosis (Score 0), hatching (Score 1), practicing (Score 2), rapprochement crisis (Score 3) and finally object constancy (Score 4). The measure was used with a pilot session, prior to its inclusion in the study; and the inter-rater agreement was found to be .60.

The descriptions and the coding criteria are as follows:

Score 0: Symbiosis

The client and the therapist are in a complete merger experience; the boundaries are non-existing. There is an uncertainty regarding what belongs to the client's psyche and therapist's psyche.

Score 1: Hatching

The client and the therapist are aware of their separateness. The client demonstrates autonomy, yet checks back with the therapist frequently for safety / soothing and sense of power.

Score 2: Practicing

The client and the therapist maintain separateness, with clear boundaries. On the other hand, momentary merger is still possible, in cases of need. The client can explore independently, but still derives safety and power from the experience of being with the therapist.

Score 3: Rapprochement Crisis

There is a painful awareness of separateness. The client is aware of his/her limits and his/her need for the therapist. There are back-and-forth experiences between total independence & denial of the need and increased need for the therapist. Illusion of self-sufficiency alternating with extreme dependence, temper-tantrum like states may characterize this score.

Score 4: Object Constancy

There is a healthy, balanced, flexible separation-individuation. The client can function autonomously, and when in need, can comfortably refer to the internalized object as well as the external therapist

Working Alliance Inventory Observer Form. Working Alliance Inventory Observer Form (WAI-O) short version was developed by Wang et al. (2005), based on Raue, Goldfried amd Barkham's (1997) study and adapted to Turkish by Soygut and Uluc (2009). The short version of WAI-O includes three sections; namely Bonds, Tasks and Goals, and is composed of 12-items. The tool requires the raters to evaluate the therapeutic alliance rating each of the 12 items on a 7-point scale ranging from "1 = strongly disagree" to "7 = strongly agree". The Cronbach's alpha of the Turkish version of the scale was 0.90. The the inter rater agreement in this study is .86.

Transference. A two-item transference measure was developed for this research to be used by observers in order to identify the affective tone and intensity of the transferential aspect of the therapeutic relationship. The measure first asks the observer to identify the affective tone of the transference by selecting either "Positive" or "Negative." Then, the intensity of the transference,

as based on the clinical intuition of the observer, is rated by assigning a number between 0 and 4. The rating 0 means that there was no observable transferential experience and the rating 4 refers to a highly intense transference. The measure was used with a pilot session, prior to its inclusion in the study; and the inter-rater agreement was found to be .68.

Countertransference. A two-item counter-transference measure was developed for this research to be used by observers in order to identify the affective tone and intensity of the countertransferential aspect of the therapeutic relationship. The measure first asks the observer to identify the affective tone of the counter-transference by selecting either "Positive" or "Negative." Then, the intensity of the countertransference, as based on the clinical intuition of the observer, is rated by assigning a number between 0 and 4. The rating 0 means that there was no observable countertransferential experience and the rating 4 refers to a highly intense countertransference. The measure was used with a pilot session, prior to its inclusion in the study; and the inter-rater agreement was found to be .65.

2.2.3. Procedure

The raters were 6 psychology students at İstanbul Bilgi Univesity, Turkey. Each raters had an adequate level of knowledge on psychoanalytic theory, with a similar academic and clinical background. They were asked to sign a contract of privacy to protect the shared transcript materials. The raters were divided into 2 groups of 3 raters. One group of raters coded the affect and therapeutic relationship variables, while the other group coded the psychosexual theme and defenses. These groups were trained separately by the researcher and the raters did not have any interactions neither between groups nor among one another.

Each group of raters received a training that was conducted in two sessions. The first meeting aimed to provide an introduction of the variables and coding system. Each variable was defined and examples were presented. By the end of the first training meeting, raters were asked to code one practice session

selected from the public transcripts of a psychoanalytic treatment data. In the second meeting, their questions about the practice data and any major divergences in the codes were discussed. They were assigned another practice session by the end of the second meeting, and inter-rater agreement were calculated based on this practice session.

Following the trainings, the transcripts of the sessions were shared with the raters as password protected soft copies. Once the raters received the transcripts, they were asked to complete the coding sheet for each of the sessions, which were comprised of all sessions and rating variables. The rating process was completed in 2 months.

CHAPTER III

RESULTS

In line with the aim of the study, the trends of change in the affect, the use of defenses and therapeutic relationship variables were investigated. Furthermore, the cross-correlations of affect and defense and therapeutic relationship variables were reported. The data were analyzed using models with time as the predictor.

3.1. Descriptive Findings

The data was checked for inter-rater agreement prior to conducting the analysis. The scores for the variables of each session were determined by taking the mean of the 3 raters; only except the categorical variables which are determined by taking the mode. Ratings were evaluated by the Intraclass Correlation Coefficients (ICC). According to Cicchetti (1994), ICC values less than .40 indicates poor inter rater reliability, while values between .40 and .59 indicates fair, values between .60 and .74 indicates good, and values between .75 and 1.0 corresponds excellent inter rater reliability. According to these cut offs, only the variables that have moderate and high inter rater agreement were used for the following analyses. The variables with low inter-rater agreements, which were namely Hidden Aggression, Hidden Fear, Hidden Envy, Hidden Guilt, Hidden Shame, Projection, Splitting, Denial and Positive Countertransference, were excluded from the analyses.

The descriptive statistics and inter-rater agreement coefficients of the variables are presented in Table 3.1.; showing mean, standard deviation, minimum and maximum values, and the Intra-class Correlation Coefficients (ICC).

Table 3.1

Descriptive Statistics and Inter-Rater Agreements for All Variables

	M	*SD*	*Min*	*Max*	*ICC*
Affect					
Hidden Aggression	2.27	0.64	0.70	3.70	-.10
Manifest Aggression	3.52	0.56	2.00	4.00	.44*
Hidden Fear	1.36	0.77	0.00	3.30	.02
Manifest Fear	3.32	0.86	0.00	4.00	.66*
Hidden Envy	1.59	1.00	0.00	3.70	.22
Manifest Envy	1.25	1.13	0.00	3.30	.48*
Hidden Guilt	1.57	0.87	0.00	3.30	.07
Manifest Guilt	1.45	1.17	0.00	4.00	.49*
Hidden Shame	0.98	0.69	0.00	2.30	-.30
Manifest Shame	1.69	1.37	0.00	4.00	.70*
Hidden Sadness	1.27	1.44	0.00	4.00	.80*
Manifest Sadness	3.56	0.48	2.30	4.00	.35
Defense					
Here & Now Defensiveness	2.78	0.38	1.70	3.70	.41*
Projection	1.89	0.23	1.00	2.00	.34
Acting Out	1.38	0.51	0.30	2.00	.46*
Splitting	1.92	0.20	1.00	2.00	.39
Denial	1.82	0.21	1.30	2.00	-.26
Dissociation	1.01	0.55	0.00	2.00	.50*
Relationship					
Level of Separation	2.16	0.57	1.00	3.00	.77*
Positive Transference	2.64	0.90	0.70	4.00	.43*
Negative Transference	1.02	0.87	0.00	2.70	.46*
Positive Countertransference	1.75	0.78	0.70	4.00	.23
Negative Countertransference	0.14	0.31	0.00	1.30	.47*
Therapeutic Alliance	6.38	0.29	5.00	6.80	.79*

Note. * *ICC* >.40

Based on the descriptive statistics, the affect world of this adolescent is defined by overall high level of manifest aggression (M = 3.52, SD = .56), manifest fear (M = 3.32, SD = .86), and manifest sadness (M = 3.56, SD = .48). In terms of the predominant theme of the sessions, the Oedipal theme is vastly dominant across the whole therapy process, representing 95% of the sessions.

In terms Defensiveness, the client seems to use high level of defences, which is especially observed in the high use of Acting Out (M = 1.38, SD = .51), and moderate level of defensiveness at the here and now (M = 2.78, SD = .38).

Regarding client's relationship with the therapist, high levels of Alliance (M = 6.38, SD = .29), high levels of Positive Transference (M = 2.64, SD = .9), visibly low levels of Negative Transference (M = 1.02, SD = .87) and Countertransference (M = .14, SD = .31) was observed.

The detailed descriptive analysis of the Level of Separation indicated that the client fluctuates between hatching and rapprochement across the whole therapy process. Symbiosis and object constancy were not coded for any of the sessions. For the first phase of the process, 4 of the sessions were marked hatching and 10 as practicing. For the rest of the process, it went back and forth between practicing (18 sessions) and rapprochement (11 sessions).

3.2. Trends of Change in Affect, Defense, Relationship and Theme

The variables that reliably measured affect, defense and relationship were continuous. Thus, the trends of change for these variables were conducted via Time-Series Analysis. In order the test the trends in each variable, a preliminary testing of the cointegration and unit root assumptions was required. The unit root test is a prerequisite for further analysis, as it indicates if the variables in the regression model are indeed stationary or not. This is important, as standard assumptions for asymptotic analysis will not be true if the series can greatly influence its properties, and this takes place when the variables are not stationary. It was understood through the Augmented Dickey-Fuller Test that some variables lack a unit root. This means that some variables are non-stationary.

The t-values and probability values of each variable are shown in Table 3.2.

Table 3.2

Results of Unit Root Tests

	t-Statistic	*Prob.*
Affect		
Manifest Aggression	-5.37	.000
Manifest Guilt	-4.79	.000
Manifest Envy	-4.98	.020
Manifest Fear	-2.96	.047
Manifest Shame	-1.92	.310
Hidden Sadness	-1.87	.343
Defense		
Dissociation	-5.21	.000
Acting Out	-5.68	.000
Here & Now Defensiveness	-7.03	.000
Relationship		
Level of Separation	-2.23	.160
Therapeutic Alliance	-3.52	.012
Negative Countertransference	-7.01	.000
Negative Transference	-4.02	.003
Positive Transference	-6.41	.000

Note. Exogenous: Constant; Lag Length: 1 (Automatic – based on AIC, maxlag = 1)

For each of the reliably measured variables, a time-series model was tested in order to identify significant trends of change. As the data is composed of stationary and non-stationary variables, and given that converting data is not meaningful in terms of the meanings of the non-stationary variables, analyses regarding the change in each variable as the sessions progress were conducted using ARIMA modeling. In order to adjust for multiple testing, Bonferroni

correction was used and the level of significance was set to .003. The results of ARIMA models are summarized in Table 3.3.

Table 3.3

ARIMA Model Parameters

	t	*Sig.*
Affect		
Manifest Aggression	-0.405	0.69
Manifest Fear	-4.636	0.00**
Manifest Envy	-2.543	0.01*
Manifest Guilt	-1.925	0.06
Manifest Shame	-3.457	0.00**
Hidden Sadness	6.59	0.00**
Defense		
Acting Out	0.841	0.41
Dissociation	-3.259	0.00**
Here & Now Defensiveness	2.672	0.01*
Relationship		
Level of Separation	4.812	0.00**
Positive Transference	3.426	0.00**
Negative Transference	-1.044	0.30
Negative Countertransference	-1.897	0.06
Therapeutic Alliance	-0.789	0.43

Note. * $p < .05$, ** $p < .003$

The interpretation of the ARIMA models are presented in the following sections separately for each variable under the main categories of affect, defense and relationship. In order to provide a visual representation of the observed trends, line charts are presented as the measured value for each variable in every session was shown in the y-axis, with the session number being constantly positioned in the x-axis. For the significant results, a trend line was added to the line chart. The theme variable was categorical, thus the change in themes over

time was analyzed via Chi-Square that is presented as the last sub-section of this section.

3.2.1. Trends of Change in Affect

Each affect variable in this study was measured in terms of both hidden and manifest demonstrations. The results indicated that Manifested Fear, Hidden Envy, Manifest Envy, Manifest Shame, Hidden Sadness and Manifest Guilt revealed significant trend analysis.

Particularly for the Manifest Fear, a significant linear relationship was observed, $t = -4.64$, $p < .001$. As seen in Figure 3.1 a trend of slight decrease was noticeable as the sessions progressed. Manifest Fear had been quite high in the beginning of the process. Although highly fluctuating, a slight decrease is observable as the session's progress.

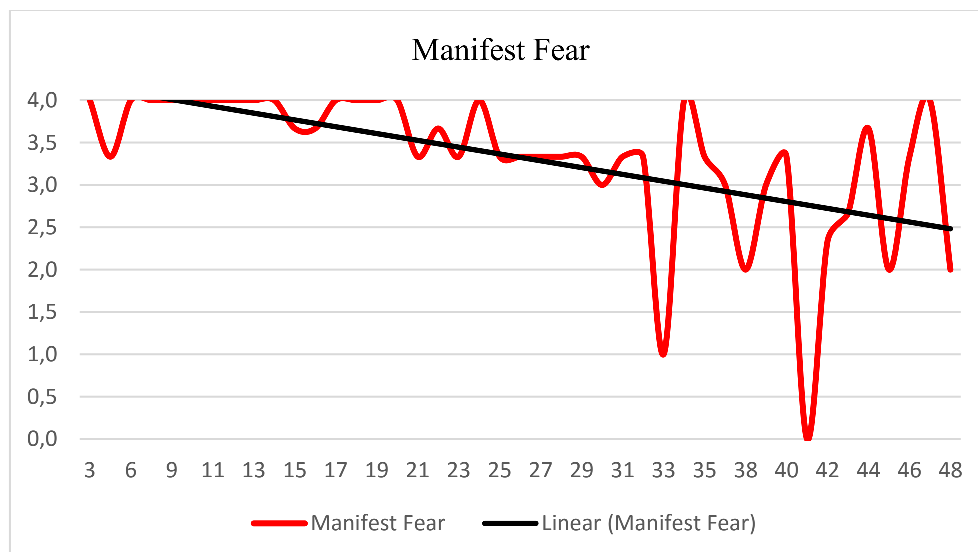

Figure 3.1

The trend of Manifest Envy was observed as seen in the Figure 3.2 with $t = -2.54$, $p < .05$. After adjusting the p-level, this finding was not statistically significant. As seen in Figure 3.2 a trend of slight decrease was noticeable as the sessions progressed.

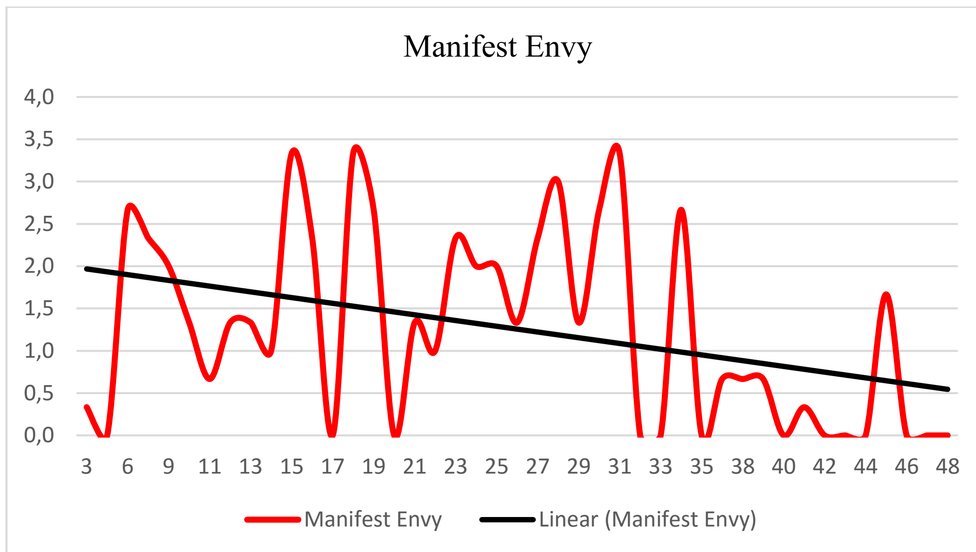

Figure 3.2

For the Manifest Shame, a significant linear trend was observed, t = -3.46, p < *.001*. As seen in Figure 3.3., Manifest Shame was noted as high in most session until the middle of the process. Following a sharp decrease around 27th session, the level as well as the variability of Manifest Shame decreases.

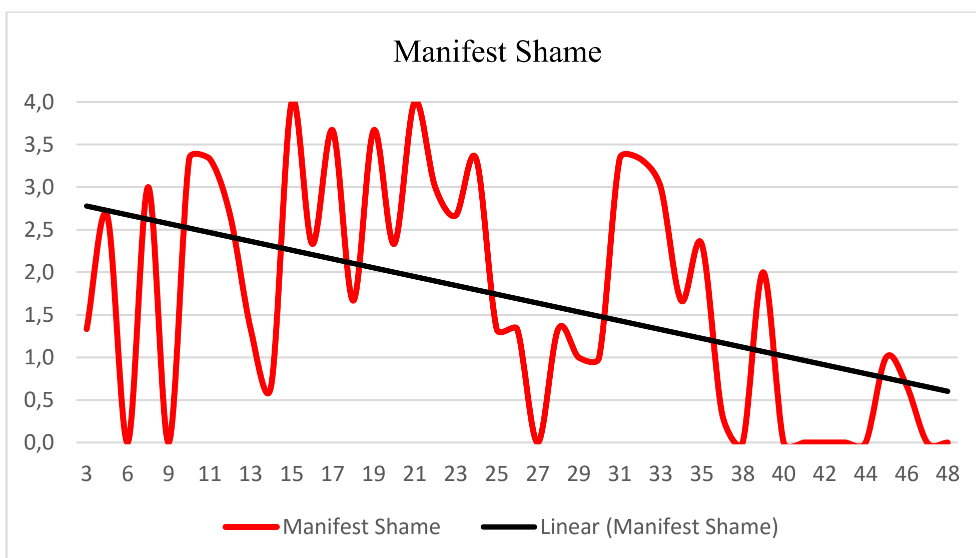

Figure 3.3

Regarding Hidden Sadness, a significant linear trend was observed, t = 6.59, p < *.001*. As seen in Figure 3.4., Hidden Sadness was initially not observed, however after 21st session a trend of sharp increase is noteworthy.

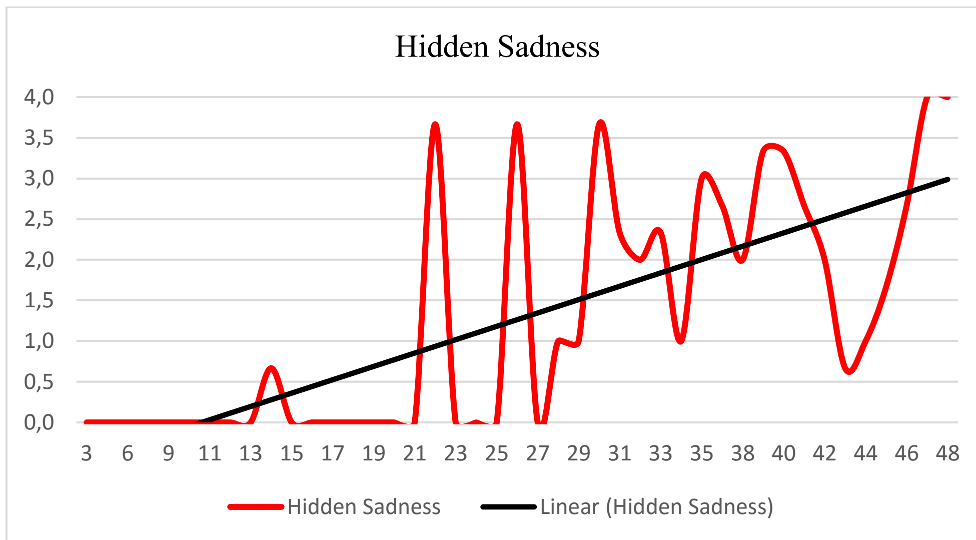

Figure 3.4.

As listed above, significant decreases in Manifest Fear, Manifest Shame and Manifest Envy; and a significant increase in Hidden Sadness were observed. On the other hand, Manifest Guilt (See Figure 3.5) and Manifest Aggression (See Figure 3.6) did not demonstrate any significant trends over time. The charts for each variable are presented below for exploratory purposes. Manifest Aggression of the client were high throughout the sessions. Manifest Guilt was constantly fluctuating with a decreased variance as the end of the process approached.

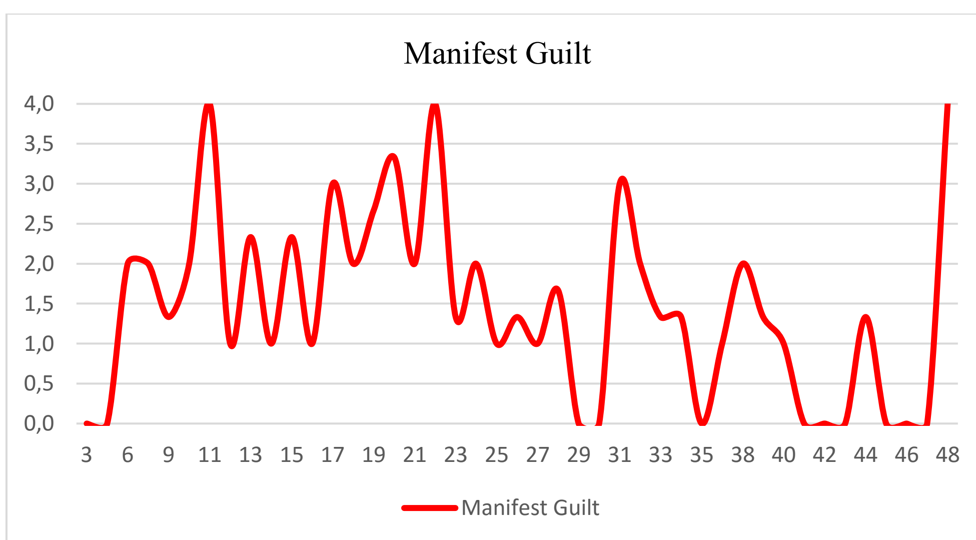

Figure 3.5

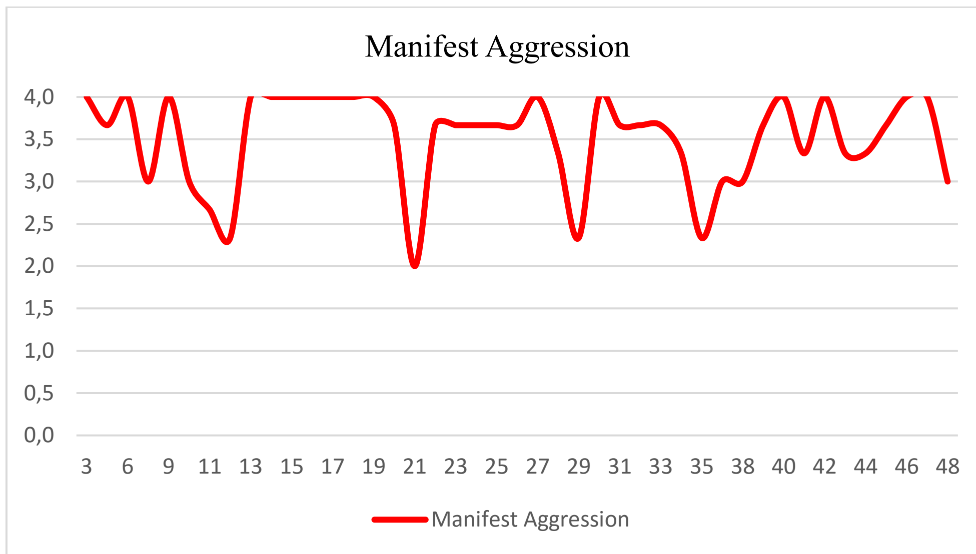

Figure 3. 6

3.2.2. Trends of Change in Defense

Here and Now defensiveness was observed in the Figure 3.7 with t = 2.67 $p < .05$. After adjusting the p-level, this finding was not statistically significant. As seen in Figure 3.7 the trend fluctuates within very limited boundaries.

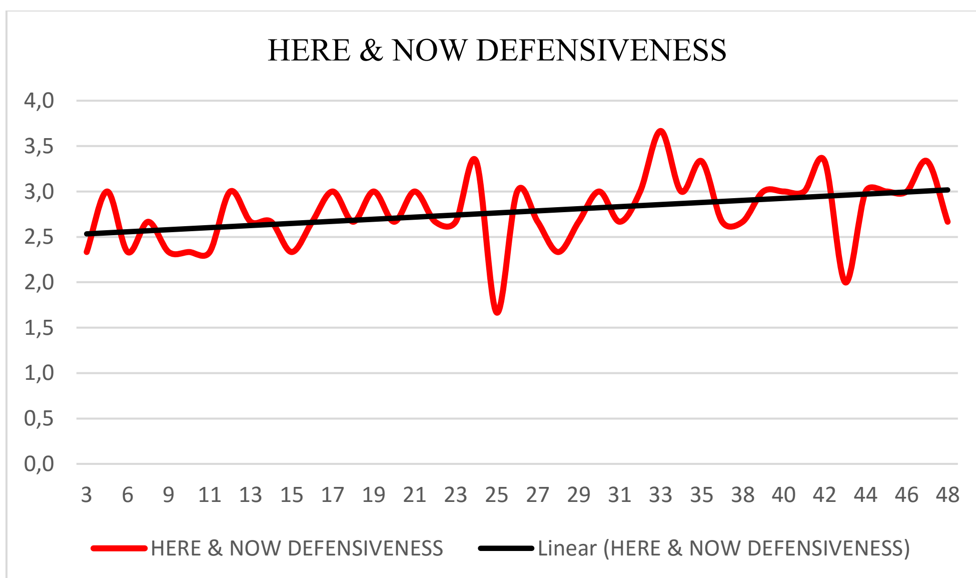

Figure 3.7

For Dissociation defense mechanism, a significant linear trend was observed, $t = -3.26$, $p < .001$. As seen in Figure 3.8 a trend of slight decrease was noticeable as the sessions progressed. Yet, the variation Dissociation seems to be too high to be explained by a linear trend.

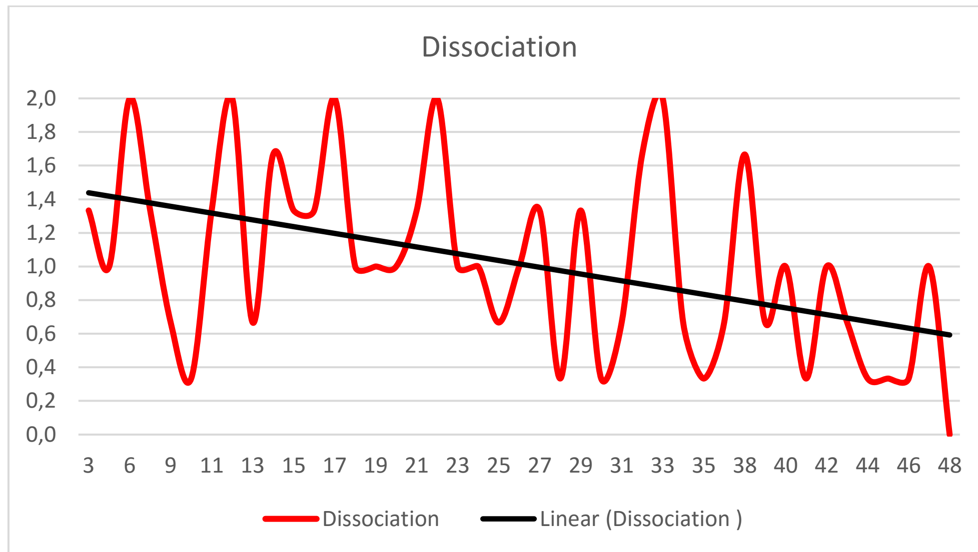

Figure 3.8

For Acting out defense mechanism the model was not significant, $t = .84$, $p > .05$. As seen in Figure 3.9. Acting-out varied throughout the process, with a slight decrease between sessions 20 to 29.

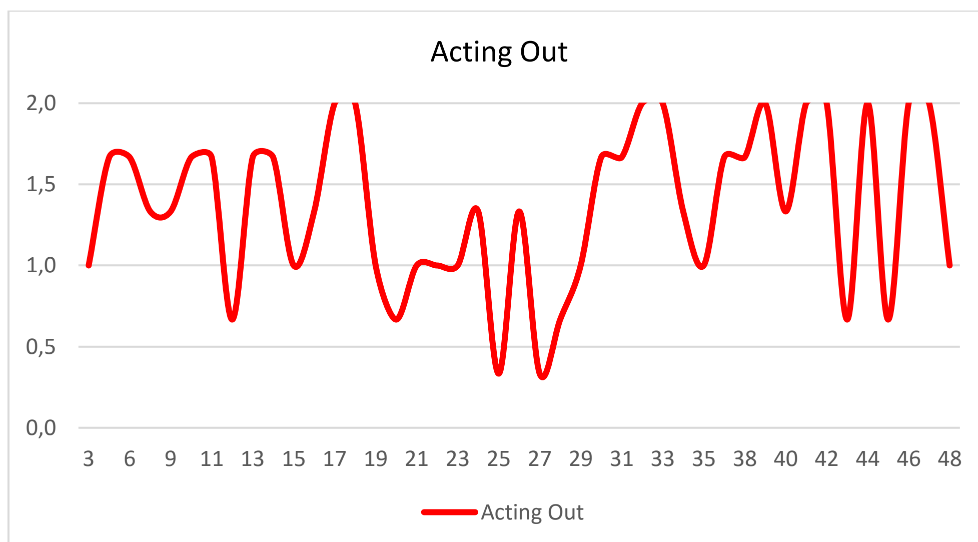

Figure 3.9

3.2.3. Trends of Change in Therapeutic Relationship

For Positive Transference variable, a significant linear trend was observed, $t = 3.42$, $p < .01$. As seen in Figure 3.10 this trend is increased at the second half of the process, Positive Transference ratings did not go below 2 over 4 in any of the sessions.

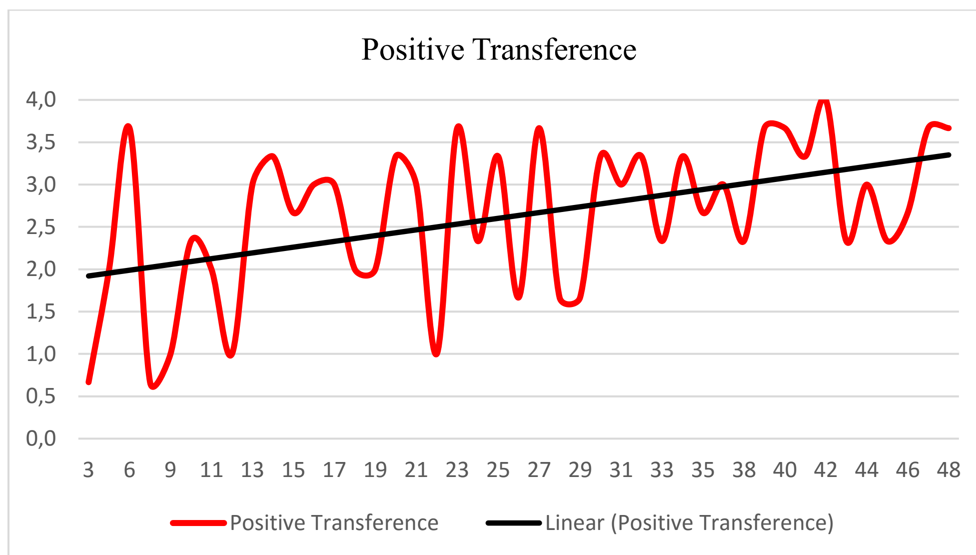

Figure 3.10

For Negative Transference variable ARIMA models did not detect a significant trend over time, $t = -1.04$, $p < .01$. However, as observed in Figure 3.11. Negative Transference demonstrated a quadratic trend that could not have been detected by ARIMA modelling. However, when the quadratic model was tested, it was found to be significant, $t = -3.22$, $p<.05$. Negative transference initially decreased and then increased. The turning point is almost exactly the middle of the process, sessions 24 to 26.

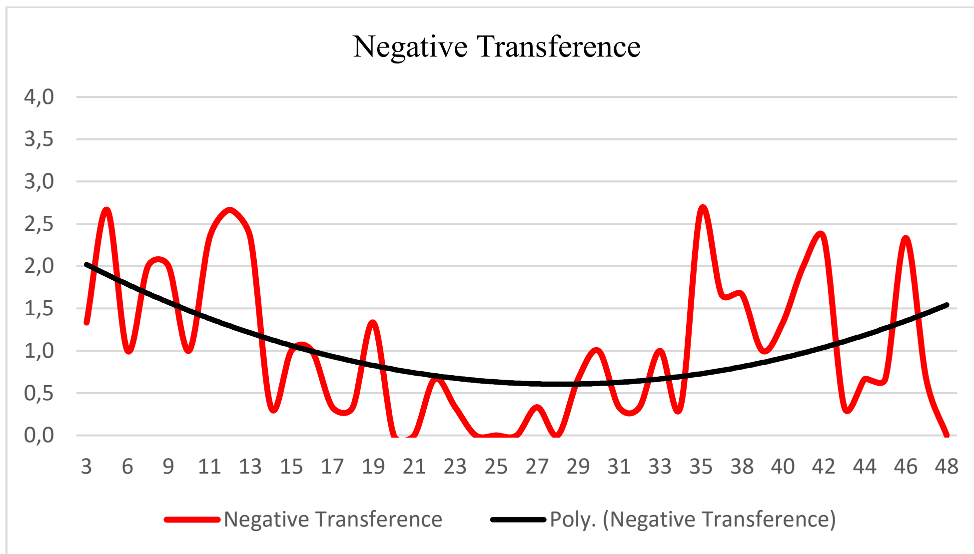

Figure 3.11

In terms of countertransference, only Negative Countertransference was reliably measured and it did not demonstrate a significant trend, $t = -1.04$, $p > .05$. As seen in Figure 3.12 Negative Countertransference was constantly low throughout the process.

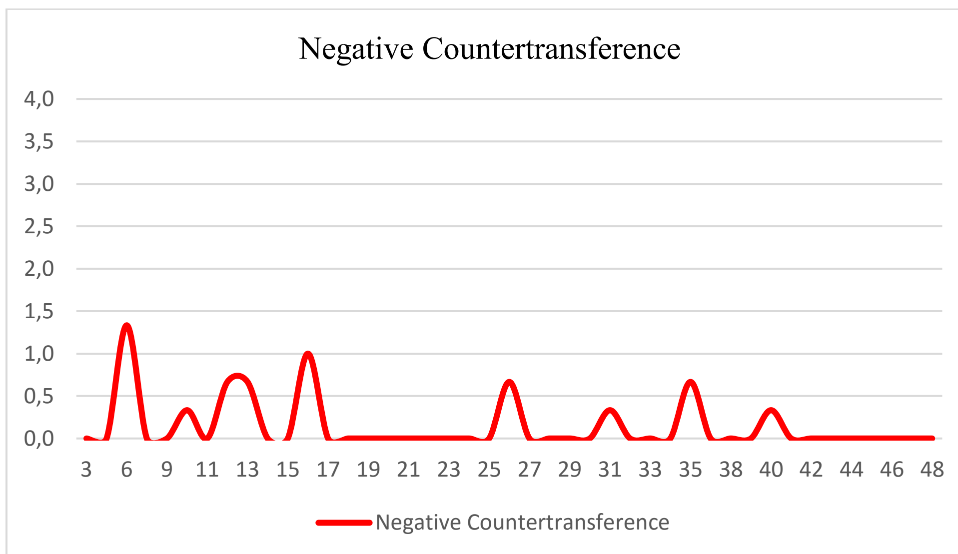

Figure 3.12

Similarly, the model for Therapeutic Alliance was not significant, $t = -0.79$, $p > .05$. As seen in Figure 3.13, Therapeutic Alliance was constantly high throughout the process.

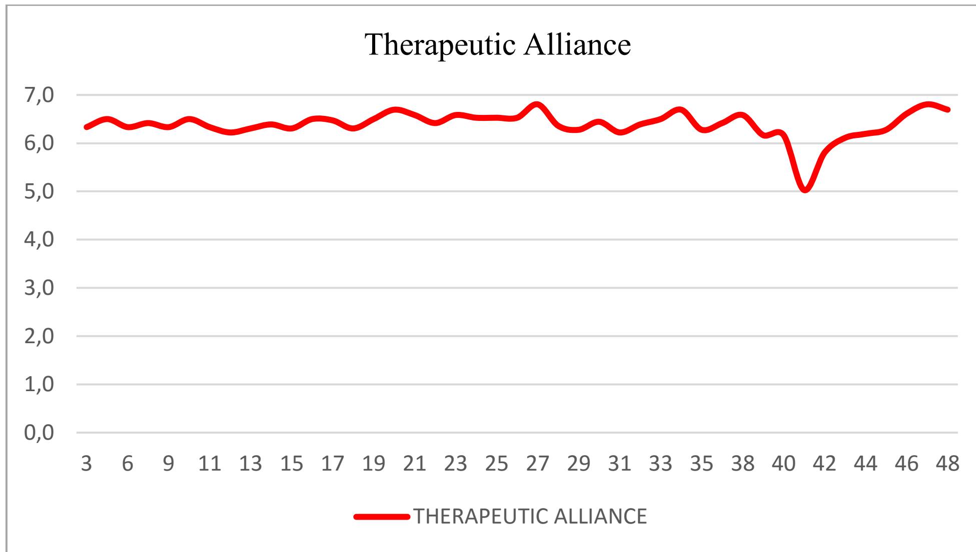

Figure 3.13

For the Level of Separation between Therapist and the Patient variable, a significant linear trend was observed, $t = 4.81$ $p < .01$. As seen in Figure 3.14 Level of Separation was changed due to progression of sessions.

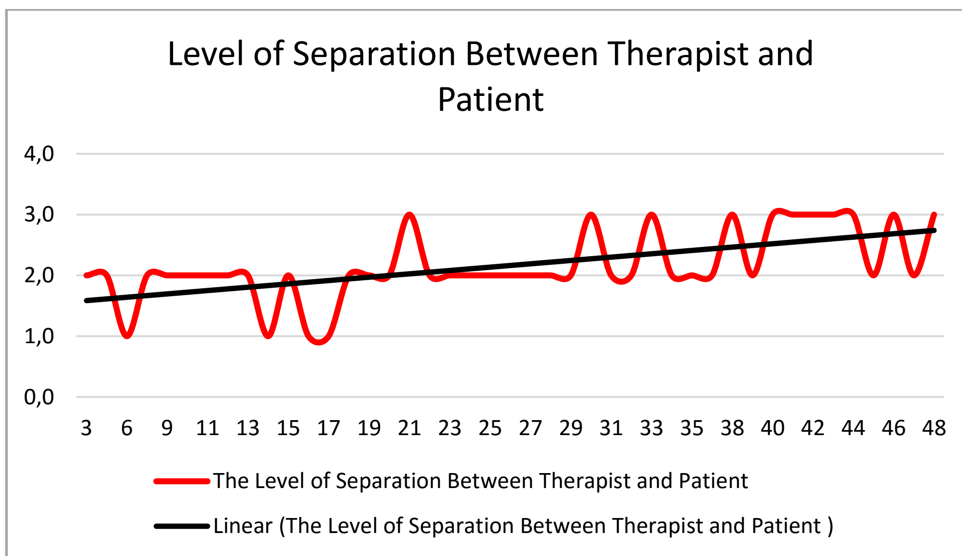

Figure 3.14

3.2.4. Change in the Predominant Theme of the Session

As the predominant themes were categorical variables, a time-series analysis was not possible. Instead, the sessions were grouped into 3 sub phases as the first 14 sessions were categorized as the 1st Phase, the middle 15 sessions as the 2nd Phase and the last 14 sessions as the 3rd Phase. Then, the themes in each phase were counted as presented in Table 3.4. This distribution of themes across phases was compared to a hypothetical distribution for which each theme was distributed equally for each phase. Since the oral theme were not observed and anal themes were observed only for a very small number of sessions, significance testing was not possible. A chi-square analysis was done for the Oedipal theme and was not significant, $\chi^2 = .56$, $p > .05$. As also seen in Table 3.4. Oedipal themes did not increase or decrease with the phase of the therapy. Oedipal theme characterized all sessions of this client.

Table 3.4

The distribution of the Predominant Themes

	Oral		Anal		Oedipal	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
1st Phase	0	0%	1	50%	13	32%
2nd Phase	0	0%	1	50%	14	34%
3rd Phase	0	0%	0	0%	14	34%

3.3. Associations of Affect, Defense and Relationship across Sessions

In order to see how affect, defense and relationship variables were associated over the course of the therapy, cross-correlation analyses that provide the serial relationship between the variables at specific time level were conducted. The aim was to explore if any of the variables were chronologically associated to each other from session to session. The patterns are assumed to have a similar trend in time. Cross lagged correlation analysis allows us to explore whether the

relationship between variables have similar relation over time or not (Little, Preacher, Selig, & Card, 2007). Also, this analysis provides us to understand the observed relationship and therefore allows us to understand the previous and predict the future sessions. For the interpretability of the results, the number of lags was limited to 1 for the analyses that allows a comparison of the preceding and following sessions.

The findings are organized into associations of defense variable and therapeutic relationship variables relationship with affect variables.

3.3.1. Cross Correlations of Defense with Affect

The results indicated a significant association between the Here-and-now Defensiveness and Hidden Sadness and Manifest Envy at Lag 0. This result revealed that observed Here-and-now Defensiveness is positively correlated with the Hidden Sadness in the same session. In terms of Manifest Envy, Here-and-now Defensiveness is negatively correlated with Manifest Envy. Hence, higher levels of Here-and-Now Defensiveness are associated with lower levels of Manifested Envy in the same session. The cross correlation coefficients of Here-and-now Defensiveness and affect variables were presented in Table 3.5.

Table 3.5

Cross correlation coefficients of Here-and-now Defensiveness and Affect variables

	Here-and-Now Defensiveness		
	Lag -1	Lag 0	Lag 1
Manifest Aggression	-.06	-.01	.18
Manifest Guilt	-.02	-.20	-.02
Manifest Envy	-.13	-.33*	-.1
Manifest Fear	-.25	-.28	-.24
Manifest Shame	-.03	.11	-.28
Hidden Sadness	.21	.43*	.20

*Note: *Cross-correlation coefficient is significant (>.30)*

The pattern of changes in the Acting-out was not significantly related to any of the affect variables in the study. The cross correlation coefficients of Acting out and affect variables were presented in Table 3.6.

Table 3.6

Cross correlation coefficients of Acting out and Affect variables

	Acting Out		
	Lag -1	Lag 0	Lag 1
Manifest Aggression	-.05	.02	.14
Manifest Guilt	-.28	-.03	.06
Manifest Envy	-.20	-.29	-.04
Manifest Fear	-.28	-.13	-.15
Manifest Shame	-.10	-.05	-.05
Hidden Sadness	.11	.29	.07

The pattern of changes in the Dissociation is related to Manifested Guilt, Manifested Envy, Hidden Sadness and Manifest Shame. Particularly, the scores on Dissociation is associated with Manifested Guilt positively at Lag -1. The results suggesting that the cross correlation of those variables are in related to each other in the previous session before the observation. In addition to that, scores on Dissociation are positively related to Manifest Envy and negatively related to Hidden Sadness at Lag 1.

The results indicate a significant negative association between Dissociation and Manifested Shame at Lag -1 and Lag 0. Precisely, these results reveal that the association between Manifested Shame and Dissociation is predicated by the previous session's increased Manifest Shame. The cross correlation coefficients of Dissociation and affect variables were presented in Table 3.7.

Table 3.7

Cross correlation coefficients of Dissociation and Affect variables

	Dissociation		
	Lag -1	Lag 0	Lag 1
Manifest Aggression	-.06	.06	.16
Manifest Guilt	.39*	.25	.18
Manifest Envy	.07	-.02	.37*
Manifest Fear	.13	.22	.14
Manifest Shame	.48*	.33*	.29
Hidden Sadness	-.21	-.27	-.32*

*Note: *Cross-correlation coefficient is significant (>.30)*

3.3.2. Cross Correlations of Therapeutic Relationship Variables with Affect

3.3.2.1. Level of Separation and Affect

Level of Separation is negatively related to Manifested Fear at Lag -1, Lag 0, and Lag 1. Specifically, as the Level of Separation scores decrease - by which the relationship between the therapist and the client becomes symbiotic like relationship - the client's Manifested Fear increases. This association can be influenced by the previous session's Manifested Fear level and also predict the future sessions' Manifested Fear level. In addition, the pattern of change in the Level of Separation is negatively related to the Manifested Envy at Lag 0 and Lag -1. Particularly, these results indicate that higher levels of Manifested Envy in one session is associated with a relatively more symbiotic Level of Separation in the session preceding it.

Also, the results reveal that the Level of Separation is negatively related to Manifested Shame at Lag -1, Lag 0 and Lag 1. Specifically, this result suggested that as Manifested Shame increase in one session is correlated with a decrease in the Level of Separation in the previous session which is associated with an increase, in other words, as the client separates, the Manifested Shame decreases.

This association can be influenced by the previous session's Manifested Shame level and also predict the future sessions' Manifested Shame level.

The pattern of differences the Level of Separation is positively related to Hidden Sadness at Lag -1, Lag 0 and Lag 1. Specifically, this result suggested that higher Level of Separation in one session is associated with higher level of Hidden Sadness in the same session, as well as in the sessions preceding and following it. In other words, the association between Level of Separation and Hidden Sadness can be influenced by the previous session's Hidden Sadness level and also predict the future sessions' Hidden Sadness level.

The cross correlation coefficients of Level of Separation and affect variables were presented in Table 3.8.

Table 3.8

Cross correlation coefficients of Level of Separation and Affect variables

	Level of Separation		
	Lag -1	Lag 0	Lag 1
Manifest Aggression	-.12	-.23	-.01
Manifest Guilt	-.24	-.20	-.26
Manifest Envy	-.41*	-.36*	-.25
Manifest Fear	-.35*	-.59*	-.33*
Manifest Shame	-.38*	-.31*	-.35*
Hidden Sadness	.43*	.43*	.42*

*Note: *Cross-correlation coefficient is significant (>.30)*

3.3.2.2. Transference, Countertransference and Affect

The pattern of change in Positive Transference is positively related to Manifested Fear. The results indicated that, Positive Transference was found to be negatively related to Manifested Fear at Lag -1 and Lag 1. This result indicates that higher level of Positive Transference is associated with lower levels of Manifested Fear in both the preceding and following sessions, but interestingly,

not in the same session.

The same pattern was also observed for Hidden Sadness, as the significant positive correlation between Positive Transference and Hidden Sadness at Lag -1 and Lag 1 indicates. Specifically, these results reveal that higher level of Positive Transference is associated with lower levels of Hidden Sadness in both the preceding and following sessions, but again interestingly, not in the same session.

The cross correlation coefficients of Positive Transference and affect variables were presented in Table 3.9.

Table 3.9

Cross correlation coefficients of Positive Transference and Affect variables

	Positive Transference		
	Lag -1	Lag 0	Lag 1
Manifest Aggression	.17	.25	-.11
Manifest Guilt	-.22	-.07	.08
Manifest Envy	-.26	-.14	-.13
Manifest Fear	-.31*	-.23	-.36*
Manifest Shame	-.09	-.27	-.02
Hidden Sadness	.50*	.25	.36*

*Note: *Cross-correlation coefficient is significant (>.30)*

The results of the cross correlation analysis revealed that there is a negative relationship between Negative Transference and Manifested Aggression at Lag -1. Specifically, the results indicated that higher levels of Negative Transference is associated with lower levels of Manifested Aggression in the previous sessions.

Regarding the Negative Transference and Manifested Shame association, a negative correlation at Lag 1 was observed. Particularly, a higher level of Negative Transference is associated with lower levels of Manifested Shame in the following session.

The cross correlation coefficients of Negative Transference and affect variables were presented in Table 3.10.

Table 3.10

Cross correlation coefficients of Negative Transference and Affect variables

	Negative Transference		
	Lag -1	Lag 0	Lag 1
Manifest Aggression	-.38*	-.16	.08
Manifest Guilt	-.12	-.28	-.14
Manifest Envy	-.06	-.30	-.20
Manifest Fear	-.03	-.08	.08
Manifest Shame	-.07	-.07	-.36*
Hidden Sadness	-.06	.01	-.05

*Note: *Cross-correlation coefficient is significant (>.30)*

To sum up, Positive Transference was associated with Manifested Fear, Hidden Sadness and Manifested Sadness; whereas Negative Transference was associated with Manifested Aggression and Manifested Shame.

The pattern of changes in Negative Countertransference was not significantly related to any of the affect variables in the study. The cross correlation coefficients of Negative Countertransference and affect variables were presented in Table 3.11.

Table 3.11

Cross correlation coefficients of Negative Countertransference and Affect variables

	Negative Countertransference		
	Lag -1	Lag 0	Lag 1
Manifest Aggression	.07	-.02	.03
Manifest Guilt	-.01	-.00	-.14
Manifest Envy	-.13	-.16	-.04
Manifest Fear	-.14	.21	-.14
Manifest Shame	-.24	-.03	-.06
Hidden Sadness	-.23	-.06	-.21

3.3.2.3. Cross Correlations of Therapeutic Alliance with Affect

The results indicate a significant positive interaction between the Therapeutic Alliance and Manifest Guilt at Lag 1. Precisely, the results indicated that higher levels of Therapeutic Alliance are associated with higher levels of Manifested Guilt in the following sessions. In addition to that, there is a positive relationship between Therapeutic Alliance and Manifest Fear was observed at Lag 0. Indicating that, higher levels of Therapeutic Alliance is associated with higher levels of Manifested Fear in the observed sessions.

The cross correlation coefficients of of Negative Countertransference and affect variables were presented in Table 3.12.

Table 3.12

Cross correlation coefficients of Therapeutic Alliance and Affect variables

	Therapeutic Alliance		
	Lag -1	Lag 0	Lag 1
Manifest Aggression	.09	.05	-.21
Manifest Guilt	.11	.27	.38*
Manifest Envy	.18	.13	.24
Manifest Fear	.21	.48*	.22
Manifest Shame	.26	.21	.27
Hidden Sadness	-.11	-.11	.04

*Note: *Cross-correlation coefficient is significant (>.30)*

3.3.3. Other Significant Cross Correlation Results

3.3.3.1 Cross Correlations of Defense Variables with other variables

Results revealed that there is a significant relationship between Here-and-now Defensiveness and Acting-out, and Positive Transference. Specifically, scores on the Here and Now Defensiveness is positively related to Acting Out behavior at Lag 0. This indicates that higher levels of defensiveness in one session is associated with higher levels of Acting out. Also, Here-and-now Defensiveness positively related to Positive Transference at Lag 1. Indicating that higher levels of defensiveness in one session is associated with higher levels of Positive Transference.

The results revealed that Acting out is positively associated with Negative Transference at Lag -1. Particularly, the results suggest that the higher levels of Acting out is associated with higher levels of Negative Transference in the previous session.

3.3.3.2. Cross Correlations of Level of Separation *variable with other variables*

The pattern of changes in the Level of Separation is negatively related to Negative Countertransference. The relationship is significant at Lag 0 and Lag -1. Specifically, the results suggest that the higher levels of Level of Separation has related to lower levels of Negative Countertransference and this relationship would have been influenced by the previous session's Negative Countertransference feelings.

The results indicated that the Level of Separation is negatively associated with Dissociation at Lag 0. Particularly, the results suggest that the higher levels of Level of Separation is associated with lower levels of Dissociation.

The pattern of changes in the Level of Separation is negatively related to Therapeutic Alliance at Lag 1. Particularly, the results suggest that the higher levels of Level of Separation is associated with lower levels of Therapeutic Alliance.

3.3.3.3. Cross Correlations of Transference variable with other variables

The results indicate a significant negative interaction between the Negative Transference and Therapeutic Alliance at Lag -1 and Lag 0. Precisely, the association between Negative Transference and Therapeutic Alliance is influenced by previous sessions' Therapeutic Alliance level.

3.4. Clinical Content of the Sessions

The quantitative analyses of the data indicated some remarkable features for some sessions. In order to understand such fluctuations, the content of the certain sessions would have to be explored.

Session 41 was a session which showed a sharp decrease in the therapeutic alliance, manifest fear; while also showing sharp increase in negative countertransference, manifested and hidden sadness, manifest guilt. Having such

outlier features, this session was examined in depth to understand the underlying dynamics. The content of 41th session is based on the therapist reminding the client of the termination day, which is nearing. After the therapist's indication of this point, the client starts crying and tells the therapist that she does not want to grow up and talks about her belief that she will have to stay alone. With such feelings, the client later says that she hopes she "…dies after leaving [the session]" and that she does not want to grow up; as in her belief, this would mean loneliness for her.

T: When something undergoes change, it does not mean it is destroyed.

Ms. H: It is not created either.

T: There was a relationship that we lived through here, that we talked here, that we established here; it was real.

Ms. H: But I will forget them.

T: We met, talked and built a relationship for a long time; that happened, that was real.

Ms. H: But it will be gone. I will forget.

T: It will improve, it will change. You will not forget (Ms. H: I do not want to forget (cries heavily)), you will not forget, I will not forget.

Ms. H: You will forget. Why would you remember?

...

Ms. H: I will have to stay alone.

T: Growing up reminds you to stay alone.

Ms. H: Yes, everyone that I get used to leave (crying) I feel lonely.

...

Ms. H: I hope I will die after leaving here. I do not want it, I do not want to grow up, I do not want anybody... I will remember you when I come here.

Also, the trend graphs indicate a large fluctuation between session 6 and session 8 (the data is not available for session 7). For the Manifest Shame variable and the Positive Transference variable, the scores are differentiating from one another. Thus, to better understand the reason behind this, the content of these sessions were overviewed.

In the session 6, data indicated that there is a large scale increase in the dissociation defense mechanism, Acting Out, Negative Countertransference, Positive Transference and Manifest Envy, as well as decrease in Manifest Shame. The content of the 6th session is based on the anxiety and fear of leaving the family. The client regresses during the session and shares the memory of the mall which she got lost in during her childhood. This experience of getting lost, the feeling of loneliness and the depressive emotional mood seems to manifest her twin fantasy and desire.

…

Ms. H: Everyone may go, but I think if I had a twin he/she may stay. For example, in the future I think I will be alone in my old age... I love twin children. Maybe I could have had a twin too, I would have wanted it. It was there since I was a kid, because there were twins in our class. Those twins were always supporting each other. Even if one did not come, the other one was taking notes for him and was helping him. They were doing things together at home, *erm*, when they wore something they were getting together, or when they went to a lesson they did not have any problems about finding friends. Because the two were side by side. When they needed something, they were getting it together. But I was alone and it was hard for me when I was young. Because if I do not go to school; I do not know, nobody would care. No one would take notes for me or do anything else. Or when I would get angry with someone or argued with someone at school, nobody would be there for me, I would always be alone. But it would not be like this if I had a twin.

…

T: You would not be alone.

Ms. H: Yes.

T: She would support you...

In the session 8, increase in Manifest Shame and Negative Transference was observed, as well as decrease in Negative Countertransference and Positive Transference. The session (#8) is mainly based on growing up and on being a woman, which is why the fears of marriage manifest and the client talks about

death and tells about her thoughts of suicide. The session maintains the fear she reflects towards others and the sexual desires. It is observed that she regresses to childhood with the presence of sexuality.

...

T: You said you're scared. From marriage ... From children...

Ms. H: I mean ... Spending life with a man feels hard for me, it feels like I will not be able to do it. Because my mother will not be by my side. For example, when I have a problem I could have asked my mother, I can ask her at home, or to my dad. But I mean, he's a stranger, I think I will have a lot of difficulty getting used to him. Apart from that, *erm*... I am ashamed to say it now, but, sexual intercourse for example, I am very scared of it. I mean, it's very difficult, so, it feels like something very disgusting to me, it's disgusting.

...

Ms. H: Two days ago, I went to city center and I was going to meet my friend. We were going home from there. It was late, so it was evening, and by late I mean it was dark, it was like 5 or half past or so. *Erm*, Well, I was very scared when people there, for example, looked at me. As if they were going to kidnap me right there, there are so many policemen around, there are people, so they cannot do it, but I mean they may kidnap me at any moment, they will do bad things to me, it feels that way, I am scared of people to that extent. For a moment I felt like I lost my mother in the shopping mall, or at a local bazaar, left all alone, I felt like a tiny child. I do not know which bus I should take, where I should take a bus, how will I go, I have no idea, which busses are going I do not know, at that moment I felt so naïve and stupid and I mean, I felt so, unprotected. I was very scared. I was returning at that moment, then thank God I saw my friend, I'm was so glad that I cannot begin to tell. Because I was so scared, I never knew what to do and how to go.

T: You suddenly felt lost.

Ms. H: Yes. So there are cops around, everybody was there, but if feel as if my life is finished, I mean, it felt like they were going to do bad things to me. I'm scared when people look at me. I mean, I'm afraid to come eye to eye with them.

This does not happen with the people I trust, but it's, I mean, it's happening a lot with people who are other than those that are close to me. .. I am extremely afraid of people. It feels like everyone may do something.

T: What types of things do you think they'll do?

Ms. H: I will be abducted, raped. I will be exposed to various kinds of torture. I mean, things like that are coming to my mind and I'm afraid. When these come in front of my eye, I have such an overreaction in my body that I start to tremble. ... I mean, for example, I always place meanings on objects. I say, for example, if it was this color, maybe I would not be scared. For example, if there were those colors in my house, I would have felt comfortable. I would have been happier if I do not have that object. This object brings me bad luck every time, I will throw it away destroy it. I place meaning on objects. In my mind I have placed such meanings to them that if they happen, my whole life will go bad but if they do not happen, like if another object or an object with another color happens then everything will go well. It's ridiculous really. That is why my mind is so confused.

In session 26, the results indicated a sharp increase in Hidden Sadness, Acting Out, decrease in Negative Transference and a slight increase in Negative Countertransference. The content of the 26th session is about being a woman, rejection of sexuality and the gender roles. The details of the session are as follows:

…

T: And what kind of a woman do you want to be?

(immediately) Ms. H: I do not want to be a woman. It feels so helpless, the boys' toy, the slave, it seems like that. If you ask dad, such things never happen in our family. For me, you and your brother are equals, he says, but the rights granted to us are the exact opposite of this.

…

Ms. H: …Sometimes I feel so old.

T: Tell me more about feeling old?

Ms. H: I feel like someone who is so exhausted, who has fears, who wants to die, someone who has lived and finished everything in life. My hand and my feet are

not moving, my body is so squeezed, and it hurts inside. My soul feels like its old. For example, I see my peers, they laugh and have fun, they are happy, but I cannot be.

T: Old age is also a time when sexuality is not present. (Ms. H: M-hmm.) Like, it is a period when your active sexuality is slowing down, decreasing, perhaps not there at all... You recently said that you do not want to be a woman, and actually one of the most important things that change after adolescence is sexuality. The fact that being sexually active, being able to be active, when you want.

Ms. H: That also feels horrible to me. I mean, I do not know how I can do it.

Additionally, in session 27, the results indicated a sharp decrease in Manifest Shame and Hidden Sadness, as well as a decrease in Acting Out. The content of the 27th session is about her childhood dreams, plays and her self-image. The details of the session are as follows:

..

Ms. H: …. I would build homes from the cushions. Like, normally the kids, they, I don't know, the boys build it as an armor, as a castle. Girls build it to have a house, like, they make a husband and a wife and a kid out of toys. Like, they do it with that emotion. But I did it with the feeling of running away from someone, based on such a thought. Hiding..

T: It felt like you needed to hide.

Ms. H: Well, that's the feeling right now. I want to run away and hide from life and people.

T: And you are hiding, at home. (P: Yes.) As you say like in the game, you say, you are running away and defending yourself from something.

Ms. H: I'm trying to protect it. I never know how long it will be. Sounds like it's never gonna get better.

T: And there's a baby there too, from some things that you've missed (H: M-mm), That you want to protect. (Ms H: Yes.) What types of things?

Ms. H: I was running away from a man that was in my dream. But for what reason I do not know.

T: What kind of man?

Ms. H: So I do not remember exactly, but he wants to hurt us. But I do not know how he wants to hurt. Rough man, like, with a beard. He was showing up in my dreams when I was younger too. So he’s not a male figure, or it's not that event.
…Later she talks about her childhood photo..
Ms. H: The photo shut when I was a child. I wish I was able to really bring it so that you could see it. I really did want to show it to you, because, like, shouldn’t the eyes of a kid of that age look so bright, and smile in a mischievous manner?
I was like, I don’t know, it was like I endured a lot of fatigue despite being so young. My smile is so half-tired, unhappy. I never recall a cheerful H., I never recall a hopeful H.

CHAPTER IV

DISCUSSION

Adolescence is a complex and challenging period of time in human life. In order to understand the underlying dynamics of an adolescent, this study explores the specific themes in the course of relational psychodynamic psychotherapy with an adolescent. Through analyzing a specific psychotherapy process, it is aimed to detect why and how changes take place as the treatment undergoes. This approach provides an extensive look inside the process, as well as the outcome (Kivlighan, Multon & Patton, 2000) The statistical perspective derived through this effort may provide important takeaways both to clinicians and researchers, and the results of this study are in line with the adolescent literature and aims to contribute to the existing body of work.

This study is designed to systematically examine the relationship between the defense, affect and the therapeutic relationship, which are shaping and are being shaped by the relational context of the therapeutic work. During a long term psychodynamic therapy, the changes in the client's affect and the variations in the defense mechanisms used by the client and the manifestation of the transference and countertransference in the relationship with the therapist could be observed.

The quantitative works with the single case of an adolescent are limited in the psychodynamic literature. However, the advantage of the single case quantitative work is that it allows for observing the trend changes that happen during the psychotherapy. With the goal of addressing this gap in the literature, an adolescent's therapy sessions which were conducted by a therapist with psychodynamic approach was selected as the data of this study.

4.1. The Psyche of the Adolescence

4.1.1. Affect

Regarding the affect variables in this study, findings show us that the hidden and the manifest demonstrations of variables have differed from one another. According to psychoanalytic theory, not only the feelings on a conscious level but also the feelings that are non verbalized on the unconscious level are present. Edgcumbe (1993) indicated that some clients fail in communicating with the therapist, due to their incapability to establish communication with themselves within their own self. This incapability stems from their lack of awareness of their own mental utility, or their lack of recognizing the importance of such an understanding and communication (Edgcumbe, 1993). Therefore, these clients cannot manifest their feelings verbally. This study shows that by finding a differentiation between the hidden and manifested demonstrations of the affect is parallel with the psychoanalytic literature.

The descriptive results of the study indicated that the client's dominant affects are aggression, fear and sadness. The latter among those three affects were emphasized by Parman (2003), where he noted that the main affect for the adolescents is sadness. This period is seen as a mourning process, since this is a period where the end of childhood, the end of bisexuality and also the end of the symbiotic-like relationship with the mother is experienced by the adolescent. It is expected that this period of loss and the subsequent start of something new, brings about a level of uncertainty that triggers fear in the adolescent. Also, the sudden changes in the client's affects, is in line with the adolescent literature that points out the challenges experienced in affect regulation (Josselyn, 1971).

The foremost affect of the client being aggression in this study, is in line with the literature (Blos, 1967). The adolescents experience aggression in a raw form, as a result of the changing object relations during the second phase of the separation individuation (Blos, 1967). Also, Anna Freud (1958) indicated that the adolescent experiences aggressiveness due to losing the close relationship with

parents and being separate from parents. Furthermore, she acknowledged that adolescent aggression can be turned against the self instead of the external objects, which causes depression. In line with the literature, the client shows high levels of aggression and it is known that she goes through a major depression episode.

4.1.2. Object Relations

The detailed descriptive analysis of the Level of Separation indicated that the client fluctuates between practicing and rapprochement phases, across the whole therapy process. In line with the literature, it is observed that the client could not reach object constancy at any session since it is a one-year psychodynamic therapy and the client is still going through the adolescence period.

In terms of predominant theme, oedipal themes mostly observed in the sessions. In line with the literature (e.g. Freud, 1905, Klein, 1958), undoubtedly, during the adolescence period, oedipal themes reappear or the struggle in this period is somewhat similar with the oedipal phase. The client in this study is also re-experiencing oedipal struggle in parallel with adolescence literature.

4.1.3. Therapeutic Relationship

In terms of the therapeutic relationship variables, it is observed that the positive transference and therapeutic alliance are at high levels, while negative transference and negative countertransference are at low levels. However, based on the distribution, one way to interpret this is a type of defensive positiveness. This is also supported by the association between here-and-now defensiveness and positive transference. The manifested pseudo-like positive relationship is also considered as a result of the adolescent's borderline object relationship patterns, which maintains the one extreme end that is the idealized and all-good close relationships with other people. Further, the tendency of the adolescents to hide

their feelings as noted by A. Freud (1958) and Josselyn (1971) might also acknowledge for this tendency to hide the negative aspects of the relationship. On the other hand, this should also be taken as an indicator of a positive therapy process.

4.1.4. Defense

In terms of Here-and-Now Defensiveness, the client is ranked at a moderate level. This result is partially in accordance with the literature, given that the adolescents demonstrate higher levels of defensiveness. However, especially the intrapsychic mechanisms are not able to cover what takes place during the psychotherapy session (Cavdar & Fisek, 2017).

According to the results in the study, the client displays moderate levels of acting out. As Blos (1963) indicated that acting out is due to the recurrence of a primary object relations, or, the struggle for reinstating reality through revisiting the memories from childhood which were banned or rejected by the others and confirming these memories in action. Although the client in this study shows moderate levels of acting out, it should be noted that she has a severe depression which might cause her to route her affects inwards, rather than outwards via acting out.

4.2. Trends of Change

Regarding the exploratory aim of this study, an overview of the results showed that the specific features of an adolescent in terms of affect and used defense mechanisms have changed during the course of psychodynamic psychotherapy process. This dynamic is one where childhood problems are reactivated and therefore, are open to change. The detailed analysis will be discussed below in detail.

The adolescence period is viewed like a borderline state based on the characteristics this period displays (Brown, 1993). Thus, as expected of the borderline level characteristics, it is not possible to observe an emotional stability (Kernberg, 1967). In line with the literature, the results revealed that the affect of the adolescent goes through rapid shifts (Hauser & Schmidt, 1991). Therefore, many sudden shifts are observed between sessions, in which the client goes through affects of Manifest Shame, Manifest Fear, Manifest Envy, Manifest Guilt and Hidden Sadness. These rapid fluctuations between sessions are in accordance with the nature of adolescence.

The results indicated that all the negative affects except the hidden sadness were observed in a decreased pattern as the sessions progressed. Particularly, the manifested fear, manifested envy and manifested shame have decreased as the sessions progressed. This result is also a good indication of the therapy work, since it seems that the client was able to contain her emotions over time.

As mentioned earlier, the way of experiencing the affect in the hidden and the manifest are different from each other. Thus, the client's hidden sadness has found significantly related to other variables compared to her manifest sadness. Considering the client's level of organization, and the client's depressive diagnosis and her age, it could be argued that she could suffer a higher level of sadness and even she is able to manifest this sadness, she might not have capacity to symbolize her intense feelings, considering her life situation and the features of the adolescence period, a difference occurs between the sadness she manifests and the hidden sadness.

The increase in the hidden sadness variable could be viewed as an indication of the client's main separation problem. As mentioned above in the psychoanalytic literature, one of the main issues in adolescence is the separation individuation process (E.g.; Blos, 1967, Josselyn, 1971). Given that this was a study conducted on an adolescent, it was expected that this process would be visible in this study between the analyst and the client, in line with the associated literature on separation individuation. The analytic literature suggests that the person's intrapsychic conflicts are expected to reappear towards the therapist

during the course of therapy. This explains why the observed level of separation in the client's relationship with the therapist in this study fluctuates at symbiotic, rapprochement and practicing phases. In this light, the increase in the client's hidden sadness could be the client's transference of core separation problem. The forced termination triggers the client's strong attachment to the analyst and therefore, as the therapy process progresses, the client feels more attached. When the session comes to a forced termination, this is coupled with the client's existing separation anxiety and this leads to the hidden sadness that the client feels deep inside.

It was observed in the study that the client's level of the use of defense mechanisms has shown a visible variation and detectable trend over the course of the sessions. The results of the trend analysis reveal that there is a decrease in the use of defense mechanisms as the sessions progressed. Specifically, it was observed that the client' use of dissociation have decreased over time. This could be interpreted as a good indicator of a functioning therapy work.

4.3. Associations of Affect, Defense and Therapeutic Relationship over Time

The results indicate that the client's Here-and-Now Defensiveness is associated with Manifest Envy and Hidden Sadness. These results show that when the client experiences Manifest Envy and Hidden Sadness in the sessions, her defensiveness is affected in the negative and positive way, respectively.

In addition to that, when the client manifests Guilt, Envy, Shame and concealed Sadness, she uses the dissociation defense mechanism in the sessions. In the dissociation defense mechanism, the individual confronts the conflicts caused by internal stressors via momentarily shift of consciousness, as the affect or the impulse that the person is unaware of, is active in the person's life (Perry, 1990). Thus, it could be concluded that the client cannot tolerate feelings of Guilt, Envy and Shame, and use dissociation defense mechanism to tolerate.

The results regarding the level of separation with affect variables indicated that the client's level of separation is associated with manifested Envy, Fear,

Shame and concealed Sadness. Specifically, the outcomes indicate that the Level of Separation is negatively related to Manifested Fear. Specifically, as the Level of Separation scores decrease - by which the relationship between the therapist and the client becomes symbiotic like relationship - the client's Manifested Fear increases. In line with the psychodynamic literature, as the level of separation increases, the fear is expected to increase.

Also, Level of Separation is negatively related to Negative Countertransference. Particularly, an increase in the Level of Separation has resulted in a decrease in the negative Countertransference and this relationship would have been influenced by the previous session's negative Countertransference feelings. Interestingly, as the client's level of separation increases – or in other words, as client approaches the object constancy level – the therapist's negative countertransference feelings have decreased.

The pattern of differences in the Level of Separation is negatively related to the Manifested Envy Particularly, these results indicate that where the low levels of separation were observed in the session, the Manifested Envy has decreased. This relationship could be predicted by the previous sessions' Manifested Envy Level.

The results regarding the transference have shown that the client's positive transference is associated with Manifest Fear negatively, and with Hidden Sadness positively. As the Manifested Fear increased, the client's positive transference decreased. The deduced outcome through this relationship was that the client was having a hard time tolerating the negative feelings she was having during the session and these feelings have an effect on her positive transferential relationship with the therapist. Again, this is parallel with borderline personality organizations that encounter hardships in positive relationship continuity and poor affect tolerance (Kernberg, 1967).

When the client experiences the concealed sadness, which she is unable to verbalize during therapy, it was found that she has positive transference that is independent of manifesting her sadness. This also underlines that the hidden and manifest feelings are experienced separately.

It is also observed during the study that negative transference is negatively related to manifest aggression and manifest shame. This tells us that, interestingly, when the adolescent is able to manifest her aggression and her shame, her negative transference decreases. This could be explained through the fact that since shame and aggression are hard to manifest for her, when she is able to manifest them, her transference approaches to positive.

In terms of the therapeutic relationship variables; positive transference and variables have increased as the sessions progressed, whereas negative transference variable decreased as well. The results of the therapeutic relationship variable show a valuable and progressive therapy work. The results indicate that Negative Transference is associated negatively with the Therapeutic Alliance. This is fully in line with the literature. The Therapeutic Alliance is affected with the type of transference.

On the other hand, this extremely positive relationship is might be due to the adolescent's need of compliance based on his/her need of external recognition, for which he/she false-self hides the needs of the true-self (Winnicott, 1965a). This false-self compliance is complemented by proof of masochistic self denial (Hanna, 1992). The unacceptable primary needs of love and nurture, which were suppressed since infancy may later form the basis of the feelings of greed, rage and envy (Hanna, 1992). Hence, it could be assumed in this case that the adolescent's extremely positive therapeutic alliance and her lack of negative transference could be considered as false-self compliance.

4.4. Content Analysis

When the content analyses are reviewed, fluctuations in the data are observed because of some sessions. As mentioned above, one of the sessions saw the therapist reminding the termination day to the client, whereby later the client's concerns about loneliness and being forgotten increases and these negative feelings and sadness causes withdrawal from the relational world. As a result, there is a strong increase in the client's depressive feelings and subsequently, her

suicidal thoughts. This shows us that the client has not yet reached object constancy level in terms of separation-individuation parallel with the results, and also her insecure attachment style.

Another session of which its content is reviewed, it is observed that the client's suicidal and paranoid thoughts are on increase. It is observed that she is unable to manage her fear, sexual desires and aggressive feelings; hence she suffers from depressive emotions which feed her suicidal thoughts. This is parallel with the adolescent literature that she cannot contain her libidinal and aggressive desires, and in order to cope her internal conflicts, she needs to project them. Her regressions to paranoid state could be in line with the Kleinian regression to the paranoid schizoid position, which is commonly seen in the adolescence period.

4.5. Limitations and Suggestions for Future Studies

This study allows us to understand the unconscious dynamics of an adolescent who is diagnosed with depression. This study should place importance on the utilized approach on this study, as this approach has been able to show the changes achieved incrementally through psychodynamic process with an adolescent, which are most prominently on defenses and affects of the client.

The first limitation of this study was the forced termination of the therapy process. Had this process continued, the study might have provided further results on defences and affects. Meanwhile, as indicated earlier, this termination might have resulted in the increased hidden sadness, whereby a listed limitation of the study has contributed to the results of the research. On the other hand, the forced termination that took place allowed the adolescent to elaborate and experience the separation processes in a more contained and healthy manner. This separation experience has resulted in a therapeutic outcome in itself for the patient.

Another limitation of this study is the amount of sessions conducted. It should be noted that via increasing the number of sessions, it would have been possible to have better analyses statistically, by having more data than is present. Also, this richer data foundation would have allowed the researcher to make

longer term projections.

Using ARIMA for the time-series analysis has brought several restrictions. A precise causal relationship cannot be deduced causality. Instead, it provides an approximation of causality and when significant causal relationships are the case, it should be bore in mind that these may be aided by unobserved variables (Jones, Ghannam, Nigg, & Dyer, 1993). Furthermore, time-lagged associations are formed through segment-to-segment time steps, therefore there is possibility that with other time lags, other associations could be formed too.

Although a very preferential approach to work on the psychoanalytic process in depth is through the longitudinal studies of single cases, the challenge presented through this approach is the problem with making generalizations out of only one case. A more comprehensive method would maintain a recurring single case design that has more time points and also a big sample of treatments to ensure satisfactory benchmarking.

Looking ahead, in order to contribute further to the efforts of this study, future studies should explore the same trends for different clients who are working with the same therapist. This would allow for elimination of the therapist differences and therefore, the transferential material could be explored in a broader perspective.

4.6. Clinical Implications

In terms of the clinical implications of this study, it was shown that the relationship between the therapist and the patient can contribute to the adolescent's separation process. As the adolescent experiences a relationship as a separate individual with the therapist, she benefits from this relationship in terms of developing to ability of constructing a healthy relationship with an adult, and it is expected that this capacity will spillover to her other relationships as well. Therefore, the relationship between the therapist and the adolescent client, has an important effect in terms of the adolescent's separation individuation's process.

Also, while the manifestation of the negative affects in the therapeutic environment is seen very often, it is also observed that these feelings are experienced or contained less by the patient over time. Thus, it could be concluded that upon the adolescent's manifestation of affects and the therapist's work on these affects by providing meaning, mirroring and containing, the adolescent is able to control, contain such feelings and hence, experiences lesser negative feelings.

CONCLUSION

This study has deeply analyzed a single case adolescent in a psychodynamic psychotherapy process. The results are fully parallel with the literature in terms of affect. The differentiation between the hidden and and manifest affect relations, shows the impact of the non-verbalized affects during the therapy process.

In general, our results have indicated that adolescence period in general is somewhat based on re-experiencing the childhood problems and transition into adulthood. As mentioned by Ms. H, the client on whom this study is constructed on, adolescence is re-living the childhood while adapting to the new skin:

"I have not experienced my childhood, and now I feel like I'm living with the fears and desires of the childhood I have not lived"

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APPENDICIES

APPENDIX-A

CODING GUIDE

The coding guide was developed by the researcher in order to provide explanation for the variables in this study, through providing explanation of the meanings of the variables, the included themes in the variables and the scoring procedure.

The variables in this study have formed 4 main categories, which are affect, psychosexual theme, defenses and therapeutic relationship. Affect category consists of 6 variables, which are aggression, fear, envy, guilt, shame and sadness. Some of the components of the affect category and the coding system are based on The Analytic Process Scales Coding Manual (APS) (Scharf, Waldron, Firestein, Goldberger, & Burton, 2010).

Psychosexual theme is composed of 3 categorical codes: oral, anal and oedipal, in which Kulosh and Mayman (1993)'s descriptions were used and the including themes will be formed according to those descriptions. The raters will be expected to select one of the three categories that represent the content of the session.

The defense mechanism section includes here-and-now defenses and the defense mechanisms that are used by the patient. Here-and-now defensiveness will be measured on a five-point scale, which was directly adopted from Cavdar & Fisek (2017). Also, defense mechanisms will be measured via the Defense Mechanism Rating Scale 5th edition (DMRS; Perry, 1990). For the purposes of this study, 5 specific mechanisms were selected: projection, splitting, acting out, dissociation and denial. The descriptions of the defence mechanisms the coding guide was directly adopted from Perry (1990). The raters will be asked to use a three-point scale to evaluate the usage of each defence mechanism.

Therapeutic relationship section will be composed of the level of separation between the therapist and the patient, therapeutic alliance, transference and countertransference variables. Level of separation between the therapist and the patient will be measured by a four-point scale item, which was formed based on Mahler's separation-individualization description. Transference and Countertransference will be evaluated on two dimensions: the affective tone (positive and negative) and intensity (5-point scale). Lastly, therapeutic alliance will be measured by Working Alliance Inventory observer form (WAI-O) which was developed by Titchenor and Hill (1989) and adapted to Turkish by Soygüt and Uluç (2009). The WAI-O scale that is used in this study had 12 items. Raters will be asked to evaluate therapeutic alliance in a 7-point scale.

Instructions for the raters are presented below.

AFFECT

For the affect section you will be asked to select a number between 0 and 4 to rate the intensity of the feeling observed or sensed by clinical intuition during the session. For each session, you will be expected to select one rating. Each affect will vary in intensity during a session. Please select the score that best represents the entire session. Please prioritize the intensity of the affect, rather than the length at which the patient talks about it.

This guide will provide you with the definitions and examples of the Scores 0, 2 and 4. You may use Scores 1 and 3 to reflect the "in-between" conditions. Based on the definitions below, when you consider a session as in-between 0 and 2, you may score 1; and as in-between 2 and 4, you may score 3.

In addition to the score of intensity, for each affect, you'll also be asked to note down whether the affect was Manifest or Hidden. When the patient explicitly displays and/or talks about a certain affect, you're required to mark it as "Manifest". When the patient does not directly display or verbalize the affect (due to defensive omission or distortion), but the existence of the affect is strongly sensed by clinical intuition, you're expected to mark it as "Hidden".

AGGRESSION

Patient speaks about, manifests or show indications of assertive, aggressive, hostile feelings, fantasies, activities, or memories. Following themes will be included: aggressive, competitive, angry, attack, assault, hostility, derogation, criticism, meanness, opposition.

Score 0: In cases where no hostile feelings or actions are displayed or mentioned by the patient.

Score 2: In cases where the patient mentions or displays a moderate degree of assertive, aggressive or hostile feelings or actions. The patient should be moderately emotionally involved in aggressive expressions or actions.

Score 4: In cases where a strong degree of assertive and hostile feelings or actions are mentioned or displayed by the patient. The patient should be strongly emotionally involved in aggressive expressions or actions.

Further mark as,

Manifest: predominantly explicit during the session

Hidden: predominantly implicit during the session; sensed by clinical intuition

FEAR

Patient perceives a threat to personal well-being. The perceived threat being either a feeling, fantasy or memory of the patient. Fear, dread, horror, terror themes will be included.

Score 0: Instances where nothing about fear, dread, horror or terror feelings, fantasies or memories are displayed or mentioned by the patient.

Score 2: Instances where the patient mentions or displays about moderate degree of fear, dread, horror or terror feelings, fantasies or memories. The patient should be moderately emotionally involved in fear related expressions or actions.

Score 4: Instances where a strong degree of fear, dread, horror or terror feelings, fantasies or memories are displayed or mentioned by the patient. The patient

should be strongly emotionally involved in fear related expressions or actions strongly.

Further mark as,

Manifest: predominantly explicit during the session

Hidden: predominantly implicit during the session; sensed by clinical intuition

ENVY

Patient speaks about or displays negative feelings towards something desirable and yet unattainable to her/him, often having desires to take away or spoil others possessions. Following themes will be included: destroying the good, devaluing the good, grudge, devouring the other off something, ill will, malice.

Score 0: Situations where feelings or memories of envy are not displayed or mentioned at all by the patient.

Score 2: Situations where the patient mentions or displays a moderate degree of feelings or memories of envy. The patient should be moderately emotionally involved in envy expressions or actions.

Score 4: Situations where a strong degree of feelings or memories of envy are mentioned or displayed by the patient. The patient should be strongly emotionally involved in envy expressions or actions.

Further mark as,

Manifest: predominantly explicit during the session

Hidden: predominantly implicit during the session; sensed by clinical intuition

GUILT

Patient speaks about or manifests guilt over a real or fantasied, past or present action. Following themes will be included: right, wrong, crime, fault, being punished or abused, responsibility, sin, immoral, deserving the bad.

Score 0: In cases where the patient does not display or make reference to anything about feelings or memories of guilt.

Score 2: In cases where a moderate degree of feelings or memories of guilt are mentioned or displayed by the patient. The patient should be reasonably emotionally involved in guilt expressions or actions.

Score 4: In cases where the patient mentions or displays a strong degree of feelings or memories of guilt. The patient should be strongly emotionally involved in guilt expressions or actions.

Further mark as,

Manifest: predominantly explicit during the session

Hidden: predominantly implicit during the session; sensed by clinical intuition

SHAME

Patient speaks about or manifests shame over the perception or treatment of self, by him/herself or others. Defective self, flawed self, humiliation, degradation, embarrassment, ridicule, disgrace, fantasies of disappearing will be included.

Score 0: Instances where nothing about feelings or memories of shame are mentioned or displayed by the patient.

Score 2: Instances where the patient mentions or displays a moderate degree of feelings or memories of shame. The patient should be moderately emotionally involved in shame expressions or actions sensibly.

Score 4: Instances where the patient mentions or displays a strong degree of feelings or memories of shame. The patient should be strongly emotionally involved in shame expressions or actions.

Further mark as,

Manifest: predominantly explicit during the session

Hidden: predominantly implicit during the session; sensed by clinical intuition

SADNESS

Patients speaks about or manifests emotional pain. Following themes will be included: feelings of loss, despair, grief, crying, sorrow.

Score 0: Situations where no display or mention of feelings or memories of sadness come from the patient.

Score 2: Situations where the patient mentions or displays a moderate degree of feelings or memories of sadness. The patient should be reasonably emotionally involved in sad associated expressions or actions.

Score 4: Situations where a strong degree of feelings or memories are displayed or mentioned by the patient. The patient should be strongly emotionally involved in sad associated expressions or actions.

Further mark as,

Manifest: predominantly explicit during the session

Hidden: predominantly implicit during the session; sensed by clinical intuition

PSYCHOSEXUAL THEME

In order to understand the predominant psychosexual theme of each session, you will be asked to evaluate each session in terms of psychosexual stages and select the one that best describes the issues discussed in the session. You're not expected to rate each theme, but to select one category among "oral", "anal" and "oedipal".

In each session, it is expected that several themes from different stages will emerge. Please only pick one predominant theme for each session. You will be provided an optional space for a second predominant theme category, but you're expected to use it cautiously. Please identify a second theme only when it is also notably predominant.

In order to identify the keywords for each theme, Mayman (1986) and Kulosh and Mayman (1993)'s psychosexual theme descriptions were used. Please select oral, anal or oedipal as the predominant theme, on the basis of the descriptions below.

ORAL: Patient specifically speaks about oral issues; suck in, eat, binge, swallow, take in, absorb, drink, gulp, wash dawn, consume, ingest, devour, soak up, bite, purge, chew.

Example: I just want to eat, eat and eat. It feels like I do not enjoy anything but food

ANAL: Patient particularly speaks about anal issues; hold, keep, tight, rigid, order, clean, stubborn, solid, resolute, intractable, tenacity, obstinacy, discharge, evict, mess, dirt, annul, force out, drive out, explode, garbage, debris, shit.

Example: Everywhere is messy and in shit…

OEDIPAL: Patient specifically speaks about oedipal issues; genitals, castration, jealousy, comparison, fear of punishment, genital intercourse, gender-based comparisons, penis envy, and pregnancy.

Example: As if all man can rape me anytime...

DEFENSE

For the defense section, you'll be asked to rate the Here-and-Now Defensiveness of the patient, regardless of the mechanism. Then, you will be asked to code five defense mechanisms separately.

HERE-AND-NOW DEFENSIVENESS

The definition and codes for Here-and-Now Defensiveness are directly adopted from Cavdar and Fisek (2017).

Here-and-Now Defensiveness refers to the level of defensiveness (regardless of the type or the mechanism) of the patient at the here-and-now. Past or present "accounts" of defensiveness or use of specific mechanisms are not included, they are rated as 0. Any rating above 0 indicates that the patient is defensive.

Please use the definition and examples below as well as your clinical intuition to assign a score between 0 and 4 for each session.

Score 0: Not defensive at all

The patient is not currently defensive. Talks and acts freely or just gives an account or answers a question. The content of the speech may include accounts of defenses, but the patient is not currently defensive.

> *Example:*
>
> *The man in the dream somehow reminded me of a boy that I used to go with. He got upset when I left him but he also got over it almost immediately. Somehow there was a feeling of many women being in the dream and that reminds me of my father and all of his affairs.*

Score 1: Slightly defensive

The patient is slightly defensive at the here & now. However, she has partial awareness of herself being defensive and/or there is something else going on, although she cannot acknowledge it.

> *Example:*
>
> *It's like it's all not real. It can't really be so. You really have to love someone to let them see the inside of you and see every horrible part. And they have to love you too. Oh! I just couldn't stand it. I don't want to be understood. (silence)*

Score 2: Moderately Defensive

The patient is moderately defensive at the here & now. There is little or no awareness of herself being defensive and/or there is something else going on. Her efforts and responses are more resistant to becoming conscious.

> *Example:*
>
> *(silence) I don't want anything to do with anybody. I want to be all by myself and I won't have to feel anything. I have so much emotion and I have no place to put it and I don't know what to do with it. My mother and father won't take it and that makes it horrible.*

Score 3: Very Defensive

The patient is very defensive at the here & now. There is no awareness of herself being defensive and/or there is something else going on. Her efforts and responses are more rigid and resistant to becoming conscious.

Example:

Sometime I'll get back at her. I'm Just waiting for the chance. (silence) This frightens me. (silence) I feel as if it's crazy. I can't ..... when I get mad like this I get a sexual feeling. I've got one now. It happens whenever I get anxious like this. It's as if I'm masturbating. (silence)

Score 4: Extremely defensive

The patient's defensive efforts distort the perception of reality and/or her relationship with the analyst. There is no awareness. Her efforts and responses are extremely rigid and resistant to becoming conscious.

Example:

Delusional projection, psychotic distortions, acting outs that might harm self or others

DEFENSE MECHANISMS

In order to assess defense mechanisms that are used by the patient during the sessions, the Defense Mechanism Rating Scale (DMRS) was used (Perry, 1990). You will be asked to assess the defense mechanism on a three-point scale where 0 refers to not using, 1 refers to probably using and 2 refers to definitely using the defense. According to the purposes of the study, 5 defense mechanisms were selected. The following section is directly adopted from DMRS 5th edition Coding Manuel (Perry ,1990)

PROJECTION

Definition: Projection: the individual deals with emotional conflicts, or internal or external stressors, by falsely attributing his or her own unacknowledged feelings; impulses; or thought to others. The subject disavows his or her own feelings, intentions or experience by means of attributing them to others, usually by whom the subject feels threatened and to whom the subject feels some affinity.

Function: Non-delusional projection allows the subject to deal with emotions and motives which make him feel too vulnerable (specially shame or humiliation) to admit having himself. Instead he concerns himself with these same emotions and motives in others. The use of projection therefore commits the subject to a continual concern with those on whom he has projected his inner feelings as a way to minimize awareness of them himself.

Score 0: There is no examples of projection in the session.

Score 1: Probable use of projection in the session

a. The subject seems overly concerned with others" feelings, misdeeds malevolent intentions toward himself or toward People in general. This is expressed along with:

1.Sarcastic comments about others (witty put-downs);

2. Comments about knowing others' "real" motives or reasons for doing things;

3. A certain air of arrogance about being knowledgeable about those whom the subject is suspicious of or concerned about.

4. The subject consistently perceives others as angry, strong, aggressive, manipulative.

b. The subject mentions not trusting people and gives various reasons which do not particularly impress the observer as reasons not to trust anyone, since they are vague or irrelevant, or S/he has a chip on hi/hers shoulder or is a collector of injustices.

c. The subject sometimes responds to questions by asking the therapist 'Why do you want to know that?" or otherwise seems suspicious but cooperative.

d. The subject sees some feeling in others when the feeling induced is one that S/he himself/herself has. However, S/he does not talk about or apparently recognize it in himself/herself.

Score 2: Definite use of projection is evident in the session. *The subject would seem somewhat 'paranoid" to most people. One or more of the following must be present.*

a. Intense denial, or extreme ambiguity to direct questions about subject's own feelings, behavior, intentions, etc. is followed closely by the subject's comments about similar feelings, actions, intentions, etc. in others.

b. The subject gives several examples externalizing blame for his own problems. Someone else is to blame for what are clearly his own shortcomings or difficulties. The subject shows definite concern or -anger in his comments about others' 'blameworthy" actions.

c. The subject avoids direct answers (other than denials) to the therapist, and instead tries to question the therapist about his motives, what he really means etc. He definitely acts suspicious when it is not warranted.

d. The subjects displays prejudice in which he or she condemns faults, which are clearly his or her own, in a minority group.

ACTING OUT

Definition: The individual deals with emotional conflicts, or internal or external stressors, by acting without reflection or apparent regard for negative consequences.

Acting out involves the expression of feelings, wishes or impulses in uncontrolled behavior with apparent disregard for personal or social consequences. It usually occurs in response to interpersonal events with

significant people in the subject's life, such as parents, authority figures, friends, or lovers.

This definition is broader than the original concept of acting out transference feelings or wishes during psychotherapy. It includes behavior arising both within and outside of the transference relationship. It is not synonymous with "bad behavior', or with any symptom per se, although acting out often involves socially disruptive or self-destructive behavior. So-called acting out behaviors, such as physical fighting, or compulsive drug use, must show some relationship to affects or impulses that the person cannot tolerate in order to serve as evidence for the defense of acting out.

Function: Acting out allows the subject to discharge or express feelings and impulses rather than tolerate them and reflect on the painful events that stimulate them. The following elements are present. First, the subject has feelings or urges which he is inhibited from expressing. Experiencing the original impulse quickly results in a rise in tension and anxiety. Second, the individual bypasses awareness and ceases any attempt to delay, reflect upon or plan a strategy to handle the impulse or feeling. Rather it is directly expressed in behavior without prior thought. This results in the expression of rather raw aggression, sex, attachment, or other impulses without taking the consequences into account. Following acting out, reflection may return and the subject commonly feels guilty or expects some punishment, unless a further defense comes into play, such as denial or rationalization ("I was so angry, I had to do it. It was his fault for stirring me up'). Acting out is maladaptive because it does not mitigate the effects of the internal conflict, and it often brings upon the subject serious, negative, external consequences.

Score 0: No instances of acting out are demonstrated within or described outside of the session.

Score 1: Probable use of acting out in the session.

a. The subject described one or two limited examples of such behavior such as binge eating or drinking, sexual escapades, drug use, reckless driving, getting into trouble, etc. which are generally uncharacteristic of subject and occur when having isolated interpersonal difficulties.

b. The subject describes certain of the above behaviors which he uses to 'drown out" certain disappointments or other painful affects.

c. The subject reports certain of the above behaviors but when queried as to why they happen, doesn't know or says that they happen only when feeling bad or tense, or irritable.

d. The subject loses his temper once in the session.

e. The subject responds to interpersonal disappointment or disagreement with impulsive behavior that may have bad consequences (e.g., missing therapy sessions after getting angry at therapist) but the emotional connection between event and behavior may be ambiguous.

Score 2: Definite use of acting out is apparent in self-report and/or evident in session.

a. The subject describes several episodes of uncontrolled behaviors, or 'tantrums that occur when the subject is feeling disappointed, angry, or rejected by someone.

b. The subject's acting out episodes have brought a number of bad consequences to health, social, or vocational adjustment (e.g. multiple hospitalizations, multiple job losses, serious problems in relationships).

c. The subject has a history of two or more impulsive, self-destructive acts (e.g. overdose, wrist-cutting, reckless driving) closely following significant interpersonal disappointments, etc.

d. The subject expresses great distress at not being able to control himself during episodes of acting out, believing he has little control over his impulses,

(e.g. "I hate sex, I just get into such lousy situations that I can't control myself every time and always with such creeps.')

e. The subject threatens or does anything threatening (e.g. throwing ashtray in reaction to the therapist, during the session), or looses his temper two or more times in the session.

f. The subject responds to an interpersonal disappointment or disagreement by impulsive behavior that has bad consequences for the subject's relationships (e.g. after getting angry in a session with a therapist, the subject impulsively quits or leaves town). The example should be quite unambiguous.

SPLITTING

Definition: The individual deals with emotional conflicts, or internal or external stressors, by viewing himself or herself or others as all good or all bad, failing to integrate the positive and negative qualities of the self and others into cohesive images; of ten the same individual will be alternately idealized and devalued.

In splitting of other's images (object images), the subject demonstrates that his views, expectations and feelings about others are contradictory and that he cannot reconcile these differences to form realistic and coherent views of others. Object images are divided into polar opposites, such that the subject can only see one emotional aspect or side of the object at a time. Objects are experienced in black or white terms. At one time an object will seem only to have such traits as being loving, powerful, worthy, nurturing, and kind, but no attributes of opposite emotional significance. At an- other time that same object may be seen as bad, hateful, angry, destructive, rejecting, or worthless, and the subject is incapable of seeing any positive attributes. In discussions, the subject commonly talks about some individuals in all positive terms and other individuals in all negative terms, as if the world is split into good and evil camps. The switch from experiencing an object as good to experiencing it as bad is unpredictable.

Splitting is revealed in two major ways. The subject may initially describe an object wholly in one way but later on describe that same object in opposite

ways. Second, each object is simply lumped with other objects into good and bad, positive and negative camps.

When the subject uses splitting of object images, he cannot integrate anything that doesn't match his immediate experience of and feeling about a given object. All of the attributes with the same feeling tone are highlighted, and contradictory views, expectations, or feelings about the object arc excluded from emotional awareness, although not necessarily from cognitive awareness.

Splitting of self-images often occurs alongside splitting of others' images, since they both were learned in response to the unpredictability of one's early significant others. In splitting of self- images, the subject demonstrates that he has contradictory views, expectations, and feelings about himself which he cannot reconcile into one coherent whole. The self-images are divided into polar opposites: at a given time, the subject's awareness is limited to those aspects of the self having the same emotional feeling tone. He sees himself in "black or white" terms. At one point in time the subject believes he himself has good attributes, such as being loving. powerful, worthy, or correct and having good feelings, or he believes the opposite; that he is bad, hateful, angry, destructive, weak, powerless, worthless or always wrong and has only negative feelings about himself. The subject cannot experience himself as a more realistic mixture of both positive and negative attributes. Moreover, the switch from experiencing the self exclusively in one polar feeling tone to the opposite feeling tone is unpredictable.

Function: Splitting of object images and self-images is the subject's defense against the anxiety of ruining the good images of people by allowing bad aspects of them to intrude upon the good.

Splitting of object images limits the anxiety the subject would feel in trying to discriminate how others will respond when he experiences or expresses his needs, feelings, etc. To see others as all good or all bad eliminates the anxiety-provoking task of trying to discern how others will behave toward the self, a task the subject believes to be impossible. Instead, the subject quickly categorizes people into good and bad camps based on subtle initial cues (e.g. 'he frowned

when I spoke so he hates me") or based largely on internal feeling states (e.g. "I feel so bad that I know you must hate me, so why should I open up to you?"). The defense is maladaptive, however, because the subject acts as unpredictably and irrationally toward others as he himself 'was treated; he forgoes the rewards he might attain if he were flexible in how he interacts with others. Using this defense, the subject wins some friends and makes some enemies, but not in a realistic way that takes into account the aggregate of others' actual characteristics.

Score 0: No examples of splitting of self or object images in the session

Score 1: Probable use of splitting in the session.

a. Once or twice in the session the subject describes an object in either a positive or negative way, and later describes the same object wholly in the opposite way.

b. At one or two points in the session the subject describes self or others as all good or all bad, but the subject has trouble describing the good and the bad together; the subject ignores one or the other.

c. Once or twice in the session, the subject says something about himself as if really believing it, then contradicts this later on in the session, as if really believing the opposite.

d. The subject reports being distressed by some contradictory behaviors towards others (acting one way, then a contradictory way) and not knowing why he or she behaves so inconsistently.

Score 2: Definite use of splitting defense mechanism in the session.

a. The subject generally refers to self or others as either all good or all bad, not more realistic mixtures.

b. On several occasions the subject contradicts his own statements which he made earlier in the session about the positive or negative features of someone or something. This is done without apparent distress over the differences and without apparent recognition of the contradictions.

c. When the therapist confronts the subject by contrasting contradictory statements the subject made about someone, the subject denies the significance of the contradiction, sticking to one view or the other, and resists the therapist.

d. The subject is unable to draw obvious conclusions about other people based on their behavior. This generally coincides with very poor judgment regarding how others will treat the subject in various situations. For example: "I didn't know whether he was trying to scare me when he put the knife to my throat. I felt confused."

e. It is obvious that a subject has taken characteristics from a major figure in the past and assigned the positive to an 'idealized' figure in the present and the negative to a 'devalued" figure in the present.

f. More than once during the session the subject talks about him or herself as either all good or all bad; although this may switch to the opposite as the session proceeds. (e.g. 'I don't care what anyone says, I'm absolutely worthless', later followed by 'I know I really am the best they have at work.")

g. The subject denies the meaningfulness or importance of his own past actions (e.g. significant acts, evidence of productiveness, etc.) as if they don't count in contradiction to his present view of himself. The subject resists the therapist's attempt to make him see both sides of himself.

DENIAL

Definition: The individual deals with emotional conflicts, or internal or external stressors, by refusing to acknowledge some aspect of external reality or of his or her experience that would be apparent to others.

The subject actively denies that a feeling, behavioral response, or intention (regarding the past or present) was or is not present, even though its presence is considered more than likely by the observer. The subject is blinded to both the ideational and emotional content of what is denied. [This excludes 'psychotic denial" in which the subject refuses to acknowledge a physical object or event within the subject's field in the present time.]

Function: Denial serves to prevent the subject who uses it and anyone querying him from recognizing specific feelings, wishes, intentions or actions for which the subject might be responsible. The denial avoids admitting or becoming aware of a psychic fact (idea and feeling) which the subject believes would bring him aversive consequences, (such as shame, grief or other painful affect). The evidence f or this is clear whenever a subject breaks through his own denial and experiences shame or other emotion at what he learns about himself, often apologizing to the interviewer and so forth.

Score 0: No evidence for denial is noticeable in the session.

Score 1: Probable use of denial is marked in the session.

a. The subject describes a life situation where one would think that certain feelings like anger, sadness, or fear might be present, but the subject denies that they were (are).

b. The subject denies certain feeling or intentions which the observer believes are present but does so infrequently and without much force, or conviction about it; he doesn't act "defensive" in making the denial.

c. Twice or more in the session, the subject claims to have done something when all evidence points to the contrary.

Score 2: Definite use of denial marked in the session.

The subject actively avoids inquiry about denied material and there may also be extreme defensiveness about what is denied.

a. In several instances the subject denies inquiries or suggestions about certain feelings, affective responses or intentions, to the point where it is clear the subject could not possibly be correct: e.g., person describes being abused but denies any associated negative responses, and attempts to avoid further inquiry.

b. The subject is hard to session because he commonly responds with 'no' to the therapist's inquiries, at least some of which should yield more elaborate answers.

c. The subject responds to the therapist's questions or statements by denial accompanied by anger, vehement attempts to avoid topic may also follow. These may only occur once or twice, but ' they are usually disruptive to the flow of the session. (e.g. Inter-viewer: " You must have felt sad." Subject: "Sad? No, that's not even relevant! I don't know why you would think that').

DISSOCIATION

Definition: The individual deal with emotional conflicts, or internal or external stressors, by a temporary alteration in the integrative functions of consciousness or identity. In the defense of dissociation, a particular affect or impulse which the subject is not aware of operates in the subject's life out of normal awareness. Both the idea and associated affect or impulse remain out of awareness but are expressed by an alteration in consciousness. While the subject may be dimly aware that something unusual takes place at such times, full acknowledgment that his or her own affect or impulses are being expressed is not made. Dissociation may result in a loss of function or in uncharacteristic behavior.

Function: Dissociated material is commonly experienced as too threatening, too conflict-laden, or too anxiety-provoking to be allowed into awareness and fully acknowledged by the subject. Examples of common threatening material include recollection of a trauma with attendant fear of death and feelings of powerlessness, or a sudden impulse to kill an intimate associate. Dissociation allows expression of the affect or impulse by altering consciousness which allows the individual to feel less guilty or threatened.

Score 0: No evidence for dissociation is noticeable in the session.

Score 1: Probable use of dissociation is marked in the session.

a. The subject occasionally associates with others who express impulses or emotions in an uninhibited manner, often involving illegal or socially improper behavior. While this is very unlike the subject's own usual behavior, the subject seems unaware of this apparent fascination in relation to the impulses they express.

b. The subject describes one or two episodes of uncharacteristic behavior expressing raw impulses (e.g. "I threw a glass of water in my friend's face'). The subject reacts with comments such as "I just don't know what made me do it, it is so unlike me.' The above must be distinguished from behavior which is generally rowdy occurring when the subject is intoxicated.

c. The subject expresses an affect or impulse through developing a symptom (such as depersonalization or a headache when angry) or through the appearance of symptomatic behavior (falling asleep on a new job).

Score 2: Definite use of dissociation is marked in the session

a. The subject describes fugue states, amnesia (not alcoholic blackouts), multiple personality, spontaneous trance states, or temporary loss of sensory or motor function which express exciting or conflict-laden impulses or affects.

b. The subject describes a recent personal injury, trauma, symptom, etc. with classic indifference, giving the observer the affective message that the event in question almost seemed not to register in its significance. The subject does not deny the event's or symptom's existence, however.

c. The subject associates with others who do dramatic and impulsive things (including illegal activities) while acting as if unaware of any such interests himself. The subject may further show evidence of his fascination with what others do by mimicking or copying their dress or manners. For example: the 'good girl' who dresses somewhat like her prostitute best friend.

d. The subject notes three or more occasions of getting him or herself into difficulty for saying or doing things he or she claims he or she really didn't intend.

e. In the session, the subject develops a symptom or clouding of consciousness (e.g. "I suddenly feel confused and can't think') in response to talking about an emotionally charged topic.

THERAPEUTIC RELATIONSHIP

For the therapeutic relationship variables in this study, you will evaluate the Level of Separation Between the Therapist and the Patient, Transference, Countertransference and Therapeutic alliance.

THE LEVEL OF SEPERATION BETWEEN THE THERAPIST AND THE PATIENT

Separation is an intra-psychic process which is an ability to move away from the object's mental representation and results in forming an autonomous self. The processes underlying separation include differentiation, distancing, boundary formation, and disengagement. For the coding in this study, following themes will be included: differentiate self, explore, check back, autonomy, dependency, venture away.

In this study, the level of separation between patient and therapist will be rated on a 5-point scale, starting from symbiotic relationship (Score 0), the level of separation gradually progress to hatching (Score 1), to practicing (Score 2), to rapprochement crisis (Score 3) and finally to object constancy (Score 4), which is the healthy level of separation between the therapist and the patient.

Please use the definition and examples below as well as your clinical intuition to assign a score between 0 and 4 for each level.

Score 0: Symbiosis

The patient and the therapist are in a complete merger experience; the boundaries are non-existing. There is an uncertainty regarding what belongs to the patient's psyche and therapist's psyche.

Score 1: Hatching

The patient and the therapist are aware of their separateness. The patient demonstrates autonomy, yet checks back with the therapist frequently for safety / soothing and sense of power.

Score 2: Practicing

The patient and the therapist maintain separateness, with clear boundaries. On the other hand, momentary merger is still possible, in cases of need. The patient can explore independently, but still derives safety and power from the experience of being with the therapist.

Score 3: Rapprochement Crisis

There is a painful awareness of separateness. The patient is aware of his/her limits and his/her need for the therapist. There are back-and-forth experiences between total independence & denial of the need and increased need for the therapist. Illusion of self-sufficiency alternating with extreme dependence, temper-tantrum like states may characterize this score.

Score 4: Object Constancy

There is a healthy, balanced, flexible separation-individuation. The patient can function autonomously, and when in need, can comfortably refer to the internalized object as wall as the external therapist

COUNTERTRANSFERECE

In the literature, various psychoanalytic schools have differing explanations for countertransference. However, in order to maintain consistency in this study, the meaning of the countertransference is specified to the explanation of the analyst's "conscious and unconscious reactions to the patient's transference" (Auchincloss, & Samberg, p. 47-49). Nevertheless, it is not possible to assess the therapist's feelings and countertransference in this study. Therefore, we will use the therapist's interpretations to understand whether or not there is countertransference material in the session.

You will first be asked to identify the affective tone of the countertransference by selecting either "Positive" or "Negative". Then, you will rate the intensity of the countertransference based on your clinical intuition by assigning a number between 0 and 4. The rating 0 means there was no observable countertransferential experience and the rating 4 refers to a highly intense countertransference.

TRANSFERENCE

Transference is referring to the "patient's conscious and unconscious experience of the analyst in the psychoanalytic situation as it is shaped by the patient's internalized early life experiences" (Auchincloss, & Samberg, p.266-270). Similar with the countertransference variable, transference will be assessed by patient's verbal content in the session.

You will first be asked to identify the affective tone of the transference by selecting either "Positive" or "Negative". Then, you will rate the intensity of the transference based on your clinical intuition by assigning a number between 0 and 4. The rating 0 means there was no observable transferential experience and the rating 4 refers to a highly intense transfererence.

THERAPEUTIC ALLIANCE

Therapeutic alliance – also known as working alliance – refers to the cooperation and collaboration in the psychotherapy process. The therapeutic alliance in this study, was measured by Working Alliance Inventory – observer form (WAI-O) which was developed by Darchuk et al., (2000) based on Raue, Goldfried & Barkham (1997) coding manuel and adapted to Turkish by Soygüt and Uluç (2009). The WAI-O includes three sections namely Bonds, Tasks and goals, and composed of 12-items.

In order to assess the therapeutic alliance in this study, you will be asked to rate the questions according to each session by using a 7-point scale ranging from "1= strongly disagree" to "7= strongly agree". The following section was directly adopted from Soygüt and Uluç (2009) and Wang et al., 2005). The English and the Turkish versions (italic) of the items and the Turkish version of the Coding Manuel is as follows.

Score 1: Client states that tasks and goals are not appropriate, and does not generally agree on homework or in-session tasks. The client may argue with the therapist over the steps that should be taken. The client does not participate in tasks.

TR: Hasta, amaç ve görevlerin uygun olmadığını belirtmekte ve görüşme içi görevleri genellikle kabul etmemektedir. Atılması gereken adımlar konusunda terapisti ile tartışmaya girebilmektedir. Görevlere katılım gerçekleştirmemektedir.

Score 2: Client is hesitant to explore and does not follow therapist guidance. The client withdraws from the therapist, or does not engage or is not attentive to the therapist or to the task.

TR: Hastanın keşfetmeye karşı tereddütleri vardır ve terapistin rehberliğine girmemektedir. Terapistten uzaklaşmakta, bağlılık hissetmemekte ya da terapiste veya görevlere karşı gereken dikkati ve özeni göstermemektedir.

Score 3: The client appears to be unsure as to how the tasks pertain to his/her goals, even after some clarification by the therapist. The client seems either ambivalent or unenthusiastic about the tasks in therapy, and could be resistant to the tasks (e.g., limited participation).

TR: Hasta, terapist tarafından yapılan açıklamalara rağmen görevlerin kendi amaçları ile ne kadar ilişkili olduğundan emin görünmemektedir. Terapideki görevlere yönelik ikircikli bir tutum sergilemekte ya da isteksiz görünmekte ve görevleri yerine getirme konusunda direnç gösterebilmektedir (örn: sınırlı katılım.)

Score 4: No evidence or equal evidence regarding agreement and/or disagreement.

TR: *Uzlaşma ve/veya uzlaşmama ile ilgili eşit derecede kanıt bulunmakta ya da hiçbir kanıt bulunmamaktadır.*

Score 5: Client follows exploration willingly with few or no therapist clarifications needed. The client becomes invested in the process, and is an active participant in the task. There is a sense that both parties have an implicit understanding of the rationale behind the tasks in therapy.

TR: Hasta, terapistin hemen hemen hiç açıklama yapmasına gerek duymadan istekle keşfe yönelmektedir. Sürece yatırım yapmakta ve görevlere aktif katılım sağlamaktadır. Terapideki görevlerin mantığı ile ilgili her iki tarafında fikir birliği içinde oldukları hissedilmektedir.

Score 6: Client openly agrees on tasks and is enthusiastic about participa- ting in tasks. Both participants are acutely aware of the purpose of the tasks and how the tasks will benefit the client. To this end, the client uses the task to address relevant concerns and issues.

TR: Hasta görevleri açık bir biçimde kabul etmekte ve bu görevlere katılmaktan memnuniyet duymaktadır. Her iki taraf da ilgili görevin amaçları ve hastaya sağlayacağı yararlar konusunda hemfikirdirler. Bu amaçla, hasta sözü edilen görevleri konu ve durumlarla ilişkilendirebilmektedir.

Score 7: Repeated communication of approval and agreement, both before and after the task is completed. The client responds enthusiastically to interventions, gains insight, and appears extremely confident that the tasks are appropriate.

TR: Her iki taraf görevin yerine getirilmesinden önce ve sonra görevle ilişkili olarak aynı fikirde olduklarını sıklıkla dile getirmekte ve onaylamaktadır. Hasta terapötik müdahalelere hevesli bir şekilde tepki göstermekte, içgörü kazanır görünmekte ve görevlerin uygun olduğu konusunda oldukça emin görünmektedir.

ITEMS

1. There is agreement about the steps taken to help improve the client's situation
   TR: Danışanın durumunun iyileştirilmesine yönelik atılan adımlar konusunda anlaşmanın bulunması
2. There is agreement about the usefulness of the current activity in therapy
   TR:Danışan ve terapistin, terapide yapılmakta olanların yararı konusunda uzlaşmanın olması.

3. There is a mutual liking between the client and therapist.

   TR: Danışan ve terapistin birbirine yakın hissetmeleri

4. There are doubts or a lack of understanding about what participants are trying to accomplish in therapy (R)

   TR: Her iki tarafın terapide neye ulaşmak istedikleri konusunda şüphelerinin ya da yanlış anlamalarının olması

5. The client feels confident in the therapist's ability to help the client.

   TR: Danışanın, terapistin kendisine yardım edebileceğine güvenmesi.

6. The client and therapist are working on mutually agreed upon goals.

   TR: Danışan ve terapistin ortak amaçlar üzerinde çalışması.

7. The client feels that the therapist appreciates him/her as a person.

   TR: Danışanın, terapistin onu insan olarak takdir ettiğini hissetmesi.

8. There is agreement on what is important for the client to work on

   TR: Üzerinde çalışılanların hasta açısından önemi konusunda uzlaşma olması.

9. There is mutual trust between the client and therapist

   TR: Terapist ve danışan arasında karşılıklı bir güvenin olması.

10. The client and therapist have different ideas about what the client's real problems are. (R)

    TR: Danışan ve terapistin, danışanın asıl sorunlarının neler olduğu konusunda farklı düşünmesi

11. The client and therapist have established a good understanding of the changes that would be good for the client

    TR: Danışan ve terapistin ne tür değişikliklerin danışanın yararına olacağı konusunda anlaşmaya varmış olması.

12. The client believes that the way they are working with his/her problem is correct

    TR: Danışanın, sorunlarının ele alınma yolunun doğru olduğuna inanması.