Université de Montréal

A Conceptual Empirical Study of Interactive Communication in Psychotherapy and Psychoanalysis

Par
Daniela Wiethaeuper

Département de psychologie
Faculté des Arts et des Sciences

Thèse présentée à la Faculté des études supérieures
en vue de l'obtention du grade de
Philosophiæ Doctor (Ph.D.)
en psychologie, option psychologie clinique dynamique

février, 2001

Université de Montréal
Faculté des études supérieures

Cette thèse intitulée :

A Conceptual Empirical Study of Interactive Communication in Psychotherapy and Psychoanalysis

Présentée par :
Daniela Wiethaeuper

a été évaluée par un jury composé des personnes suivantes :

Marc-André Bouchard
Mireille Cyr
Hélène David
Steven Rosenbloom

Thèse acceptée le 6 juin, 2001

Page d'identification du jury

Université de Montréal
Faculté des études supérieures

Cette thèse intitulée:

A Conceptual Empirical Study of Interactive Communication in Psychotherapy and Psychoanalysis

présentée par:

Daniela Wiethaeuper

a été évaluée par un jury composé des personnes suivantes:

..... Mireille Cyr
..... président-rapporteur

..... Marc-André Bouchard
..... directeur de recherche

..... Hélène David
..... membre du jury

..... Steven Rosenbloom
..... examinateur externe

.....
..... représentant(e) du doyen

Summary

This thesis aims to present, describe and examine both conceptually and empirically a model of linguistic styles and complementarities of both patient and therapist based on David Liberman's initial clinical descriptions. The Liberman Linguistic Styles Measure (LLSM), developed in an effort to operationalize and delimit a complex theoretical perspective, into a valid measure applicable to psychotherapy research. The main objective of the thesis is to test the LLSM and its application in psychotherapy process research, related to outcome. Two psychotherapeutic beginnings offered by the same therapist were analyzed aiming to intensively explore both psychotherapy processe; one with poor and the other, with good outcome.

The first paper explores the theoretical grounds on which is based the LLSM, defined by the works of Argentinean analyst David Liberman who regarded as unavoidable the use of semiotics to understand the interaction field. The Semiotic rules are character originated, and in pathology contribute to repetitive patterns and miscommunications, which can observed in the therapeutic field. He defined different linguistic styles, and identified distinct therapist linguistic complementarities. A positive communicative interaction depends on the therapist's use of complementary linguistic styles, which are different in nature and quality from the ones used by the patient at a

certain point in the session. Liberman's model linked each style with specific psychopathological cases. However, the core of the LLSM is based on the linguistic styles as a result of a dimensional, process-oriented and descriptive approach to the various sequences in stylistically distinct communicative mental states of the ego, as observed during the sessions. In the second paper we briefly present the LLSM, which is constituted of three parts: a description of a preliminary segmentation process of each transcript, followed by a detailed description of nine linguistic-stylistic components or functions, and finally, a list of positive (complementary), negative and neutral linguistic interactions.

The LLSM was applied on the beginning of two psychodynamically oriented psychotherapies, of two distinct patients (14 sessions each), offered by the same therapist. The uniqueness of this material is that we not only had two cases with the same therapist, but with different outcomes.

This instrument was developed aiming to be applied to intensive process psychotherapy research. The application of the LLSM verified important and distinct progressions of each therapeutic dyad in terms of styles and complementary and non-complementary interactions.

"Liberman negative" had a negative effect on clinician's ratings of helpfulness. "Liberman positive" combined with the therapist's mental state, verified the instrumentality of interactions for this pair. Finally, the "Liberman neutral" were related to specificities in the defensive-characterological functioning of each patient.

We conclude the thesis with a discussion of psychoanalytic and psychotherapeutic process as an unique interactional field in which the patient and the therapist share similar semantic fields and a collaborative pragmatic interaction, less instinctually infiltrated by aggression and idealization. In other words, increased integration and plasticity within the ego functioning and in communication and interaction with others.

Résumé

Cette thèse a pour objectif de proposer une nouvelle approche conceptuelle et empirique des séquences variées de communication stylistique en psychanalyse et en psychothérapie. L'approche est dimensionnelle, descriptive et orientée vers l'étude des processus stylistiques qui accompagnent les états mentaux du moi du patient et celui du thérapeute. Ce travail propose une mesure opérationnelle (la Liberman Linguistic Styles Measure; LLSM, Wiethaeuper, 1999) de ces phénomènes linguistiques et stylistiques de communication, fondée sur les contributions du psychanalyste argentin David Liberman. Cette mesure est mise à l'épreuve dans une étude intensive du processus thérapeutique dans ceux cas contrastés de psychothérapie offerte par le même thérapeute d'expérience.

Le premier article cherche à explorer les fondements de la communication stylistique au sein du champ thérapeutique. Le modèle de Liberman concerne le lien entre la sémiotique et notre compréhension de la psychopathologie du développement et de la psychothérapie. Selon lui, la situation analytique résulte d'un champ interactif mis en place et structuré par les styles linguistiques et l'interaction communicative du patient et du thérapeute. Les règles sémiotiques sont inhérentes au caractère et dans la psychopathologie elles contribuent à la présence de patterns répétitifs et de difficultés de communication.

Ce premier article discute du concept des résistances intrinsèques au caractère. Il examine aussi comment se forment le caractère et les expressions non-verbales. Ces traits du caractère sont conçus comme des références métaphoriques et figuratives à des

conflits plus fondamentaux, tels que décrits par la théorie psychanalytique. Nous soutenons qu'un aspect important mais peu considéré du caractère, nous est rendu accessible par la communication à travers les expressions para-linguistiques, linguistiques et non-verbales de l'organisation caractérologique même de l'individu, exprimée à travers des patterns linguistiques spécifiques, qui constituent un style particulier de communication.

Dans la psychopathologie, ce style particulier contribue à des patterns répétitifs et à des difficultés au sein de la communication qui sont observés dans le champ thérapeutique. Afin d'exercer une influence bénéfique, le thérapeute devra accorder une importance particulière aux caractéristiques stylistiques, en allant quelquefois même au-delà du contenu des associations du patient. Dans le processus d'*encodage*, l'analyste communique au patient les signifiants inclus dans le message et dont ce dernier n'est pas conscient. Dans les conditions optimales, l'analysant reçoit le message linguistique de l'analyste et le place au sein d'une classification de signifiants auxquels sont attachés de nouveaux signifiés. Dans ce cas, le patient est en mesure de saisir de façon optimale la transmission de l'analyste. La notion de complémentarité stylistique, abordée de manière sémiotique, constitue donc une forme différente du style habituel du patient qui permet d'éveiller en lui des dispositions nouvelles, et d'accéder à des dimensions sémantiques inusitées et enrichies.

Afin d'étayer davantage ces conceptions, nous présentons dans ce premier article, l'exemple clinique d'une analyse terminée prématurément et dans laquelle certaines des caractéristiques stylistiques du patient se sont cristallisées autour d'une résistance

massive. Le champ communicatif fut ainsi transformé en séquences de mauvaises communications ce qui a éventuellement conduit à mettre fin à l'analyse, la relation étant rendue en une impasse. Nous explorons la possibilité d'aborder certaines de ces caractéristiques stylistiques dès le début du traitement, en faisant notamment usage de styles linguistiques complémentaires. Ce patient (V4) a pu détourner l'attention de l'analyste de ses distorsions sémantiques et le thérapeute a pour sa part tenté d'interpréter la personnalité narcissique du sujet en utilisant des interprétations portant sur le contenu. Des aspects plus subtils des traits de caractère du patient étaient à l'oeuvre dès le début, observables notamment au moyen d'expressions pragmatiques subtiles. La participation de l'analyste, par son usage du style narratif, aurait pu être vitale pour l'obtention de résultats thérapeutiques plus positifs.

La conclusion de cet article repose sur le raisonnement qu'à partir de la théorie de Liberman et en lien avec l'illustration clinique, il est possible d'explorer davantage les racines linguistiques de certaines défenses archaïques mises au service de la structure caractérielle; et d'envisager également comment ces racines sont représentées par des caractéristiques linguistiques subtiles. De là, on peut concevoir comment un thérapeute peut chercher à se «déprendre» de façon analytique et linguistique en utilisant des interprétations adéquates tant du point de vue de la forme que du contenu. L'étude des styles linguistiques est en effet un outil important dans le travail des résistances caractérielles.

Le second article étudie la validation empirique du modèle théorique d'interaction stylistique en utilisant la mesure opérationnelle issue du modèle de Liberman : la LLSM.

La LLSM fut appliquée à deux suites de 14 séances initiales de psychothérapie, offertes par le même thérapeute. La première donna lieu à une impasse et à un abandon précoce du traitement après 14 rencontres; la seconde psychothérapie a pu être menée à terme, et après plus de 200 séances, l'issue était favorable. Les liens entre les indices de la LLSM et trois autres mesures, furent examinés : le niveau d'aide perçue par des cliniciens (HRS, Elliott), l'activité défensive (DMRS, Perry) et les états mentaux (réactif, réflexif, objectif-rationnel; Normandin & Bouchard, 1993). Les fréquences de séquences spécifiques complémentaires et non complémentaires des comportements linguistiques de chaque paire furent également analysées.

Pour chaque paire, nous observons des intercorrélations spécifiques entre les styles. Les séquences complémentaires et non complémentaires distinctes dans le comportement linguistique patient-thérapeute peuvent être évaluées. Les résultats démontrent que les patterns d'interaction positive, négative et neutre mesurent des caractéristiques distinctes : nous retrouvons plus de patterns linguistiques positifs et moins de patterns neutres dans la thérapie menée à terme, mais aucune différence n'est observée dans les proportions d'interaction négative en comparant les deux paires. La grande et constante incidence des interactions «neutres» dans la thérapie avortée est une observation imprévue. Mais il a semblé après examen plus détaillé que ces séquences dites neutres étaient en corrélation avec les spécificités du fonctionnement défensif et caractérologique, ce qui a pu contribuer à faire avorter le processus.

Parmi les résultats obtenus, la structure interne du LLSM aurait tendance à recouvrir deux catégories de complémentarités plutôt que trois. Alors que, tel qu'attendu,

Résumé

Cette thèse a pour objectif de proposer une nouvelle approche conceptuelle et empirique des séquences variées de communication stylistique en psychanalyse et en psychothérapie. L'approche est dimensionnelle, descriptive et orientée vers l'étude des processus stylistiques qui accompagnent les états mentaux du moi du patient et celui du thérapeute. Ce travail propose une mesure opérationnelle (la Liberman Linguistic Styles Measure; LLSM, Wiethaeuper, 1999) de ces phénomènes linguistiques et stylistiques de communication, fondée sur les contributions du psychanalyste argentin David Liberman. Cette mesure est mise à l'épreuve dans une étude intensive du processus thérapeutique dans deux cas contrastés de psychothérapie offerte par le même thérapeute d'expérience.

Le premier article cherche à explorer les fondements de la communication stylistique au sein du champ thérapeutique. Le modèle de Liberman concerne le lien entre la sémiotique et notre compréhension de la psychopathologie du développement et de la psychothérapie. Selon lui, la situation analytique résulte d'un champ interactif mis en place et structuré par les styles linguistiques et l'interaction communicative du patient et du thérapeute. Les règles sémiotiques sont inhérentes au caractère et dans la psychopathologie elles contribuent à la présence de patterns répétitifs et de difficultés de communication.

Ce premier article discute du concept des résistances intrinsèques au caractère. Il examine aussi comment se forment le caractère et les expressions non-verbales. Ces traits du caractère sont conçus comme des références métaphoriques et figuratives à des

encourageant pour les recherches futures, un pas que n'avait pas franchi Liberman. Il est évident que la fidélité inter juges de la LLSM s'est améliorée avec la précision du Manuel de cotation (voir annexe).

La LLSM présente un certain nombre d'inconvénients et de limites. Elle prend plusieurs heures à apprendre et à administrer. Certains styles demandent encore à être mieux différenciés l'un de l'autre (v.g. le lyrique et le dramatique esthétique). Le critère d'utilisation instrumentale devrait sans doute être ajouté à la cotation des interactions linguistiques positives. Afin de pallier à ce manque, une possibilité serait d'inclure la cotation d'état mental (réflexif, réactif, objectif-rationnel).

La validité de notre mesure pourrait bénéficier de recherches additionnelles, surtout en lien avec d'autres mesures établies de la relation thérapeutique. De plus, la comparaison des caractéristiques caractérologiques de chaque style avec des mesures comme la classification AAI qui permet de différencier des modalités linguistiques distinctes en lien avec des désordres psychologiques contribuerait à la validité de construit du LLSM, tant dans les convergences que dans les divergences.

Néanmoins les résultats obtenus à date restent encourageants surtout en ce qui concerne les champs de l'interaction au sein de la psychothérapie. La LLSM semble mettre en évidence une vision très différente de la formation du caractère, de son expression dans l'interaction thérapeutique, ainsi que de la juste approche thérapeutique de ces résistances par l'utilisation des styles complémentaires.

Pour conclure, il semble que plusieurs résistances caractérielles présentes dans le discours sont subtiles, mais qu'il est possible et nécessaire de les repérer, de les codifier

et de les retourner en quelque sorte au patient. La forme du travail interprétatif dans ce cas devrait être guidée au plus haut niveau de priorité, par la possibilité de rétablir la communication sur le plan linguistique, qui seule permet au patient de comprendre ce qu'on lui retourne. C'est à cette seule condition que peut se construire un véritable champ thérapeutique et interactionnel nouveau. Il est supposé que dans ces conditions, l'individu peut acquérir nouvelles composantes à son répertoire linguistique, et ainsi modifier son expérience interne et son caractère. Ceci implique un moi plus intégré (images de soi et des objets internes), plus de « plasticité » dans la communication et l'interaction. Autrement dit, selon le langage contemporain, ces conditions sont favorables à la formation de nouvelles « cartes neuronales », assurant du coup la configuration de liens plus flexibles et complexes entre les divers systèmes de mémoire.

Références

Elliott, R. (1985). Helpful and Nonhelpful events in brief counseling interviews: an empirical taxonomy. Journal of Counseling Psychology, 32(3), 307-322.

Normandin, L., & Bouchard, M. A. (1993). The effects of theoretical orientation and experience on rational, reactive, and reflective countertransference. Psychotherapy Research, 3, 77-94.

Perry, J. C. (1990). Defense mechanisms rating scales. Cambridge, MA.

Wiethaeuper, D. (1999). The Liberman Linguistic Style Measure. Scoring manual. Unpublished material . Université de Montréal: Montreal.

Contents Table

Tables List

Paper 1

Paper 2

Figures List

Paper 2

Remerciements

C'est avec joie que j'exprime ma profonde gratitude à mon directeur de thèse, M. Marc-André Bouchard, Professeur titulaire. Sa très grande disponibilité et son support, surtout à la fin de ce travail, m'ont beaucoup aidé à traverser la fatigue, et parfois même, le découragement devant la tâche de finaliser la thèse. Ses précieux conseils et sa capacité de synthèse ne cessent jamais de m'impressionner. Je pense que nous avons réussi à établir « a shared semantic field »! J'espère bien pouvoir continuer de collaborer avec lui dans de recherches futures.

Un gros merci à ma famille pour le support affectif et financier, leur compréhension, leur tolérance et leur appui inconditionnel à mes projets, même si cela signifiait des années si loin de vous. Je vous admire énormément!

A mon mari, toujours présent avec sa tolérance et son amour.

Aux collègues du Labo : Chantal Picard, Caroline Audet, Serge Lecours, Patrice St-Amand et Silvie-Hélène, merci pour ces années de travail stimulant et des heures de plaisir !

Un remerciement spécial à Natali Sanlian pour être là quand j'en ai eu besoin; ses conseils pour la LLSM, les traductions en français et son amitié m'ont beaucoup touché.

A mes chères « coteuses », Brigitte Bolduc, Josiane Dubourg, et Sophie Jalbert, pour tout leur dévouement et pour leur contribution au développement la LLSM. Leur générosité et leurs excellentes suggestions ont abouti à la cinquième version de la mesure.

Je remercie aussi la Directrice du « Centro de Ciências da Saúde » de l'UNISINOS, Prof. Cornélia Hulda Volkart, M.Ps., pour son aide administrative et son appui personnel, qui a beaucoup contribué à faciliter notre séjour au Québec.

Cette étude a été réalisée grâce au support financier de CAPES (Centro de Aperfeiçoamento de Pesquisa e Ensino, Brasil), UNISINOS (Universidade do Vale do Rio dos Sinos – Brazil),du Département de Psychologie de l'Université de Montréal, et du FCAR Ministère de l'Education, Québec, Canada.

To the ones who have left,
"Opa" Arthur and "Opa" Walter.
To the one who has brightly arrived,
Gabriel

Introduction

This thesis follows the steps of more recent psychotherapy process research. More precisely, we propose to contribute to the understanding of the crucial components present in psychotherapy and psychoanalytic treatments, whether successful or not. The notion of communicative interaction receives the main attention since we introduce the theoretical model of stylistic interaction in psychoanalysis and psychotherapy and propose the development and validation of a new measure based on Liberman's (1982, 1983) model: The Liberman Linguistic Styles Measure (LLSM). This thesis is submitted as two related papers, one theoretical-clinical, the other empirical.

Linguistic styles and complementarities in linguistic communicative interaction are conceptions brought by the Argentinean psychoanalyst David Liberman who has offered a key contribution towards linking semiotics to knowledge of psychopathology and development and psychotherapy. In his view, the analytic situation is a result of an interaction field, structured by each participant's linguistic styles and their communicative interaction. The semiotic rules are character originated, and in pathology contribute to repetitive patterns and miscommunications, which are observed in the therapeutic field. The therapist, in order to exert any beneficial effect, has to focus on these stylistic features, sometimes over and above the content of the patient's associations. Thus, in order to establish a positive communicative interaction, the therapist, 'as a part of his working models' (Greenson, 1960), is required to instrumentally use specific linguistic styles that are complementary to the ones used by the patient. Only then will the message be received with minimal distortion, and the character resistances surmounted. These complementary styles are linguistic forms of

verbal communication, different in nature and quality from the ones used by the patient at a certain point in the session (Liberman, 1982, 1983).

Liberman's initial theory was based on psychopathology and nosology, and he presented some important discussions of the styles related to ego functioning. The issues of how linguistic styles become part of one's character, how they become resistances in the treatment, and how they can be identified and worked-through, are examined in the first article. We present a clinical example of an analysis with a poor outcome, in which some of the patient's initial stylistic features eventually turn into massive resistances while the communication field is transformed into sequences of miscommunications. This patient terminated the analysis after 660 sessions, as a result of a clear deterioration of the relationship. It is argued that some stylistic features may have been profitably addressed by the analyst from the beginning of the treatment, and sure of the possible complementary linguistic styles are discussed.

The concept of stylistic interaction becomes even more significant when we realize that the examination of the contents of wishes, symptoms, language utterances, character formation and some non-verbal expressions through character traits, have been privileged as figurative references to deeper conflict (Hernández, 1999). These are usually addressed in the content of interpretative work that mostly values the content of the patients' associations. Perhaps less considered is the value of character as an organizational structure expressing its peculiarities through paralinguistic, linguistic and non-verbal expressions. To address these character features implies to value the <u>form</u> of interpretative-communicative work. This we see through some aspects of the patients'

discourse, which is often repeated, and when any effort towards content interpretation, fails. In such circumstances, the patient's often feel misunderstood and criticized. Other patients, may actively and pragmatically avoid the therapist's attempts to establish a working communication field. In these cases, we often only much later recognize these pragmatic aspects, when projective identification has become massive, the communicative interaction field shattered, and acting-outs following, to our regret. Such unfortunate developments underline the importance of linguistic features.

This conceptual and linguistic reexamination has significant implications for psychoanalytic and psychotherapy process research. Psychotherapy research studies do not typically include complex definitions of the main interactive components of syntax, pragmatics and semantics, while is a major limitation. Our aim is to contribute to the study of the vicissitudes of stylistic character resistances within the psychotherapeutic - interaction field.

The LLSM seeks to operationally account for the theoretical concepts mentioned, but differently from Liberman's (1982, 1983) view, the core of the LLSM is based on the idea that linguistic styles are a result of a dimensional, process-oriented and descriptive approach to the various sequences in stylistically distinct communicative mental states of the ego, as observed in sessions. It is here applied to the discourse of patients and therapists, trying to identify stylistic features and complementarities leaving aside the study of prosody. This methodological choice was based on the need to adapt to the rigorous demands of empirical research and to the verbatim of clinical transcribed material. Liberman (1982) proposed some paralinguistic aspects that could be used to

specify some styles (like the use of monotone voice for the narrative style). Our task here was first to ensure the development of reliable and valid operational definitions of each style within the discourse, which in itself was an arduous and lengthy process.

The most recent version of the LLSM, (version 5.1 in French) was used for the empirical work presented in this thesis. It is constituted of three parts: a description of a preliminary segmentation process of each transcript, in which the judges are required to be already fully in command of each description of each style, while for segmentation rules are considered. The second part of the manual (LLSM) contains a complete description of each of the nine linguistic styles and components, separately for therapist and patient. These are: concrete, reflective-schizoid, lyric, epic, narrative, dramatic suspense, dramatic aesthetic and two insight form or meta-styles. The concrete mode and the meta-styles were added to the initial list proposed by Liberman (1982). Marty's (1990, 1991) description of poorly mentalized psychosomatic patients, was based in part on previous work by de M'Uzan (Marty & de M'Uzan, 1963) on concrete thought. The two "meta-styles" was based on the notion of insight as the ideal form of communication in terms of message transmission, with almost perfect syntax, semantics and pragmatics and no visible use of a specific style. The final part of the LLSM, a complete list of positive, negative and neutral linguistic interactions, based on specific therapist responses to the patient's attempts, are defined. We stress that the positive, negative and neutral interactions are not self-reported conclusions reached by the participants, but rather a consequence of independently rated judgments based on a provided list of linguistic complementarities and non-complementarities of the dyad. Numerous clinical examples

are provided, as well as a decision tree for the rating of styles. The empirical paper illustrates the application of this version of the LLSM on two psychotherapeutic beginnings offered by the same therapist. One quickly developed into an impasse, which led to premature termination. The other patient continued until session 202 with satisfactory results. We aimed to explore the internal structure of the LLSM, and to contribute to its validation by comparing to other measures (DMRS, Perry, 1990; HRS, Elliott, 1985; The Mental States Rating Systems; Bouchard, Picard, Audet, Brisson & Carrier, 1998) using two distinct interaction fields

The present LLSM version is a result of a three-year intensive work on the definitions and application of the measure, to a long variety of psychotherapeutic and psychoanalytic sessions, all part of a data bank available to us. The second version, included the concrete style, since it appeared as an important feature of certain aspects of some of the patients' discourse. The third version included the meta-styles, or insight-form of discourse, based on previous work identifying more elaborate therapist reflective mental states as part of the global countertransference response: content emergence, and immersion developed into an elaboration (Bouchard, Normandin, Fröté 1994; Bouchard, Normandin & Séguin, 1995; Dubé & Normandin; 1999; Lecours, Bouchard, Normandin, 1995; Normandin & Bouchard, 1993). The insightful discourses of patients were rated as insight 1 (first level) when it was an emergence or immersion, and insight 2 (second level) when is was an elaboration. The first three LLSM versions, identified each style component (definition) and requested a separate rating for each. For example, for the narrative style, the component "rigid description of time events" was given a nominal rate

of 101 (100 was the nominal value attributed to the narrative style); 102 was "detailed description of situations", etc. This proved unpractical however, and led to lengthy consensus unsatisfactory reliabilities. This directed us to ratings that considered a more global understanding of each style, using each component as apart of the general description of each style. In each new version, revisions of categories and descriptions were made, and categories difficult to be applied were discarded. The final (5.1) version, was used for the empirical work of this thesis (Wiethaeuper, 1999).

The main purposes of this thesis are: 1) To define linguistic styles and complementarities within the therapeutic interaction communication field, exploring the concept of character and resistances, and their implications on the clinical work. These are the essential aspects of the first paper, to be submitted to the International Journal of Psychoanalysis. 2) To explore the utilization of the LLSM as a potentially reliably and valid measure capable to identify positive, negative and neutral communicative interactions related to outcome. An intensive process analysis of two single cases is performed; taking opportunity from an unique situation: two contrasted cases seen by one therapist. The effort of this empirical research using the LLSM at the core of the second paper, to be submitted to Psychotherapy Research.

References

Bouchard, M.-A., Normandin, L., & Fröté, P. (1994). De l'écoute à l'interprétation: une approche des phenomènes de contre-transfert. Revue Québécoise De Psychologie, (1), 155-192.

Bouchard, M. A., Normandin, L., & Seguin, M. H. (1995). Countertransference as an instrument and an obstacle: A comprehensive and descriptive framework. Psychoanalytic Quarterly, 64(4), 717-745.

Bouchard, M. A., Picard, C., Audet, C., Brisson, S.-H., & Carrier, M. (1998). Scoring manual. Unpublished manuscript. Differentiating mental states: therapists, patients, human subjects . Montreal.

Dube, J. E., & Normandin. L. (1999). The mental activities of trainee therapist of children and adolescents: The impact of personal psychotherapy on the listening process. Psychotherapy, 36(3), 216-228.

Elliott, R. (1985). Helpful and Nonhelpful events in brief counseling interviews: an empirical taxonomy. Journal of Counseling Psychology, 32(3), 307-322.

Greenson, R. R. (1960). Empathy and its vicissitudes. International Journal of Psycho-Analysis, 41, 418-424.

Hernández, M. (1999). Affect, language and communication: loose ends. International Journal of Psychoanalysis, 80, 341-355.

Lecours, S., Bouchard, M. A., & Normandin, L. (1995). Countertransference as the therapist's mental activity: Experience and Gender differences among psychoanalytically oriented psychologists. Psychoanalytic Psychology, 12(2), 259-279.

Liberman, D. (1983). Linguistica, interaccion comunicativa y processo psicoanalitico tomos I e II. Buenos Aires: Kargieman.

Liberman, D. (1982). Psicopatologia. Rio de Janeiro: Ed. Campus.

Marty, P. (1991). Mentalisation et psychosomatique. Paris: Laboratoire Delagrange.

Marty, P. (1990). La psychosomatique de l'adulte. Collection Que sais-je? Paris: Presses Universitaires de France.

Marty, P., & de M'Uzan, M. (1963). La pensée operatoire. Revue Française De Psychanalyse, suppl. 27, 1345-1356.

Normandin, L., & Bouchard, M. A. (1993). The effects of theoretical orientation and experience on rational, reactive, and reflective countertransference. Psychotherapy Research, 3, 77-94.

Perry, J. C. (1990). Defense mechanisms rating scales. Cambridge, MA.

Wiethaeuper, D. (1999). The Liberman Linguistic Style Measure. Scoring manual. Unpublished material . Université de Montréal: Montreal.

Paper 1

Linguistic Styles, Complementarities and Resistance

Running Head: LINGUISTIC STYLES, COMPLEMENTARITIES AND RESISTANCE

Linguistic Styles and Complementarities in Working with Resistance: A Clinical Reexamination

Daniela Wiethaeuper[1]

Marc-André Bouchard

Université de Montréal

To be submitted to the International Journal of Psychoanalysis

---

[1] The author wishes to acknowledge the support received from CAPES (Centro de Avanço de Pesquisa e Ensino – Brazil), UNISINOS (Universidade do Vale do Rio dos Sinos – Brazil), the Département de Psychologie, Université de Montréal, as well as from the FCAR Ministère de l'Education, Québec, Canada.
Requests for reprints should be sent to Marc-André Bouchard, 42 rue Courcelette, Outremont, Québec, Canada, H2V 3A6.

Abstract

The notion of character as a central organizing structure is reexamined using Liberman's notion of character as a unique stylistic-communicative constellation. Rigid and defensive linguistic style creates resistance within the analytic linguistic context. This resistance can only be surmounted by the analyst's instrumental use of complementary linguistic messages. The style of communication of both analyst and patient thus become organized elements of a communicative interaction cycle, which ideally may allow both participants to take part in a shared semantic field, the precondition to the generation of new meanings. However, when resistance becomes stronger and is not overcome by an instrumental reflective complementary linguistic attitude, miscommunication occurs. A clinical illustration is presented. From three sessions taken at the beginning, middle and end phases of an unsuccessful analysis of a narcissistic patient called V4 where continually from the beginning the analyst was unable to use complementary linguistic styles, in the face of this patient's recurring defensive epic (or action-oriented) communications. V4 was thereby successful in distracting the attention away from this paradoxically conspicuous characterological distortion.

Linguistic Styles and Complementarities in Working with Resistance: A Clinical Reexamination

In approaching the human psyche in conflict, psychoanalysts have given much attention to the *content* of psychical productions. This was in part in response to the initial aim of understanding and interpreting the unconscious meaning of associations brought by patients, hoping thus to resolve conflictual personality functioning as a main source of suffering (Freud, 1900, 1911, 1914; see Gedo, 1996). Thus unfolded our gradual but successful attempts to unveil first the unconscious wishes, then the defensive aspects of the ego and eventually the superego functions and its associated structural contributions. Selective attention to contents dates back to Freud's striving to understand the unconscious meanings at the root of symptoms and the formation of neurosis. This prevailed in spite of his initial interest in the formal properties of language as revealed in aphasia and also in spite of his important observation on some forms of language conflicts in everyday language. The examination of the contents of wishes, symptoms, language utterances, character formation and some non-verbal expressions through character traits, were thus privileged as figurative references to deeper conflicts.

Concurring with these observations, Hernández (1999, p. 343) noted that 'the themes of language and meaning in all their variants have ultimately imparted an uni-dimensional bias to the relevant schools of psychoanalytic theory, practice and writing'. Of course, psychoanalytic reinterpretations and integrations of linguistic phenomena have followed, as illustrated by the works of Lacan, Laplanche, Green, Bollas and others. Both empirical and clinical interest in the *form-type* of verbal, non-verbal and paralinguistic

communication within the analytic situation also increased particularly in reference to issues of outcome (Watzlawick, 1967, Tuckett, 1983, Canestri, 1994, Makari & Shapiro, 1993, Poland, 1986, Russell & Stiles, 1979).

Perhaps less considered through the years is the value of character as an organizational structure expressing its peculiarities through paralinguistic, linguistic and non-verbal expressions. One relevant exception to this trend comes from the Argentinean analyst, David Liberman, who has developed an integrative approach that uses semiotics to understand the analytic interaction through the concepts of *linguistic styles* and *communicative interaction* as related to character structures and functions. In his view, character originates semiotic rules, and contributes to repetitive meanings and miscommunications to which the analyst must attend (Liberman, 1982) if he hopes to exert any beneficial effect. This is achieved by focusing on rules of form, since stylistic features are embedded within the usual meanings. It is Liberman's contention that if this semiotic level is ignored there is greater chance that analysts will contribute to generating and maintaining impasses. Liberman's ideas appear especially useful when treating some types of character resistance that are expressed through linguistic and paraverbal traits that cannot be otherwise accessed except by using a linguistic complementary style. It is our purpose to critically present and illustrate the relevance of Liberman's views.

Character Resistance

Reich (1933) first systematized a description of character resistance as having the formal aspects of general behavior, putting into sharp focus a characterological signature imposed on the expression of drives, defenses and classical economical aspects. For

example, Reich observed that the hysterical character, especially in women, demonstrates a kind of 'body agility', a coquetry in gait, gaze and speech, softness and over-politeness while the phallic-narcissistic character is self-assured, arrogant, energetic, coldly reserved, and sometimes 'bristly' (p. 217) or, as a result of repression in some women, with shame and blushing.

Fenichel (1945) followed Reich's path in taking into account the importance of character and character resistance, underlining a definition of traits as either the result of sublimation or reaction formation. Nunberg, Brenner, Sandler, Kernberg and others later focused on the dynamics of character formation, their typology and assessment. These contributions stimulated further work on the meanings of character-dependent behavior within the analytic treatment. For instance, Gitelson (1963) described what he called an impulsive neurotic character, who, contrary to the character neuroses did not seem to have submitted their impulsive trends to any prior transformation of instinctual drives and presented peculiar ways of acting-out ungratified impulses. Easser & Lesser (1966), following Reich's path and by opening up the study of 'communication styles', explored the dramatizations of hysterical characters, expressed in particular in non-verbal ways that served to maintain the spectator unaware of the real conflict. In turn, Dorpat (1982) explored a form of language expression of symbiotic relationships in a depressive patient whose family members completed each other's phrases. These contributions, influenced either by classical Freudian or object relations theory, tended to link character traits expressed non-verbally to the concept of action, or *acting-out*, which is an important, yet

comparatively restricted view of the communicative interaction compared with the more encompassing semiotic-linguistic views proposed by Liberman.

Communicative Interaction

Liberman's model is based on the notion of communicative interaction (Liberman 1971, 1982, 1983) which underlines that since psychoanalysis and psychoanalytic therapy are based on communication and dialogue, the careful examination of rules of semiotics is required to achieve a deeper understanding of the interaction. The analytic situation and setting create a *linguistic context* and stable background against which to study communicative interaction. The *linguistic context* involves the process and the structure that contains a temporal sense and a series of linguistically organized dialogues, which amalgamate various syntactic, semantic and pragmatic aspects of language:

> The speech and the verbal mimic that happens in the course of successive changes of structures and functions, added to the changes, as well as the crises and new structuralizations of the patient, considering also what the patient does not speak in the session, his or her silences, the analyst's silences, the election and the discard of different forms of interpretations that compose the linguistic style, all constitute the empirical basis of psychoanalysis.[1]

Liberman was critical of the use of psychoanalytic conceptual vocabulary, or even of metaphors if meant to express content, by trying to 'talk directly to the patient's unconscious' (or 'infantile part'; Liberman, 1982, p. 81). Influenced by Carnap (1967) and Popper (1962), he considered the observation of language and its many channels of expression as the only valid and concrete material from which to generate hypotheses and

to formulate deductions towards general and empirically based conclusions. Yet, he also held a truly interactionist point of view, considering each treatment as having a unique character, composed of a sphere of mutual influence between patient and analyst (Ponsi 1997). Indeed, his basic idea that the analyst's reflective work on the communicative interaction has a decisive impact on the evolution of the treatment, is closely linked to contemporary constructivist, interactionist and intersubjective views (for example: Stolorow, 1997).

Liberman's originality rests in his view of the psychoanalytic treatment as a mutual-working field of linguistic complementary interactions. He wrote:

> ... we do not study one patient but an interactional universe between two people in which the patient reacts according to his dispositions to the stimulus that the other represents, and the analyst inquires and has an effect on the patient during the time the session elapses.[2]

In order to understand what takes place in the linguistic field, Liberman based his ideas on the semiotic theories of Morris (1946), Prieto (1966) and Ogden and Richards (1923) as applied to psychoanalytic treatment. The patient is the transmitter of a message through his production and use of signs. These constitute evidence or indicators for the analyst whose task is partially to detect ('decode') a collection of elements that have common properties. When he recognizes the relationships of these properties, he structures these primary signifiers into a *secondary signifier*. He thus seizes the non-intentional signifieds (unconscious messages) sent by the patient. In other words, the analyst carries out a transformation process that uncovers, from a universe of signs, the

non-intentional signifiers that contain signifieds unknown to the patient. These give access to unconscious motivations of symptoms, character function and formation.

The function of secondary signifiers is related to the hypothesis of unconscious determinism. The analyst's conceptual view is crucial to the mental elaboration and understanding of these implied signifiers, which point to what patients are trying simultaneously to communicate and miscommunicate. This appears contradictory since on the one hand Liberman criticized possible misuses of theoretical conceptualization applied to the patients' internal processes, yet on the other hand, he felt that theory was crucial to the analyst's elaboration process. A possible resolution perhaps lies in the fact that since he wanted to underline the interaction, he stressed the risks of constantly 'forgetting' the linguistic context in favor of theoretical postulates.

In the *encoding* process, the analyst, now as transmitter, informs the patient of the signified in the messages he inadvertently emitted. In optimal conditions, the analyst organizes the signified that best contain the signifiers of the message sent by the patient. This is encoded into words in the form of interpretations. As a result of this emitting, decoding and recoding cycle, the analysand receives the analyst's linguistic message and places it in a class of signifiers to which other signifieds are attached. This way the patient is optimally allowed to seize what the analyst is transmitting.

Through this admittedly simplified and partial idealized decoding/encoding/interpretation process, Liberman (1974) points out that the ideally reflective analyst has several *options* at his disposal in choosing an optimal quantity of codes, circumstances and indications that can help the patient better understand

(internalize) his message. On the patient's side, *choices* are also present and more or less determined by early fixations of object relations, by how symbolization unfolds, by language rules and finally, by the immediate quality of the interaction itself within the linguistic context.

Liberman (1971, 1983) realized that the process of symbolization was much more than an ensemble of signifiers and signifieds, his explanations of the interactional cycle in terms of broad linguistic concepts were insufficient. He needed an understanding of symbol formation, and attempting to unite the cognitive and emotional universes, he appealed to the Kleinian description of the process of internalization of object relations. This became a basic dynamic of communicative interaction.

A Neo-Kleinian View of Symbolization Processes

The process of symbolization would be based on the relationship between the infant and the mother's breast as the primary object. Developmental phases described by Freud (1905) and Abraham (1973) involve the relationship first with the internalized persecutory breast with its associated affects and representations. These introjects would become part of character, and would influence the semantic, syntactical and pragmatic 'choices' of communication. A highly condensed positive therapeutic scenario may have this appearance. Any patient's channels of communication are, in this view, strongly determined by envy and a depriving breast (oral phase), which potentially results in a persecutory curiosity in the face of the analyst's interventions on a semantic level. Thus an analysand's 'choice' of words and interaction may be marked by compensatory and defensive abstractedness. In response to this, the analyst's expressions would need to be

rich in imagery and symbolism, in other words, using a complementary 'dramatic aesthetic' mode (Liberman, 1982, 1983). This reintroduces the affective emotional impact within the linguistic context and the patient may proceed eventually towards reparation (Klein, 1975), following which he may then be able to emit messages marked with a sense of nostalgia, and to become capable of participating in a shared semantic field.[3] Further semiotic internalizing of interpretations contribute to a renewed capacity for generating new meanings and experiences.

Today, some may find Liberman's linking of semiotic processes with Kleinian theory somewhat limiting, arbitrary and unjustified. It is possible however to relate his semiotic analysis to other metapsychologies. Following Jacobson (1964), Kernberg (1976, 1992) for instance, has broadened the concepts of object relation's theory as related to the structural point of view, which has produced an articulate understanding of character formation and pathology. We may underline in particular the idea of an evolving sequence in the process of introjections, identifications and ego identity towards an integration of self and object images under the influence of the drives (Kernberg, 1976). It is reasonable to assume that the more evolved linguistic styles should imply better ego synthesis. Consequently, the need is reduced for pragmatic manipulation and syntactically hidden meanings that maintain splitting and ultimately lead to negative outcomes. Similarly, less primitive defenses should be expressed by the individual's capacity to establish a shared semantic field and a collaborative pragmatic interaction, less instinctually infiltrated by aggression and idealization.

Besides his original use of Kleinian ideas, Liberman (1982, 1983) developed interesting structural points of view in which he rightfully stressed the *ego* as having a central role in the organization of communication. He identified six ego functions, and in relation to each of these, he described six linguistic styles and their use within the matrix of interaction. Each style is detailed in table 1, although satisfactory introductory descriptions in English are available elsewhere (Liberman, 1974, 1978; Etchegoyen, 1991). We present a brief account of the six ego functions and their associated linguistic styles. Each function is described as an ego's capacity to focus on a specific aspect of the communicative interaction, and to use the appropriate style in order to adapt to the other's communicative style leading to the least possible noise and miscommunication. However, when each function is rigidly used as a result of character conformation, the styles applicable to both therapist and patient lose their communicative action since the ego is no more able to adapt. The functions are 1) the capacity to dissociate oneself and observe things *as a whole* without becoming involved giving little if any affective participation. Associated with this function is the *schizoid-reflective style*, which demonstrates a non-participant observer search for the unknown (incognito) without creating suspense (non-participant observer). This capacity is directly related to the ego's capacity for observing its functioning. When used rigidly it will be in the service of schizoid defenses. The analyst can use this function instrumentally, which is indeed allied to the 'observing ego'. 2) The ability to observe details of the whole without confounding part and whole is associated with the *lyrical style*. This helps the subject to focus on a specific detail of the communication that contains the truest message sent by the

transmitter, for example, the tone of voice as the only sign of the sender's depressive state. Although it is possible to know it represents only a part of the message sent, this function allows the recognition of the deeper aspect of what is communicated. Used defensively, the subject will focus on one aspect, such as the tone of voice, to codify the messages and ignore the complexity of the whole. Used instrumentally, this function allows the analyst to decode, and hear the non-verbal and paralinguistic aspects such as irony and subtle contempt. Countertransferentially, the analyst can also be caught focusing on one detail of patient's verbalization, and thus losing his capacity to reflect on the complexity of what is being communicated. 3) The capacity to balance desire and the possibilities of its fulfillment that implies a faculty of listening to wishes and their concrete gratification when possible. The action-oriented *epic style* corresponds to this function. This key aspect of will is a capacity to relate desires to gratification via action with inevitable aggression in the service of the ego involved. Pathologically, however, this may lead to difficulties with impulsivity, unending overgratification, aggression and violence, narcissism and psychopathy. Used instrumentally by the analyst, this epic mode helps when facing the patient's controlling discourse. Within countertransference this results in pathological immediate wish gratification. 4) The capacity to adapt to different circumstances and relationships, which also includes the capacity to be alone, is associated with the *narrative-logical* style. This style contributes to establishing a shared semantic field between participants by precise descriptions and explanations within communication. When the individual is capable of giving a different meaning to a word, he is capable of accepting others' meanings to the same word reflecting tolerance of

aloneness. However, when used rigidly in severely obsessional patients, the subject will try to continually control and impose his own meanings to words and phrases. Used instrumentally, the analyst will be able to describe and explain in logical order a patient's actions, especially when they serve as an attack on the setting. Countertransferentially, the analyst can be caught in endless discussions with the patient of who said what, and when. 5) The capacity to tolerate a certain amount of uncertainty and anxiety that prepares the individual for action, relates to the *dramatic style,* which creates *suspense*. Functionally, suspense can then be tolerated in a conversation, which makes it possible for example, for negotiations to take place. It may also serve as a method to make things more interesting for the listener who becomes more involved in the narration. As analysts, we may find it useful to leave phrases open, thus inviting patients to further associative exploration. As a manifestation of countertransference, the analyst may avoid 'hysterically' to 'call a cat, a cat' or to put into full verbal support patient's associations, due to anxieties related to a wish or a desire. 6) The last function allows for robust possibilities to send a message in which the action, the idea and the affect expression are usefully combined. This *dramatic style* with *aesthetic impact* is a rich and symbolic mode that transmits vividly the messages that are readily understood by the listener who is transposed into the drama as told. The defensive or countertransferential use of this function implies that a powerful affective drama is told, yet serves to keep the listener at bay (wordless, startled, seduced, impressed, and so on).

The ego's capacity to use these functions in a non-rigid manner verifies its strength and assures a greater capacity for establishing a gratifying communicative

interaction with least possible miscommunications and noises. However, repetition of early relationships through linguistic, non-verbal and paralinguistic patterns is a part of a characterological organization that is not only a product of experiences organized and stored, but is also an active organizer of new experiences. In other words, the states presently activated are communicated among other means via the six described functions into actualized styles of communication that activate new ways of internalizing, interacting and communicating in contact with new linguistic and complementary forms used by the analyst.

The Superego and the Ego Ideal

A fruitful collaborative partnership with David Maldavsky (Liberman & Maldavsky, 1975) renewed Liberman's interest in the superego-ego-ideal structure[4]. This component referred classically to two functions: one prohibitive, the other containing the narcissistic formations issued from special kinds of internalized object relations. Liberman and Maldavsky's (1975) more original concern was to point to the role of superego structures in creating *semantic universals*[5], which form the basis of values, standards and principles to be followed by the ego. This system implies that individuals ascribe *unconscious meanings* to internal and external stimuli, in part by means of attributing *values* to these experiences.

Therefore, the *semantic* aspect of every communication, the meaning that each communicative interaction has for each individual results not only from the ego representation system and its many functions of language, thought and memory, but also and crucially, from the values imposed by the superego. To illustrate, for patients with a

predominant lyrical style, typically presenting with a depressive-masochistic character (Liberman, 1982), there is a marked overlap between the verbal emissions and the affects generated by these emissions. As a consequence, emotions overwhelm them. They use a lot of adjectives to classify emotions or to criticize themselves and others. Some phrases are not completed since they seem to 'swallow' words, presumably for Liberman, as a result of oral sadistic impulses present at the moment. In terms of semantic universals and values, each interaction is filled with an intense and preoccupying issue whether they are loved or rejected, and whether they can be forgiven or not. This leads to a constant search for answers in the object's words and actions, as he becomes a container of superego projections.

In a hysterical patient with a predominant dramatic suspense style, the superego maintains and reactivates a possible inner source of threat and danger whenever some unmanaged free expression surfaces. This leads to a reinforcement of the dramatization in the form of suspended uncertainty (interrupted phrases, stories interrupted by other stories, phrases constructed using the third person pronouns), as one key attempt to reestablish the ego's safety. But simultaneously, to the analyst this leaves the burden of filling in the blanks and projecting his own desires into the interrupted field.

The ego and the superego systems are also affected by progressions and regressions in functioning, especially concerning semantic universals. If some unresolved conflict between the intra-structural and reality demands prevails, the individual is faced with two choices: 1) Regress to a less mature semantic dimension, either integrated or a pathological one; 2) Try to maintain the same semantic dimension while suffering some

degree of consequent disorganization. In most conflictual communications, the self is projected onto others and the individual loses the capacity to maintain appropriate differential meanings in relation to the external experiences beyond the projection. A strong pragmatic distortion of interpersonal relations may ensue and the individual may lose any common ground of communication with others. For example, with the dramatic suspense method (or style), when the dramatic verbalization through suspense fails to establish the ego's safety, the subject may either initiate a counter-phobic action or else develop some generally avoidant behavior. In the last instance, a regression to a less mature semantic dimension may lead to use a mode of functioning of the schizoid type (or the schizoid-reflective style). The individual then becomes abstract and general but no suspense is necessary since anxiety is no longer present.

Consider a progressive scenario between two semantic dimensions: a subject may use more mature ego and superego functions and values. For example, when a person with a typical lyric style is able to tolerate, if only momentarily, not being loved or forgiven by the analyst, he can concentrate on the meanings of the analyst's words and interpretations. Access to his internal and external world may be renewed, and he may begin to generate new meanings. This would be demonstrated eventually via, for example, more frequent use of a dramatic style.

The combination of signs, signified, signifiers, symbols, and language rules are processed within the subject and transmitted mainly unconsciously through several channels, thus actualizing the character formed by the complex of id, ego and superego within the analytic situation and object relations acting as an organizer. The

developmental phases are part of this process resulting in basic styles observable as traces of this inner developmental history. Each person generates either one or a combination of basic styles that are singular to his 'way of being', and depending on unique patterning, specific to the linguistic context through which they are observed. Typically, styles will be set in motion and acquire their specificities in interactions with particular others, making each relationship distinct.

Transference and Countertransference

Liberman (1982) tried to avoid both a 'totalistic' notion of transference where for instance, all external actions are seen as necessarily to be interpreted in the context of the transference realm, and a 'reductionistic' notion of transference as strictly repetitive forms of regression. He understood transference broadly as the expression of the patients' 'dispositions' actualized when facing a complex message created by the analytic situation and setting, underlining the analyst's participation in the linguistic context. Transference is part of an active, original and particular field. Based on the work of many contemporary Latin American colleagues, such as Bleger (1967), Pichon-Riviere (1960) and Racker (1968), the therapeutic field is seen a figure ('gestalt') against a background or field. An unconscious fantasy is configured in which analyst and patient co-construct and participate: if something changes within the field, the whole field is affected (Baranger & Baranger 1969; 1983).

If transference is definitely influenced by the patient's momentarily shifting unconscious motivations, the analyst's method and interpretative technique are decisive in its evolution. This requires diverse capacities:

> The interpretative technique of transference processes...requires [from the analyst] altogether the scientist's capacity to place himself at some distance from phenomena, the capacity of a literary creator to generate new verbal codes, the unconscious fantasy and ingenuity of the inventor to deploy instrumental means to transmit the information in a way that is exact in contents and correct in meaning.[6] (1964, p. 253)

In positive transference, the analyst's interpretations awake new dispositions that lead the patient to new and enriched semantical dimensions. Even when faced with inexact or incomplete interpretations, the analysand will tend to produce new messages 'orienting us' to recode and understand. In contrast, when negative transference is present or in moments of resistance, the patient will amplify or distort certain messages in order to mislead the analyst in the direction of a 'wrong path' presumably, for example to soothe an 'internal persecutor' and maintain safety or delay displeasure. In this case, patient and analyst participate in totally distinct semantical dimensions, each providing a different meaning to the therapeutic process, with the patient using increasingly pragmatic utterances in order to manipulate and again, mislead. Rabih (1981) has offered a description of patients that form pseudo-alliances in which aggressive and narcissistic tendencies work beneath a cooperative façade. This is often the case with perverse, borderline, narcissistic or antisocial characters who generate constant projective efforts to attack the setting. An example, for instance, is withholding significant information from the analyst while presenting a seemingly cooperative attribute of 'free-association' or

continually seeking to gratify idealized dependency wishes and assimilating any interpretive work into this trend.

Following Kernberg (1965), Rabih (1981) suggested using our countertransference reactions in these cases. Liberman (1982) invites us be very attentive to choice of words, paraverbal aspects, and the whole style of communication, as these may reveal participation in a completely different pragmatic and semantic dimension. Some typical pragmatic forms of pressure include the following: silence to evade discussion, tangential answers, constant changes in verbal tense, humor or strong statements used to disqualify our understanding, and asking questions repeatedly to get us to participate, trying to invert roles. In terms of semantics, these patients will not share the same values and beliefs about the treatment. In the end, both analyst and patient seem to be constantly attributing different meanings to the same words.

In such circumstances, Liberman (1983) suggests the use of the narrative style with phrases put in logical and sequential order when attempting to display to the patient the observed discrepancies between the semantic and pragmatic channels. Implications are spelled out for both participants within the setting. For example:

> You began the session very late, but saying that you are motivated about your treatment, then you continued to say that you feel I understand you deeply, but you did not agree with my questioning of your motivation to be here, and then you continued telling me a story of how people usually get distant from you even when you try so hard to be close. This back and forth is a way, for you I believe, to share your uncertainties about our work together, without saying it in so many words. So as this is going

on, we are not talking about it. But I am trying now. Do you see what I am referring to?

Such comments move beyond clarification and, appropriately, often imply some level of confrontation (Kernberg et al., 1989, Kernberg, 1997). Further they carry some pragmatic implications, but it is believed that the narrative style of interpreting is especially important, as the sequential and logical presentation of what is being observed at the level of enactment, facilitates the establishment of same-shared semantic work. This contributes to a level of semantic understanding by introducing, new content unknown to the patient even for a short moment. But beyond this it also allows the patient to internalize and exert a characterological -communicative function previously deficient or inhibited.

With patients who establish fragile pseudo-alliances, we may continue for many years interpreting wishes and defenses even within the transference with little result. Alternatively, we may seek to point to possible unconscious motivations for behaviors that may in fact, be close to, but still leave untouched, at least some of the truthful roots of their communicative pathology. Thus one patient eventually confessed wanting to use the analyst to 'learn better arguments in order to better manipulate others'. The analyst had correctly understood such hidden motivations as resulting from a paranoid and perverse type of transference. But since analyst and patient did not participate in a shared semantic field, interpreting the contents or even the process at a semantic level had

limited impact. True communication here can only be accomplished when we are able focus on pragmatic efforts through the use of a complementary narrative mode.

The Analyst's Mental States, Ego Functions and Instrumental Use of Complementary Linguistic Styles

Complementary styles are linguistic forms of verbal communication that are different in nature and quality from the ones used by the emitter at a certain point in the session, by providing new structural matrices that generate new and complex verbal meanings (Chomsky, 1965). They 'fill in the gaps' in ego functions, and help patients acquire new linguistic components that are lacking both in message transmission and inner experience (Liberman, 1982, 1983). Each complementary style is based on one of the six functions described earlier that lead the analyst to use the maximal linguistic resources with the highest adequacy and received with minimal distortion. The complementarities (see table 2 for a more detailed description) can be understood dynamically as ego functions that are involved in grouping messages. For the patient, these functions confer different qualities to distinct processes of reparation. We think that these functions become a part of our reflecting and observing ego (Bouchard et al., 1995; Séguin et al., 1995) which helps bring together all processes involved in the elaboration of interpretations and in the evolution of therapy itself.

Liberman's expression 'instrumental use of complementary linguistic styles' may lead to the impression of having either to 'memorize' complementarities or to be constantly aware of which style a patient is using and which style we have to choose in order to interpret appropriately. In short, this may contribute to the creation of more

superego pressures. And indeed at first glance, Liberman's exemplars seem to violate the basic rule of maintaining 'an evenly suspended attention.' At the same time, he was also aware of problems such possible premeditations can bring into the treatment when the use of theory may distance both participants away from an analytically full and truer process based on the uniqueness of each participant.

In the analysts' observation of ego, theoretical concepts are always present as 'working models' (Greenson, 1960) and as part of the elaboration process and involved in our capacity to synthesize our patients' experiences, communication style and our own countertransferences (Abend, 1989; Heimann, 1977). Liberman's work seems particularly useful when successions of miscommunications are present in the dialogue or when typically, the *style* the patient is using suddenly becomes emergent to the analyst's mind. It is also useful in situations where we see ourselves reacting countertransferentially to the way a patient is speaking to us and not to the content of the material or affect per se.

To illustrate, the depressive-lyrical mode is described as a process of communication centered on the transmission of feelings and the regulation of self-esteem, based on a wish to feel ideally fused with the object, and continually promising and filled with all the riches. Others are felt to be responsible for the deeper meaning of their life. Consequently, everything is necessarily frustrating. Words have a tremendous emotional impact, but the person is on the lookout for love, acceptance or rejection, as reflected for instance in the tone of voice. Interpretations are often swallowed whole, while the patient demonstrates little distance from what he is saying, thus repeating the scenario. A logical-

narrative mode on the analyst's part reintroduces a useful separating function, by underlining for instance the dual identities, the *me* as frustrating-guilty (analyst, mother, etc) and the *you* as voracious (patient, infant). Indeed in general the analyst using the narrative mode tries to rescue his identity while helping the patient to discriminate internal objects that seem to be undifferentiated and projected. When successful, this complementarity typically creates an opportunity for the patient to focus on emotionally significant differential details. This, in turn, may facilitate some mourning and acceptance of the unavoidable losses and frustrations, while maintaining self-esteem.

For instance:

> **P**: 'I was thinking that my mother always pushed me to do things I did not want to and now I realized it made me sad, but also angry. I could not say anything, she would allow me, I could never go against her or I would be put in my room for hours…I remember thinking I was never good enough, I feel often like that, all negative, always feeling guilty…but as you said, maybe I felt angry but somehow I pushed it away. I have been coming here to get angry, and I really do get sometimes, I really do, I really am trying to have less control over that.'
> **T**: 'You believe *I* am asking *you* to come here to be angry and have less control. *You* feel *I* am being as demanding as perhaps your mother, while you continue to push yourself, doing what *you* think I am asking for. Maybe this is how you end up being prisoner of the 'good little girl' position we have discussed.'

Conversely, an analyst falling into this mode within a *reactive* countertransference mental state may become submerged by feelings originating from

one split part, taking it as the whole. What follows illustrates such an occurrence, at a microscopic level.

> **P**: 'I feel more easily hurt nowadays, but it does not show. The people around me do not seem to perceive that. Things that didn't affect me before, now seem to hit me.'
> **T**: 'Did I hurt you again lately?'
> **P**: 'No, not you, but people close to me like my daughter, she says things that normally I would take easily or ask why she would say such things, but now it just makes me sad.'

In this vignette, the undifferentiated objects are projected ('the people around me…') and presented transferentially by allusion. The analyst seems to be countertransferentially responding in a lyrical mode as if feeling like an attacking object towards a fragile subject (patient, infant). This resulted in guilt feelings and (lyrical) countertransference: 'acknowledgment' of culpability. Further, the analyst's asking a question has pragmatic implications as seen in the patient's response that showed increased defensiveness in avoiding recognition of feelings towards the analyst.

In order to defend against chaos, such as seems to emerge in this last example, a narrative work as complementary to the epic mode allows the analyst to use his own reflective capacity to apply a coherent system of observations and values to support the hypothesis and understanding. The loss of boundaries between the *me* (analyst) and the *you* (patient) is shown in the sadistic wishes and associated defenses present in the analyst's intervention.

Conversely, in the example of a patient's overuse of the narrative mode, an epic attitude on the analyst's part became complementary. The analyst's instrumental use of 'action language' to avoid being controlled by the length of the patient's obsessional narration and his defenses against forbidden impulses is often experienced by the patient as a 'surprising' feat against his own excessively controlling part. It may also be felt as stimulating an impulse that they cannot control and may appropriately lead to a rise in its associated material closer to a 'point of urgency' (Klein, 1975) which is known from clinical wisdom to be often a vital contribution to a stale process (e.g. Salzman, 1980). A less appropriate, countertransferential misuse of such function may lead the analyst to an unsubstantiated and projective misattribution of latent aggression, or seduction with the patient therefore perceived as trying to projectively inject something into the analyst. In such circumstances, the interpretation has the effect of a suggestion and the patient may accept it as true, thus damaging the alliance and repeating some sado-masochistic scenario. To illustrate, we have the situation of a female patient seeking intensive psychotherapy, who was very concerned about the risks of further involvement in the therapy, and who did not clearly say so. Meanwhile, she gave all sorts of reasons for not being able to attend more frequently:

> **P1**: 'When I went to see the doctor, I was sleeping really bad and he gave me some pills, which I took some of them in June, some in July and then things went finer. I was sleeping better...and even my headaches, when I went to see the doctor my headaches could last for 48 hours, so the sleeping

> pills he gave me in June, were also effective for the headaches. But they started over again for some time now…
> **T1** (interrupting): Do you like the therapy?
> **P2**: No, not really (laugh), when you asked me last time if I found you tiresome, no, not so far, not you but the therapy, yes. There is a part of me who sees, it's funny, it's like the guardian of my secrets is starting to find this very tedious, of being, being…
> **T2** (interrupting): Attacked...
> **P3**: Attacked and it feels like it pushes, pushes… And you know, more sessions in a week means I have to work much more. Like an incessant process, but I tell myself that if I want to go further, this has to constant.'

In P1, the patient presented with a somatic view of her problems and their solution. This was used as an implicit devaluation or attack against the usefulness or relevance of the present psychotherapeutic effort. The posture was controlled and distant, expressed in an intellectualized narrative mode. The analyst's question (T1) has an epic form that was also a comment on the patient's latent aggression. But his own countertransference mental state was reactive rather than reflective (Bouchard et al., 1995). Perhaps a more instrumental and reflective pragmatic intervention might look like this:

> What you are presenting now are your headaches and pills, and the relief brought by your doctor's prescriptions and care. You seem to say, in effect, that this therapy is giving you headaches that I'm giving you headaches, while your doctor was bringing you relief. Can you see a link?

In her response (P2), the patient initially agreed with the analyst's intervention, but she was also taken by surprise as witnessed her laughing. But the intellectualization

continued. The aggressive impulse remained unassessed. The protective stance became justified (the guardian), against attacks and pushes that were attributed to the potentially intrusive analyst and the too frequent sessions. The enactment was also via an epic mode in the form of an interruption (T2).

Another particularly apt form of complementary linguistic communicative interaction is illustrated by the hysterical mode of the dramatic self-interrupted syntax to avoid anxiety and the analyst's use of his reflective-schizoid functioned to explore the avoided inner contents while keeping some distance from the apparently crucial and avoided phobic theme. As in the following:

> **P**: 'I had a dream… a dream last night where uh, I was in here (laugh) with of course two other women and it was sort of, we were all doing not together but each, each of us had fifteen, twenty minutes or something and euh it just makes me laugh you're sitting a good four feet away from me completely in a non-threatening way, I mean I guess what I am wondering is eventually I am going to remember these situations differently and then I sort of… (laugh), or that I am somehow exaggerating..'
>
> **T**: 'It seems it is difficult for you to keep focusing on the feelings you have towards me, which seem to appear in the dream in a scenario of competition between you and other women. Instead you avoid these emotions and what they represent, by not telling me your dream in full or your thoughts about it. You even try to dilute your feelings by saying to yourself that your are exaggerating those feelings.'

Within the countertransference realm this would illustrate an appeal to the capacity to use a comparatively more inner and abstract (schizoid-reflective) perception, while keeping some distance and refraining from embarking upon the manifest

hysterically affective participation. This underlines the 'real' but repressed inner self as a wishful subject. In contrast, countertransference participation in the dramatic style would mean becoming amused and caught by the exhibitionistic and entertaining theatrical defensive aspects. The schizoid- reflective attitude may also help us to orient our approach in the face of dramatic-aesthetic impact to focus on either inhibited or dissociated parts instead of becoming a 'castrated' spectator of the highly metaphorical and plastic images that serve the theatrical mode.

Consider conversely the relevance of our capacity as analysts to generate an aesthetic impact via dramatic form, aiming to communicate with emotion our perception and listening to a patient's affectively withdrawn schizoid-reflective mode, as expressed through highly elaborated and abstract descriptions of his inner world. We may also need to consider our capacity to sense and to tolerate phobic/anxious resistance as a compromise from oedipal wishes, which implies a capacity to meet investments such as oedipal transference love and rivalry. But, if for countertransference motives we avoid these signal anxieties produced by the patient, miscommunications will occur (Racker, 1968).

Clinical Example

The case presented and discussed has been previously examined as a component of on-going multi-site clinical research sponsored partially by the American Psychoanalytic Association.[7] The case of a male narcissistic patient and his male analyst appeared as clearly illustrating some of the difficulties created whenever character

resistance is involved in creating miscommunication and the analyst cannot adequately respond.

The patient, known as V4[8] presented with important difficulties in relationships in general, but most particularly in his view the lack of intimacy in his relationship with women. He had previously been in analysis at a time when he was divorcing his first wife. This pattern was repeated in his relationship with the analyst beginning with a seemingly positive reaction that gradually led to an increase in distance and growing feelings of being misunderstood. The analyst became identified with the patient's split and projected part in search for contact and intimacy. Eventually the analyst reacting with frustration blamed the patient for his incapacity to keep his marriage and for sessions constantly missed. In three transcribed sessions (numbers 4, 340 and 652) that we examined, the analyst indeed seemed to become progressively more confrontational and the patient increasingly resistant. The analysis ended after 660 sessions and was apparently unsuccessful.

Session Number Four

Four excerpts from the available transcription of this session are examined.

Excerpt One

The patient starts with:

> **P1**: 'This is one of those days when analysis feels out of context with life. I haven't been...I haven't been preparing for it psychologically, you know, and I'm not, you know (laughs) it's going to take me a few minutes to get into the mood, I think. I've been rushing around doing chores this morning.'
> **T1**: 'Maybe meeting with me, has put you out of the mood'.

P2: 'Mmm... I don't think so. I'm not aware of it.'
T2: 'At least, I mean, perhaps it has some effect other than just the usual coming in and lying down and starting'.
P3: 'Well, I was aware of this feeling as I drove down here so that, uh...that I was coming to analysis, uh, only because it was the next thing on the schedule but, uh, you know, I wasn't highly motivated today. I didn't have really anything on my mind to talk about and in terms of how I was feeling about things, there were no particular strong feelings or anything but I'll come up with something.'

Comment. In P1 the patient used a narrative-logical mode in describing his actions and feeling states before coming to the session, showing a rather controlled verbalization. The resistance was manifested in bringing his associations, especially in the context of his transference feelings. His response, P3 to the analyst's comments involved some rationalization to explain his actual state, instead of further exploration. One exception to this use of the narrative mode was when he asserts (P1) not being 'prepared for it', using *it* (a non-specific pronoun) for the therapy. He showed a faulty syntactical construction, followed by a laugh, which may create in the listener an impression of being left in a 'suspended state', due to the incomplete sentence. This illustrates a dramatic component, usually revealing anxiety linked to some material that is being warded off, a kind of 'linguistic phobic movement'. Often the effect on the listener is to expect more developments in the unfolding drama, but the main story is typically interrupted and some other perspective or sequence is introduced, sometimes in a never-ending suspense, as often

in hysterical subjects. In this case, the patient showed anxiety over not being 'prepared'. This may involve a need to control the closeness of this new relationship.

The analyst commented (T1) on the transference in a narrative mode, using the pronoun *me*: 'Maybe meeting *me*…', therefore making the relationship more personal. This comment demonstrated his sense of the patient's avoidance and an attempt to bring him closer seems to amplify the issue. Here Liberman (1982, 1983) would suggest a schizoid-reflective mode, a distancing from the suspense created, focusing instead on the internal conflictual contents. A silent response in the early part of the session may communicate listening to all aspects of the manifest and latent communications. Whereas, a reflective mode may be voiced thus: 'You expressed your inner sense of analysis and of coming here as out of context with your life and therefore requiring some preparation and that creates pressure. But you didn't say more about these feelings.' Instead, the analyst in T1 and T2 appeared to react in a counter-phobic way, apparently wishing to decrease the distance, when in fact, the patient was already suggesting that he felt unprepared for a more personal relationship. He may then have seemed to wish to avoid further exploration of the alluded inner conflictual anxieties.

Perhaps and not surprisingly, the patient responded that he was not aware of any feeling related to the transference, thus showing a clear reluctance to explore his internal feelings as they relate to the analyst. Partially understood in the context of the analyst's contribution, this may illustrate a process of miscommunication at a microscopic level. Instead of being helped in renovating his efforts towards sending a clearer message about his difficulties, the patient used disqualification (P2, 'I'm not aware…'), a pragmatic utterance,

which makes ineffective the analyst's attempts to understand. Such a sudden disqualification may express only a momentary increase in resistance, one justified in part by the analyst's unwitting contribution. But its eventual repetitive use by the patient may alert us to a possible manifestation of a paranoid character trait. In other words, if the patient systematically used such pragmatic devices at key moments, he was at the same time constantly harming the therapeutic alliance through misleading messages. Undetected, these developments lead to transference-countertransference impasses.

Then the analyst produced a parapraxis (T2), starting with 'at least' before rephrasing it as: '…I mean, perhaps it has some effect,…' It seemed that indeed there was some effect, perhaps as an enactment of his countertransference feelings of being 'rejected', as if his interpretation was a part of his being ignored. In this (microscopically amplified) projective identification process, one may speculate that the patient's need for affection and closeness were now part of the analyst's self-experience while the patient acted out the indifferent and resistant object.

But further, the analyst's style was narrative, controlled, and the anger reactivated in the here-and-now was neutralized by undoing and reaction formation (T2): 'I mean, perhaps…' Pronouns became impersonal: *it* instead of *me* ('if it is not meeting with *me* that causes some affect, *it* is then *treatment-it*, that at least has some effect other than the usual lying down'). At a semantic level, the phrase covered strong affects of rejection that were controlled by a syntactically well constructed narrative clarification in the form of a restatement.

Excerpt Two

Following is a continuous, uninterrupted series of associations that may help better understand the patient's present characterologically determined linguistic mode of communication.

The patient continued, sharing his difficulties in keeping his relationships exciting: they usually started in a passionate way, but suddenly, as he said, "it all goes down", and depression sets in:

> **P**: 'This question of highs and lows and, uh, excitement in life, I guess, there are only a few things that excite me--really excite me--*really turn me on.* One is a new relationship with a woman--and there have been lots of beginnings and endings to relationships with women-- but there is something about the *quality of beginning a relationship that, uh, is very thrilling--very exciting*. Unfortunately, it doesn't usually continue that way for very long. A few months maybe, and then--well, for one thing I stop being as excited about uh-uh, about sex with that person and find that her body is not nearly as stimulating--as exciting as it was anymore. It's *rather a tragedy* right now with my wife because *I really am not turned on by her at all.* At one time, I certainly was. The other category of things that excite me- -things that excite me--is, uh, *something creative--making something--building something, designing something*. I can get pretty turned on about that. Uh, but the problem of feeling something intensely--which I feel like I need --somehow life gets to be really disappointing when there isn't something exciting going on--something that *I feel a passion* about or something that I look forward to very much. Uh, in other words, just ordinary everyday--you know, day to day living is-is, uh--a little bit of a let down and then I start getting philosophical about how life is just, you know, the space between dentist appointments and things like that and there's really nothing--there's no *spice* in it' (our italics).

Comment. In this excerpt, the patient revealed a pattern typical of his narcissistic involvement and particularly a succession of defensive idealizations and devaluations. Some allusions to transference may also be noted (for example, in the space between dentist appointments). Omnipotence and grandiosity were expressed for instance, around the issue of being creative.

The stylistic mode changed completely at this point and turned suddenly to a dramatic aesthetic form, producing phrases with greater emotional expression filled with metaphors and exaggerations, presumably in the service of his expansive ego. This mode, the richest and the most creative of styles, can be quite entertaining, which may lead to our considering it as reflecting higher levels of development in terms of ego function. But as in the present situation, it may also be recruited as part of a grandiose-defensive posture against likely narcissistic depressive affects. Indeed on the one hand, he felt most creative and 'alive' at the beginning of relationships, including analysis and on the other hand, he seemed to 'escape' the initial threatening closeness with the analyst, to present a content where he feels safer. Are the anxiety concerns issues related to his sexual identity, Oedipal rivalry, or more primitive dependency issues or both? This cannot be safely determined from our limited material

He then suddenly voiced 'what the hell is it all for anyway?' The *it* refers to his need for excitement and 'spice' in his life. This was an epic moment, the enactment of his anger in being prisoner of his constant and frustrating search. He then reverted back to a narrative mode, stating in a rational way that stimulation was much needed to get through

his 'depression', before his verbalizing in a dramatic mode about another woman in his life that he now found exciting.

These sudden shifts in subject, style, and type of words usually have an inoculation effect of creating confusion in the listener. As analysts, we are left to search for where may lay the more 'urgent' affect or defensive activity while the lack of meaning and continuity within associations is already a result of the defensive activity per se. We can relate this to the use of projective identification that also has an inoculation effect of confusion and loss of meaning, since the boundaries of self-object are lost through splitting. In this case, the entire verbalization becomes an acting-out of split objects present in the shifts in styles from more regressed to less and vice versa, and no reparable meaning can be distinguished. That is one reason that in terms of complementarity, a narrative mode, describing in logical order his verbalizations, the shifts in the themes and why, may help the patient to build bridges against lost connections.

Excerpt Three

Later in the same session, the following occurred:

P1: 'I guess, the question is whether I could ever have a long--a long, long, long-term relationship with somebody that goes on being satisfying, with a woman--that goes on being satisfying'.

T1: 'Why do you doubt it?'

P2: 'Well, because it's been my pattern to have short relationships. Not so short. Before *B.- not before *B.-before *H., there was *B. and, uh, I was close with *B. for five years and then finally ended that relationship which is when I was in analysis. Uh - why do I doubt it? (pause) I doubt it because

my relationships have always been deteriorating over time. They've not intensified--they've not become more gratifying. They've not become-richer. They seem to start out high and-and it's downhill from then on - which I guess, is some kind of indication of what kind of relationship I'm having. Uh - you know, I think it's- -I think it's neurotic. I don't think it's--I don't think my relationships have ever been very healthy - a lot of mother transference goes on. (pause) A lot of mother transference goes on. And, uh - you know, even though I have a lot of insights, I think, into the kinds of feelings that any woman I'm exposed to will arouse in me, uh, and have certainly discussed lots and lots of things in analysis, I'm not sure it's- -I'm not sure it's helping that much. (pause) I guess I'm a little concerned that maybe I will not get anywhere with this problem because, you know, it's something I've talked about so much in analysis before and, uh , I'm not sure anything has changed, even though, I think, that, you know, we gained some correct insights into-into what-what my struggles were about. My struggles with-with (inaudible).'

Comment. The patient first seemed genuinely concerned with his incapacity to maintain a satisfactory long-term relationship. The analyst (T1) may be seen to encourage further reflective exploration of the patient's doubts. The response (P2) was a rather elaborate but shallow exploration of the reasons for the relationships' endings, with some devaluation and blaming of his previous experience with another analyst, which was seen as not having helped in spite of the patient's full collaboration. Possibly as a result of some projecting of the guilt, it was as if the analyst was felt as accusatory. This points to the existence of possible superego conflicts.

Most importantly, meanings and objectives did not seem to be shared at this point. The patient used several pragmatic utterances in order to divert the analyst's attention from

his anxieties and conflicts, while stating that he wanted to work through his difficulties. It was observed that he started treatments at a point when his marriages seemed to fail, when he needed another 'exciting' relationship in attempting possibly to escape from his deeper depression and emptiness.

There exists a risk in developments of stylistic miscommunication that both patient and analyst increasingly participate in totally different semantic fields. Talking to one another, but rarely understanding each other, some patients escalate to destructive acting-outs. In this case, there was an intensifying devaluation of the analyst:

Excerpt Four

> **P1**: 'I noticed that, uh, we shared [patient describes similar physical characteristics he shares with the analyst] and that definitely stimulated some-some kind of identification. I'm particularly fond of the paint on the ceiling and, uh, kind of schleppy couch that I lie on and I think I can tell you why that is, uh--and the rather unattractive view out the window. Uh, I had a thing with C. [last analyst], let me tell you how I see I see him as a very efficient and a very serious man--the efficiency I can handle. I think it's the seriousness, uh-- perhaps, too much attention to details and things done a little bit too properly. Uh, too rational maybe - too precise. All those things trouble me - because I've always been too serious about life, I think-- about myself and because mistakes or problems or whatever always seem too serious--too overwhelming - and I've always liked very much people who kind of laugh at themselves and at their own--and at the foolishness of their own lives and don't take--don't take things too seriously. I also have seen him as a man who is, uh, very aware of and concerned with proper, uh--correct, proper, uh, ways of doing things. Uh - his office is a little bit fancy and, uh, a little bit too fancy for some-some

reason for my taste--a little bit too fancy--and I guess, that to me, that somehow says that he takes the whole thing a little bit too seriously. …'

T1: 'I don't think it's a matter of whether or not I take things seriously--I think you're wondering how seriously I take myself and how much involved I am in myself and am I going to be involved in myself at your expense.' Patient's answer: 'That's a good point. That's-that's just what I was saying the other day--the whole business of empathy and, uh, so forth. …'

Comment. At this point after the separate semantic fields had been established, the analyst chose to make a correct transference interpretation of this devaluating mechanism, seen as originating in the patient's fear of the analyst as representing his indifferent and exploiting mother.

The analyst seemed indeed to have been taken by the patient's miscommunications as we now try to explain. After keeping a rather silent attitude, it seemed that he was successful in correctly formulating in an intellectually plausible manner, one aspect of the patient's representation of him as overly narcissistically uninvolved and unempathic. But the impression is that the patient's agreement was mostly defensive; at the surface level the content being immediately transformed into 'jargon' (for example, 'the whole business of empathy'), subtly transformed into a devaluating view. Meanwhile, within the larger linguistic context, the patient's actions to misguide the process were ignored.

Given the stylistic variability, the changing of subjects, styles and use of analytic words, interventions should perhaps now address the issue of the presence or not of a shared semantic space with this specific patient. 'Are we (patient and analyst) giving the same meaning to the same signifieds and having the same objectives with the treatment?' In order

to answer this, the analyst could use a narrative style to ask for definitions that would help to reestablish a shared semantic field, and to clarify the real definitions and objectives of the linguistic expressions. For example, what does he mean by he had 'gained some insights' in his last analysis, or what does he mean by 'I felt a few minutes of identification with you'?

Liberman would likely consider this as a situation in which a semantic universal conflict of the patient is set on the tormentor-persecuted dilemma, actualized in terms of the superego. The patient's search for relationships is based on using others as a tool to be manipulated. The constant devaluation and misleading from the truth of the source of conflict represent a paranoid type of transference.

By the end of the session and in spite of an apparent collaborative but strained 'progress', the patient seemed to have been successful in moving the work away from his anxieties. He was able to further devaluate the interventions and keep the analyst at a different semantic level.

Session Number 340

The picture here is quite different particularly in terms of the patient's linguistic styles, while the analyst demonstrated attempts at complementarity. Yet, what continues was the patient's devaluation of the analyst's transference interpretations.

The patient started by saying he felt very depressed which he related to his seeing his dreams not being fulfilled with his wife from whom he wanted to separate. He still found it difficult to come to a decision.

Excerpt One

> **P1**: 'I guess, yesterday, I was feeling, again, the loss aspect. There are times when I feel like there is nothing left to lose and I just want to get out of this marriage and, uh, find something someplace else--find somebody else with whom I can get some gratification and then there are time like yesterday when I begin to feel all the losses in terms of the fantasies--things that I would do--we would do short pause) It feels--it makes me feel like I don't--that there's absolutely nothing stable about my--my own wishes--in terms of what I want out of life and that scares me because it's like, you know, every three years there's a whole different notion I have of what I want then--what's worth putting my time and energy into' ... 'she [wife] said, 'because I can't go on like this. I have to get some affection from somebody.' She gets none from me. I don't feel any affection toward her. I can like her in the way I did yesterday which is kind of--I don't know--feeling some empathy, perhaps, with her aspirations--things that she wants out of life, uh, but another level--at another level, I can't really feel any affection for her and certainly can't feel any desire for her.'

Comment. Most noteworthy perhaps is the move from the lyrical-depressed at the beginning to the schizoid-reflective towards the end, where he seemed to express some insightful comments and some possible concern or some sense of guilt. But this was short-lived, still very shallow, and the experience became split and projected as he started to speak in an abstract detached manner. This was the theme throughout the session.

These lyrical moments seemed to have encouraged the analyst to work on transference issues, as the patient seemed to have made contact with depressive feelings. However, when the analyst tried to make connection with transference, the repetitive cycle of disqualification of analyst started. To illustrate:

P1: Sadness, in the sense, of not going anywhere with my own life and of having always to turn things upside down after I once get started whether it's professionally or in my marriage or anything--my analysis. Spending two, three, four, five years at something and then it's not what I want anymore--discontinuity. Break things off and start again.
T: (pause) 'So you're suggesting that there's that much of a parallel between your marriage and your analysis'
P2: 'Well, I don't know. I was thinking of my--my fears with the previous analyst and I don't know that I really ended that, I think, previous analyst kinda helped me to do it--but the same feeling was there. Starting something and . . . (pause) I don't know if I can feel the parallel here... I know the issue is not what I want, the issue is what—what realistically can I get from a marriage. I mean, it's not--well, the issue is, of course, what I want but-- even without knowing for sure what it is I want out of marriage without being able to state that precisely--what I want from Wife--whether I want the marriage or not--I know that I can't get much from Wife. I can't get enough to make me feel good about being married to her. That's all I have to know. I don't need to know any more than that and I know that already.'

After the analyst's intervention, the patient then continued to speak in a dramatic suspense mode avoiding the transference issues brought by the analyst. Soon he started to use more disqualifications, strongly asserting that his actual and true problems rested with his *wife's* incapacity to give him what he expected from their marriage. The session ended with a discussion between the analyst and the patient about where the dependency problems really were with one trying to 'convince' the other.

Again in this session the patient was successful in misguiding the analyst away from his true feelings. The analyst for the most part followed the paths suggested, ending in an exploration of the patient's problems with his wife, clearly diverting from the immediate transference. One possible approach with Liberman's conception in view might be:

> You began the session talking about how difficult it is for you to separate from your wife and how you avoid talking directly about this with her. Then you spoke about your constant difficulty in keeping all relationships, including analysis. When I asked you about the possible connection between this general pattern and your relationship with me here, you became very general, saying: I don't know, I was thinking of my previous analyst, I don't feel any parallel here. You then tried hard to convince me that your problem rests with your wife and you even became angry. It seems that you are trying to hide your feelings from everyone, including me.

Session Number 652

The session started with the patient speaking about his girlfriend, whom he had seen the night before. He seemed to have felt criticized about a comment she had made about her valuing when a couple was able to have orgasms together, which had not been the case the night before. The patient felt hurt (even though he did not recognize his feelings), distanced himself from her, and blamed her for his 'pulling away'.

The analyst started mumbling something that the patient asked him to repeat, saying he was not following what the analyst was trying to say and then the analyst continued:

T: 'You say it doesn't make any difference how [sex] it's done, but nevertheless when she didn't like the way you are doing it, it seems your idea about it, you pulled away, so it does make a difference.'

P: 'You could think something, but I can't figure out what is.

T (inaudible): 'You see on the one hand, the idea is to give pleasure and'

P (interrupts): 'And that form is irrelevant?'

T: 'And it doesn't make any difference how.'

P: 'Right. And she is saying that the form is everything.'

T: 'She said, your way is not her way.'

P: 'No. She's not saying that. She's saying (repeated what girlfriend told him) but she's saying the form is important.'

T: '...but it was last night.'

P: 'I'm getting very angry at this. I feel that you're twisting something to fit a preconception.'

Comments. In this verbatim we see how the patient resisted the analyst's interpretation and his feeling afraid that he would be 'squeezed into a model' that he felt only existed in the analyst's mind. One might think, for instance, that his sadistic superego, which attacks his masculine identity, was projected on the analyst and his girlfriend. At this point, boundaries became unclear and patient felt very anxious about loosing himself, finally succumbing to this despoiling and sadistic object. He regressed, and protected himself from affects with defenses from a schizoid position.

In terms of linguistic styles and complementarities, we see a cycle of miscommunications that seem to have started with the analyst's mumbling something and patient asking for clarification. This kind of paralinguistic feature is suggested by Liberman

to be the result of superego actions that 'swallow' words and voice pitch to a point that they become incomprehensible.

When the patient clearly asked for clarification, the analyst was able to communicate his thought, but using a Dramatic Suspense Style that reveals anxiety linked to what he tried to communicate. The phrase was syntactically incorrect with many sentences in between, expressing many ideas at the same time, as if the analyst wanted to put together many split parts of the patient, unsuccessfully. We see that patient cannot understand what the analyst was trying to say, so they started to put together the pieces of information, in logical order, using the Narrative Style, both completing each others' phrases, like trying to unify separate pieces of one object.

The analyst interpreted what the patient's girlfriend was trying to say to the patient the night before, using a Reflexive Style. That was when the cycle of misunderstanding restarted. The patient's narcissistic self felt under attack by a (projected) sadistic superego. At this point the use of Reflective Style was not complementary, since the patient was still trying to put together split parts that became split pieces of communication. The patient clearly said that when the analyst does not narrate in logical order the facts, he saw the analyst's interpretations as 'twisting' information to fit pre-conceptions. Present was a paranoid-type of transference, a strong type of resistance that could perhaps have been interpreted and overcome through a continuous use of a Narrative Style.

Conclusion

Psychoanalytic treatment mobilizes many of those aspects of one's structure and functioning aiming the working-through of conflicts and disturbances. Character has been

studied as one of the most resistant aspects in the process of changing. The main causative element in the formation of character in Freud's theory would always be the relative weakness of the ego to deal with impulses and the ego's deformation and syntonicity of the traits (1926, 1933). What is noteworthy however, is that Freud continued to apply the theory of neurosis to understand the formation of character, using both concepts of conflict between structures and the concept of identification. With Reich, character resistance was seen as narcissistically invested and especially expressed in formal aspects of general behavior. However, many authors followed Reich's tendency but approached these general behaviors with the concept of acting out.

Klein (1975), Riesenberg-Malcolm (1989) and Segal (1982), saw *acting-out* as both a substitute for verbalization and as a more primitive form of expression of impulses as expressed in the context of internal object relations. Kernberg (1976) later stated specifically and repeated (Kernberg, 1992) that the degree of pathology is conveyed most significantly by non-verbal behaviors in severe character disorders. For these types of patients, the transference situation serves as an occasion for an acting-out of impulses that instead of being contained and transformed, are expelled, continually re-projected and facilitated in part by a lack of integrated oedipal superego.

But it was questioned whether enactments were a 'true' form of communication or not, which relates to the question of prior transformation and mentalisation (Lecours & Bouchard, 1997). From a different point of view, Rangell (1968), Garzoli (1981) attempted to differentiate neurotic actions that communicate something (as in the case of hysteric dramatization), from the ones used to resist analysis, used *instead of*

communication, thought and memory (Etchegoyen, 1991). These 'non-communicating' words and acts would typically serve narcissistic tendencies and were seen as regressive in nature. Gedo (1995) called these 'derailments of the analytic dialogue' as merely defensive maneuvers resulting from the patient's regression from a more advanced psychic functioning to a less organized and differentiated organization. He proposed that analysts intervene in a brief and direct manner to show the patient the incongruities between the contents and form of his message in an attempt to restore some congruity between channels of communication. McLaughlin (1991, 1995) proposed an interactionist view of enactments as an interpersonal regressive behavior co-determined by the patient's and analyst's dynamics.

Following contemporary trends, we argue that enactments are expressions of affective memories tightly linked to early relationship patterns that are activated in the session. In this view, old patterns of transactions are internalized and form procedural memory traces, which become active without participation of the processes of consciousness. These recurrent patterns of fantasy and behavior are based on experiences represented in the implicit memory system for which the explicit, either semantic or autobiographic, or episodic explicit memory system has no explanation (Siegel, 1999, Wheeler, Stuss & Tulving, 1997).

Neurobiological arguments are sometimes too narrow to describe the complexities of internal psychic structure and functioning (Shapiro, 2000). The possibility exists but is yet unsubstantiated that the presence of a new (therapeutic) interaction amplifies the interconnections with other experiences, and allows the formation of new neuronal maps

and the configuration of new and fortified links between declarative and implicit memory systems (Fonagy, 1999).

We are still in need of an integrative theory of enactment, but our present and more limited purpose was to explore an 'alternate route' to enactment. The style of communicating of both analyst and patient are seen as a part of a shared communication cycle that ideally has to be complementary and a generator of new meanings for the patient.

The discussions between the analyst and patient V4 were somewhat convoluted, but basically, a person's total communicative behavior in a session, although sometimes considered as a form of primitive communication, is often considered either as resistance or regressed oppositions to insight and elaboration. This issue is debatable but at a clinical level we frequently face situations in our clinical work where some patients present interesting styles of communication that are either a part of their 'way of being', that could easily be classified as resistance (by their repetitive and rigid nature), or that could also be understood as using 'instead of' communication. With progress we may notice that some of these communicative styles change. Yet, others come back repeatedly, and it seems that any effort towards content interpretation, which tries to unveil some specific unconscious wish or object relation as related to the style, fails. From the patient's perspective it often seems that these aspects of their stylistic expression fall 'on deaf ears' and can be felt as an analyst's lack of understanding or a criticism.

More recently, some studies have empirically explored complementarities. Anstadt et al (1997) contend that the analyst's 'complementary affective reactions' (p. 3) are related to good outcome, in contrast to paraphrasing that lends to further intellectualizations. Their study of short-term treatments with several different approaches showed that when therapists' facial responses were complementary to the patients', the outcome was favorable. However, when the therapist maintained a more superficial and social interaction (smiling for example) as pressured by and consonant with the patient's non-verbal scenario, the outcome was not favorable. Thus, good outcome seemed to depend on the therapist's capacity to contain and express the affects that the patient was not able to process at the moment.

Most interesting about Liberman's point of view is that the analytic situation is seen in a new dimension where the styles not only testify someone's character formation, but also how the communicative interaction is structured and structures the here-and-now. Finally, it can be added that the importance of the analyst's participation is vital to the therapeutic outcome in the decoding/encoding and interpretation in terms of content and form and in actively helping to establish a good cycle with the least possible noise.

These issues were crucial to the cycle of miscommunications that occurred in the case we have presented. From the beginning, the patient tried to divert the analyst's attention away from the true core of his conflict. His style of communicating however, demonstrated where his character resistance lay. In this case, even though we had an experienced analyst with an accurate idea of the patient's narcissistic personality and who was trying to work with dynamics by using content interpretations, the more subtle

aspects of the patient's character traits were already being acted-out from the beginning of the treatment. The patient actively and pragmatically avoided the analyst's attempts to establish communication.

Usually in our clinical experience, we much later recognize these pragmatic aspects of patients' using an epic mode when projective identification has became already massive. In some cases, we can instinctively change our communication form by adopting a more narrative style. Nevertheless, in the works of Clarkin et al (1999) we find remarks of how to interpret borderline patients especially with regard to the setting, interpreting not only their attacks on the setting, but also showing their actions in chronological order. However, Liberman's theory amplifies this notion when he specifies other types of manipulative actions present in the linguistic form of those specific kinds of patients. Based on an understanding of Liberman's theory, we are better able to find the linguistic roots of projective identification, how countertransference is 'passed' through communication and how what is projected and enacted can be linguistically disengaged using adequate interpretations in form and content.

Linguistic styles and the work with complementarities enlarges our theoretical field and can be a useful adjunct to the elaboration of the functioning of one's ego especially when facing significant character resistance.

References

ABEND, S. (1989). Countertransference and psychoanalytic. Psychoanal. Q., 58, 374-95.

ABRAHAM K. (1973). Selected Papers in Psychoanalysis. London: Hogarth.

AKMAJIAN, A., DEMERS, R. A., FARMER, A. K., & HARNISH, R. M. (1990). Linguistics: an introduction to language. Cambridge: MIT Press.

ANSTADT, Th., MERTEN, J., ULLRICH, B., & KRAUSE, R. (1997). Affective dyadic behavior core conflictual relationship themes and success of treatment. Psychotherapy Research, 7: 397-417.

BARANGER, M., & BARANGER, W. (1969). Problemas del campo psicoanalitico. Buenos Aires: Kargieman.

_____. (1983). Process and non-process in analytic work. Inter. J. Psychoanal., *64*: 1-15.

BLANCHÉ, R. (1966). Les structures intellectuelles. Paris: Vrin.

BLEGER, J. (1967). Psicoanálisis del encuadre psicoanalítico. Rev. Psicoanál., 24: 241-58.

BOUCHARD, M.-A., NORMANDIN, L., & SÉGUIN, M.-H. (1995). Countertransference as instrument and obstacle: A comprehensive and descriptive framework. Psychoanal. Q., 64: 717-45.

CANESTRI, J. (1994). Transformations. Inter. J. Psychoanal., 75: 1079-92

CARNAP, R. (1967). El carácter metodológico de los conceptos teóricos. In Herbert Feigl, & Michel Scriven (Ed), Los fundamentos de la ciencia y los conceptos de la psicología y del psicoanálisis. Chile: Ed. de la Universidad de Chile.

CHOMSKY, N. (1965). Aspects of the theory of syntax. Cambridge: MIT Press.

CLARKIN, JOHN F, YEOMANS, FRANK E & KERNBERG, OTTO F. (1999). Psychotherapy for borderline personality. New York,: John Wiley & Sons.

DORPAT, T. L. (1982). An object-relations perspective on masochism. In P. L. Giovachini, & L. B. Boyer (Ed), Technical factors in the treatment of severely disturbed patients. New York: Jason Aronson, pp. 490-513.

EASSER, B. R., & LESSER, S. R. (1989). Transference Resistance in Hysterical character neurosis. In Ruth F. Lax (Ed), Essential papers on character neurosis and

treatment . New York: New York University Press.

ETCHEGOYEN, R. H. (1991). The fundamentals of psychoanalytic technique. New York: Karnac Books.

FENICHEL, O. (1945). The psychoanalytic theory of neurosis. New York: W. W. Norton.

FONAGY, P. (1999). Memory and therapeutic action. Int. J. Psychoanal., *80:* 215-224.

FREUD, S. (1900). The interpretation of dreams. S.E., 4-5.

_____. (1905). Three essays on the theory of sexuality. S.E. 7.

_____. (1911). Formulations on the two principles of mental functioning. S.E., 12.

_____. (1914). On the narcissism: An introduction, S. E., 14.

_____. (1916). Some character types met with in psychoanalytic work S.E.14.

_____. (1926). Inhibitions, Symptoms and anxiety. S. E. 20.

_____. (1933). New introductory lectures. S. E.

GARZOLI, E. H. (1981). Sobre la adición de transferencia. Psicoanál., 3: 193-229.

GEDO, J. E. (1996). The languages of psychoanalysis. Hillsdale: The Analytic Press.

_____. (1995). Psychoanalysis and nonverbal communication. Australian J. of Psychoth., 14*: 45-53*

GITELSON, M. (1963). On the problem of character neurosis. Hillside J. Clinical Psychiatry, 12: 3-17.

GREENSON, R. R. (1960). Empathy and its vicissitudes. Int. J. Psycho-Anal., 41: 418-424.

HARTMANN, H., & LOWENSTEIN, R. M. (1962). Notes on superego. Psychoanal. Study of the Child, 17*:* 42-81.

HEIMANN, P. (1977). Further observation on the analyst's cognitive process. J. Amer. Psychoanal. Assn, 25: 313-33.

HERNÁNDEZ, M. (1999). Affect, language and communication: loose ends. Inter. J. Psychoanal., *80:* 341-55.

JACOBSON, E. (1954). The self and the object world: vicissitudes of their infantile cathexes and their influence on ideational affective development. Psychoanal. Study of the Child, 9: 75-127.

KERNBERG, O. (1965). Notes on countertransference. J. Amer. Psychoanal. Assn, 13: 38-56.

_____. (1976). Object-relations theory and clinical psychoanalysis. Northvale: Aronson.

_____. (1992). Borderline conditions and pathological narcissism. Northvale, NJ: Jason Aronson.

_____. (1997).

KERNBERG, O., SELZER, M. A., KOENIGSBERG, H. W., CARR, A. H., & APELBAUM. (1989). Psychodynamic psychotherapy of borderline patients. New York: Basic Books.

KLEIN, M. (1975). The writtings of Melanie Klein, vls 1-4. Under the general editorship of Roger Money-Kyrle in collaboration with Betty Joseph, Edna O'Shaughnessy & Hanna Segal. London: Hogarth Press.

LECOURS, S. & BOUCHARD, M. A. (1997). Dimensions of mentalisation: outlining levels of psychic transformation. Int. J. Psycho-Anal., 78: 855-75.

LIBERMAN, D. (1971). Rasgos de la verbalización y cualidades de las fantasias inconscientes. Rev. Psicoanál., 28: 559-91.

_____(1974). Complementariedad estilística entre material e interpretación. Rev. Psicoanál., *31:* 201-224.

_____ (1978). Affective response of the analyst to the patient's communication. Inter. J. Psychoanal., *59:* 335-340.

_____ (1982). Psicopatologia. Rio de Janeiro: Ed. Campus.

_____ (1983). Linguistica, interaccion comunicativa y processo psicoanalitico tomos I e II. Buenos Aires: Kargieman.

LIBERMAN, D., & MALDAVSKY, D. (1975). Psicoanalisis y Semiotica: Sentidos de realidad y categorizaciones estilísticas. Buenos Aires: Paidós.

MAKARI, G., & SHAPIRO, T. C. (1993). On psychoanalytic listening: language and unconscious communication. J. Amer. Psychoanal. Assn., 41: 991-1020.

MCLAUHLIN, J. (1991). Clinical and theoretical aspects of enactment. J. Amer. Psychoanal. Assn., *39*: 595-614.

_____. (1986). Touching limits in the analytic dyad. Psychoanal. Q., 64: 433-65.

MORRIS, C. W. (1946). Signs, language and behavior. New Jersey: Prentice Hall.

OGDEN, C. K., & RICHARDS, I. A. (1923). The meaning of meaning. London: Routledge & Kegan Paul.

PIAGET, J. (1937). La construcción de lo real en el niño. Buenos Aires: Proteo.

PICHON RIVIÈRE, E. J. (1960). Técnica de grupos operativos. Acta Neuro-Psiquátrica Argentina, 6: 32-8.

POLAND, W. (1986). The analyst's words. Psychoanal. Q., 55: 244-72.

PONSI, M. (1997). Interaction and transference. Inter. J. Psychoanal., 78*:* 243-63.

POPPER, K. (1962). La lógica de la investigación científica. Madrid: Tecnos.

PRIETO, L. J. (1966). Messages et signaux. Paris: PUF.

RABIH, M. (1981). La seudoalianza terapéutica. Algunas de sus manifestaciones clinicas. Psicoanál., 3: 169-91.

RACKER, H. (1968). Transference and countertransference. New York: International University Press.

RANGELL, L. (1968). A point of view on acting-out. Inter. J. Psychoanal., 49: 195-201.

REICH, T. (1933). Character analysis. New York: The Nooday Press.

RIESENBERG-MALCOLM, R. (1986). Interpretation: the past in the present. Inter. Rev. Psychoanal., 13*:* 433-43.

RUSSELL, R. L., & STILES, W. B. (1979). Categories for classifying language in psychotherapy. Psychol. Bul., 86*:* 404-19.

SALTZMAN, L. (1980). Treatment of the Obsessive Personality. New York : Aronson.

SEGAL, H. (1982). Early infantile development as reflected in the psychoanalytic process: steps in integration. Inter. J. Psychoanal., 63*:* 15-21.

SÉGUIN, M.-H., NORMANDIN, L., & BOUCHARD, M.-A. (1995).

Countertransference as an instrument and obstacle: a comprehensive and descriptive framework. Psychoanal. Q., *64:* 717-745.

SHAPIRO, D. (2000). Dynamics of character. New York: Basic Books.

SIEGEL, D. J. (1999). The developing mind: toward a neurobiology of interpersonal experience. New York: Guilfor.

STOLOROW, R. D. (1997). Dynamic, dyadic, intersubjective systems: An evolving paradigm for psychoanalysis. Psychoanal. Psychol., 14: 337-46.

TRIER, J. (1934). Das sprachliche feld. Eine auseinandersetzung. Neve jahrbücher für jugendbildung. v 10. pp 428-49.

TUCKETT, D. (1983). Words and the psychoanalytical interaction. Inter. Rev. Psychoanal., *10*: 407-413.

WALDRON, S., SCHARF, R. D., CROUSE, J., FIRENSTEIN, S. K., BURTON, A., & HURST, D. (2000). Saying the right thing at the right time: Psychoanalytic Interventions of good quality lead to immediate patient productivity. Paper presented at The Joseph Sandler Research Conference, London, March.

WATZLAWKY, P. (1967). Pragmatics of Human Communication. A Study of Interactional Patterns, Pathologies, and Paradoxes. New York: W. W. Norton.

WHEELER, M. A., STUSS, D. T., & TULVING, E. (1997). Toward a theory of episodic memory: the frontal lobes and autonoetic consciousness. Psychol. Bulletin, 121: 331-54.

Footnotes

[1]From the Spanish: 'El habla y la mímica verbal que acontecen en el curso de la sucesión

cambiante de estructuras y funciones, sumadas a los cambios, las crisis y las nuevas estructuraciones en el paciente, considerando también lo que el paciente no habla en las sesiones, sus silencios, los silencios del terapeuta, la elección y el descarte en la forma de interpretar, que implican estilos lingüísticos, constituyen las bases empíricas del psicoanálisis' [our translation] (Liberman, 1983, p 46).

[2]From the Spanish: (...) no se estudia un paciente, sino un universo de interacción entre dos personas en el cual una de ellas, el paciente, reacciona de acuerdo a sus disposiciones y al estimulo que significa la otra, el terapeuta que indaga y opera en el paciente durante el lapso en que transcurre la session' (our translation). (1982, p. 80).

[3]The concept of semantic field was defined by many German and Swiss scholars especially Trier, (1934) who studied the evolution of languages and how different lexical fields structured a same conceptual field at different periods. On a general level the words in a semantic field, though not synonymous, are all used to talk about the same general phenomenon, or how a phenomenon can be described using many types of words but sharing similar meaning (Akmajian et al, 1995). Liberman used this concept meaning that analyst and patient, although using different linguistic styles, were able to share similar meanings in terms of affective experiences, goals with the analytic treatment, and therapeutic alliance within the same analytic field as defined by Baranger & Baranger (1969; 1983).

[4]Here we use the ego ideal as part of the superego as stated by Jacobson (1954) and Hartman & Lowenstein (1962) and from this point on the concept of superego is meant to cover both functions: the ego aggrandizing and ideal, and the ego limiting.

[5]This term was used before by Piaget (1937) and later by Blanché (1966) to comprehend the cognitive systematization of human knowledge and how it is used to influence others' wills and behaviors during a human communicative interaction. However, the cognitive developmental tradition differs from Liberman and Maldavsky's theory, which moves beyond the cognitive and information processing aspects to understand human communication as under the influence of the affective component of the superego-ego-ideal structure.

[6]From the Spanish: 'La técnica interpretativa de los processos transferenciales...requiere a la vez la capacidade del científico para ubicar-se a cierta distancia de los fenómenos, la capacidade del creador literario para poder recrear un codigo verbal, la fantasia inconsciente y el ingenio del inventor para desplegar los medios instrumentals para transmitir la información de uma manera tal que sea ajustada en contenido y en certera en significado' (our translation).

[7]The authors wish to acknowledge the help of Dr. Sherwood Waldron, President and Chairman of the Board, The Psychoanalytic Research Consortium, New York for permission to use the present material.

[8]Waldron, Scharf, Crouse, Firenstein, Burton and Hurst (2000) used the Analytic Process Scales (APS) independently and to carefully examine three sessions of this case, one in the beginning, one in the middle and one towards the end. The APS consists of

three clusters of variables focusing on the analyst's participation: intervention quality, core analytic activities (interpretation, clarification, resistance, transference and conflict) and affective involvement. For the patient, the central variable is productivity. Each feature is rated by expert clinical judges on a five-point scale in which 0 represents the absence and 4, a strong presence (Waldron et al, 2000). The aim is to relate the quality of interventions to productivity. In the present case their examination revealed that both the analyst's interventions and the patient's productivity were low level. The analyst used frequent transference interpretations but with decreasing complexity in terms of connections between affect, impulses, defenses and examples of similar responses with others. On the patient's side, there was slow progress in understanding of the depth and extent of his own conflicts. His emotional involvement was low and in accordance with low productivity.

Table 1

Description of Liberman's Linguistic Styles (Liberman, 1982)

Styles	Patient	Analyst
1. Dramatic Aesthetic	This mode fascinates by the richness of their verbal and non-verbal expression. Usually, the subject effectively tell stories with a sequential and argumentative line so the analyst's attention never drops. Castration anxiety is managed through projection, dramatization and the creation of an aesthetic impact. The style's use of representative symbols of facts as if they were the facts themselves; others feel like the scene is happening just now, as if they were participating in the drama. In this style are included the metaphors, hyperboles, exaggerations and other symbolic features of languages. The discourse can be also equated to a dream.	The analyst names the patients' internal contents but in a symbolic and imagistic manner linking the affect and the representation. It is rich in visual and plastic contents. He can also present exhibitionistic traits in his verbal expression. As the oedipal transference is activated, he can lose the capacity to perceive the impact of his seductive aspects on the patient.
2. Dramatic Suspense	This style usually have the worst syntax of all since the anxiety is almost always present and invades the verbalization process They will stop phrases in the middle and avoid certain themes by not using the first person (I) but the third (he, she). The effect on the listener is one of confusion, misunderstanding and obscurity. When the subject is able to get in contact with these repressed aspects, they are able to generate new symbolic meanings in phrases with optimal syntax.	The analyst avoids any theme implying in an unconscious fantasy or object relation that could cause him anxiety. I.e. making transference interpretations to clear transference contents. The patients' inquires for clarifications are answered in a tangential manner. The verbalizations are ambiguous and unclear. Sometimes expressed in long phrases where it is unclear which is the most important sentence. He can stop phrases in the middle leaving the patient to complete them. Or he can make unclear and incomplete questions. The effect is one of "suspense".
3. Narrative	This Style concentrates on the verbal aspects of communication especially the syntax and the semantics, not being interested at all in the pragmatics or the effect their discourse has in others. This subject is excessively preoccupied with controlling the way people understand them and the way they must talk. The narrations are sequential, with very little (if any) images or dramatic aspects. The listener feels little 'room" to fantasize or to make a plastic image of the narration. The sentences are filled with logic and frequent usage of associations by temporal or spatial proximities or by similarities.	The analyst is very meticulous in describing situations or in asking questions about facts. Sometimes the questions may resemble a court hearing where one can only respond with "yes" or "no". There is an emphasis on the use of formal logic and the correctness of the syntax. In some cases the analyst can put an emphasis on the differentiation of the subjects in the phrase such as "you" or "I" in order to work on the patient's conflicts on differentiating himself from others. The analyst descriptively explains the effects of patients' words and actions on others. Or, make clarifications and interpretations linked to the setting.
4. Epic	This style always reveals a second intention towards the treatment, very different from the therapeutic purposes. The subject us an inoculators of his wishes. He presents a "conative language" where linguistic utterances evoke a conception of intentions towards the other person (receiver of communication) that are not usually clear or explicit. Scenarios, and story characters change so much that it become impossible to understand the symbolic contents of their discourse as well as what they intent to communicate. Usually, this kind of discourse is not used to communicate something, but rather to hide, control or to indirectly convince the listener with something. The characters in the stories are usually very "crude" as they often represent primitive partial object relations.	The analyst can try to induce the patient to feel things he is not prepared to. The analyst loses his capacity to think and can use action, in words, as a result of a coutertransference reaction. He may interrupt the patients' speech, or become angry. Or he may instrumentally use the "action in words" in order to interrupt the patients' endless and controlling discourse. He can also (instrumentally or not) bring into the discussion a completely different subject, using an epic modality.

5. Lyric	There is a high degree of convergence between the verbal emissions and the affects related to these emissions. The subject tends to get overwhelmed with emotions. Their listening is an avid "open mouth" as they also lose the capacity to differentiate between the self and others. The analyst is seen as someone who regulates their self-esteem and the problems with the superego. So interpretations are understood as a proof of the analysts' feelings towards the patient. This creates a in a semantic distortion of the messages. It is a complaining-type of expression, with the sense of guilt being always projected. It may seem they emit insight-form of verbalizations, as they demonstrate emotions, some culpability and preoccupation with causes of behaviours and situations. However, they are either projecting the guilt or turning it against themselves.	The analyst (as result of a countertransference) can make interpretations or use the patient in order to appease any negative internal feelings resulting from conflicts in his own superego. Or the analyst can feel he has to pacify the patients' superego through reassurances and encouragements. The analyst can be very critical or feel criticized by the patient.
6. Reflective	For the patients this style is called *Reflective-schizoid*. Thoughts rather then emotions and emotional connections with others, are almost exclusively invested aspects. Anxiety is non–existent and the discourse is markedly philosophic, detached and abstract. This detachment is more structural than defensive. They usually have a good relation with the reception and transmission of messages since the dissociation helps them not be personally compromised with the message. They describe emotional situations or important facts in their lives as if they were describing a scientific documentary. The impression is being in the presence of a good police report of the facts, without any emotion involved. When using the *reflective-schizoid* style, patients are usually under the influence of distrust or disbelief. They respond by being impersonal and very abstract.	The analyst makes an instrumental use of his "schizoid" parts (detachment) in order to name the inside contents that are avoided by the patient. This kind of dissociation makes possible to keep facts and situations vivid in our memory. The schizoid- reflective attitude may also help us to orient our approach in the face of dramatic-aesthetic impact. This helps to focus on either inhibited or dissociated parts instead of becoming a 'castrated' spectator of the highly metaphorical and plastic images that serve the theatrical mode. Silence can be used as a defense or as an important "refuge" in order to find a better way to interpret the patients' conflicts. The analyst can also ask interpretive questions, aiming to make the patient think about unconscious conflicts.

Table 2

Description of Linguistic Complementarities

Subject's style	Analyst's Complementarities
1. Dramatic Aesthetic	A reflective analyst, in an instrumental utilization of his schizoid in order to give a name to patients' "mute parts" (dissociated or inhibited); give also an abstract name to patient's autoplastic activity compromised by his dramatization.
2. Dramatic Suspense	A reflective analyst, in an instrumental use of his schizoid parts in order to give a name to inside contends that are avoided because of anxiety.
3. Narrative	An epic analyst in an instrumental use of the action language, showing how the patient tries to control the session in order to prevent the unexpected reactions that could create in the patient feelings of chaos and uncertainty.
4. Epic	A narrative analyst in an instrumental use of logical phrases in relation with the setting. Tries to put order to the chaos of patients' projective identification. The analyst describes the effects the patients provoke in others, how they react and how a therapeutic dialogue can be accomplished.
5. Lyric	A narrative analyst in an instrumental use of logical phrases before interpretation where the analyst can rescue his identity, putting an emphasis on the differentiation of the subjects in the phrase such as "you" or "I" in order to work on the patient's conflicts on differentiating himself from others.
6. Reflective	A dramatic analyst in an instrumental utilization of dramatic style in a symbolic and imagistic manner linking the affect and the representation, lacking in patients' discourse.

Paper 2

Linguistic Styles and Complementarities Compared in Two Psychotherapy Beginnings

Running Head: LINGUISTIC STYLES AND COMPLEMENTARITIES IN TWO PSYCHOTHERAPY BEGINNINGS

Linguistic Styles and Complementarities Compared in Two Psychotherapy Beginnings Offered by the Same Therapist

Daniela Wiethaeuper[1]
Marc-André Bouchard
Caroline Audet
Patrice St-Amand. Université de Montréal

To be submitted to Psychotherapy Research

---

[1] Preparation of this manuscript was supported in part by the CAPES (Centro de Avanço de Pesquisa e Ensino- Brazil), UNISINOS (Universidade do Vale do Rio dos Sinos) Brazil; the Département de Psychologie of the Université de Montréal, and grants to the second author from the Research Advisory Board of the International Psychoanalytic Association and the FCAR, Ministère de l'Education, Québec, Canada.

Correspondence concerning this article may be addressed to Marc-André Bouchard, Département de psychologie, Université de Montréal, succursale Centre-Ville, Montréal, H3C 3J7, Québec, Canada. Electronic mail may be sent to: boucharm@psy.umontreal.ca.

Abstract

Patterns of linguistic interaction were examined in two contrasted series of the beginnings of 14 psychotherapy sessions, one (A) a premature termination, the other (B) a positive outcome, offered by the same therapist. Based on Liberman's interactive communication concepts, the Liberman Linguistic Styles Measure (LLSM; Wiethaeuper, 1999) was related to clinician-rated perceived helpfulness, defensive activity and mental states. For each pair, (Pair A and Pair B) specific intercorrelations among styles were found and distinct complementary and non-complementary sequences in patient-therapist linguistic behaviors were documented (Wampold, & Kay-hyon 1989). Results point to the validity of the LLSM's positive, negative and neutral interaction patterns as measuring distinct features: more positive and less neutral linguistic patterns were found in Pair B; negative interactions were negatively correlated with clinicians' ratings of helpfulness. So-called "neutral" interactions were related to specificities in the defensive-characterological functioning of each patient (narcissistic in case A; obsessional in case B).

Linguistic Styles and Complementarities Compared in Two Contrasted Psychotherapy Beginnings Offered by the Same Therapist

The mutual influence of patient and therapist is now seen as a fundamental aspect of psychotherapy and an essential unit of analysis in psychotherapy process research (Kiesler 1982, 1996; see also Stiles, Honos-Webb, Knobloch, 1999). More specifically, the quality of the relationship emerges as a significant factor in therapeutic success (Lambert & Bergin, 1994). In recent years, process researchers have been focusing on patient-therapist interaction *per se*, rather than concentrating exclusively on each participant's processes or qualities. The aim is to describe which ingredients that are actively at work within a therapeutic dyad are associated with good outcome (Bachelor & Horvath, 1999; Bordin, 1979).

Previous studies have directed our attention to specific elements of the situation, sometimes called "facilitative conditions" (Lambert & Hill, 1994). Some examples are empathic resonance and mutual affirmation (Kolden, Howard, & Maling, 1994); undistorted (real) perception of the relationship as part of transference and countertransference issues (Gelso & Carter, 1985, 1994); and the therapeutic alliance as an important process tool and predictor of outcome across different approaches (Luborsky, 1976; Bordin, 1989, 1994; Hovarth, 1981; Gaston & Marmar, 1994; Gaston, Marmar, Thompson & Gallagher, 1988). Still, a different view stresses the importance of communicative patterns within the therapeutic interaction and asserts that in a profitable encounter, the therapist and patient are co-constructors of a new less problematic narrative that is "construed as the activity of generating meanings which might

potentially transform experience through collaborative dialogue" (Kaye, 1995, p.35). Within this last "constructivist" view, increasing empirical and clinical interest in the *form* of verbal, non-verbal and para-linguistic communication within the therapeutic situation has emerged. This is also an articulation of the possible links between the areas of philosophy of language, pragmatics (Stiles 1979; 1987), and psychotherapy research, in reference particularly to the issue of outcome (Watzlawick, 1967, Tuckett, 1983, Canestri, 1994, Makari & Shapiro, 1993, Poland, 1986, Russell & Stiles, 1979).

Therapist interventions have been characterized linguistically (Meara, Shannon & Pepinsky, 1979), while patient styles were related to psychopathology and medical diagnostic issues (Fernandez-Zoiela, 1981; Hambleton, Russell, & Wandrei, 1996; Gottchalk & Gleser, 1969; Gottchalk, Stein and Shapiro, 1997; Irigaray, 1987). Stone, Dunphy, Smith and Ogilvy (1966) created the General Inquirer (based on the Harvard psychosocial dictionaries) that accessed specific words considered to be linked to need states, social roles, etc. This technique has been put to use particularly with the aim of better distinguishing medical from psychiatric diagnoses (Rosenberg, Schnurr & Oxman, 1990).

Relating personality features and linguistic styles, Pennebaker, James & King (1999) explored written samples of students, and were able to draw reliable linguistic profiles that could be meaningfully related to Thematic Apperception Test (TAT) scores, and other self-report and behavioural measures. One style, labelled rationalization, was composed of individuals with higher insight, greater use of causation and fewer negative

emotions, was positively correlated with need for affiliation measured by the TAT, and was negatively correlated with achievement measured by the Personality Research Form.

In psychotherapy process research, Stiles (1992) and also Russell, van den Broek, Adams, Rosenberger, and Essig, (1993) described both form and intent of self-disclosure (modality) of patients and therapists. The therapies judged the highest in terms of quality (good) process, had a prevalence of modality expressions on patient's and therapist's discourse (Essig, & Russell, 1989). Bucci (1993, 1997) and Bucci & Mergenthaler (1999) extensively used computer-assisted word-dictionary measures of referential activity (CRA). Referential activity is understood as the capacity to link non-verbal sub-symbolic forms of representation via imagery (a non-verbal symbolic code) to symbolic verbal representation. Patterns of emotional tone and abstraction complement this description (see Mergenthaler, 1996; 1997). Some preliminary results consistently link high referential activity with outcome measures (Bucci, 1997).

Horowitz, Milbrath & Stinson, (1995) defined levels of dyselaboration (for example, faulty syntax, broken phrases), which helped determine how a subject's discourse became less structured in the face of trauma and conflict. Sandell and Lipschütz (1992) defined linguistic regression as a lack of precision, an inability to express thoughts at a specific moment, and the presence of breaks and interruptions. In a presumably successful intensive outcome study, they found an increased capacity by the patient to control regressive speech.

Hölzer, Mergenthaler, Pokorny, Kächele, and Luborsky (1996) compared 10 successful and 10 unsuccessful psychodynamic psychotherapy cases, using a

computerized measure (the RID) to classify words according to three main categories (verbal activity of patient and therapist, presence of regressive imagery, and size of private and shared vocabulary). They found that the improved group showed a greater tendency on the therapist's part to accommodate to the patient's language (shared vocabulary) than the unsuccessful cases. The Vanderbilt I and II Psychotherapy Research Projects (Henry, Schacht, Strupp, & Hans,1986, Henry, Schacht, & Strupp, 1990) revealed that therapists exhibited markedly different interpersonal behaviours in the poor outcome cases, shown by their being less affirming and understanding, less protecting and more belittling and blaming. Frequently, hostility from one member of the therapeutic dyad was immediately followed by the same from the other in the negative outcome situations. Henry et al. (1986) found that in good psychotherapy outcomes, only 1% of the therapist's and none of the patient's communication was hostile, whereas in poor outcomes, these figures went up to 19% and 20% respectively. Tracey (1986) sustained the importance of complementary interactions, defined as agreement over the tasks and goals of therapy, a view much closer to the notion of therapeutic alliance than our use of linguistic complementarity (see below). However, there are other studies that did not find any relation between complementarity and outcome. In a study by Friedlander, Thibodeau, & Ward (1985) metacomplementary behaviour was that of a therapist in a more passive role but structuring the patients' behaviour; and no differences were found between good and bad therapy hours. Thompson, Hill & Mahalik, (1991) found no differences between initial and later sessions in their study of eight therapists on their complementary behaviours that were understood to be behaviours reinforcing the

usual rigid characterological structure of the patient. This unexpected result did not confirm the initial hypothesis of more flexible interactions occurring as the therapy advances.

A major limitation of these studies is that they do not include a complete definition of the complex and interactive components of syntax, pragmatics and semantics and their influence on the constitution of styles and the therapeutic interaction. It is our opinion that the fields of psychopathology and empirical psychotherapy research can benefit from careful attention to the concept of character as a developmental and organizational structure expressing its peculiarities notably through paralinguistic and linguistic expressions. These, in turn affect massively such a communicative interactional field as the psychotherapy situation. This implies that both participants contribute linguistically to the field via their character structure. The Argentinean analyst and psychotherapist, David Liberman, has offered a major contribution towards linking semiotics to knowledge of psychopathology and development and psychotherapy. He approached the analytic situation through the concepts of linguistic styles and communicative interaction as related to character structure and functions. In his view, semiotic rules are character originated, and in pathology contribute to repetitive patterns and miscommunication which are stimulated and observed in the therapeutic field. As therapists we must attend to these, if we are to hope exert any beneficial effect (Liberman, 1982). This is achieved by giving priority to rules of form or stylistic features, which are embedded within the usual meanings. It is Liberman's contention that if this semiotic level is ignored, chances are that in some way therapists are led unwillingly to

maintaining, generating, or contributing to impasses. However, Liberman's clinical descriptions provided only limited empirical support to his view. Yet, he continuously and convincingly stressed the importance of linguistic field as one of the most important empirically accessible bases of psychotherapeutic interaction.

From Liberman's initial careful and inspiring descriptions, a measure was developed linking characterological traits through communicative modes. This further aimed to assess the therapeutic process, showing the specificity of each therapeutic field. In our study we contrast two psychodynamically oriented psychotherapy beginnings by the same therapist with these objectives 1) to test the application of David Liberman's Linguistic Style Measure ((LLSM); Wiethaeuper, 1999) in a context of psychotherapy process research; 2) to explore patterns of linguistic interaction and the role of the therapist's linguistic complementarity on outcome; and 3) to demonstrate that each psychotherapeutic interaction is character-specific.

Liberman Linguistic Style Measure

The LLSM (Wiethaeuper, 1999) is based on the concept that the individual's characterological organization will find expression through specific linguistic patterns that constitute a particular style of communicating. More specifically, a style is defined as the manner or form of communication used in different channels: verbal, non-verbal and paraverbal. To illustrate: one person may express himself mainly uniformly, explaining in detail each and every idea or fact and use a monotone voice with almost no gesticulation; another person may employ numerous channels and their transmission and their discourse will be rich in metaphors, vivid scenes and dramatic expression (Liberman, 1983).

Style, considered part of someone's character and someone's manner of expression is formed developmentally through stages of acquisition in communication skills and is influenced by communicative relationships with parental figures that include their own style of communicating, and their conflicts, and so on (Rosen, 1969; Liberman 1982). During developmental stages new functions and complexities in the use of language and channels of communication are acquired. The ego becomes a central organizer of thought and language. Progress is always observable in stylistic features of communication that express more or less integrated, plastic, and self-regulating functions of the ego. Consequently, characterological resistance in the psychotherapeutic treatment (Liberman 1982, 1983) is seen as rigidity in linguistic style.

Liberman's initial theory was based on psychopathology and nosology. For example, the depressive character was seen as electing a lyrical style, while the obsessional character would use the narrative-logical style. In other words, his was in fact a categorical approach. The development of his ideas resulted in the LLSM in which we adopted a dimensional, process-oriented and descriptive approach to the various sequences in stylistically distinct communicative mental states of the ego as observed in sessions. As expected in any given session, either patient or therapist is seen to use several linguistic styles in potentially clearly identifiable sequences. It is a part of Liberman's psychotherapeutic theory that these styles combine to establish a communication cycle between the patient and the therapist. Ideally, these combinations will allow both participants to understand each other's messages. In a defensive stance, however, they serve to systematically miscommunicate. In other words, it is the

therapist's responsibility to use linguistic styles that are complementary (Racker, 1968) to the patient's. This means to employ ego functions that decode a message and elaborate an adequate response to the patient's presently activated "style-character" components that need to be met (Liberman, 1982, 1983). Thus, the therapist's use of complementary linguistic styles is understood as a part of "observing ego" and of an elaboration process in which theoretical concepts are always present as 'working models' (Greenson, 1960) and not used as "memorized procedures" depending on which style is present in the patient's discourse.

As an instrument, the LLSM consists of three parts: a description of a preliminary segmentation process of each transcript, followed by a detailed description of nine linguistic-stylistic components or functions, and finally, a list of positive (complementary), negative and neutral linguistic interactions, based on Liberman's clinical and theoretical analysis (Liberman, 1982).

A segment is a proposition containing a subject and a complement that together may form a complex phrase (Kreuz and McNeally, 1996). Some linguistic components can be expressed across many propositions, such as when the subject tells a story or describes an event where only one style can be observed. Occasionally, a style is recognizable in less then one phrase such as in the use of swearwords that are typically rated as epic.

Judges who are asked to segment are required to be already fully in command of each description of each style and its components. Fortunately however, changes within a patient's discourse in terms of word type and phrase construction, syntax, semantics or

pragmatics are usually accessible to observation and agreement, even without prior knowledge in the LLSM. For example, a subject is describing very specifically a certain event, worried about every detail of the scene and character; suddenly he or she starts to complain about something, using emotionally laden adjectives. These kinds of changes are marked with a differentiation in terms of segments.

Each style is also related to a typical theme, like seduction and beauty for the dramatic aesthetic mode, or action and endless adventures for the epic style. These features are also useful and taken in consideration in order to rate the material (see Wiethaeuper, 1999).

The second part of the manual (LLSM, 37p.) contains two separate complete descriptions of each of the nine linguistic styles and components for therapist and patient. These are concrete, reflective-schizoid, lyric, epic, narrative, dramatic suspense, dramatic aesthetic and two-insight form or meta-styles. The concrete mode and the meta-styles were added to the initial list proposed by Liberman (1982). Marty's (1990, 1991) description of poorly mentalized psychosomatic patients, based in part on previous work by Marty and de M'Uzan (1963), was our main reference. This is seen with patients who are engaged in descriptions of somatic dysfunction and actions devoid of meaning, and who have very poor capacity for symbolization, an inability to establish any relation with these somatic concerns and potentially stressful moments or any other aspect of mental life. Descriptions of the two "meta-styles" are based on the notion of insight as the most ideal form of communication in terms of message transmission, with almost perfect syntax, semantics and pragmatics and no visible use of a specific style. This reveals one's

capacity to approach a psychic situation in a creative and new way that includes unconscious feelings and experiences. Usually when the subject expresses this kind of experience, he is able to communicate without defensive or characterological activity, and therefore no specific style is used.

This general approach implies that styles are positioned on a hypothetical scale of maturity, from the more regressed concrete style, to the lyrical, the epic, the narrative, the dramatic suspense, and the aesthetic mode and meta-styles. In our view, the more evolved linguistic styles mean that the individual is more able to utilize numerous channels of communication in a symbolic manner as a consequence of an integrative ego capacity and internalized stable object relations.

Finally, a complete list of positive, negative and neutral linguistic interactions, based on specific therapists' responses to the patient's attempts is defined within the LLSM. The list is based on the idea that the *form* or the style the therapist uses to verbalize his comments, observations, confrontations or interpretations, has to be in essence a concern that provides us with an operational index of therapeutic action. It is important to stress that the positive, negative and neutral interactions are not self-reported conclusions reached by the participants but instead, a consequence of independently rated judgements based on a provided list of linguistic complementarities and non-complementarities of the dyad.

This exploratory study combines an intensive examination of two contrasted beginnings in psychodynamic psychotherapy. The first one, considered a negative

outcome, was the premature termination of treatment by Mrs. A after session 14. The second, Mrs. B, continued successfully to session 202.

Hypotheses

Several hypotheses are made. Mrs. A was seen as functioning mostly on a level of narcissistic resistance to dependency, while Mrs. B was seen as mostly neurotic and histrionic, anxious and inhibited, but perhaps more able to involve herself in a long-term psychotherapeutic commitment. We hypothesize that, based on clinical evaluation and observed differences in character structure and manifest outcome, it is expected that patients will differ in terms of perceived helpfulness of the treatment, mental states and defense mechanisms. Linguistic communication will also be quite different between the two dyads, each producing unique patterns. Mrs. A will show more frequent regressed reactive mental states (see below), and more regressed defensive activity, while Mrs. B will be seen to be more process-oriented. In terms of defensive maturity, we expect that Mrs. A will show more regressed levels compared to Mrs. B. We expect to find indications of deterioration in terms of helpfulness, mental states and defensive maturity in Mrs. A, contrary to Mrs. B who is expected to show progression in all measures.

Characterological aspects of both cases expressed in different linguistic styles will emerge. We expect that Mrs. A will use a more regressed linguistic style (the epic-action style) as a result of her narcissistic features, while Mrs. B should lead to observe more frequent use of the two higher-level dramatic styles. Furthermore, in the prematurely terminated case, we should find less fluidity in using different styles across sessions.

The patients' styles will have an observable and differential impact on the therapist and therefore on the interaction field. Not only should each pair present a specific linguistic configuration, but we may assume that given the presence of an impasse, Pair A will indicate less fluid sequential patterns and more negative linguistic complementarities. Conversely, Pair B will show more positive instrumental and complementary interactions.

Frequencies in the patterns of linguistic interactions should differ between the two cases, with more positive and less negative in the second case. Significant correlations with the clinician's assessments of helpfulness (the HRS) are also expected: negative interactions being negatively related, while positive interactions should relate positively.

The LLSM index of overall linguistic maturity is expected to correlate moderately but positively with the Overall Mental States Maturity index and the Overall Defensive Functioning.

Method

Subjects and material

Sessions of two beginning psychodynamic psychotherapies offered by the same therapist are used for this study[1]. One case was prematurely terminated by the patient following the 14th session, while the second continued to a positive outcome for a little over 200 sessions from which are currently analyzed the first 14. In the first case, Mrs. A, 44, is a divorced mother of three children who are in their early twenties. She was maintaining a relationship with a man twenty years older with whom she had a distant

and conflicted relationship. She started the treatment following the loss of her job after six years as a management secretary. The evaluation sessions demonstrated the following DSM-IV (APA, 1994) diagnoses: on Axis I, an adjustment disorder with mixed anxiety and depressed mood (309.28), and both Avoidant (301.82) and Dependent (301.6) personality disorders on Axis II. The Global Assessment of Functioning (GAF) based on the three first sessions provided a score of 70 on Axis V. On a clinical basis, it also appeared that this person presented clear narcissistic traits while functioning at a borderline level of object relating.

Mrs. B, 27, had just completed an undergraduate program. Her main complaints were anxiety, depressed feelings and dyspareunia. The complete therapeutic process lasted for a total of 202 sessions, two times per week. The evaluation sessions revealed the following DSM-IV diagnoses of Depressive Disorder not otherwise specified (311) on Axis 1. The GAF based also on the three first sessions provided a score of 70 on Axis V. The therapy was first conducted face to face but she eventually used the couch. All 202 sessions were audiotaped. Four blocks of 14 interviews were transcribed: 1-14, 65-79, 120-135, 184-198 and revised once.

The therapist was male, mid-forties, fully trained with more than 20 years of clinical experience.

Instruments

The Helpfulness Rating Scale. The HRS is a 9-point, bipolar, adjective-anchored rating scale. This instrument was initially used to ask patients to reveal their experience of the degree of helpfulness of the therapists' responses (Elliott, 1985). In a modified use

of this scale for the present study, psychodynamically oriented clinical psychologists were asked to review all 28 sessions and to score each session segment[2] and each session globally. They used the HRS with a score of 1 corresponding to 'extremely hindering', while 9 is anchored with 'extremely helpful', and 5 was considered neutral. These judges were not trained specifically on the HRS, but they were asked explicitly to make judgements based on their personal clinical experience. As a result, inter-observer agreement was expected to be low.

The Mental States Scoring System. The Mental States scoring manual (Bouchard, Picard, Audet, Brisson & Carrier, 1998) refers to the modality or category of endopsychic activity that is inferred to be happening within a human subject. The present distinctions expand and elaborate previous work separating three therapists' mental states as part of the global countertransference response (Bouchard, Normandin, Fröté 1994; Bouchard, Normandin & Séguin, 1995; Dubé & Normandin; 1999; Lecours, Bouchard, Normandin, 1995; Normandin & Bouchard, 1993): the Reflective, the Reactive (two forms) and the Objective-Rational modes. The Reflective Mental State (REF), implies some level of metacognitive capacity (for example, Pinard, 1989; Main, 1991) as a basis for further self-observation, self-reflection and self-understanding. In the therapist's case, it aims at a mental perception and elaboration of the patient's conflicts often as an elaboration of the countertransference response. In contrast, the Reactive mental state (REAC) is a mental activity presumably out of awareness. It may be a moment of psychic discharge, often a repetition, as opposed to a "remembering" (Freud). One subcategory within the Reactive mode is the Defensive Reactive mental state whose purpose is to maintain or to re-

establish the ego's sense of safety. The Defensive Reactive mental state is also, in turn, subdivided into two categories: the inhibited higher-level mode of defense (DEF-HIGH), and the often uninhibited driven, lower level mode of defense (DEF-LOW) that often takes the form of a discharge or projective identification. The third main group of mental activities is the Objective-Rational mental state (OBR). Its aim is one of distancing, either towards the inner world or through a third-person detachment (as opposed to a first person involvement).

The Defense Mechanisms Rating Scale. The Defense mechanisms Rating Scale (DMRS, Perry, 1990; Perry, Kardos, & Pagano,1993) defines 28 defense mechanisms distributed in seven different levels of maturity. Each defense is well defined with a description of its intrapsychic function, a list of similar defenses and a rating scale. This allows trained judges to identify on the transcripts the beginning and end points of each occurrence of each defense that may then be measured by frequencies of the total number of words found under each occurrence. A score of Overall Defensive Maturity (ODF) is obtained by averaging the products of the patient's percentage of words for each occurrence, weighed by the appropriate level of maturity (1 to 7)[3]. Reliability of the scale has been demonstrated with a median intraclass reliability = .74 for the summary defense scales (Perry & Cooper, 1989) and intraclass correlations r = .89 for the Overall Defensive Functioning (Perry, et al., 1993).

Rating Procedure

Three clinical psychologists independently rated the material using the HRS. Ratings of Mental States procedures involves two steps: 1) segmentation of the material

by two independent judges using the MTCM segmentation procedures (Bouchard, 1996); and 2) a second pair independently scores the material to specify one Mental State for each segment. Two independent judges rated the 28 sessions with the DMRS, seeking to describe defensive maturity. The LLSM required three independent pairs of raters: 1) two judges first segmented the material; 2) two different independent judges used the LLSM manual to identify patient and therapist styles; and 3) positive and negative stylistic interactions were identified by a third pair, based on the list of positive complementary linguistic intercommunication.

At each step in the rating procedure for all three measures, separate judgements were used to assess reliability before seeking a consensual opinion that was obtained following a discussion enlightened by each manual to which observers were systematically referred.

Judges

For the HRS, three psychodynamically oriented clinical psychologists (one female, two males) with respectively 2, 5 and 15 years of post-graduate experience were asked to review and rate each segment and each session globally. They deliberately did not receive any training for the HRS, and they were asked to approach the material according to their usual current clinical view and to rate each segment from each session in sequence using the HRS. Two female clinical psychologists (6 and 7 years of clinical experience) performed the preliminary segmentation of the material in preparation for the rating with the Mental States. They received approximately 20 hours of training. For the DMRS, one male and one female clinical psychologist, both with 3 years of clinical

experience, were trained and supervised for 35 hours by J. C. Perry. Two clinical psychologists with respectively 2 and 7 years of clinical experience segmented the material following 10 hours of training. Another pair of female graduate students (with 2 and 3 years of clinical experience) received 45 hours of training before proceeding to rate with the LLSM. A final pair of two female graduate students in psychology (2 and 7 years of clinical experience) identified the positive and negative interactions.

Scores for Analysis

For the HRS, Global scores were averaged for each judge per session. Each judge based his or her global scores on previously scored segments in each session. For the Mental States Rating System, the DMRS, and the LLSM, results are expressed in percentage scores of words under a category, over the total number of words produced by the subject (patient or therapist) during a session. In addition, for the LLSM, frequency counts of patient and therapist sequences of styles were used (see below).

Results

Reliability estimates

The HRS (Elliott, 1985), yielded a mean intraclass R of .39 (range of -.38 to .65 across sessions). Interrater agreement for ratings with the Montreal Transference Countertransference Measure (which included the Mental States) varied from 67% to 79% (M=74%). The kappas ranged from .63 to .87, which indicates good agreement beyond chance.

Interrater agreement for the DMRS yielded a mean intraclass R of .81 (range .37 to .96 across sessions) for the first case and a mean intraclass R=.71 (range .49 to .88) for the second case. The LLSM segmentation task yielded percentage agreements ranging from 72% to 86% (M =81%; Stinson, Milbrath, Reidbord, & Bucci, 1994) for 11 randomly selected sessions (first case sessions 3, 5, 9, 11, 12, 14 and second case sessions 1, 3, 4, 7, 14). For linguistic styles, reliability estimates based on 10 randomly selected sessions (respectively sessions 5, 6, 10, 11, 13, 14 and 1, 7, 11, 13) led to a mean kappa of .71 (range from .52 to .88). The identification of positive and negative linguistic interactions in the LLSM were initially made by one rater but when tested against an independent rater for three sessions (sessions 2, 3, and 6 of the first case) agreement was 100%. Identification of these units follows a well-specified list and it appears that little subjectivity was involved in reaching these judgements.

Two Contrasted Beginnings

We shall first examine a number of indices that on empirical grounds should help to establish the dissimilarity between the two patients in their beginning psychotherapies. Based on convincing clinical observations, Mrs. A clearly abandoned her psychotherapy with the present therapist given an impasse. In contrast, Mrs. B pursued her psychotherapy for over 200 sessions with a satisfactory outcome, notably as concerned her initial complaining symptom (dyspareunia). Nevertheless, we need to ascertain these differential outcomes on empirical grounds.

Mean HRS scores are similar in the two cases [$M_A = 6.1$, $SD_A = 1.4$; $M_B = 6.6$, $SD_B = 0.76$; $t\,(13) = -1.98$, $p > .05$]. Judges globally found the treatments neutral to

slightly helpful, which was not expected since Mrs. A clearly terminated her treatment after 14 sessions. Clinical observation revealed that a turning point occurred, around session 7 in this case. So Mrs. A's HRS global scores in the last 7 sessions were compared with the 7 first, indicating a significant perceived deterioration [$\underline{M}_{1\text{-}7} = 6.5$, $\underline{SD}_{1\text{-}7} = 0.9$; $\underline{M}_{8\text{-}14} = 5.7$, $\underline{SD}_{8\text{-}14} = 1.1$; $\underline{t}(13) = -4.8$, $\underline{p} < .05$] whereas for Mrs. B, no such difference is observed [$\underline{M}_{1\text{-}7} = 6.4$, $\underline{SD}_{1\text{-}7} = .0.9$; $\underline{M}_{8\text{-}14} = 6.8$, $\underline{SD}_{8\text{-}14} = 5.4$; $\underline{t}(13) = 0.91$, $\underline{p} > .05$].

Please insert table 1 here

Table 1 presents means, standard deviations and t-tests for Mental States for both participants of each dyad. Specific characteristics for each Pair are also revealed. Contrary to our expectations, Mrs. A was found significantly more Objective-rational ($\underline{p} < .001$) but as expected also more Reactive-defensive at low level ($\underline{p} < .05$). These results suggest that paradoxically, Mrs. A treated her own endopsychic activity either as something to be observed and approached from the outside or conversely that she actively blocked or distorted the reflective process in the sessions. Compared to Mrs. A, Mrs. B used significantly more the Reflective (process-oriented) mode ($\underline{p} < .01$), which suggests a higher capacity of being involved in some kind of inner, subjective self-perception, self-observation and self-analysis in the present activated situation, which was also expected. The therapist's mental states seem to parallel the patients' mental states. With Mrs. A he was significantly more Objective-Rational ($\underline{p} < .05$) and Reactive

($p < .05$), and also less Process Oriented ($p < .05$) compared with Mrs. B. Consequently, it can be stated that with Mrs. B, the therapist was able to maintain overall a more "constructive" attitude linked to the process.

The DMRS and Overall Defensive Functioning (ODF) also serve to contrast the two psychotherapies, and clearly, results differ. Mrs. A's ODF of 3.9 places her within the narcissistic range of functioning (Perry, et al.,1993), while Mrs. B receives a mean score of 4.6 situating her within the neurotic level of functioning. This mean difference is significant [$t(13) = -2.4$, $p < .05$], and supports the initial clinical impressions. Furthermore, contrary to Mrs. B, the maturity of defenses decreased throughout sessions, as shown by a significant negative correlation of Mrs. A's ODF score with session number (1 to 14), ODF: $r_s = -.56$, $p < .05$. This observation concerning maturity is a specific phenomenon, since, if we take the quantity of defenses (reflected in the percentage number of words rated as defensive) no trend is observed for Mrs. A ($r_s = .43$; $p > .05$), while for Mrs. B, a clear decrease is seen ($r_s = -.91$, $p < .01$).

Looking at specific defenses, results show that Mrs. A used significantly more level 1 defenses (acting-out, passive aggression and hypochondriasis) compared to Mrs. B [$M = 10.2$, $SD = 5.2$; $M = 5.3$, $SD = 4.8$; $t(26) = 2.6$, $p < .05$] as well as more Obsessional defenses (isolation, intellectualization and undoing), [$M_A = 13.9$, $SD_A = 13.3$; $M_B = 0.9$, $SD_B = 2.4$; $t(26) = 3.6$, $p < .01$]. These results concur with the paradoxical findings in mental states of both more Objective-rational and lower level Reactive-defensive activity. In contrast, Mrs. B used significantly more level 5 defenses

(repression, dissociation, reaction formation and displacement), [$M_A = 5.3$, $SD_A = 4.8$; $M_B = 10.6$, $SD_B = 5.2$; $t(26) = -2.45$, $p < .05$].

For Mrs. A, each level of maturity with session number shows a negative correlation with levels 5 (neurotic defenses) and 6 (Obsessional defenses), ($r_s = - .68$, $p < .01$; $r = -.56$, $p < .05$) and a positive correlation ($r_s = .54$, $p < .05$) with level 3 (minor image distorting). This is in line with two trends already noted in mental states, one an increase in objective-rational mode, now interpreted as an increase in higher level defenses, the other an increase in low level defensive activity, which seems to converge with an increase in level 3 defenses. For Mrs. B, we find a rather generalized decrease in most levels ($r_{s\ level2} = -.54$, $p < .05$; $r_{s\ level3} = -.78$, $p < .001$; $r_{s\ level5} = -.62$, $p < .05$; $r_{s\ level6} = -.88$, $p < .001$ and $r_{s\ level7} = -.64$, $p < .05$).

Taken together, these observations converge to indicate deterioration in Mrs. A's beginning psychotherapy compared to Mrs. B. These include perceived deterioration in helpfulness, less reflective and more reactive mental states, a decrease in maturity of defenses (A) compared to a decrease in intensity of defenses (B), and the therapist's being less process-oriented and more reactive. Having established these differences, we may now examine the main focus of this work: linguistic styles.

The LLSM

Overall Portrait of Linguistic Styles

Please insert Table 2 here

Table 2 reveals differences in the use of specific linguistic styles. Mrs. A used more Narrative style ($p < .001$) and Mrs. B used the dramatic suspense mode ($p < .001$). This indicates that Mrs. A demonstrated rigidity in sequential logic narration with very little (if any) images or dramatic aspects, while Mrs. B's discourse had ambiguous, uneasy and poor syntax construction probably as a result of anxiety. The therapist's style was interestingly also distinct between the two patients. He used significantly more dramatic aesthetic words ($p < .05$), more epic utterances ($p < .05$), and less reflective-schizoid words ($p < .01$) with Mrs. A. This would tend to support one of Liberman's main notions that each encounter should lead to unique linguistic combinations and should create a specific interaction field (see Wiethaeuper & Bouchard, submitted).

Intercorrelations – The LLSM Internal Structure

Another hypothesis is to expect each style a priori to form a separate dimension, assuming an orthogonal structure to reflect maximum flexibility. Results indicate global confirmation of this but with notable exceptions. In both cases, a negative correlation is found between the dramatic aesthetic (exhibitionism via metaphor and hyperbole) and the dramatic suspense (anxious and interrupted discourse) styles ($r = -.58$; $p < .05$; $r = -.70$, $p < .01$). Thus, two separate forms of expressing anxiety were used: a syntactically poor and interrupted discourse or a colourful, imagistic, exaggerated, theatrical discourse. Whether or not this indicates a systematic internal structure of the LLSM remains to be evaluated.

Please insert Table 3 here

Specific correlations also found for each case when taken separately perhaps reflect some of the characterological processes. For Mrs. A, we find a negative correlation between the narrative and both the lyrical and reflective-schizoid styles (r_{ly} = -0.54; $p < .05$; r_{re} = -0.59; $p < -0.05$). In Mrs. B, a negative correlation is seen between the narrative and epic styles (r = -.58, $p < .05$). The other categories seem to be independent. Finally, no common correlation is found among the therapist's styles between the two cases, which may again underline each dyad's specificity in stylistic communication.

Correlations between neutral, positive (complementary) and negative linguistic interactions, as defined a priori by Liberman's model, were computed. For both cases, results show a very high negative correlation between neutral and positive interactions (r_A = -.82, $p < .001$; and r_B = -.87, $p < .001$) and a high negative correlation between neutral and negative interactions for case A only (r = -.74, $p < .01$). This suggests that in future work we may need to consider the neutral category as antithetical to the positive; perhaps it may appear as redundant. Frequencies of positive and negative interactions are unrelated (r_A = .25, $p > .05$; and r_B = -.40, $p > .05$).

Changes Across Sessions

In order to assess the overall maturity of linguistic styles per session, the total number of words rated under each style, divided by the number of words uttered by the patient were weighed by their level of maturity. The following scale was used concrete = 1, reflective-schizoid = 2, lyric = 3, epic = 4, narrative = 5, dramatic suspense = 6, dramatic aesthetic = 7, meta-style1 = 8, and finally, meta-style2 = 9). Surprisingly, results

show that both patients demonstrated an increasing level of maturity of linguistic styles as sessions proceeded ($r_{s\ Mrs.A} = .70$, $p < 0.01$; $r_{s\ Mrs.B} = .58$, $p < .05$), which will require further examination and qualification. It has been our impression that any increase in "good form" (that is, narrative style, objective-rational mental state or level 5 or 6 defenses) may illustrate an ego capacity recruited and used to re-establish a sense of safety (as seems plausible in case A). Although it may also simply reflect better functioning (as seems plausible in case B), the difference emerges only when considering other processes and the larger context (see below).

In terms of specific linguistic styles, Mrs. A showed an increase in the dramatic aesthetic mode as sessions progress ($r_s = 0.76$, $p < 0.01$) and so did the therapist ($r_s = 0.56$, $p < 0.05$) who was employed the dramatic suspense mode less frequently ($r = -0.62$, $p < 0.05$). This seems to concur with the DMRS findings of increasing narcissistic defenses, which are expressed through exhibitionistic linguistic features. For Mrs. B, a negative correlation was found between the narrative style and session number ($r_s = -0.54$, $p < 0.05$), demonstrating that linguistically, the patient became less rigid in descriptions and in the use of formal logic to share her experience. This we tend to relate to the emergence of a positive regression that is combined with the observed reduction in defensiveness. Interestingly, the therapist shows a corresponding regressive tendency in usage of the narrative style ($r_s = -0.60$, $p = 0.05$).

Linguistic Styles and Specific Defenses.

Correlations between each level of maturity of defenses and each linguistic style were computed. Some formal differences were found, where some defenses were part of

a given style for one patient, but not the other. More precisely, for Mrs. A the only significant observation was between the dramatic-suspense style and the mature level of defenses ($r = 0.55$, $p < 0.05$; affiliation, altruism, anticipation, humour, self-assertion, self-observation, sublimation and suppression). This could be expected given the hypothesised level of maturity of the dramatic suspense mode, but it also suggests that her other mature defenses are related to both mature and immature styles. Her frequent narrative style, in other words, is not coincident with the presence of obsessional or neurotic defenses, but is also to be found in the context of less mature defenses, such as her frequent "help-rejecting complaining" (hypochondriasis) and omnipotence. This is in contrast with Mrs. B whose narrative style is positively correlated with both level 5 (neurotic: repression, dissociation, reaction formation and displacement; $r = 0.56$, $p < 0.05$) and level 6 of defenses (obsessional defenses such as isolation, intellectualization and undoing; $r = 0.55$, $p < 0.05$). These findings seem to support the idea that contrary to Mrs. A, in case B, neurotic and obsessional defenses are part of the narrative style, which is congruent with a neurotic compared to a narcissistic level of functioning. Further, in case B, the lyric style is negatively correlated with level 1 of defense maturity (action defenses) ($r = -0.57$, $p < 0.05$), which was not expected since the hypochondriasis and passive aggression can be expressed in a lyric form. However, the quantity of defenses in general decreased over the sessions with non-occurrences of level 1 on 10 sessions, so this result may represent a statistical artifact. The absence of any other finding however is perplexing. It does seem to point to a complex, and highly individualized relation

between the one level (of formal defensive activity, as described by the DMRS) and the other level of linguistic communication.

Patterns of linguistic interaction

In order to explore patterns of sequential linguistic interactions, Wampold's (1992) procedures were applied. The sequences in the frequencies of styles for both patient and therapist across sessions were considered unidirectionally[4]. The objective was to establish whether specific therapist linguistic behaviour was preceded by specific patient styles more often than would be expected by chance. A transformed kappa was calculated to measure the direction and strength of non-random occurrences (Wampold, 1989; 1992).

Please insert Table 4 here

Examination of Table 4 reveals findings that may not be easy at first to appreciate. To illustrate one first approach to such observations, in session 1 for Mrs. A, the only non-random transition was for the patient initiating an interaction in the dramatic suspense mode, followed by the therapist's same mode. This indicated a shared anxious communicative style. The significant kappa means that this sequential pattern of behaviour was non-random, and further, according to Wampold's (1989) suggestion, the level of dependency reached between these two variables was estimated at 5% ($k'=0.05$) beyond what is expected by chance.

But, in general, Mrs. A frequently started a sequence in a narrative manner that was followed either by the therapist's narrative, or dramatic aesthetic, epic or reflective mode. The greater magnitude of dependence between two styles occurred at session 8 for the narrative/narrative sequence ($z = 3.3$; $p < o.001$), at an estimated level of 40% above what is expected by chance ($k' = 0.4$). This narrative/narrative link was also strong in sessions 9, 13 and 14 ($k' = 0.12$, $p < 0.01$; $k' = 0.11$, $p < 0.01$; $k' = 0.13$, $p < 0.05$). Other non-random sequences involve the dramatic suspense mode with the strongest link being the dramatic-suspense/narrative sequence of session 8 ($k' = 0.6$, $p < 0.05$). The epic/narrative sequence, a complementary one, according to Liberman, was strongest in session 2 ($k' = 0.7$).

For Mrs. B, the same narrative/narrative sequential pattern occurred with a greater magnitude seen during session number 3 ($z = 3.7$, $p < 0.001$; $k' = 0.35$). Obviously, expressing oneself in logical order, relating facts and experiences is a common way of communicating in psychotherapy. Other non-random patterns included the dramatic-suspense/reflective-schizoid and epic/ narrative sequences, where we found the strongest dependence between two variables, which occurred in session 11 ($k' = 1.0$, $p < .001$). Such observations may reflect clinically important moments, specific to one session. But our present interest is on more stable patterns. Following this initial step in the analysis of sequences, an external criterion was used to establish the reliability of the findings.

To test for the reliability or significance of the kappas across sessions, a one sample t-test was conducted for each pattern with the assumption that if a given pattern is robust across sessions, it would generate a mean transformed kappa greater than zero

(Wampold, 1989). Mrs. A's narrative mode reliably led to an increase in the probability of the following therapist linguistic behaviour: narrative (mean transformed k'= .09, SD = 0.1; one-sample $\underline{t}(14) = 3.4$, $\underline{p} < .01$), dramatic aesthetic (mean transformed k'= .01, SD = 0.02; one-sample $\underline{t}(14) = 2.7$, $\underline{p} < .05$), epic (mean transformed k'= .01, SD = 0.02; one-sample $\underline{t}(14) = 2.7$, $\underline{p} < .01$) and schizoid-reflective (mean transformed k'= .01, SD = 0.02; one-sample $\underline{t}(14) = 2.5$, $\underline{p} < .05$). A dominance test (Wampold, & Margolin,1982) was conducted to test for asymmetric in predictability between these behaviours. The first, narrative/narrative pattern, was dominant, which means that the use of narrative after patient's narrative is more predicable then use of dramatic aesthetic ($\underline{z} = 2.5$, $\underline{p} < .50$), epic ($\underline{z} = 2.6$, $\underline{p} < .01$) or reflective ($\underline{z} = 2.5$, $\underline{p} < .05$). This is seen as a "neutral sequence" in Liberman's concept of complementarity. Then, following Mrs. A's dramatic-suspense discourse, the therapist was systematically and reliably narrative, again a neutral sequence (mean transformed k'= 0.13, SD = 0.16; one-sample $\underline{t}(14) = 3.2$, $\underline{p} < .01$). Finally, after the epic mode the therapist was predominantly narrative (mean transformed k'= 0.26, SD = 0.23; one sample $\underline{t}(14) = 4.3$, $\underline{p} < .001$).

The picture is different with Mrs. B: Reliable patterns across sessions started with the patient's dramatic suspense style, which systematically led to one of three linguistic behaviours from the therapist: narrative (mean transformed k'= 0.11, SD = 0.10; one-sample $\underline{t}(14) = 3.8$, $\underline{p} < .01$), dramatic suspense (mean transformed k'= 0.05, SD = 0.08; one sample $\underline{t}(14) = 2.1$, $\underline{p} = .05$) and lastly, the reflective-schizoid a positive interaction (mean transformed k'= 0.06, SD = 0.10; one sample $\underline{t}(14) = 2.4$, $\underline{p} < .05$). The dramatic-

suspense/narrative, a "neutral sequence" according to Liberman was more dominant then the dramatic suspense ($z = 2.1$, $p < .05$) or the reflective-schizoid ($z = 2.7$, $p < .01$).

The presumably positive epic/narrative sequence observed in patient A seemed also strong in this case (mean transformed $k' = 0.33$, $SD = 0.34$; one-sample $t(14) = 3.6$, $p < .01$). Globally, there seems to be less frequent reliable sequences in Pair B compared to Pair A, perhaps as reflecting our expectation of a more fluid relationship, as some behaviours occurred in some sessions, but were not present in others. In other words, Pair A's reliable and predominant narrative/narrative sequence may possibly be linked to the previously noted decrease in maturity of defensive activity and reduced fluidity within the relationship. We tried to examine this further.

Exploring linguistic complementarities

Therapist complementary linguistic styles are forms of verbal communication that are different in nature and quality from the ones used by the patient. They can be instrumentally used by the therapist to "fill-in" the presumed gaps in the patient's ego functions, helping the patient to acquire new linguistic components that are lacking in his message transmission (Liberman, 1982, 1983). Some examples of linguistic complementarities are now given: epic/narrative, where the therapist tries to show the patient by means of descriptions, how he (patient) uses pragmatically charged verbalizations, and how this may greatly affect others; the narrative/epic sequence means that an instrumental utilization of action language is necessary to rupture the patient's controlling verbal behaviour; the dramatic-suspense/ reflective-schizoid sequence attempts an instrumental use of the schizoid capacity to create some distance from the

situation in order to observe the psychic experience and give it a name in the face of anxiety and avoidance and so on. Some examples of neutral interactions are patient narrative to therapist narrative, dramatic suspense to dramatic suspense, narrative to aesthetic, narrative to suspense and vice-versa.

Pair A demonstrated more neutral [$\underline{M}_{PairA} = 89.4\%$; $\underline{SD}_{PairA} = 5.4$; $\underline{M}_{PairB} = 77.0\%$; $\underline{SD}_{PairB} = 7.4$; paired $\underline{t}(14) = 5.4$, $\underline{p} < .001$] and less positive [$\underline{M}_{PairA} = 7.0\%$; $\underline{SD}_{PairA} = 3.8$; $\underline{M}_{PairB} = 18.2\%$; $\underline{SD}_{PairB} = 7.9$; paired $\underline{t}(14) = -4.5$, $\underline{p} < .001$] interactions, while negative interactions were not different in both cases [$\underline{M}_{PairA} = 3.6\%$; $\underline{SD}_{PairA} = 2.8$; $\underline{M}_{PairB} = 3.7\%$; $\underline{SD}_{PairB} = 3.9$; paired $\underline{t}(14) = -0.91$, $\underline{p} > .05$]. This partly supports Liberman's predictions and our hypothesis, at least as far as the contribution of positive interactions goes, while the equivalence in negative interactions is contrary to our expectations. The presence of more frequent so-called "neutral" interactions again raises the same question that was implied earlier when reporting the paradoxical increase in stylistic maturity. The term "neutral" may here be misleading. In Pair A, as we have seen, the most robust "neutral" sequence is the narrative/narrative one. At this point we could only speculate that this finding could perhaps be related to the previously noted <u>decrease</u> in maturity of defense and increase in objective-rational thinking, a mental state whose form is fully compatible with the narrative style. This may point to a defensive collusion within the dyad, more comfortably interactive at a narrative level, and yielding in Pair A to more frequent "neutral" interactions to the detriment of the positive ones.

In order to explore the presence of systematic temporal trends in linguistic interaction, what we may now term "Liberman positive", "Liberman negative" and

"Liberman neutral", interactions were correlated with session number. That no significant correlation was found for Pair A suggests a constant picture throughout the process. In contrast, Pair B showed a decrease in frequency of neutral interactions with time (r_s = -.60, $p < .05$); and further, some increase in "Liberman positive" interactions can be documented through sessions 11 to 14 (M = 27.1, SD = 2.7), compared to the first 10 sessions (M = 14.5, SD = 6.1); $t(12) = 5.3$, $p < .001$). This suggests a revised view of Liberman's predictions such that in a productive process (Pair B), neutral interactions gradually yield to more positive ones, while in some negative ones (as in the present Pair A), the neutral sequences predominate over the positive ones, perhaps reflecting defensiveness. But clearly from these observations, and contrary to expectations, it seems that the "Liberman negative" interactions do not demonstrate that they relate to the quality of process or outcome.

Reliable patterns of positive stylistic complementarities. A final pointed examination led us to identify from the initial list of sequential patterns, those "Liberman positive" sequences that were also identified as reliable (see above, with the modified kappa). For the first pair, we found the epic/ narrative and narrative/epic positive complementarities; for the second, the epic/ narrative and dramatic-suspense/ reflective-schizoid remained (see Figure 1).

Please insert Figure 1 here

Of these four patterns, the epic/narrative in Pair B is the only one to relate to clinical ratings of helpfulness ($r_s = .64$, $p < .05$). This observation led to ask if another condition, beyond the "Liberman positive" stylistic complementarity is required to contribute to a positive outcome. In other words what makes for a good, or "instrumental" use of therapist stylistic complementarity? Does a therapist's mental state influence the impact of his stylistic complementarity? We elected to further examine these questions.

In order to further examine this question we designed an alternate method (method 2) and recoded the sessions, using four new categories of complementarity: positive instrumental (combining reflective or objective-rational therapist mental state and Liberman's positive criterion), positive non-instrumental (combining therapist reactive mental state and Liberman's positive), negative instrumental (reflective or objective-rational therapist mental state and Liberman's negative criterion), and finally, negative non-instrumental (therapist reactive and Liberman's negative criterion). Both methods were correlated and the results show that the criterion of instrumental use is crucial for positive, but not negative interactions. Looking at negative interactions first, for both pairs, correlations are moderate to high, between the initial (LLSM, method 1) and the new index (method 2), for the instrumental and non-instrumental categories, respectively: Mrs. A $r = .69$, $p < .01$; $r = .73$, $p < .01$; Mrs. B $r = .69$, $p < .01$; $r = .96$, $p < .001$. Positive interactions yield high correlations for both pairs for the instrumental category ($r = .92$, $p < .001$; $r = .94$, $p < .05$; respectively), while importantly no correlation is seen between methods in the non-instrumental condition ($r_A = .10$, $p = .73$;

$r_B = .19$, $p = .52$). This supports our re-examination of complementarity combined with mental state, and underlines the need to include the concept of instrumental compared to non-instrumental. Finally, positive instrumental interactions were significantly lower in Pair A ($M_A = 6.3$, $SD_A = 3.8$; $M_B = 15.8$, $SD_B = 7.9$; paired $t(13) = -3.8$, $p < .01$), which is in line with the previous observation.

LLSM External Validity

The LLSM and the HRS

Correlation between clinician's HRS and "Liberman positive", "Liberman negative" and "Liberman neutral" interactions (method 1), revealed a significant negative correlation for the "Liberman negative" interactions, in both cases ($r = -.53$, $p < .05$ and $r = -.60$, $p < .05$). No significant correlation was found for "Liberman positive" ($r = -.20$, $p > .05$ and $r = .38$, $p > .05$) or "neutral" ($r = .17$, $p > .05$ and $r = -.11$, $p > .05$). This suggests that clinicians rate sessions as less helpful where more negative interactions are produced. Using method 2, a similar observation is made, but only for Pair B ($r = -.69$, $p < .01$). Instrumentality seems to be of less importance in judgments of since no significant correlations were found for the categories "Negative instrumental" ($r_A = -.39$, $p > .05$ and $r_B = -.48$, $p > .05$), "Positive non-instrumental" ($r_A = -.12$, $p > .05$ and $r_B = .31$, $p > .05$) or "Positive Instrumental" ($r_A = .22$, $p > .05$ and $r_B = -.24$, $p > .05$).

Correlation Between the LLSM and the DMRS

No correlation was found between linguistic styles, the quality of linguistic interactions (method 1) and the overall defensiveness score (ODF). As for method 2, for Pair A, a negative correlation was found between the ODF and the negative non-

instrumental (r = -.56, p < .05), while for Pair B the negative correlation was between ODF and positive non-instrumental. Again, this new categorization points to specificities for each case.

LLSM neutral and the maturity of defenses

Neutral interactions were higher in pair A, while it decreased over time with pair B. It was hypothesized that such "neutral" interactions, particularly in pair A would related to defensiveness, perhaps related to characterologically determined communications, opposed to the progress of the therapy. To explore this question, correlations between the LLSM neutral categorie with defensive maturity levels were conducted (see table 5). Results show a positive significant correlation of narcissistic defenses and "Liberman neutral" for pair A. (p < .05). As for the pair B., the only significant correlation was between the neutral interactions and the obsessional defenses (p < .05). This systematic result for both pairs concerning the Neutral interactions, suggests that these may depend on the characterological aspects of each patient activated in certain moments of sessions or during the entire process as in pair A.

Discussion

Our main objective was to test the application of a newly developed measure of psychotherapy process, the LLSM (Wiethaeuper, 1999). One significant finding revealed the positive process to be associated with more LLSM positive and less LLSM neutral interactions, while contrary to predictions, negative interactions did not differ between the two situations. This observation at a level of global efficacy or "therapeutic space" (Racker), partly supports Liberman's analysis of linguistic complementarity. But, at a within–session level of perceived efficacy, negative LLSM interactions are found to uniquely relate negatively with ratings of helpfulness. This underlines again the complex relationship between the different supra-ordinate levels of process and outcome and supports the specific contribution of each LLSM category to an understanding of process. Opinions on the perceived helpfulness of a session do not necessarily assess the same processes as may emerge and may be observed at a more macroscopic level, across the 14 sessions, such as result in premature termination.

Temporal descriptions underlined that neutral interactions decreased with time for Pair B, while positive ones increased. Thus, initial findings point to a possible mislabeling of so-called neutral interactions, given their prevalence in the negative outcome case A, and their decrease in the other. Some understanding that was given some support holds that these moments may often reflect patient-therapist collusion in defensive activity. Indeed, defensive maturity levels congruent with each patient's character were specifically related with the defensive neutral session score: narcissistic defensive activity with A, and obsessional activity with B. Clearly more observations are

required to secure a robust understanding of this phenomenon, especially when it may possibly be linked to each patient's and therapist's characterological structure as activated within the global interactive field.

Intercorrelations among the three categories of complementarities point to the use of only two categories instead of three. While the positive and negative categories are unrelated, as expected, neutral and positive interactions seem to be mutually exclusive indicating some redundancy. It seems too early, however, to drop the LLSM neutral category; all categories are in need of further empirical study.

Inclusion of a criterion of instrumentality defined by the added notion of the therapist's mental state was tested (method 2). Findings seem to support the notion that such a criterion may be useful to discriminate "true positive" (instrumental positive) from "false positive" (non-instrumental positive), but that it is irrelevant for either the neutral or negative interactions. In future work we would recommend a separate examination of the two phenomena reflected by methods 1 and 2, and always to include the concept of instrumental contrasted with non-instrumental use of stylistic complementarity.

Both the dramatic aesthetic (exhibitionistic) and the dramatic with suspense (interrupted) modes were sharply differentiated and mutually exclusive. This may reveal an internal structure of the LLSM, but further testing is needed. Some styles, such as the insight-elaboration meta-style, were not used. This approach makes sense given the premature termination and the early phase of the other psychotherapy; the concrete style was also almost never used, which may reflect the particularities of the two-character structures observed in this study, which appeared to be quite "mentalized".

Linguistic styles and defenses seem to entertain relations unique to each person or character structure. With Mrs. A, the clinicians perceived a deterioration following session 7, contrary to patient B. Assessment of defensive activity is becoming quite sophisticated and points to some specific differences between the cases congruent with these differences between the processes. Mrs. A showed decreasing maturity, but stable intensity (percent number of words); in contrast, Mrs. B maintained a stable level of maturity but was rated as less frequently defensive with time. Further, patient B's narrative style is related to obsessional and neurotic defenses, which is not true of patient A's narrative moments. This points to the need to understand each patient's stylistic and defensive dynamics as related to process and outcome.

One of Liberman's main predictions was supported: each therapeutic interaction in this study created a different and unique communicative field, presumably as each patient's character structure led to a specific form of communicating, with observable and distinct different effects on the therapist, who in turn interacted differently.

In Pair A, the interaction was more narrative yet defensive, and the therapist more epic and dramatic aesthetic, two styles where some kind of action is present. The narrative/epic sequence, considered positive for Liberman, was an attempt by the therapist to use action words in order to disturb the defensive-narrative style. Similarly, it appeared that the dramatic-aesthetic mode of exaggeration and hyperbole was an attempt to counteract defensiveness. However, both stylistic responses seemed to come more from a more reactive mental state within the countertransference than to result from an instrumental use of complementarity (see Table 1).

In Pair B, the patient was more anxious-dramatic with suspense, while the therapist responded systematically in a complementary schizoid-reflective mode. Yet the overall picture of sequential interactions seemed more fluid, showing less reliable patterns across sessions. This may reflect a positive flexibility and less "pathology" within the communicative field. The therapist responded to the dramatic-suspense mode using diverse linguistic components, either trying to organize it in a narrative mode, or being anxious himself, used the same style (dramatic-suspense) or also being schizo-reflective and complementary.

However, in both cases there was an increased probability that the therapist would follow an epic mode using a narrative style, which was positively correlated with helpfulness only for Pair B. This suggests some limitation in LLSM's method 1 approach, and points to the need for a consideration of instrumentality as reflected by mental states (method 2).

Clearly, psychotherapeutic success cannot be reduced to characteristics of the patient or the therapist, or considered as separate entities. The unique interaction of each therapeutic field provides an important tool that contributes to psychotherapeutic outcome.

References

American Psychiatric Association. (1994). Diagnostic and statistic manual of mental disorders. Washington, D.C.: Author.

Bachelor, A., & Hovarth, A. (1999). The therapeutic relationship. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds), The heart and soul of change: What works in therapy. (pp. 133-178). Washington, D.C.: American Psychological Association.

Bordin, E. S. (1989). Building therapeutical alliances: The base for integration. Paper presented at the Annual meeting of the Society for Psychotherapy Research, June .

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. Psychotherapy: Theory, Research, and Practice., 16, 252-260.

Bordin, E. S. (1989). Of human bonds that bind or free. Presidential address delivered at the Annual meeting of the Society for Research in Psychotherapy, June.

Bordin, E. S. (1994). Theory and research on the therapeutic working alliance. In A. O. Horvath, & L. S. Greeenberg (Eds.), The working alliance: Theory, research and practice (pp. 13-37). New York: Wiley.

Bouchard, M.-A. (1996). The Montreal Transference-countertransference Measure version 5.2. Montreal: Université de Montreal.

Bouchard, M.-A., Normandin, L., & Fröté, P. (1994). De l'écoute à l'interprétation: une approche des phenomènes de contre-transfert. Revue Québécoise De Psychologie, (1), 155-192.

Bouchard, M. A., Normandin, L., & Seguin, M. H. (1995). Countertransference as an instrument and an obstacle: A comprehensive and descriptive framework. Psychoanalytic Quarterly, 64(4), 717-745.

Bouchard, M. A., Picard, C., Audet, C., Brisson, S.-H., & Carrier, M. (1998). Scoring manual. Unpublished manuscript. Differentiating mental states: therapists, patients, human subjects . Montreal.

Bucci, W. (1993). The development of emotional meaning in free association. In A. Wilson, & J. E. Gedo (Eds), Hierarchical concepts in psychoanalysis: Theory, research and clinical practice . New York: Guilford Press.

Bucci, W. (1997). Psychoanalysis and cognitive science. New york: Guilford Press.

Canestri, J. (1994). Transformations. International Journal of Psychoanalysis, (75), 1079.

Elliott, R. (1985). Helpful and Nonhelpful events in brief counseling interviews: an empirical taxonomy. Journal of Counseling Psychology, 32(3), 307-322.

Essig, T., & Russell, R. L. The Vanderbilt Psychotherapy Process Scales and self-disclosing discourse features: Good process and subjectivity during inpatient psychotherapy session. Paper presented at 20th meeting of the Society for Psychotherapy Research .

Fernandez-Zoiela, A. (1981). Writing in the head: The psychopathological process seen as a written story. Confrontations Psychiatriques, (19), 250-280.

Friedlander, M. L., Thibodeau, J. R., & Ward, L. G. (1985). Discriminating the good and bad therapy hour: A study of dyadic interaction. Psychotherapy, (3), 631-642.

Gaston, L., & Marmar, C. (1994). The California Psychotherapy Alliance Scales. In A. O. Horvath, & L. S. Greenberg (Eds.), The working alliance: Theory, research and practice (pp. 85-108). New York: Wiley.

Gaston, L., Marmar, C. R., Thompson, L. W., & Gallagher, D. (1988). Relation of patient pretreatement characteristics to the therapeutic alliance in diverse psychotherapies. Journal of Consulting and Clinical Psychology, 56(4), 483-489.

Gelso, C. J., & Carter, J. A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during the treatment. Journal of Counseling Psychology, 41, 296-306.

Gottschalk, L. A., & Gleser, G. C. (1969). The measurement of psychological states through the content analysis of verbal behavior. Berkley: University of California Press.

Gottschalk, L. A., Stein, M. K., & Shapiro, D. H. (1997). The application of computerized content analysis of speech to the diagnostic process in a psychiatric outpatient clinic. Journal of Clinical Psychology, 53, 427-441.

Greenson, R. R. (1960). Empathy and its vicissitudes. International Journal of Psycho-Analysis, 41, 418-424.

Hambleton, G., Russell, R. L., & Wandrei, M. L. (1996). Narrative performances predcts psychopathology: a preliminary demonstration. Journal of Narrative & Life History, 6(1), 87-105.

Henry, W. P., Schacht, T. E., & Strupp, H. H. (1990). Patient and therapist

introject, interpersonal process, and differential psychotherapy outcome. Journal of Consulting and Clinical Psychology, 58, 768-774.

Henry, W. P., Schacht, T. E., Strupp, H. H., & Hans, H. (1986). Structural analysis of social behavior: Application to a study of interpersonal process in differential psychotherapeutic outcome. Journal of Consulting and Clinical Psychology, 54(1), 27-31.

Hölzer, M., Mergenthaler, E., Pokorny, F. P., & Luborsky, L. (1996). Psychotherapy Research, 6(2), 95-108.

Horowitz, M. J., Milbrath, C., & Stinson, C. H. (1995). Signs of defensive control locate conflicted topics in discourse. Archives of General Psychiatry, 52, 1040-1047.

Horvath, O. (1994). Research on the alliance: Theory, research and practice. In A. O. Horvath, & L. S. Greenberg (Eds.), The working alliance: Theory, research and practice (pp. 259-287). New York: Wiley.

Irigaray, L. (1987). Le sexe linguistique. Langages, 85, 81-123.

Kaye, J. (1995). Postfoundationalism and the language of psychotherapy research. In J. Siegfried (Ed.), Therapeutic and everyday discourse as behavior change . Norwood, N. J.: Ablex.

Kiesler, D. J. (1996). Contemporary interpersonal theory and research: personlaity, psychopathology and psychotherapy. New York: Wiley.

Kiesler, D. J. (1982). Interpersonal teory for personality and psychotherapy. In J. C. Anchin , & D. J. Kiesler (Eds), Handbook of interpersonal psychotherapy (pp. 3-24). New York: Pergamon Press.

Kolden, G. G., Howard, K. I., & Maling, M. S. (1994). The counselling relationship and treatment process and outcome. The Counselling Psychologist, 22, 82-89.

Kreuz, R., & McNeally, M. S. (1996). Empirical approaches to literature and aesthetics. New Jersey: Ablex Publishing.

Lambert, M. J., & Bergin, A. E. (1994). The effectiveness of psychotherapy. In A. E. Bergin, & S. L. Garfield (Eds.), Hanbook of psychotherapy and behavior change. (4th ed., pp. 143-189.). New York: Wiley.

Lambert, M. J., & Hill, C. (1994). Assessing psychotherapy outcome and processes. In A. E. Bergin, & S. L. Garfield (Eds.), Handbook of psychotherapy and behavior change. (4th ed., pp. 72-113). New York: Wiley.

Lecours, S., Bouchard, M. A., & Normandin, L. (1995). Countertransference as the therapist's mental activity: Experience and Gender differences among psychoanalytically oriented psychologists. Psychoanalytic Psychology, 12(2), 259-279.

Liberman, D. (1982). Psicopatologia. Rio de Janeiro: Ed. Campus.

Luborsky, L. (1976). Helping alliances in psychotherapy. In J. L. Cleghorn (Eds), Successful psychotherpy (pp. 92-116). New York: Brunner/Mazel.

Main, M. (1991). Metacognitive knowledge, metacognitive monitoring, and singuler (coherent) vs (incoherent) models of attachment: Findings and directions for future research. In P. Harris, J. Stevenson-Hinde, & C. Parkes (Eds), Attachment accross the lifecycle (pp. 127-159). New York: Routledge.

Makari, G., & Shapiro, T. C. (1993). On psychoanalytic listening: language and unconscious communication. Journal of the American Psychoanalytic Association, (41), 991-1020.

Marty, P. (1991). Mentalisation et psychosomatique. Paris: Laboratoire Delagrange.

Marty, P. (1990). La psychosomatique de l'adulte. Collection Que sais-je? Paris: Presses Universitaires de France.

Meara, N. M., Shannon, J. W., & Pepinsky, H. B. (1979). A comparison of the stylistic complexity of the language of counselor and client across three theoretical orientations. Journal of Counseling Psychology, 26(3), 181-189.

Mergenthaler, E. (1997). A cyclic model of therapeutic processes: the flow of emotion abstraction patterns in a long term psychoanalytic treatment. Paper presented at the 20th workshop Psychoanalytic Processes Research Strategies .

Mergenthaler, E. (1996). Emotion-abstraction patterns in the verbatim protocols: a new way of describing psychotherapeutic processes. Journal of Consulting and Clinical Psychology, 64, 1306-1315.

Mergenthaler, E., & Bucci, W. (1999). Linking verbal and non-verbal representations: computer analysis of referential activity. British Journal of Medical Psychology, 72, 339-354.

Normandin, L., & Bouchard, M. A. (1993). The effects of theoretical orientation and experience on rational, reactive, and reflective countertransference. Psychotherapy Research, 3, 77-94.

Pennebaker, J. W., & King, L. (1999). Linguistic Styles: Language use as an

individual difference. Journal of Personality and Social Psychology, 77(6), 1296-1312.

Perry, J. C. (1990). defense mechanisms rating scales. Cambridge, MA.

Perry, J. C., & Cooper, S. (1989). An empirical study of defense mechanisms: I. Clinical interview and life vignette ratings. Archives of General Psychiatry, 46(5), 444-452.

Perry, J. C., Kardos, M. C., & Pagano, C. J. (1993). The study of defenses in psychotherapy using th Defense Mechanism Rating Scales (DMRS). In U. Hentschel, & W. Ehlers (Eds), The concept of defense mechanisms in contemporay psychology: theoretical, research, and clinical perspectives. New York: Springer.

Pinard, G. (1989). Discussion: psychotherapies of depression: psychodynamic, cognitive and behavioral approaches. Psychiatric Journal of the University of Otawwa, 409-412.

Poland, W. (1986). The analyst's words. Psychoanalytic Quarterly, (55), 244-272.

Racker, H. (1968). Transference and countertransference. New York: International University Press.

Rosen, V. (1969). Sign phenomena and their relationship to unconscious meaning. International Journal of Psycho-Analysis, 50(2), 1969.

Rosenberg, S. D., Schnurr, P. P., & Oxman, T. E. (1990). Content analysis: A comparison of manual and computerized systems. Journal of Personality Assessment, 54, 298-310.

Russell, R. L., & Stiles, W. B. (1979). Categories for classifying language in psychotherapy. Psychological Bulletin, 86(2), 404-419.

Russell, R. L., van den Broek, P., Adams, S., Rosenberger, K., & Essig, T. (1993). Analyzing narratives in psychotherapy: A formal framework and empirical analysis. Journal of Narrative and Life History, 3, 337-360.

Sandell, R., & Lipschütz. (1992). Linguistic Style as an indicator of psychotherapeutic regression: a case study. Psychoanalytic Psychology, 7(3), 265-278.

Stiles, W. B. (1992). Describing talk: A taxonomy of verbal response modes. Newburry Park, CA: Sage.

Stiles, W. B. (1987). "T have to talk to somebody". A fever model of disclosure. In V. J. Derlega, & J. H. Berg (Eds.), Self-disclosure: Theory, research and therapy (pp. 257-282). New York: Plenum Press.

Stiles, W. B. (1979). Verbal response modes and psychotherapeutic technique. Psychiatry, 42, 49-62.

Stiles, W. B., Honos-Webb, L., & Knobloch, L. M. (1999). Treatment research process research methods. In P. C. Kendall, J. N. Butcher, & G. N. Holmbeck (Eds), Research methods in clinical psychology (2 e.d. ed., pp. 364-402). New York: John Wiley & Sons.

Stinson, C. H., Milbrath, C., Reidbord, S. P., & Bucci, W. (1994). Thematic segmentation of psychotherapy transcripts for convergent analysis. Psychotherapy, (31), 36-48.

Stone, P. J., Dunphy, D. C., Smithe, M. S., & Ogilvy, D. M. (1966). The general inquirer: A computer approach to content analysis. Cambridge: MIT Press.

Thompson, B. J., Hill, C., & Mahalik, J. (1991). A test of the complementarity hypothesis in the interpersonal theory of psychotherapy: Multiple case comparisons. Psychotherapy, (4), 572-579.

Tracey, T. J. (1986). Interactional correlates of premature termination. Journal of Consulting and Clinical Psychology, 54(6), 784-788.

Tuckett, D. (1983). Words and the psychoanalytical interaction. International Review of Psychoanalysis, (10), 407-413.

Waldron, S., Scharf, R. D., Crouse, J., Firenstein, S. K., Burton, A., & Hurst, D. Saying the right thing at the right time: Psychoanalytic Interventions of good quality lead to immediate patient productivity. Paper presented at the The Joseph Sandler Research Conference .

Wampold, B. E. (1992). The intensive examination of social interactions. In T. R. Kratochwill, & J. R. Levin (Ed), Single-case research design and analysis: New directions for psychology and education (pp. 93-131). Hillsdale, NJ, USA: Lawrence Erlbaum Associates, Inc.

Wampold, B. E., & Kim, K. (1989). Sequential analysis applied to counseling process and outcome: A case study revisited. Journal of Counseling Psychology., 36(3), 357-364.

Wampold, B. E., & Margolin, G. (1982). Nonparametric strategies to test the independence of behavioral states in sequential data. Psychological Bulletin, 92(3), 755-765.

Watzlawky, P. (1967). Pragmatics of Human Communication. A Study of Interactional Patterns, Pathologies, and Paradoxes. New York : W. W. Norton.

Wiethaeuper, D. (1999). The Liberman Linguistic Style Measure. Scoring manual. Unpublished material . Université de Montréal: Montreal.

Wiethaeuper, D., & Bouchard, M. A. (submitted). Linguistic styles and complementarities in working with resistance: A clinical reexamination. International Journal of Psychoanalysis , 52p.

Footnotes

[1] These data are part of an ongoing project examining the vicissitudes of psychodynamically oriented psychotherapy and psychoanalytic processes and outcomes. Our present sources are the following: the Psychoanalytic Research Consortium, New York (see Waldron, Scharf, Crouse, Firenstein, Burton and Hurst, June 2000), the Centre de psychologie Gouin, Montréal; the Département de psychiatrie, Hôpital Notre-Dame, Montréal; the Jewish General Hospital, Montréal; Centre d'Études et de Recherches Psychoanalytiques (CERP) Montréal. All participants, patients and therapists signed consent forms for the present anonymous use of the material. Our deep appreciation to all is now renewed.

[2] Segments used were the same as those generated as part of the preliminary rating of the independently rated MTCM (Montreal Transference-Countertransference Measure; Bouchard, 1996). In order to rate an object relation, independent judges need to distinguish the expression of a self-representation, of an object-representation, and an affect or transaction between the subject and another person (external past or present, or with the therapist). These may be as short as one turn of the conversation (patient-therapist-patient), or may involve several pages of transcription (over 10 minutes).

[3] This method differs from the one originally proposed by J. C. Perry that was based on the frequency of occurrence of each defense weighed by its level of maturity. In our view it seems a more sensitive process measure, compatible with the way we define other measures (the LLSM, the Mental States).

[4]Some patterns of interaction occurred on only very few occasions. Nevertheless, the z-value was significant. For example, the concrete/reflective-schizoid sequence occurred once in session 5, which produced a z-value of 8.4 ($\underline{p} < .001$), and $\underline{k}' = 1.0$). However, this interaction was discarded from the present analyses since our interest here was to test for the non-randomness of patterns that would also consider greater frequencies of linguistic behavior. Infrequent sequences were eliminated based on the mean of interactions for each session. Any interaction below the mean was discarded.

Tables

Table 1

Overall portrait of mental states

Mental States	Patient						Therapist					
	Mrs. A		Mrs. B				Mrs. A		Mrs. B			
	M	SD	M	SD	t	G/D	M	SD	M	SD	t	G/D
Mental States												
1. Objective-Rational	24.2	11.3	2.0	4.2	0.9***	A>B	14.7	14.6	5.3	6.7	2.2*	A>B
2. Reflective (Process Oriented)	22.2	14.6	49.8	31.3	-3.0**	A<B	58.9	25.7	79.9	15.3	-2.6*	A<B
3. Reactive Defensive High	40.6	12.1	29.4	24.0	1.6	N/S	19.8	23.7	12.8	15.5	0.92	N/S
4. Reactive Defensive Low	6.30	9.8	0	0	2.4*	A>B	0.6	2.1	0	0	2.4	N/S
5. Reactive Drive-related	6.30	11.0	12.5	21.8	-0.93	N/S	1.4	5.1	0	0	-0.9*	A>B
6. Silence	--	--	--	--	--	--	4.2	10.1	1.2	3.7	1.0	N/S

Note: n = 14. Reactive Defensive H = Reactive defensive High; Reactive defensive L = Reactive defensive Low

G/D = Group Differences. N/S = Non significant

*p < .05. **p < .01. ***p < .001.

Table 2

Overall portrait of linguistic styles

Styles / Mental States	Patient						Therapist					
	Mrs. A		Mrs. B				Mrs. A		Mrs. B			
	M	SD	M	SD	t	G/D	M	SD	M	SD	t	G/D
Styles												
1. Narrative	43	8.6	17	6.9	8.8***	A>B	41	9.7	33	13.1	1.7	N/S
2. Dramatic suspense	11	4.7	28	12.2	-4.9***	A<B	14	11	22	14.2	-1.5	N/S
3. Dramatic aesthetic	28	9.1	34	10.9	-1.7	N/S	17	9.9	8.9	15	2.3*	A>B
4. Epic	3.0	2.3	3.8	1.9	-1.0	N/S	11	12.9	3.5	2.5	2.4*	A>B
5. Lyric	12	7.2	13	6.5	-0.5	N/S	1.5	0.65	2	3.1	-2.0	N/S
6. Reflective-schizoid	1.0	1.6	1.5	1.5	-1.1	N/S	15	7.1	30.4	17.8	-4.2**	A<B
7. Concrete	0.5	1.0	0.4	1.0	1.0	N/S	00	0.5	00	0.1	1.2	N/S
8. Insight 1	1.5	1.6	1.2	2.2	-0.1	N/S	--	--	--	--	--	--
9. Insight 2	0	0	0	0	--	--	--	--	--	--	--	--

Note: n = 14. Reactive Defensive H = Reactive defensive High; Reactive defensive L = Reactive defensive Low

G/D = Group Differences. N/S = Non significant

*p < .05. **p < .01. ***p < .001.

Table 3

Intercorrelations of linguistic styles

Styles	Patient								Therapist						
	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7
1. Narrative	-	-.40	.04	-.58*	-.42	.15	-.04	.51	-	-.34	.07	-.03	-.20	-.48	-.50
2. Dramatic suspense	-.27	-	-.70**	-.07	-.19	.26	-.06	-.33	-.58*	-	-.40	.26	.15	-.28	.05
3. Dramatic aesthetic	-.24	-.58*	-	.08	-.24	-.50	-.09	-.24	-.06	-.22	-	-.43	-.07	-.51	-.03
4. Epic	-.06	.08	-.12	-	.38	-.02	-.17	-.14	-.19	-.14	-.64*	-	-.32	.10	-.22
5. Lyric	-.54*	.34	-.52	-.15	-	-.09	.33	.17	-.55*	.43	-.08	-.03	-	-.35	-.14
6. Reflexive-schizoid	-.59*	.13	-.11	.15	.53	-	-.31	.15	.16	-.03	-.14	-.33	.36	-	.04
7. Concrete	.27	-.31	-.02	.06	-.16	-.32	-	-.17	.16	-.33	.52	-.24	-.21	-.18	-
8. Insight 1	-.26	.29	-.05	-.17	.06	.06	-.03	-	--	--	--	--	--	--	--
9. Insight 2	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Note: n = 14. Mrs.A / Mrs.B. G/D = Group Differences

*p < .05. **p < .01. ***p < .001.

Table 4

Transformed kappas for Patient to Therapist Behaviors (Unidirectional) for Mrs. A. and B.

	Mrs. A.													
	Sessions													
Pattern	1	2	3	4	5	6	7	8	9	10	11	12	13	14
PN to TN	0.01	0.04	0.06*	0.02	0.13***	0.02	0.12**	0.4***	0.12**	0.05*	0.01	0.07*	0.11**	0.13*
PN to TDE	0	0.01**	0.03	0.02*	-0.01***	0.01	0.02	0.03*	0.04	0.02	-0.01	-0.01*	0	0.06**
PN to TEp	-0.01	0.07	0.02	0.04	0.07	0.02	0.01	0.1	0.02	0.01*	0	0.06	-0.01	0.07*
PN to TRe	0	0.01	0.01*	-0.01	0	0	0.01*	0.05	0.04*	0.04	0	0.03	0	0.04**
PDS to TN	0.02	0.11*	0.3***	0.03	0.11*	0.1	0.09	0.6*	-0.04	0.16*	0.16**	0.18*	-0.03	0.14*
PDS to TDS	0.05*	-0.01	0.03	0.05	0.02	0.05	0.04	-0.03	0.04	-0.01	0	-0.02	-0.01	0.07**
PDS to TLy	0.02	0	0	0	-0.04	0	-0.01	0	0	0	0	0	0	-0.02
PDS to TRe	0	0	0	0	0	0	0.03	0	0.04	0	0.07	-0.1	0.09	0.01
PEp to TN	0.3	0.7***	-0.2	0.5	0.05	0.17	0.06	0.3	0.4	0.43	0.44	0.09	0.25**	0.20**
PEp to TDS	-0.04	-0.01	-0.03	-0.03	0.15*	-0.02	0.1	0.14	-0.02	-0.01	0	0.18	-0.01	0.14*
PEp to TDE	-0.03	-0.01	-0.03	-0.03	0.15	-0.02	-0.03	-0.01	-0.04	-0.01	-0.01	0.07	0.05	-0.03
PEp to TRe	0.3	0	0.23	0	0	0.23	0.09	0	0.15	0	0	0.05	0.05	0.02
PLy to TN	0.05	-0.2	-0.06	0.3	-0.14	-0.1	0	0.5	-0.2	-0.06	0.04	0.15	-0.08	0.01
	Mrs. B													
PN to TN	0.19**	-0.09	0.35***	-0.1	0.16*	0.03	0.1	0.13*	0.04	0.30*	0.33*	0.13	-0.27	0
PN to TDE	-0.01***	-0.03	-0.01	0.08	-0.01***	-0.02	-0.01	0	0	-0.03	0	0.15	-0.02	0
PN to TEp	0.12	0	0.03	-0.02	0.30	0.05	0	-0.01	0.08	0	0.07	0*	-0.02	0
PN to TRe	0.02	0.04	-0.02	0.06	0.01	0.04	0.08	-0.01	-0.04	0.05	0.13	0.30	-0.06	0
PDS to TN	0	0.12	0.11	0.1	0.30**	0.30*	-0.01	-0.04	0.12	0.14*	0.04	0.17	0.05	0.07
PDS to TDS	0.03	0	0	-0.02	0.02	0.05	-0.01	0	-0.02	0.03	0.03	0.22*	0.1	0.23**
PDS to TLy	0	0	0	0	0	0	0	0	0	0	0*	-0.02	-0.02	0
PDS to TRe	0.06*	0.03	-0.02	-0.07	0.20	-0.02	-0.07	0.18	0.14*	0.15**	0.15**	0.02	0.20**	-0.03
PEp to TN	0.06	0.61*	0.26	0.40*	0.44**	0.09	0.42**	0.04	-0.17	0.16	1***	1	0.05	0.35
PEp to TDS	-0.05	0	0.40***	-0.02	0.20	-0.02	0.08	0	0.24	-0.03	-0.04	-0.08	0.19	-0.08
PEp to TDE	0.19	-0.03	-0.05	0.30***	-0.01	0.07	-0.01	0	0	0.14	0	-0.02	-0.02	0.19
PEp to TRe	-0.06	-0.03	-0.02	0.11	0.05	0.07	0.03	0.22	0.43*	-0.07	-0.09	-0.08	-0.06	-0.03
PLy to TN	-0.02	-0.17	-0.3	-0.3	-0.25	-0.07	-0.30	-0.16	-0.17	0	0.11	0.50*	0.79***	0.35

[1] See Wampold (1989)

Note. PN= narrative patient, PDS = dramatic suspense patient, PDE = dramatic aesthetic patient, PEp = Epic patient, Ply = lyric patient, PRe reflexive-schizoid patient, TN= narrative therapist, TDS = dramatic suspense therapist, TDE = dramatic aesthetic therapist, TEp = Epic therapist, Tly = lyric therapist, Tre = reflexive therapist.

Table 5

Correlations Between LLSM Positive, Negative, and Neutral with Defensive Maturity

	Pair A							Pair B						
Defensive Levels/ LLSM	1	2	3	4	5	6	7	1	2	3	4	5	6	7
Neutral	-.15	-.36	-.07	.65*	.39	.19	-.49	.38	.29	.34	.09	.42	.55	-.05

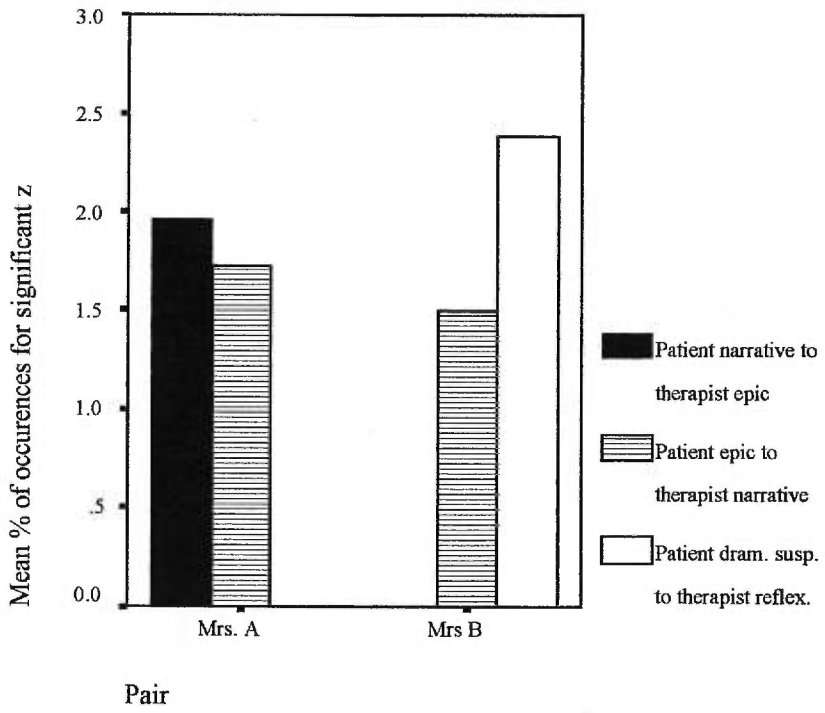
Note: n = 14. 1 = maturity of defenses level 1; 2 = maturity level 2; 3 = maturity level 3; 4 = maturity level 4; 5 = maturity level 5; 6 = maturity level 6; 7 = maturity level 7.

*p < .05. **p < .01. ***p < .001.

Figures

Figure 1

Reliable Sequential Patterns of Positive Complementarities



Conclusion

The articles presented in this thesis are preliminary steps towards the conceptualization and validation of the Liberman Linguistic Styles Measure (LLSM). We hope to have contributed to our further understanding of the important elements present in a psychoanalytic or psychotherapeutic treatment.

The first article presented some theoretical aspects on which is based the LLSM. The notion of character as a central organizing structure was reexamined using Liberman's notion of character as a unique stylistic-communicative constellation. Characterological features have been considered as one of the most resistant aspects in the process of change. The perception of characterological features expressed through rigid and defensive linguistic style provides a new opportunity for analytic work within the therapeutic field. Furthermore, the idea that specific resistances within the analytic linguistic context can be surmounted by the analyst's instrumental use of complementary linguistic messages is also surprising. In using specific combinations of complementarities, it is expected that both participants in the therapeutic dyad are helped towards sharing the same semantic field, the precondition to the generation of new meanings. By contrast, with stronger resistances, while the therapist is unable to develop an instrumental reflective complementary linguistic attitude, strong miscommunications often occur: and termination of the therapy or analysis follows, prematurely or even after much effort.

One of the most interesting suggestions in David Liberman's view of complementarities, is the use of the narrative style as complementary to the epic style. In this last style, the use of typical pragmatic forms of pressure are constant: silence to evade discussion, tangential answers, constant changes in verbal tense, humor or strong

statements used to disqualify our understanding, and asking questions repeatedly to get us to participate, trying to invert roles. In terms of semantics, these patients will not share the same goals concerning the therapeutic work. The theories of enactment may account some actings out verbal discharge (swearing or screaming), but the pragmatic forms of communication are more varied and subtle forms of enactments, and may form the basis of massive projective identifications felt by therapists with some patients. In such circumstances, Liberman (1983) suggests the use of the narrative style with phrases put in logical and sequential order while attempting to display to the patient the observed discrepancies between the semantic and pragmatic channels, since these patients cannot presently use of content interpretations, given their split discourse and linguistic field.It is Liberman's suggestion that only with instrumentally use of narrative phrases, linking those fragmented discourse patterns to their effects on others, can the patient fully understand, with less noises, their characterologically determined mode of relating.

A clinical illustration of a pragmatic epic type of interaction field was presented. Three sessions taken at the beginning, middle and end phases of an unsuccessful analysis of a narcissistic patient called V4 were discussed. It was shown that this patient was successful in distracting the attention away from his semantic distortions. The discussions between the analyst and patient V4 were difficult; and the analyst, even though experienced, was trying hard to interpret his dynamics but by using mostly content interpretations. He based his interpretations on an accurate idea of the patient's narcissistic personality. However, the more subtle aspects of the patient's character traits already being acted-out within the transference were not tackled. For instance, V4's

constant disqualifications of therapist's interpretations in the form of tangential answers and strong affirmations left the analyst angry, hurt and frustrated. He persisted in his interpretative approach but was systematically diverted away by the patient's pragmatic efforts. As the analysis progressed, miscommunications grew stronger and a shared semantic field seemed more and more out of reach. The analysis ended in a stalemate. The analyst's participation, vital to the therapeutic outcome in the decoding/encoding and interpretation in content and form, did not actively contribute to establish a favorable cycle with the least possible noises. From the patient's perspective, this was felt apparently as a lack of understanding and criticism on his analyst's part.

With Liberman's model, the analytic situation may be seen through a new dimension where the styles not only testify to someone's character structure now being turned into a process, but also as a communicative interaction unfolding in the here-and-now. This allows us to explore the possible linguistic roots of projective identification including how countertransference is 'passed' through communication and how one can reverse this, in using adequate interpretations both in form and content. This indeed appears as a potential tool to the working-through of some of the linguistic character resistances, and many others.

Some positive results supported several of our predictions. In the two intensively analyzed cases, patterns of linguistic interaction were examined. One of Liberman's main prediction was given support: each therapeutic interaction created a different and unique communicative field, presumably as each patient's character structure led to a specific

form of communicating, with observable and distinct different effects on the therapist, who in turn, interacted differently.

For each pair, specific intercorrelations among styles were found, and distinct complementary and non-complementary sequences in patient-therapist linguistic behaviors were documented. Results pointed to the validity of the LLSM's positive, negative and neutral interaction patterns as measuring distinct features: more positive and less neutral linguistic patterns were found in the good outcome situation compared to the other. The high frequency of "neutral" interactions in this unfavourable case came as an initial surprise. Looking more closely at this phenomenon, we realized that neutral interactions related to specificities in the defensive-characterological functioning of each patient It was suggested that these moments were probably reflecting the patient-therapist collusion in defensive activity.

As for the measure's internal structure, intercorrelations among the three categories of complementarities pointed to the use of two categories instead of three. While the positive and negative categories are unrelated, as expected, neutral and positive interactions seem to be mutually exclusive, which indicates some redundancy. Nevertheless, it is yet too early however to drop the LLSM neutral category, especially when it seems to point to defensive collusions within the therapeutic dyad.

The inclusion of a criterion of instrumentality, defined by the added notion of therapist mental state (method 2), seemed useful to discriminate "true positive" (instrumental positive) from "false positive" (non-intrumental positive). Future work is needed however, to further examine these trends. In both cases, the dramatic aesthetic

(exhibitionnistic) and the dramatic with suspense (interrupted) modes were sharply differentiated and mutually exclusive. This may have revealed an internal structure of the LLSM, but further testing is needed. Some styles of the LLSM such as the insight-elaboration meta-style, and the concrete style, would need to be tested for their occurrence in further research using more subjects.

In order to use the LLSM in larger samples, the rating process should be simplified as it is still too time consuming. Segments are small (usually phrases) and whole interviews (or sessions) are rated. We wish to develop the measure so it could support larger segments. Ratings of the styles and the impact it has on the other (either aesthetic impact or suspense impact) needs to be developed. This brings us closer to a dynamic and interactional perspective of the linguistic style.

One further development should be in the measure will be the writing of an additional section of the Manual, which would account for the differentiation between styles. Raters had some difficulty differentiating for example, the dramatic suspense and the lyric styles. One patient would use the complaining-type of discourse with many adjectives (lyric), also using exaggerations within the same segment. For these "problems" we decided to use some rules to help the decisions, but we feel that still, this part of the Manual has to be developed. Finally, the notion of instrumental use of complementary style on the therapist's part needs improvement. So far, we rated as positive whenever a complementary style was used on the therapist's part, but it turned into a problem when we realized that sometimes when the therapist was Epic (in Mrs. A case), it was more in a reactive mental state, as a consequence of non-elaborated

countertransference issues. The use of a criterion for Mental States' ratings seems useful and can be added to the LLSM's ratings.

Considering the complexity of the material and the many choices raters had to face, results are encouraging. Reliability started on negative levels and increased as the Manual got more precise. In terms of validity, more testing with a greater sample may reveal other aspects of the internal structure of the LLSM and help specify each style. Further tests for the validity of the interactional aspects of the LLSM, should involve such measures as measuring the Relationship Episodes as in the Core Conflictual Relationship Themes (CCRT; Luborsky, 1990), the Montreal Transreference-Countertransference Measure, and positive and negative relationship configurations (PNRC: Audet, 1999), or finally, the therapeutic alliance, such as in the California Psychotherapy Alliance Scales (CALPAS; Gaston & Marmar, 1994). The characterological features of each style, compared to other measures such as the AAI classification and Self-Reflective Functioning (Fonagy & Target, 1997) in Adult Attachment protocols, would contribute to the construct validity of the LLSM. Contrasting convergences and divergences of both measures, since the Self reflecting functioning has been considered a promising tool in differentiating psychological disorders (Strauss, 2001).

Concluding, the notion of interactional field seems to put into evidence a distinct view of the character formation and its expression in the therapeutic field. The complementary linguistic styles may be an important tool in the working-through of characterological resistances expressed in the patient's discourse.

Following Kernberg (1976, 1992) ideas of character we underline the notion of character formation as an evolving sequence in the process of introjections, identifications and ego identity towards an integration of self and object images under the influence of the drives. In terms of linguistic styles, the better capacity of the ego synthesis, more evolved, semantically and pragmatically, will be the linguistic styles used. Consequently, the need for pragmatic manipulation and syntactically hidden meanings that maintain splitting and ultimately lead to negative outcomes is reduced. The individual is more capable to establish a shared semantic field and a collaborative working process less instinctually infiltrated by aggression and idealization. However, in non integrated of self and object images, repetitions of early relationships through linguistic, non-verbal and paralinguistic patterns may turn into strong resistances and miscommunications within therapeutic field. The self and object persecutory images will be predominant in linguistic styles that "search" for manipulation and domination, such as the case of the Epic style.

Concluding, our view of the therapeutic process can be summarized as the following: the characterological resistances within the discourse are subtle, but important to be identified, encoded and interpreted back to the patient using styles that are different in nature and form of the ones used by the patient. In this way, the patient will not only better understand the message (as the gaps of his message transmission are "filled"), but he will be able to acquire new linguistic components that lack both in his message transmission and inner experience. This means improved ego integration, and plasticity within communication and interaction. In other words: formation of new and improved

neuronal maps and configuration of more complex links between memory systems. In the therapeutic field, a true therapeutic and shared semantic field is established.

References

Audet, C. (1999). The Positive and negative relationship configurations PNRC. Unpublished Papaer.

Fonagy, P. & Target, M. (1997). Attachment and Reflective Function: Their Role in Self-Organization. Development and Psychopathology, 9, 679-700.

Gaston, L., & Marmar, C. (1994). The California Psychotherapy Alliance Scales. In A. O. Horvath, & L. S. Greenberg (Eds.), The working alliance: Theory, research and practice (pp. 85-108). New York: Wiley.

Kernberg, O. (1976). Object-relations theory and clinical psychoanalysis. Northvale: Aronson.

Kernberg, O. F. (1992). Aggression in personality disorders and perversions. New Haven: Yale University Press.

Liberman, D. (1983). Linguistica, interaccion comunicativa y processo psicoanalitico tomos I e II. Buenos Aires: Kargieman.

Luborsky, L. (1990). The everyday clinical uses of the CCRT. In L. Luborsky, & C. Cristoph (Eds), Understanding Transference: the CCRT method . New York: Basic Books.

Strauss, B. M. (2000). Attachment theory and psychotherapy research-editor's introduction to a special section. Psychotherapy Research, 10(4), 381-389

Annexe

Manuel de Cotation – Liberman Linguistic Style Measure (LLSM)

Liberman Linguistic Style Measure (LLSM) version 5.1 en Français

La présence dans ces pages de matériel clinique anonyme fait en sorte que la lecture et l'usage de ce matériel sont soumis à des règles déontologiques strictes. Ceci implique notamment de la part de l'usager, la signature d'un formulaire d'engagement à respecter ces règles. Le formulaire peut être obtenu à l'un ou à l'autre des adresses suivantes:

- Daniela Wiethaeuper, Departamento de Psicologia, UNISINOS. Av. UNISINOS – Centro2, São Leopoldo, Brasil. Courriel : dwiethaeuper@hotmail.com (55)(51) 590-3333.

- Marc-André Bouchard, Département de psychologie, case postale 6128, Université de Montréal, succursale Centre-Ville, Montréal, H3C 3J7, Qc., Canada. Courriel élétronique : marc.andre.bouchard@umontreal.ca

STYLES LINGUISTIQUES

En s'inspirant des travaux de Ruesch (1957) portant sur l'étude linguistique et analytique, Liberman (1982, 1983) tente de décrire l'implication des styles linguistiques dans la transmission d'un message, dans la structure sémiotique et ce, couplé à des facteurs psychologiques.

Différents Types de Styles – Transmission de Message et Réception

Jakobson (1963) définit 6 facteurs et fonctions au sein d'une communication verbale : le transmetteur ou le facteur (la fonction expressive), le contexte (la fonction référentielle), le message (la fonction poétique), le contact (la fonction pathique), le code (la fonction métalinguistique) et le récepteur (la fonction conative).

Le transmetteur, étant la source, envoie un message au récepteur. Afin d'avoir un impact, le message doit se transmettre dans un contexte spécifique, à l'aide de codes pouvant à la fois s'appliquer aux deux participants ainsi qu'un contact entre les deux protagonistes (une connexion psychologique entre les participants).

Transmetteur (fonction expressive)	Source (émotive)	Contexte (fonction référentielle) Message (fonction poétique) Contact (fonction pathique) Code (fonction métalinguistique)	Récepteur (fonction conative)

Liberman (1983) s'inspire de ce modèle afin de définir six styles linguistiques en termes de réception et de transmission de l'information. Par exemple, pour le style Narratif, ce qui prédomine dans la communication est le *contexte* ou *la fonction référentielle*. Cela se comprend par le fait que pour transmettre un message, le transmetteur mettra l'emphase sur le contexte, décrivant les situations, la temporalité et les localisations de façon méticuleuse. Cette personne se préoccupe peu ou pas du type de message, du contact ou des différents types de codes qu'elle pourrait utiliser ou encore de la capacité du récepteur à recevoir un message.

Ce même raisonnement peut s'appliquer à chacun des styles linguistiques différents avec chacun leur emphase spécifique sur les six facteurs. Les facteurs correspondant à chacun des styles linguistiques sont exposés ci-dessous.

Pour ce qui est du style Réflectif, l'emphase de la communication porte sur le transmetteur (le sujet) et comporte une dissociation nette des aspects émotifs du message. Pour ce qui est du style Lyrique, la fonction émotive est amplifiée et il existe des

difficultés marquées entre la différenciation des composantes partielles et entières de l'environnement, et des stimuli intérieurs.

Le style Dramatique, quant à lui, met l'emphase sur le message; et le contact est souvent un problème dans le style dramatique avec suspense. Des problèmes avec les codes sont plus représentatifs d'un style Concret au sein duquel il existe des difficultés du processus de représentation des codes verbaux, dû à des fonctions somatiques. Cependant, Liberman (1983) affirme que chaque patient n'ayant pas un univers commun de codification avec le thérapeute a également un problème évident avec cette partie de la réception et de la transmission dans le processus interactionnel.

Le style Épique met l'emphase sur la fonction conative et sur le récepteur (utilisant les autres pour des fins de manipulation).

Ce processus de réception et transmission des messages décrit dans le schéma ci-haut, lorsqu'il fonctionne à un niveau optimal, sans emphase évidente sur un aspect du processus, permet une communication et une interaction optimales.

Différents Types de Styles en Fonction de la Sémiotique

Selon Liberman (1983), chaque style peut également se comprendre par l'emphase spécifique qu'il porte sur trois domaines de la sémiotique : la syntaxe, la pragmatique et la sémantique. Nous procéderons en un premier temps à définir ces termes pour par la suite décrire chaque style et sa spécificité à la sémiotique.

Les trois domaines de la sémiotique décrits par Pierce (1931-1958) font référence à une désignation de types de signes sémiotiques qui composent le langage. Morris (1946) précise et vulgarise ces termes en les définissant comme suit : « la pragmatique est la portion de la sémiotique qui se réfère à l'origine, aux usages et aux effets des signes à l'intérieur du comportement où elle prend place; la sémantique se penche plus spécifiquement sur la signification des signes dans tous les modes de signification; la syntaxe traite plutôt de la combinaison de signes sans se soucier de leur signification spécifique ou du lien qu'ils peuvent entretenir avec les comportements dont ils font partie[1]».

Cette classification des signes et de leur usage fait partie de la réflexion de Liberman dans sa définition des différents styles. Liberman décrit non seulement les styles mais tente également de comprendre comment chaque style se réfère aux signes et aux codes de la sémiotique dans la transmission d'un message. Ainsi, pour Liberman (1983), le style épique démontre une prédominance marquée et déséquilibrée du domaine pragmatique alors que cette prédominance est du côté de la sémantique au sein des styles réflexif, lyrique et concret, et dans la syntaxe pour ce qui est des styles narratif et dramatiques (esthétique et suspense). Il est important de mentionner que lorsque Liberman (1983) affirme que chaque style présente des difficultés avec un champ sémiotique spécifique, il n'entend pas pour autant que les autres champs ou domaines ne présentent

[1] Traduction libre de : «pragmatics is that portion of semiotics which deals with the origin, uses and effects of signs within the behavior they occur; semantics deals with the significations of signs in all modes of signifying; syntactic deals with combinations of signs without regard for their specific significations or their relation to the behavior in which they occur» (p.218-219)

aucun problème, mais il décrit plutôt la prédominance d'une dysfonction marquée dans un domaine particulier plutôt que dans un autre. Nous décrirons donc chaque style et sa spécificité en fonction d'une analyse sémiotique.

Le style Épique s'applique plus spécifiquement aux individus qui ont de la difficulté dans l'usage et dans l'effet d'un signe particulier au sein de leur comportement. Ces individus sont incapables de décoder un certain message et d'y réfléchir avant d'agir; le langage devient par conséquent l'acte à proprement parler.

Ils transposent également leurs désirs dans les autres afin de les transformer en des instruments malléables et contrôlables. Souvent, ce qu'ils énoncent s'oppose à leurs intentions, celles-ci étant d'inoculer les autres de leurs idées et affects. L'identification projective est utilisée massivement à des fins d'invasion, de manipulation et pour imposer à l'autre le rôle de contenant de leur agression. En termes de construction de phrases, ces patients font souvent preuve de la meilleure syntaxe puisqu'ils sont experts dans l'usage des signes pour des fins de manipulation et sont également très doués avec des combinaisons syntaxiques sans signification, pouvant ainsi compromettre leur véritable essence.

Cependant, alors qu'ils ne présentent pas de difficultés dans la création des codes telles les personnes usant le style Concret, ils présentent des distorsions sémantiques dans la manière qu'ils encodent des messages, surtout lorsqu'un besoin doit être transformé en une verbalisation afin d'être compris et satisfait par les autres. Puisqu'ils ne peuvent satisfaire leurs besoins ou leurs émotions, ils passent à l'acte afin de réduire la tension. En d'autres termes, ils transforment le besoin en action musculaire pour le gratifier par l'exploitation et l'utilisation des autres. Par exemple, ils consultent en thérapie en ayant une intention différente au processus thérapeutique ou au dialogue analytique, en utilisant le thérapeute comme un simple contenant de leur agression afin de le vider. Pour ce faire, ils semblent faire ce dont on s'attend d'eux en séance (association), mais ils essaient fondamentalement de trouver des moyens pour accomplir leurs fins.

De plus, c'est de façon distortionnée que ces patients comprennent l'usage du sens des signes dans l'interprétation des thérapeutes. Habituellement, ces interprétations sont entendues comme des confessions des aspects reliés à la personne du thérapeute, et non comme s'appliquant à eux.

Le style Épique est le seul qui présente des difficultés avec le domaine pragmatique, mais Liberman (1983) décrit également des patients avec des distorsions fondamentales dans le domaine de la sémantique, tels les styles Concret, Réflexif et Lyrique.

En d'autres termes, les patients utilisant les styles Concret, Réflexif et/ou Lyrique ont des difficultés dans le processus de codage/encodage ce qui signifie qu'ils vont privilégier certains signifiants sur d'autres par une attribution rigide de certaines catégories. En dialogue, il est difficile pour eux d'établir un univers commun de signifiants avec les autres ce qui donne l'impression quelquefois que la communication est établie alors que le dialogue se fait à des niveaux complètement différents.

Tel que Liberman (1983) le décrit, une expression ne peut avoir une certaine signification que si sa présentation est complètement déterminée par le contexte, plus particulièrement par le contexte interactionnel. Ces patients ont une relation objectale

intériorisée très primitive et par conséquent le contexte qu'ils établissent pour la communication est tout aussi primitive. Ainsi, il leur est très difficile d'accorder de nouveaux signifiants aux nouveaux contextes et ceci crée souvent un climat d'incompréhension au sein de la séance. Pour ce qui est de l'identification projective, elle est utilisée de façon différente des patients présentant des difficultés pragmatiques. Alors que ces derniers utilisent l'identification projective à travers les fonctions motrices, les patients présentant des difficultés avec la sémantique l'utiliseront à travers le pôle perceptuel.

Plus particulièrement, dans chaque style les difficultés sémantiques apparaissent tel que suit : pour ce qui est du style Concret, la rigidité dans l'usage des signifiants apparaît en tant que symptômes somatiques. Ils ont des difficultés majeures dans la codification de l'information somatique et dans sa transformation verbale. Ainsi, ils ont tendance à exprimer leurs émotions, leurs besoins et leurs tensions à travers des sensations corporelles ou des maladies, ce qui démontre une pauvre capacité de représentation et d'élaboration symbolique, une diminution dans la production nocturne (rêves) et la fantasmatisation couplée avec une augmentation de la pensée concrète.

Pour ce qui est des personnes usant le style Réflexif, leur méfiance et leur curiosité contribuent à répondre de façon impersonnelle et abstraite, ce qui les dispense du danger de l'interaction. Ils se méfient des autres aussi bien qu'ils croient que l'on se méfie d'eux. Plus le climat en est un de méfiance, plus les phrases utilisées sont impersonnelles et abstraites. Ces patients se sentent très seuls puisque incapables de donner et de recevoir de façon authentique. Quelquefois, l'envie est tellement présente que leur comportement est distant et froid et les réponses aux interprétations de l'analyste ne seront pas reconnues, même si justes.

Pour ce qui est du style Lyrique, la distorsion sémantique se penche plutôt sur la manière d'écouter les autres, surtout le ton de la voix. Ce qui importe avant tout est leur écoute de la charge émotive du ton de voix, avant même des mots utilisés. Le ton de la voix ainsi que les autres expressions extra-verbales existent uniquement pour montrer aux patients s'ils sont aimés ou non. Ainsi, la communication leur sert de régulation de leur estime de soi.

Le dernier groupe de patients, qui comprend ceux présentant des difficultés syntaxiques, est décrit par Liberman (1983) comme étant le groupe bénéficiant le plus du dialogue analytique. Les concepts de confiance fondamentale et d'alliance thérapeutique s'appliquent mieux à ces derniers. Les défenses du moi sont plus matures mais elles se manifestent dans le discours par une construction syntaxique pauvre où l'on trouve des manifestations d'un écart entre les connexions verbales, les interruptions dans le dialogue et des signes d'anxiété. Il se pourrait que l'aspect le plus évident chez ces patients soit leur capacité à établir un univers commun de signifiants et de significations avec le thérapeute et conséquemment, une nouvelle grammaire (où les pensées latentes sont présentes) à l'aide d'association libre. Pour l'analyste, il est plus facile de comprendre les liens entre le contenu latent et les associations manifestes et par conséquent de les conceptualiser comme un fantasme inconscient. Ainsi, dans la situation transférentielle, l'analyste peut offrir une compréhension plus étayée et complexe que celle du patient (Liberman, 1983).

Les styles correspondant au dernier groupe sont : le style narratif, le style dramatique avec suspens et le style dramatique avec impact esthétique.

Le style Narratif se définit par une extrême préoccupation avec une construction exacte des phrases ainsi qu'une précision dans l'usage des termes. En d'autres termes, cela se manifeste par l'usage de défenses obsessionnelles, telles l'intellectualisation, la rationalisation, la formation réactionnelle et l'annulation rétroactive qui viennent entraver le travail de l'association libre en agissant sur la communication verbale. Cependant, lorsque la personne devient moins défensive, le patient a accès à des motions inconscientes et à ses relations d'objet internes, ce qui permet une forme abstraite de perlaboration.

Le style Dramatique avec Suspense se reconnaît par un niveau d'anxiété plus élevé, qui se manifeste dans le discours à travers les interruptions, les changements de sujet (lorsque la personne s'approche d'un fantasme oedipien dangereux), les réponses tangentielles et ambiguës qui laissent au patient un espace pour cacher ses pulsions inconscientes remises en acte par les interprétations transférentielles. Comme précédemment, lorsque la personne se défait de ses défenses phobiques dans son discours, le thérapeute a accès aux fantasmes inconscients et il y a place à la perlaboration à un niveau de mentalisation abstraite.

Le dernier style, le style Dramatique avec impact Esthétique est le style le plus évolué en termes d'usage de pensées symboliques et abstraites. Les personnes utilisant ce style sont en mesure d'établir un bon synchronisme entre les expressions verbale et non-verbale ce qui leur permet d'utiliser de manière plus diversifiée des codes et des symboles pour se faire comprendre. Cela contribue par conséquent à la richesse de la communication. Ces individus perdent le synchronisme uniquement lorsque les aspects plus oedipiens émergent. Lorsque cela se produit, ils perdent le contact avec les aspects non-verbaux de la communication et se présentent de manière séduisante en gardant une certaine «naïveté» de leur impact sur autrui. Lorsque le lien entre les aspects verbaux et non-verbaux se rétablit par l'interprétation, ces patients ont également accès aux contenus inconscients. De plus, puisqu'ils peuvent mieux user de la pensée abstraite et symbolique, leur discours est plus souvent chargé de métaphores et d'exagérations.

Tel que nous l'avons énoncé plus haut, chaque style présente un déséquilibre dans un aspect de la sémiotique : pragmatique, sémantique et syntaxique. Ces trois domaines de la sémiotique nous guident dans la différenciation des styles. Nous pouvons ainsi nous questionner : les phrases servent-elles à la communication ou nous induisent-elle en erreur ? L'impulsion est-elle clairement énoncée dans ce qui est dit ou les phrases servent-elles à cacher la pulsion ? Jusqu'à quel point les phrases sont-elles symboliques et jusqu'à quel point se rapprochent-elles du vécu corporel ? Dans ce qui est énoncé, les phrases sont-elles bien construites ou pas ? Les réponses à ces questions, nous aiderons à classifier un discours par rapport à un style ou à un autre.

Nous présenterons maintenant le processus de segmentation, les règles de la cotation, la description des styles ainsi que l'instrument de mesure LLSM (Liberman's Linguistic Style Measure) pouvant s'appliquer à des séances entre patients et thérapeutes à des fins empiriques.

Chaque style est présenté à l'aide d'une description générale brève suivie de caractéristiques divisées en trois groupes : pragmatiques, sémantiques et syntaxiques.

Comme nous le verrons, chaque style aura une description plus extensive du domaine plus problématique.

LLSM

Cet instrument a pour bases théoriques les travaux de Liberman (1982, 1983), de Liberman et Maldavsky (1975) et des auteurs plus contemporains en linguistiques et psychanalyse. Il consiste en sept styles linguistiques (le style Concret n'est pas décrit par Liberman) et deux méta-styles, le second correspondant au processus d'insight. Les trois premiers styles décrits sont les plus évolués : le style Narratif, le style Dramatique avec Suspense et le style Dramatique avec impact Esthétique. Les styles plus régressés sont décrits subséquemment : le style Épique, le style Lyrique et le style Concret. Les trois premiers styles représentent les styles avec des difficultés syntaxiques, le quatrième (le style Épique) est celui dont les difficultés se centrent autour de la pragmatique alors que les deux derniers styles (Lyrique et Concret) présentent des difficultés sémantiques. Les deux dernières catégories de l'instrument sont les méta-styles ou les catégories d'insight. Tel que l'a énoncé Liberman (1983), lorsque les patients sont en mesure d'un certain insight et d'une élaboration de leur propre existence, les phrases sont généralement bien construites, sans déséquilibre dans la pragmatique ni la sémantique puisque l'effet de la communication est centré autour de la personne et la signification est approfondie, liant ainsi plusieurs signifiants aux signes.

Segmentation

Nous utilisons la définition du *segment* de Kreuz et al. (1996). Un segment est une préposition contenant un sujet et un complément, qui ensemble, forment une phrase complexe. Cependant, il est important de considérer que certains styles peuvent s'exprimer à travers plusieurs prépositions. C'est le cas lorsque le sujet raconte une histoire ou décrit un événement où un seul style peut être répertorié. Dans ce cas, le segment comprendra plus d'une phrase. Rarement, un segment peut être constitué par moins d'une phrase, en quelques mots, souvent lorsque la personne utilise des jurons qui seront cotés par le style Épique.

Ce principe général de segmentation démontre que pour segmenter, les coteurs doivent se familiariser avec les différents styles et leurs caractéristiques. Cependant, il est important de noter qu'en termes de types de mot et de construction de phrases, on peut facilement distinguer un changement dans la syntaxe, dans la sémantique ou dans la pragmatique. Par exemple, un sujet décrit de manière très précise certains événements, se penchant sur les détails de l'histoire, des personnages et des circonstances et tout d'un coup il commence à se plaindre, utilisant plusieurs adjectifs affectifs. Ce type de changement est marqué par une différenciation en termes de segments. Il arrive également que le sujet devienne plus dramatique, utilisant des dialogues pour décrire des événements, comme s'il y avait deux personnes (ou plus) en face de la personne qui écoute. Ceci constitue également un différent segment des deux autres. Ainsi, les métaphores, les hyperboles, le discours ironique, les comparaisons, les questions, les affirmations

indirectes, les questions rhétoriques et les clichés marquent tous et chacun des styles différents et aident à segmenter la séance.

Tous les exemples cités ci-haut démontrent en quoi la connaissance des différents styles est implicite à la segmentation du texte puisque les styles sont exprimés par l'utilisation distinctive de la syntaxe, de la sémantique et de la pragmatique dans la communication. Liberman (1982) ajoute à cela des thèmes spécifiques à chaque style, tel le thème de la séduction et de la beauté pour le style Dramatique avec impact Esthétique, le thème de l'action et des aventures interminables pour le style Épique. Ainsi, tous ces aspects doivent entrer en ligne de compte lors de la segmentation des entrevues ou des séances.

Il est important de noter que certaines personnes utilisent de multiples styles alors que d'autres sont plus rigides dans leur communication. Lorsque cela se produit, les segments sont plus longs puisque la rigidité est exprimée par l'usage d'un style linguistique spécifique sur de longues périodes au cours de l'entrevue.

Enfin, il est également important de considérer les phrases avec insight ou certaines phrases sont segmentées puisqu'elles seront cotées plus tard comme des méta-styles (ou des non-styles, ou le style parfait). Exemples spécifiques de segmentation :

> P : Mais vous avez expliqué que ce ne serait pas comme cela, alors je devrai me rappeler que ce ne sera pas comme ça. Vous savez, je suis contente d'être en congé demain, il y a certaines choses que je veux faire, j'espère qu'il fait beau et vous savez, c'est juste euh, ben il m'a demandé, Nick m'a demandé : « qu'est-ce que tu lui dis ? Lui as-tu parlé du fait que ton frère a fugué ? », Je lui ai dit : « Oui, je le lui ai déjà dit ».

Dans cet exemple, la patiente commence la phrase en acceptant quelque chose du thérapeute et la termine par un ordre (je devrai). Après cela, elle devient plus superficielle, en parlant du temps et de son congé (analyse) et ce dans un mouvement phobique par les mots, en ne finissant pas sa phrase. À la fin, elle rapporte une conversation qu'elle a eue avec son époux sous forme de dialogue, comme s'il était présent dans la séance. Dans cet exemple, nous pouvons répertorier l'usage de 3 styles différents tels que définis par le LLSM : le style Narratif, Le style Dramatique Suspense et le style Dramatique avec Impact Esthétique. Ainsi, le verbatim se segmente comme suit :

Seg 1 P : Mais vous avez expliqué que ce ne serait pas comme cela, alors je devrai me rappeler que ce ne sera pas comme ça.

Seg 2 Vous savez, je suis contente d'être en congé demain, il y a certaines choses que je veux faire, j'espère qu'il fait beau et vous savez, c'est juste euh

Seg 3 ben il m'a demandé, Nick m'a demandé : « qu'est-ce que tu lui dis lui as-tu parler du fait que ton frère a fugué? », je lui ai dit : « Oui, je le lui ai déjà dit ».

N.B. Souvent, dans le langage parlé, les gens ont tendance à marquer les pauses par l'usage de «mais…» ou «euh…» ou d'autres expressions similaires. Cela influence souvent les juges à coter le style Dramatique Suspense. Ainsi, si la phrase précédant ces expressions est définitivement Dramatique Suspense, alors nous incluons ces expressions *à la fin du segment*. Cependant, si le style précédant ces mots est de tout autre type, nous aurons tendance à finir le segment *avant* ces expressions.

Ex 1 P: «Je ne sais pas, j'aurais aimé pouvoir dire …euh.., je vais dire exactement ce qui s'est produit hier lorsque la voiture rouge est sortie de nulle part et est entrée dans ma voiture.»

Seg 1 Je ne sais pas, j'aurais aimé pouvoir dire …euh..

Seg 2 je vais dire exactement ce qui s'est produit hier lorsque la voiture rouge est sortie de nulle part et est entrée dans ma voiture.

Ex 2 P: «J'aurais aimé pouvoir dire à mon frère jusqu'à quel point il m'a blessée lorsqu'il m'a dit qu'il quitterait la famille, mais… bien sûr il avait ses raisons, surtout parce que tous les hommes sont enclins à quitter la famille, c'est même expliqué par l'anthropologie.»

Seg 1 P: «J'aurais aimé pouvoir dire à mon frère jusqu'à quel point il m'a blessée lorsqu'il m'a dit qu'il quitterait la famille

Seg 2 : mais… bien sûr il avait ses raisons, surtout parce que tous les hommes sont enclins à quitter la famille, c'est même expliqué par l'anthropologie.

La Segmentation du Discours du Thérapeute

Le discours du thérapeute est toujours segmenté comme une unité peu importe les changements des types de mots. Souvent, lorsqu'il y a des changements, l'interprétation est confuse et est cotée par le style Dramatique Suspense.

Le Processus de Cotation

Généralement, chaque séance est segmentée à partir des règles spécifiques de cotation décrites ci-dessous. À la suite de la cotation, les coteurs relisent chaque segment et assignent des codes (1,2,3,4,5,6,7,001,002) au segment, en fonction du style et/ou du méta-style qui s'applique au segment (en se référant aux caractéristiques des styles telles que décrites plus loin). Cependant, certaines règles doivent être suivies afin de mieux coter chaque segment.

Les Règles d'Or de la Cotation

En nous basant sur le contexte théorique proposé, nous établissons certaines règles à suivre lors de l'utilisation des styles pour déterminer les segments d'une entrevue ou d'une séance :

1. Lire le manuel avant tout, en essayant de revoir chaque cotation et les exemples;

2. Lire le segment à coter et le coter, en choisissant le style qui s'applique le mieux au segment;

3. Essayer d'utiliser le moins d'inférence ou d'interprétation possible, en restant le plus prêt des mots utilisés. Cependant, certaines fois, le contexte de la situation doit être considéré. Par exemple, le thérapeute utilise un style narratif mais interrompt le patient; dans ce cas, coter l'interruption (qui se cote par le style Épique);

4. Si plus d'un style s'applique au segment, notamment lorsqu'un segment commence avec un style et finit avec un tout autre, considérer comment le sujet finit le segment. Si le sujet progresse ou régresse dans l'usage des styles, cela reflète la manière qu'il structure la communication. Ainsi, si le sujet commence avec le style Narratif mais régresse au style Lyrique, la cote sera Lyrique parce que nous choisissons de «démontrer» cette régression. S'il progresse à un style Dramatique, c'est parce qu'il est en mesure de structurer une manière plus mature de communiquer. Tel que nous l'avons mentionné, le style Dramatique est un style linguistique de communication plus mature puisque le sujet peut utiliser des canaux de communication variés avec des aspects plus symboliques. Nous considérons cette règle lorsque la phrase fait preuve de deux styles différents. Cependant, si un segment est narratif et il y a une simple hésitation tel, «mais, euh…», nous ne coterons pas le style Dramatique Suspense puisque le sujet est en mesure de parler et de terminer sa pensée dans un style narratif; ainsi le segment sera coté comme étant narratif. Dans ce cas, nous pouvons dire que le sujet semble vouloir parler de quelque chose d'autre ou qu'il tente juste d'unifier deux phrases ou encore qu'il essaie de combler les espaces et les silences. Puisque l'hésitation est trop courte pour nous laisser comprendre les intentions du patient, nous le laisserons dans le style Narratif.

5. Si pour un segment, nous pouvons à la fois coter 2 styles différents, nous essaierons de voir l'impact du discours chez l'autre en voyant si cela nous aide à nous décider. Si cela ne nous aide aucunement, il est préférable de donner «le bénéfice du doute» et de coter à l'aide d'un style linguistique plus mature. Cette règle a uniquement une exception : le style Épique. S'il est clair que par exemple, le sujet utilise le style narratif dans un segment avec l'intention évidente de manipuler le thérapeute, nous coterons le style Épique qui s'applique le mieux à ce segment.

6. Voici la liste des styles du plus régressé au plus mature pour le **patient** : réflexif, lyrique, épique, narratif, dramatique suspense, dramatique esthétique.

7. Pour le **thérapeute**, nous avons une façon différente de fonctionner. S'il y a des doutes quant aux styles, nous donnerons «le bénéfice du doute» mais en utilisant un tout autre système de cotation. Liberman (1983) dit que le thérapeute doit utiliser des styles linguistiques complémentaires à ceux de son patient :

7.1. **Patient Réflexif qui recherche l'anonymat ⇔ Thérapeute Dramatique** (utilisation instrumentale du style dramatique)

7.2. **Patient lyrique ⇔ Thérapeute Narratif** (utilisation instrumentale de phrases logiques précédant l'interprétation, où le thérapeute peut sauver son identité)

7.3. **Patient Épique ⇔ Thérapeute Narratif** (utilisation instrumentale de phrases logiques en lien avec le cadre. Avec le patient Lyrique, l'identification projective orte sur la personne du thérapeute avant d'être intériorisée, mais avec le style Épique, le patient impose une façon de parler et l'identification projective porte sur la pensée et la psyché du thérapeute. Le style Narratif met de l'ordre dans le chaos. Le thérapeute tente de montrer au patient par une description, l'effet qu'il produit sur les autres, comment les autres réagissent à cet effet et comment un dialogue thérapeutique peut être établi).

7.4. **Patient Narratif ⇔ Thérapeute Épique** (utilisation instrumentale du langage en actes, en montrant au patient comment il essaie de contrôler la séance afin de prévenir les réactions imprévues du thérapeute pouvant créer chez le patient des sentiments d'incertitude et de chaos).

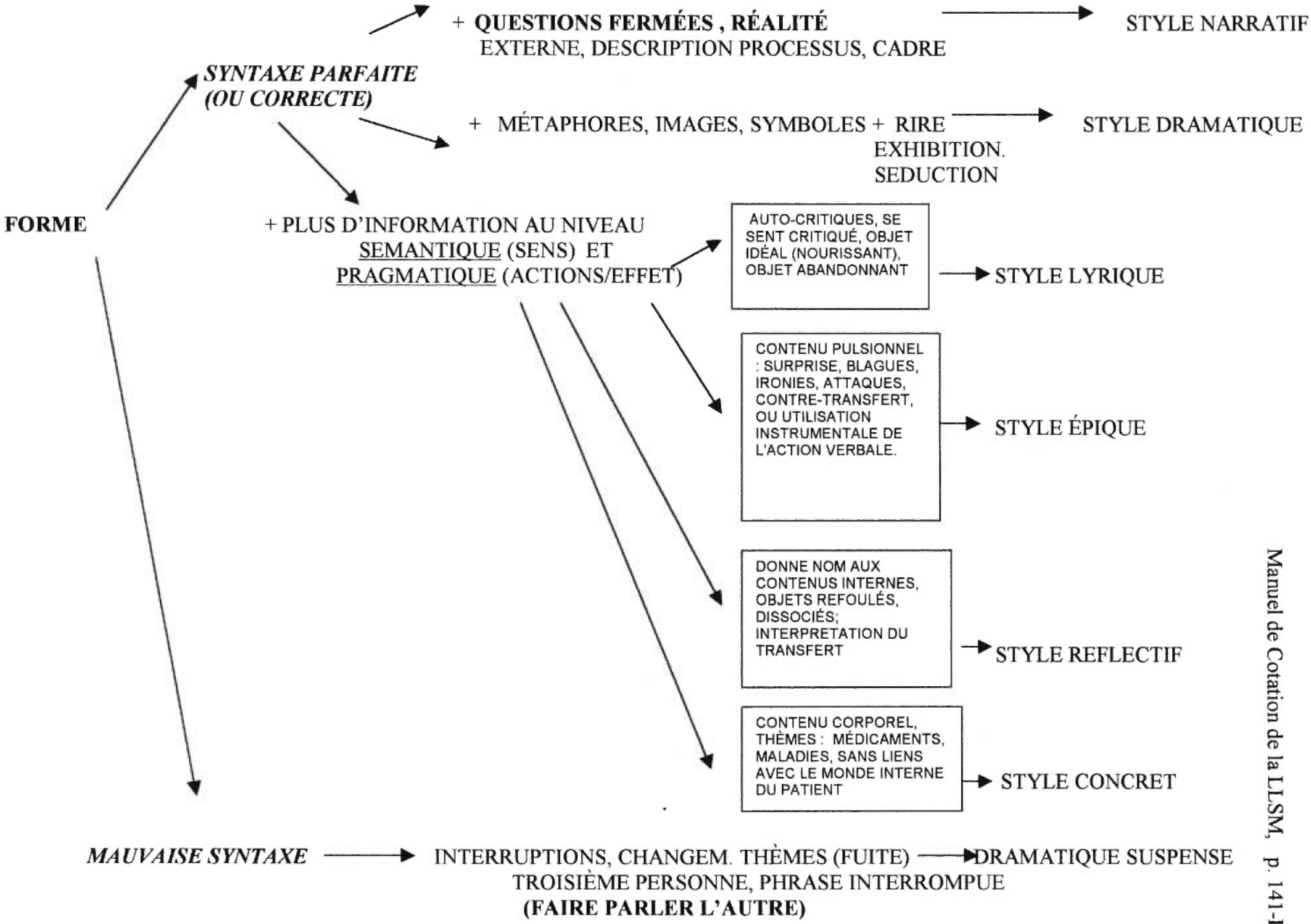
7.5. **Patient Dramatique créant un Suspense ⇔ Thérapeute Réflexif**, qui cherche l'anonymat mais ne crée pas de suspense chez le thérapeute (utilisation instrumentale des parties schizoïdes du thérapeute afin de nommer des contenus internes qui sont évités à cause de l'anxiété).

7.6. **Patient Dramatique avec impact Esthétique ⇔ Thérapeute Réflexif**, qui cherche l'anonymat mais ne crée pas de suspense (utilisation instrumentale des parties schizoïdes du thérapeute afin de nommer les «parties muettes» du patient (dissociées ou inhibées). L'utilisation de ce style permet également de nommer de façon abstraite l'activité autoplastique du patient auquel il est réduit à travers la façon dramatique qu'il a de jouer plusieurs rôles).

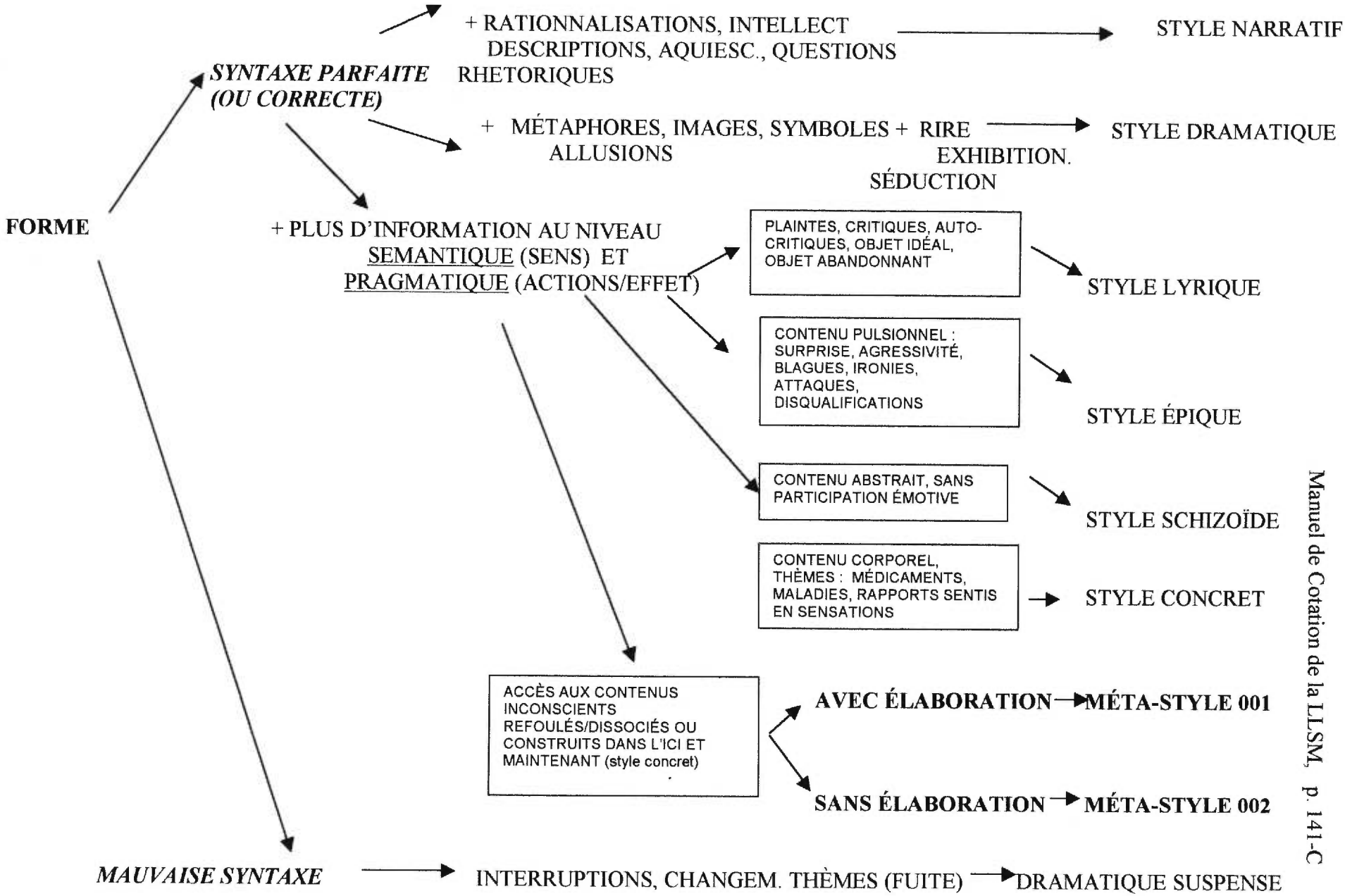
Lorsque nous doutons du style du thérapeute et qu'un des choix est un choix complémentaire, nous choisirons alors ce dernier style (le style complémentaire). Ce choix se fait uniquement si l'on pense que le thérapeute utilise le style linguistique complémentaire de façon instrumentale. Par contre, si le thérapeute est sous l'influence d'une réaction contre-transférentielle, nous n'appliquerons pas cette règle. Dans ce cas, nous utiliserons les même règles énoncées aux points 4 et 5 pour le patient.

Nous présenterons maintenant deux arbres décisionnels : un premier pour le thérapeute et un second pour le patient. Ces arbres seront utilisés pour coter chaque

segment à l'aide de styles linguistiques. Ils devront être utilisés après avoir lu les caractéristiques spécifiques des styles et leur but est d'aider le coteur dans sa prise de décision dans la cotation de chaque segment.


+ QUESTIONS FERMÉES , RÉALITÉ
EXTERNE, DESCRIPTION PROCESSUS, CADRE
STYLE NARRATIF
SYNTAXE PARFAITE
(OU CORRECTE)
+ MÉTAPHORES, IMAGES, SYMBOLES + RIRE
EXHIBITION.
SEDUCTION
STYLE DRAMATIQUE
FORME
+ PLUS D'INFORMATION AU NIVEAU
SEMANTIQUE (SENS) ET
PRAGMATIQUE (ACTIONS/EFFET)
AUTO-CRITIQUES, SE SENT CRITIQUÉ, OBJET IDÉAL (NOURISSANT), OBJET ABANDONNANT
STYLE LYRIQUE
CONTENU PULSIONNEL : SURPRISE, BLAGUES, IRONIES, ATTAQUES, CONTRE-TRANSFERT, OU UTILISATION INSTRUMENTALE DE L'ACTION VERBALE.
STYLE ÉPIQUE
DONNE NOM AUX CONTENUS INTERNES, OBJETS REFOULÉS, DISSOCIÉS; INTERPRETATION DU TRANSFERT
STYLE REFLECTIF
CONTENU CORPOREL, THÈMES : MÉDICAMENTS, MALADIES, SANS LIENS AVEC LE MONDE INTERNE DU PATIENT
STYLE CONCRET
MAUVAISE SYNTAXE
INTERRUPTIONS, CHANGEM. THÈMES (FUITE)
DRAMATIQUE SUSPENSE
TROISIÈME PERSONNE, PHRASE INTERROMPUE
(FAIRE PARLER L'AUTRE)

ARBRE DE DÉCISION DU STYLE CHEZ LE PATIENT



Les Styles

Style Narratif

Les patients utilisant de façon prépondérante ce style, mettent l'emphase sur les aspects verbaux de la communication, plus particulièrement sur la syntaxe et la sémantique, en s'intéressant peu ou pas à la pragmatique ou aux effets que produit leur discours sur les autres. Ces patients se préoccupent démesurément de la manière qu'on les comprend ou qu'ils parlent. Leur seule motivation à parler est de contrôler leurs émotions, leurs pensées inconscientes ainsi que la capacité des autres à fantasmer.

Lorsque Liberman (1982, 1983) décrit ce type de patient, il fait plutôt référence au type de personnalité obsessionnelle et à la manière dont les conflits surgissent chez ces patients en termes de communication. Par exemple, les transformations qui peuvent se produire à l'intérieur de la personnalité ou dans les routines quotidiennes soulèvent pour ces patients des préoccupations émotives et suggèrent un univers chaotique qu'ils tentent de cacher. Conséquemment, il est impératif de contrôler les autres en contrôlant leurs propres idées et actions. Pour ce faire, ils parlent de façon détaillée pour de longues périodes, mettant l'emphase sur les détails et tentant ainsi de contrôler la sémantique ou le sens de la communication.

Les affects comme la rage, la peur et l'affection sont présents mais sous-jacents à un mur défensif composé d'isolation de l'affect et d'intellectualisation. Dans le langage parlé, ces défenses sont manifestes lorsque, par exemple, le patient est colérique ou affectif dans son discours et utilise l'annulation rétroactive en corrigeant et en spécifiant ses paroles. Ceci se manifeste par l'utilisation de tournures, telles : «ce n'est pas ce que je voulais dire vraiment...», «oubliez ce que je viens de dire, ce que je veux dire est...», ou «je vais recommencer ...».

L'isolation de l'affect est également évidente lorsque le patient est préoccupé par le respect des classifications et des classes d'espèce et exige que le thérapeute en fasse autant. En ce sens, les verbalisations ont un ordre à respecter dans leur exposition et dans leur transmission de signes. Ces productions se réfèrent à des règles très strictes énoncées par les patients (Liberman, 1983). De façon non-verbale, l'annulation rétroactive et l'isolation de l'affect se manifestent également dans le ton, le rythme et la modulation de la voix.

Les narrations sont très séquentielles, avec très peu de métaphores ou d'aspects dramatiques. L'écouteur sent qu'il y a très peu de place au fantasme ou à une image plastique de la narration. Les phrases sont logiques et les associations par proximité temporelle, spatiale ou de similarité sont fréquentes. Toute expression d'émotions pouvant se manifester par l'usage d'adjectifs sont inexistants et les adjectifs sont plutôt utilisés pour décrire les situations, les choses et les personnes (petit, grand, etc.).

Tel que Liberman (1982, 1983) l'énonce, les patients ayant recours à ce style n'ont pas de difficultés à comprendre les propositions symboliques faites par le thérapeute à travers ses interprétations et sont en mesure d'établir un univers commun de codes avec ce dernier. Ils n'ont pas un problème de sémantique; ils essaient plutôt de contrôler le sens que les autres trouvent à leur discours. Les difficultés pragmatiques que l'on rencontre chez ces sujets sont exprimées à travers le manque d'un acte dans l'expression de leurs émotions ainsi que le manque d'intérêt dans l'effet que leur style peut avoir sur les autres. De plus, le contrôle des autres à travers l'exagération syntaxique de leur discours ou le contrôle du milieu par une routine compulsive se comprennent comme étant des actes défensifs afin de se protéger des pulsions internes et de leur dépendance. Cependant, ces patients peuvent bénéficier de l'activité interprétative afin de se comprendre, de faire des liens et de changer de manière symbolique. Ainsi, ils n'ont pas de difficultés pragmatiques fondamentales tels les patients épiques chez qui les actes servent à manipuler les désirs des autres, comme si ces derniers consistaient en leur extension narcissique.

Il est important également de mentionner que pour ce qui est de l'application de cet instrument (LLSM), nous ne nous intéressons pas à savoir si un patient souffre d'un trouble obsessif-compulsif. Même si ces patients ont plutôt recours au style narratif, ils utilisent également d'autres styles linguistiques. Ce qui nous intéresse est l'usage des différents styles par des patients souffrant de pathologies diverses.

Il est aussi important de mentionner que tel que nous l'énonce Liberman (1983), le style narratif est le style le plus utilisé dans les conversations quotidiennes puisqu'il concerne plutôt les aspects dans la réalité et l'établissement d'un dialogue commun entre le transmetteur et le récepteur.

Nous définissons ici les caractéristiques du style Narratif et de ses applications sur les segments de la séance. Chaque caractéristique est séparée en trois domaines de la sémiotique, tout dépendant du domaine sur lequel porte l'emphase (pragmatique, sémantique ou syntaxique).

<u>Les Caractéristiques Pragmatiques du Discours Narratif</u>

1. Le sujet ne démontre aucun intérêt pour les aspects pragmatiques du discours ni pour l'effet, sur autrui, de sa manière de communiquer.

2. Le sujet est préoccupé de ce que l'autre a pu comprendre de son propos. Il arrive que le sujet devienne querelleur en cherchant à préciser qui a dit quoi et quand.

3. Il s'attend à ce que l'autre soulève toutes sortes d'interdits face à tout ce qui peut mener à une action, passée ou à venir.

4. Le sujet se préoccupe du "savoir-faire" social. Ex : « My wife learned that her cousin was going to Chile and she wanted to go too. So, I went to a travel agency with her and there I learned that she wanted to go by herself. At the moment when I was realizing that she took a cigarette and started smoking, which bothered me. I didn't think it was nice for her to go by herself to a hotel and to be smoking at the moment. A woman who takes out a

cigarette and starts smoking is like a prostitute calling for men when is the man who has to call for the woman".

5. Les questions rhétoriques (auxquelles le sujet ne veut pas de réponse).

6. Le sujet raconte quelque chose en forme de dialogue mais il n'y a qu'une seule personne rapportée (ou qui « parle ») Ex : you know what really stands out in my mind the most awful about that besides the physical memories of after the operation; that was bad; (sighs) was, uh - I think how I was treated afterwards on one hand, all my aunts gave me cards and presents and I got to stay by grandma's house; my mother's mother; and I can remember that that very vividly being there and being on the phone with my mother and saying, *"I don't want to come home. I don't want to go to school. " (?) I could stay another day.*

Les Caractéristiques Sémantiques du Discours Narratif

1. Le sujet ne manifeste aucun intérêt pour les motivations inconscientes. Après une interprétation le patient ne veut rien savoir des motivations inconscientes proposées par le thérapeute.

2. Le sujet s'intéresse de manière excessive à la correction de son vocabulaire, à la manière dont il doit parler e aussi à la manière dont il doit chercher à comprendre

3. Il y a présence de doutes obsessionnels.

4. Le sujet s'adapte facilement au discours du thérapeute à fin de mémoriser les propos plus que de se laisser porter par la signification. Il répétera les mots et les phrases. (« style perroquet »)

5. Le patient s'attend à ce que le thérapeute respecte les classifications, les genres et les espèces. Au besoin il corrigera le thérapeute à ce sujet.

6. Le patient acquiesce ce qui dit le thérapeute avec « oui » ou « non » ou encore « bien sur », sans continuer de parler de ce qui a proposé le thérapeute comme une manière « retentive »d'avoir le contrôle.

7. L'information est transmise essentiellement sur le mode verbal avec une utilisation exagérée de la logique formelle. (intelectualisation). Le sujet utilise aussi la logique formelle pour éviter de parler des émotions. Les « fausses excuses » (rationalisation) sont aussi inclues ici.

Les Caractéristiques Syntaxiques du Discours Narratif

1. Rigidité dans la description temporelle des événements. La séquence est toujours respectée. Ceci peut aller des descriptions générales du temps jusqu'à des descriptions temporelles très détaillées.

Ex : « P : Other than that I was yawning from 9 to 10 o'clock . I was so tired I went to bed at 10 and fell asleep almost instantly and the woke up with that dream and then I was awake, tossing and turning the rest of the night too. »

2. Le sujet est méticuleux dans sa description détaillée des situations. Ceci peut aller des descriptions générales des faits jusqu'à des descriptions très détaillées des faits.

Ex : « Some days ago I went with my wife to buy a book but before going out she interviewed a new maid and while doing so, she placed herself in front of a mirror so she could observe my reactions to the woman and vice-versa. When we left the house I told her what I thought about the woman and my wife asked me why I was telling her that since she hadn't asked anything. I told her that I would never tell her anything again and she told me that the need to tell things was mine."

3. Les lieux sont également décrits de manière méticuleuse ce qui inclut parfois l'heure précise où les événements ont eu lieu. Ceci démontre une préoccupation avec la description des lieux qui peuvent être décrits d'une façon très détaillée. Ex : « I didn't want to come here today, I wanted to stay in the yard since it is so nice outside ».

4. En raison d'un contrôle excessif, le sujet ne peut terminer ce qu'il cherche à dire. Il raconte plutôt des histoires interminables très bien décrites.

5. Le sujet est toujours occupé à clarifier/décrire son propos Ex : Patient talking about mother : « she writes uh she doesn't write books but letters, you know uh, to friends, family you know, she, I guess that's her, because she's pretty philosophical, I, I would say, pretty philosophical, I mean, she can write nice poems and because she can write she writes to people…» .Aussi, des expressions du type : « ce que je voulais dire, ce que je veux dire, c'est-à-dire… ». (Le sujet fait un effort pour clarifier et décrire de plus en plus en croyant que ceci aide l'autre à mieux comprendre).

6. Le récit fait penser à la rhétorique d'un texte juridique, c'est à dire, les mots sont élaborés, la syntaxe est parfaite.

7. Le sujet utilise des expressions telles que : "alors reprenons", "oubliez ce que je viens de dire", etc. Cela pour tenter d'être plus précis et à la fois pour tenter d'échapper à l'aspect émotionnel du discours.

<u>Autres</u>

1. Au début de la séance ou pendant la séance, le patient et le thérapeute parlent des événements de la réalité externe.

P : Is it recording now ?
T : Hein ?
P : Is it recording ? Is it going to play ?
T : I think it is recording now.

Ou

T : How did you get here ?
P : By bus
T : Did it take long ?
P : Oh no, about 30 minutes.

Ou

P : A big wheel is a toy , it is not a trycicle
T : How is it not a trycicle ?

Thèmes

Le thème des similitudes et des différences est fréquent ainsi que les associations par contiguïté. Ex : Patient parle de sa femme Anna qui a le même nom que sa belle-sœur Anna, et qui lui rappelle un livre connu qui s'appelle Anna Karenina.

Spécificités du Style Narratif Pour le Thérapeute

Les caractéristiques du Style Narratif sont les mêmes autant pour le thérapeute que pour le patient, cependant, le thérapeute a d'autres caractéristiques qui font partie de ce Style :

1. Le thérapeute est méticuleux dans sa description détaillée des situations. Le thérapeute fait des questions dans lesquelles il veut plus de détails sur les faits, c'est comme une collecte d'information sur les faits.

Ex : T : « Could you tell me a bit about your family ? »

2. L'information est transmise essentiellement sur le mode verbal avec une utilisation exagérée de la logique formelle. Dans ce cas aussi, le thérapeute peut utiliser le "Moi" et le "Vous" pour essayer de différencier le patient de lui-même.

3. Le thérapeute explique d'une façon descriptive l'effet que les mots et les actions du patient ont sur les autres.

4. Le thérapeute fait des questions où la réponse peut être seulement "oui" ou "non". Il reste sur les faits comme dans un tribunal où le témoin peut seulement répondre avec « oui » ou « non ».

Ex : « Anybody in your family has emotional problems ? » « Does anybody in your family has psychiatric problems ? »

5. Le thérapeute utilise des interprétations, des clarifications ou des explications qui se rapportent au cadre thérapeutique. Il explique les rôles, le setting, l'horaire, de même que les essais du patient de s'échapper des arrangements préétablis relatifs au cadre. Le thérapeute fait des questions avec « Pour qoui, quoi, où, qui »

Style Dramatique avec « Suspense »

Les patients utilisant ce style ont habituellement la pire syntaxe de tous puisque l'anxiété est omniprésente et entrave le processus de verbalisation. Ces patients doivent à tout prix éviter tout thème ou toute relation qui les met en contact avec leurs pulsions refoulées et fait par conséquent monter l'angoisse. Ils auront tendance à s'arrêter au milieu d'une phrase et ont des difficultés à exprimer certaines de leurs pensées. La seule manière qu'ils ont de contrôler leur angoisse est d'éviter certains thèmes ou en évitant d'utiliser la première personne (je) et de parler à la troisième (il, elle).

L'évasion représente également une difficulté dans l'aspect sémantique de la communication. Pour des fins d'évitement, ces patients utilisent souvent des métaphores et des symboles qui peuvent s'exprimer par l'ambiguïté de leurs phrases. Les doubles sens que ces ambiguïtés peuvent recouvrir démontrent la richesse de leur discours, surtout lorsque cette ambiguïté permet l'accès aux sens cachés de leur communication. Lorsque le thérapeute interprète un seul sens de la phrase ambiguë, le patient trouve refuge dans l'autre. Conséquemment, le transfert est marqué par l'ambiguïté, l'évitement et une grande curiosité de la manière que le thérapeute peut comprendre et révéler certaines pensées secrètes du patient.

Tous ces aspects causent une certaine confusion, une mésentente et une obscurité chez celui qui écoute. Ces effets pragmatiques se différencient de ceux causés par les patients épiques puisque l'intention du patient dramatique avec suspense n'en est pas une de manipulation mais plutôt d'évasion de ses propres désirs oedipiens. Lorsque ces patients prennent conscience de ces aspects refoulés, ils sont en général en mesure de générer de nouvelles significations symboliques avec une bonne syntaxe.

Comme pour le style narratif, même si les patients phobiques utilisent plus particulièrement ce style, nous nous intéressons à son usage chez des patients souffrant de psychopathologies diverses.

Caractéristiques Pragmatiques du Discours Dramatique Suspense

1. Le sujet est très attentif aux stimuli provenant de l'autre de façon à pouvoir établir des conditions de fuite au besoin.

2. La réponse aux questions ou aux demandes de clarification est tangentielle. Nous avons l'impression de ne pas avoir eu une réponse claire et directe.

3. Le sujet se demande toujours comment l'autre en arrive à saisir quelque chose qu'eux-mêmes n'aient pas compris. Ex : "when you told me that I had said something that I didn't want to say, that I was giving you money…I felt ashamed…disclosed…I don't know how you pulled out this things in what I was saying to you last Friday".

4. Le sujet crée ou maintient une incertitude, une attente, en ne clarifiant jamais. Il peut à la fois, chercher à en savoir plus long. EX : (Patient was asked if anybody in his family had psychiatric problems) P : « I wouldn't say so, no, not, I don't think like me, I don't know, but uh, I guess I have some type of, uh, I don't know ».

Ex : « I don't know, it is strange, I, I kept thinking that I was going away july 1st or, or that something is ending for me, or that the next 2 weeks are sort of blank and not in a bad way, but sort of feeling put on hold ».

Ex : . But… I want to tell you something…yes! It is nothing new…but yes, I felt it differently here…

Ex : « I say, uh, you know, you can't expect a person to; you know, it's different; I don't know"

Caractéristiques Sémantiques du Discours Dramatique Suspense

1. Le sujet évite tout thème qui implique une relation objectale ou un fantasme inconscient (aussi relationnel) qui pourront susciter une angoisse. Cette personne perçoit rapidement le stimulus "dangereux" et évite rapidement de l'explorer la situation qui l'inclurait. Dans ce cas, le sujet va s'évade du thème avant que l'angoisse prenne dessus.

Ex : « It's so funny that not funny whatever that feeling pinned down by you in a way although I woldn't have said that but it sounds like any of it happens literally in here, it's all, whatever, the difference with Lewis. »

2. Les phrases ont le plus souvent une signification double. Si on interprète une des significations, le patient peut toujours faire appel à l'autre sens (ambiguïté).

Caractéristiques Syntaxiques du Discours Dramatique Suspense

1. Dans ce cas aussi, le patient peut utiliser la troisième personne pour parler de quelque chose qu'elle vit avec le thérapeute.

Ex : P : « but like the last two days or so, it, uh; I mean, everything that came to my head, I was saying and, uh, when you start thinking about saying everything you're thinking, it's; you know, you wonder; gee; mm.

T: gee what ?

P: you know, what does the person think of you, you know, that's; I shouldn't be worrying about that, you know."

Ex: P: "I even told nick yesterday that I am kind of tired going there and talking about myself and also how it feels degrading".

Ex: "she said something monday or Tuesday that (sighs) really; she says; you know, she had a lady friend that went to a psychiatrist and, uh, all you do is go and lay there on the couch and do all the talking and cure yourself and that's; uh uh; that's sometimes what I feel I'm doing just, you know"

2. Le discours de ces sujets est toujours interrompu par une angoisse qui se manifeste par des changements soudains de thème ou par des interruptions soudaines au milieu d'une phrase. Leur syntaxe est ainsi la plus affectée de tous. Il faut préciser qu'ici l'angoisse est manifestement présente.

Ex : I'm very.. confusing this sex, sexuality and I mean maybe to, in a way, it seems like it could be two separate things, I mean, it's, you know, I don't I don't know suddenly how to approach my boyfriend ».

Ex : « En fait, ça c'est quelque chose que je voulais discuter c'est que (pause 8 secondes), c'est difficile (pause 15 secondes) ».

3. Le sujet raconte une histoire qu'il greffe au milieu d'un autre récit, auquel il retourne après avoir terminé de raconter l'histoire secondaire.

Autres

1. Style dramatique suspense avec des aspects non verbaux

Ex : T: you have a feeling you're supposed to want to come ?
P: uh - yeah. (laughs)" (Ici le fait de répondre et de rire a été considéré comme une "réponse suspense").

Thèmes

1. Les thèmes sont: l'aventure et le risque, les découvertes, tout ce qui s'oppose à la routine.

Spécificités du Style Dramatique Suspense Pour le Thérapeute

Les caractéristiques du Style Dramatique Suspense sont les mêmes autant pour le thérapeute que pour le patient, cependant, le thérapeute a d'autres caractéristiques qui font partie de ce Style :

1. Le thérapeute évite tout thème qui implique une relation objectale ou un fantasme inconscient qui pourrait susciter une angoisse. Il perçoit rapidement le stimulus "dangereux" et évite rapidement de l'explorer. Au niveau du transfert, le thérapeute peut l'interpréter sans s'inclure spécialement quand le contenu est pulsionnel. Aussi, il peut utiliser des phrases ou il n'inclut pas le patient.

Ex: "Du mal a été fait sur l'autre".

2. La réponse aux questions ou aux demandes de clarification est tangentielle.

3. Le thérapeute crée ou maintient une incertitude, une attente, en ne clarifiant jamais. Le thérapeute peut utiliser des phrases longues avec beaucoup d'information ou dans lesquelles l'information la plus importante est à la fin ou au début et à la fin (dans le milieu, il n'y a rien d'important). Il peut aussi arrêter au milieu d'une phrase afin de maintenir une incertitude en cherchant à en savoir plus long.

Ex : « What are your parents like, you said you can kid with your mother and… »

4. Le thérapeute raconte une histoire (ou fait une interprétation) qu'il greffe au milieu d'un autre récit, auquel il retourne après avoir terminé de raconter l'histoire secondaire. Cependant, le thérapeute est capable de revenir à la première idée après avoir fini la deuxième.

5. Le thérapeute fait des questions qui ne sont pas explicites ou incompréhensibles ou encore dites à moitié, ce qui a un effet sur la compréhension de son discours.

Ex : T : Ceci est lié à….
P : A quoi ?

Ou :

T : Il est claire que ça n'a rien à voir avec le problème principal.
P : Mais…quoi et quel problème ?

<u>Style Dramatique avec « Impact Esthétique »</u>

Ces patients divertissent facilement les thérapeutes puisqu'ils fascinent par la richesse de leurs expressions verbales et non-verbales. Habituellement, ils racontent des anecdotes de manière séquentielle et argumentative si bien qu'ils soutiennent l'attention du thérapeute. L'angoisse de castration est contrée par la projection, la dramatisation et la création d'un impact esthétique, ce qui crée chez la personne qui écoute une certaine forme de castration à travers l'écoute attentive qui leur est accordée. Afin de capter l'attention, ils ont souvent recours à des symboles représentent les faits afin de remplacer les faits mêmes. En d'autres termes, lorsqu'ils rapportent un événement, la personne qui écoute a souvent l'impression que la scène se reproduit devant ses yeux, comme si elle faisait partie

du drame. Ce style comprend toutes les formes de métaphores, d'hyperboles, d'exagérations et de symboles que l'on retrouve dans le langage.

Non seulement que ces patients savent très bien utiliser les symboles mais ils sont également en contact avec les aspects non-verbaux et para-linguistiques du langage, rendant ainsi la transmission très efficace. Le discours de ces patients peut se comparer à un rêve en termes de plasticité visuelle et de contenu symbolique, ce qui facilite le travail de compréhension et d'interprétation de ces contenus.

Les mots ont un impact important chez ces patients, particulièrement les interprétations que peut leur livrer leur thérapeute, dont les effets peuvent être immédiats. Liberman (1983) énonce qu'il est quelquefois nécessaire de différencier cet effet de celui de la suggestion. Une autre composante pragmatique essentielle concerne l'exhibitionnisme ou le besoin d'attention liés aux aspects du conflit oedipien.

Liberman (1983) nomme ce type de patients «personnes démonstratives», en les rapprochant plus précisément du versant hystérique. En ce qui concerne le LLSM, nous nous intéressons à l'usage de ce style chez tous les patients peu importe la catégorie nosologique à laquelle ils appartiennent. Pour nous, ce style est celui qui est le plus évolué et mis à part l'insight, il consiste en la meilleure façon de communiquer.

Caractéristiques Pragmatiques du Discours Dramatique Esthétique

1. Le sujet traite les symboles comme s'ils étaient les faits eux-mêmes. Il peut raconter un fait comme s'il était présentement en train de se produire, incluant sa charge symbolique. Les aspects verbaux sont décrits sous une forme dramatique et théâtrale, riche en contenu visuel, plastique, symbolique. L'interlocuteur peut avoir l'impression d'y être. Le thérapeute est un spectateur qu'il s'agit de toujours divertir. Le récit se compose d'une suite qui doit maintenir l'intérêt à un niveau élevé, et ne jamais décroître. Le patient peut utiliser des expressions du type : « See doctor » ou « Listen doc » pour maintenir tourjours l'attention.

2. Le sujet a des traits exhibitionnistes qui facilitent la transmission de l'information.

3. Lorsque le transfert oedipien est activé, cette synchronie est interrompue par le refoulement. Le matériel change de qualité: le patient s'exprime plutôt sur le mode de l'action, par exemple la séduction. Cette dernière a un caractère plus pré-conscient ou des fois, l'action est menée de façon inconsciente. Le sujet perd alors la capacité de percevoir l'impression que ses actions crée sur autrui: cécité ou naïveté hystérique. Ceci différencie les actions épiques qui sont menées consciemment afin d'inoculation, l 'action est ici symbolique, le corps et les spectateurs étant utilisés à des fins symboliques..

4. Les récits sont présentés de telle manière que le patient en semble le héros. Même si au départ les événements racontés pouvaient présenter le patient en position ridicule, à la fin le patient redevient le héros.

Caractéristiques Sémantiques du Discours Dramatique Esthétique

1. Le sujet est particulièrement sensible à l'interprétation et à l'usage des mots qui exercent alors un effet de suggestion (*moyen psychologique de convaincre un individu que ses croyances, ses opinions ou ses sensations sont fausses et qu'à l'inverse, celles qui lui sont proposées sont vraies. Une personne peut, par la parole, en influencer une autre et modifier sont état affectif. Le thérapeute est à la place de l'idéal du moi, et sa toute-puissance est limitée par un lien d'amour...conduite imitative. Les origines du symptôme ne sont pas objet de préoccupation. Per via de porre de Leonard da Vinci, contraire per via de levare dans la sculpture où on enlève quelque chose) (Roudinesco et Plon, 1997). Par fois, le thérapeute fait des questions concernant la présence ou non des symptômes chez le patient et il commence à les sentir.*

Caractéristiques Syntaxiques du Discours Dramatique Esthétique

1. Le discours évoque des images, des métaphores et des allusions transferentielles.

Ex: P: « I feel whatever I say or begin would sort of be nipped in the bud »

Ex: « Believe me doctor, I don't know how she could be interested in such a type. My wife before would clean the house, it would always be clean, put in order and happy. See doctor, I don't what to do anymore, now my house is as if the sun had never came in." Dans le cas de l'allusion c'est le patient qui fait le lien entre le thérapeute est quelque chose dans la réalité qui le répresente.

Ex : (c'est la dernière scéance avant les vacances du thérapeute) : it seems I was dreading this was the last session and I don't know if I am nuts but D. wants to go to Vancouver and I am thinking that I want to stay here, whi knows things may change and I mean he may not want me, he may not want to stay two years but that's sort of holding me from wanting to go with him. » Ici nous voyons clairement l'allusion au fait que son thérapeute parte car elle commence son discours en parlant de ceci et finit avec le déplacement sur son ami de son sentiment d'être laissée par son analyste. Quand l'allusion demande une trop grande interprétation on ne la considérera pas comme telle.

2. Utilisation des hyperboles, métaphores, dialogues où il y plus d'un personnage, exagérations.

3. Les éléments suivants sont systématiquement absents du récit dramatique: l'opposition, la cause de la situation, le fait d'appartenir, pourquoi les choses arrivent comme elles arrivent, les limites thématiques ne comptent pas.

Thèmes

1. Les thèmes principaux sont les suivants: la beauté, l'érotisme, la fascination, la force et la faiblesse, la grandeur et la petitesse, la puissance et l'impuissance.

Spécificités du Style Dramatique Esthétique Pour le Thérapeute

Les caractéristiques du Dramatique Esthétique sont les mêmes autant pour le thérapeute que pour le patient, cependant, le thérapeute a d'autres caractéristiques qui font partie de ce Style :

1. Le thérapeute nome des contenus internes du patient, mais d'une façon. Imagé, symbolique.

2. Le thérapeute fait des interprétations riches en contenu symbolique, en liant l'affect et la représentation correspondante, riche en contenu visuel, plastique.

3. Le thérapeute a des traits exhibitionnistes dans sa manière de parler.

4. Lorsque le transfert oedipien est activé, le thérapeute s'exprime plutôt sur le mode de la séduction. Le thérapeute peut perdre la capacité de percevoir l'impression l'impact de la séduction crée sur le patient

5. Le thérapeute exerce alors un effet de suggestion (*moyen psychologique de convaincre un individu que ses croyances, ses opinions ou ses sensations sont fausses et qu'à l'inverse celles qui lui sont proposées sont vraies. Une personne peut, par la parole, en influencer une autre et modifier sont état affectif. Le thérapeute est à la place de l'idéal du moi, et sa toute-puissance est limitée par un lien d'amour...conduite imitative. Les origines du symptôme ne sont pas l'objet de préoccupation. Per via de porre de Leonard da Vinci, contraire per via de levare dans la sculpture où on enlève quelque chose) (Roudinesco et Plon, 1997)*

Style Épique

Liberman (1983) affirme que les patients usant particulièrement ce style sont les plus difficiles en thérapie puisqu'ils mettent toujours de l'avant une seconde intention, contradictoires aux objectifs thérapeutiques. Ils attribuent leurs désirs aux autres et présentent un «langage conatif» où le discours évoque des intentions envers l'autre (celui qui écoute), intentions qui ne sont pas claires pour le sujet du discours (Edelson 1973, 1975). Le « langage conatif» est un langage d'action, où les mots sont équivalents à des actes.

Ces patients ont tendance à raconter des anecdotes dont le style ressemble à un style dramatique, mais ils y changent tellement le scénario et les personnages qu'il devient impossible de comprendre les contenus symboliques du discours tels qu'ils les communiquent. Habituellement, ce genre de discours n'est pas utilisé pour communiquer quelque chose mais bien pour cacher, contrôler ou convaincre indirectement l'autre. Par exemple, ils peuvent rapporter plusieurs histoires sexuelles en menus détails non pas pour que le thérapeute comprenne le conflit sous-jacent mais bien pour le cacher en provoquant

chez l'autre une certaine forme d'excitation sexuelle. Ils peuvent également poser de nombreuses questions au thérapeute afin que ce dernier participe, ou encore être très ironiques, raconter des blagues ou toute autre «parole en acte».

Les personnages sont souvent décrits de manière crue et font preuve du niveau de maturité des relations objectales du patient, à savoir des relations primitives d'objet partiel. Les individus décrits sont soient persécutés ou endommagés par une force supérieure (projection d'un surmoi persécuteur sadique) ou sont eux-mêmes les persécuteurs et causent ainsi des torts sous l'influence de leur propre moralité et de leur code éthique.

Liberman (1983) démontre que ces patients ne peuvent être satisfaits dans leurs relations puisque toute relation comporte des aspects de dépendance et de partage dont ils sont incapables. Par conséquent, ils se sentent non seulement seuls mais également déprimés. Cette dépression est plutôt ressentie comme une tension et lorsqu'ils sont en contact avec ces émotions, celles-ci devront être évacuées par l'agir. C'est pour cela qu'ils ont énormément de difficultés de penser avant d'agir puisque cela signifierait d'entrer en contact avec leurs sentiments dépressifs, chose qu'ils tentent à tout prix d'éviter.

La défense la plus courante chez ces patients est l'identification projective où l'autre est transformé par cet acte en un simple outil qu'ils peuvent manipuler. Ils frustrent l'autre, le dérobent de ces moyens, l'utilisent pour leurs propres besoins, mettent les gens un contre l'autre et utilisent les idéaux des autres comme s'ils leur appartenaient.

Contrairement aux patients dramatiques où les interprétations servent à montrer les aspects non-verbaux refoulés de leur discours qui sont agis à travers la dramatisation, les interprétations avec les patients épiques les aident plutôt à comprendre la séquence de leurs actes afin de mettre en lumière non seulement leur besoin d'évacuer mais aussi les sentiments qu'ils tentent d'esquiver.

Liberman (1983) énonce que ce style est plutôt utilisé par les psychopathes, mais il semble qu'aujourd'hui nous pouvons dire que les patients narcissiques en général, en incluant les patients limites, utilisent fréquemment ce type de discours. Cependant, tous les types de patients peuvent utiliser ce style soit lors d'une régression soit d'une progression. C'est ce que tente de démontrer entre autres le LLSM. De plus, nous rencontrons également ce type de langage (en actes et manipulatif) dans les discours politiques (ou rhétoriques) afin de convaincre et de persuader les électeurs.

Le style épique peut également être utilisé de façon instrumentale par le thérapeute. De nombreux patients qui contrôlent la séance par l'usage de longs discours (tels les patients qui utilisent le style narratif) ont besoin d'une certaine forme d'interruption et de surprise afin d'entrer en contact avec leurs affects et certains contenus inconscients. Lorsque le thérapeute utilise le style épique de façon instrumentale avec un patient narratif, son discours est considéré comme une action qui ne résulte pas de sa réaction contre-transférentielle au patient mais plutôt comme un instrument thérapeutique.

<u>Caractéristiques Pragmatiques du Discours Épique</u>

1. Le patient change constamment et rapidement de scénario, de rôle et de personnage. Ceci est apparenté à une sorte d'inoculation, dont le but est de contrôler l'attention de l'interlocuteur et de l'éloigner des intentions véritables. Il est parfois difficile de saisir la

signification de leurs propos. Ces changements peuvent être démontrés par des changements soudains et répétitifs de temps verbaux. Une autre façon d'éloigner le thérapeute de ses véritables intentions est d'utiliser la généralisation.

Ex : "My teats and my glasses were for me a public expression of impotency. When I was 29 I met Manuel the first homosexual relationship that I had with actual some kind of spiritual bond. At that time I was feeling depressed but never thought in suicide; my Jewish friends were getting married and also my brothers, and me, I was alone".

2. Ils cherchent à induire le thérapeute à agir ou à éprouver certaines choses. Par exemple, certains décriront divers scénarios sexuels afin d'exciter le thérapeute.

Ex : "It happened one day, I was in a bus in my home's neighborhood, we saw each other, touched hands and 15 minutes after we were in his apartment...for me, this meant to calm all my suffer. Manuel was a very sexy handsome blond men, very well built, with very white teethes; we satisfied each other touching one another face-to-face, we caressed each other a lot it was very sensual...he would take all my clothes, slowly and would touch me slowly...."

3. Ils ont des gestes destructeurs qui font partie d'une épopée dans laquelle le thérapeute peut se retrouver involontairement. L'action est menée sur le mode de l'épopée, là où les intentions véritables du héros ne sont jamais révélées, de peur de mettre en péril l'objectif ultime (un peu à la manière d'une stratégie guerrière qui doit être protégée de l'ennemi).

4. Les représentations verbales des faits sont les faits eux-mêmes. La parole est agissante. Ex. Le patient fait des menaces ou essaie de séduire le thérapeute ou encore, il utilise des phrases humoristiques ou raconte des « jokes ».

5. Le patient affirme fermement quelque chose (strongly affirms something) comme : « Moi, je pense comme ça ! ». Des fois ils utilisent des expressions comee « jamais ! » ou « toujours ! » pour insister sur un sujet ou accentuer ce qu'il disent. (les patients lyriques peuvent utiliser ces expressions mais elles sont liées plus aux affects comme : « Elle ne m'a jamais aimée ! »)

Ex : T: « It seems to be an issue inside you »
P: « Yes in a more comical way (laugh).-

6. Leurs propos concernant les relations et les activités humaines ne sont jamais constructifs. Dans les histoires racontées, il y a toujours une troisième personne qui subit des torts.

Ex: "I remember that I saw a movie where there was a retarded Russian that seemed more like a creature; he moved me because he had a sadistic tendency to caress silky stuff. He went with a wise man to look for a job and a sadistic prostitute seduced him. When her

husband realized that he wanted to kill him and the prostitute gave him a horse to escape which he did through a swamp followed by the husband."

7. Les actes dans la séance sont comme des phrases non dictés (acting in).

8. Les jurons sont des actes dans le langage

9. L'action est toujours menée afin d'induire les autres à y participer. Il peut par exemple, faire plusieurs questions au thérapeute afin de le faire participer et parler plus.

10. Dans ses propos le sujet dit combien il a été ou s'est senti endommagé/utilisé par les autres.

11. Le patient utilise des disqualifications par rapport à la thérapie ainsi que par rapport au thérapeute.

Ex : « J'ai inventé une machine et dès que je la lance sur le marché, tous les problèmes seront résolus.

Caractéristiques Sémantiques du Discours Épique

1. Le patient arrive à la thérapie avec des intentions très différentes de celles qui sont attendues d'un dialogue analytique ou psychothérapique car ce sont des patients qui ont leur propre code moral et éthique. Ils n'ont pas de valeurs en commun avec les autres, ainsi une base sémantique commune ne peut pas être établie, soit dans les séances, soit avec leurs relations.

2. Le patient présente des difficultés dans la symbolisation. L'incapacité pour la symbolisation apparaît aussi quand le patient se montre confus entre la signification littérale et métaphorique d'une phrase. Ils font aussi des questions redondantes où la capacité de penser avant se montre absente.

3. Ils ne semblent pas apprendre de l'expérience passée et racontent des histoires où les mêmes comportements sont répétés, comme si aucune modification fondée sur l'expérience n'était possible.

4. Il raconte comment il se rend à différents lieux afin d'évoquer un passé dont il ne peut se rappeler autrement.

Caractéristiques Syntaxiques du Discours Épique

1. Les phrases sont bien construites, presque sans problèmes au niveau syntaxique. Ils semblent des fois êtres narratifs mais leurs intentions sont construites sur une base sémantique différente.

Thèmes

1. Leurs thèmes sont souvent réduits à la justice et à l'injustice. Ils pourront choisir la cause de certaines minorités à fin de lutter contre des préjugés, comme si c'était leur cause.

2. Le héros de leurs histoires est toujours en train de lutter contre des forces supérieures.

Spécificités du Style Epique Pour le Thérapeute

Les caractéristiques du Style Épique sont les mêmes autant pour le thérapeute que pour le patient, cependant, le thérapeute a d'autres caractéristiques qui font partie de ce Style :

1. Le thérapeute cherche à induire le patient à agir ou à éprouver certaines choses.
Ex: "You must had felt depressed with this situation as you must feel depressed know since it is the same situation you are experiencing".

2. A partir des gestes destructeurs de certains patients, le thérapeute se retrouve involontairement inclut tout en perdant la capacité de penser sur les faits.

3. La parole est agissante comme résultat d'un contre-transfert.

Ex : Le thérapeute peut interrompre le patient au milieu d'une phrase ou peut devenir fâché. Ici il est claire que l'intervention du thérapeute est le résultat d'un contretransfert où nous pouvons voir clairement une pulsion où les contenus propres internes du thérapeute y font partie (« noyaux aveugles »).

4. Le thérapeute utilise le langage afin d'interrompre le patient qui essaie de contrôler la séance par une verbosité exagérée. Ici c'est une utilisation instrumentale du langage d'action. Normalement le thérapeute utilise ce type d'intervention quand le patient est pris avec un discours interminable soit descriptif ou pulsionnel.

5. Le thérapeute amène un sujet complètement différent de ce que se parle dans le moment. C'est préoccupation contre-transferentielle qui est amenée dans le moment.

Style Lyrique

«In literature, lyric poets would let their souls come out to the public»
(Liberman, 1983).

Ces patients n'arrivent pas à différencier leur discours verbal des affects reliés à ce discours. Par conséquent, ils ont de la difficulté à s'observer en relation et à distinguer le message qu'ils envoient. Ils ont tendance à être accablés par les émotions. Non seulement qu'ils transforment leur écoute en une avidité orale mais ils perdent également la capacité

de se différencier des autres. Le thérapeute n'est pas uniquement vu comme le régulateur de leur estime de soi et des difficultés surmoïques qu'ils peuvent rencontrer, mais également comme un objet sadique ou encore, masochique.

Tous ces aspects font preuve d'un type de relation fusionnelle qu'ils entretiennent et qui les empêchent d'avoir toute forme d'objectivité, de comprendre les interprétations et le processus analytique. Ils ont tendance à comprendre les interprétations positives comme une récompense et les interprétations négatives comme une critique. Le thérapeute est perçu comme étant soit nourricier ou persécuteur. En ce sens, les personnes utilisant ce style ont un problème sémantique inhérent à leur discours, qui doit être évalué.

En termes de langage, on a souvent l'impression qu'ils sont sans cesse en train de se plaindre, projetant fréquemment leur culpabilité sur autrui. Quelquefois, nous avons l'impression qu'ils ont recours à l'insight lors de leurs verbalisations, puisqu'ils démontrent beaucoup d'émotions, de culpabilité, et se préoccupent des causes de leurs comportements et des situations en général. Cependant, si l'on se penche davantage sur leur discours, nous remarquons qu'ils projettent leur culpabilité ou le tournent vers l'intérieur, ce qui fait preuve d'un conflit surmoïque majeur.

L'identification projective est leur seule défense et elle est placée sur le pôle de la perception. Cela signifie que leur ouïe, leurs paroles et leur communication ne sont pas exempts de conflits internes. Pour Liberman (1983), lorsque le conflit avec le «mauvais sein» est réactivé ou que la personne est envieuse du « bon sein », elle est non seulement incapable de recevoir l'information que lui transmet son thérapeute, mais elle attaque également ce qu'elle reçoit en écartant certaines parties de l'interprétation. Lors des verbalisations, le patient lyrique démontre une incapacité de transmettre les véritables aspects de sa personnalité et utilise son discours comme une forme d'expulsion du « mauvais sein intériorisé ». Il utilise également ce style pour priver les autres des « bons » aspects, particulièrement, la gratitude.

Même si les patients dépressifs utilisent plus particulièrement ce style, nous nous intéressons à toutes les formes de pathologies pour étudier ce style.

<u>Caractéristiques Pragmatiques du Discours Lyrique</u>

1. Le patient recherche l'attention et l'admiration. Le sujet peut, dans son discours, demander au thérapeute (directement et indirectement) qu'il ait pitié de lui ou encore, dans cette catégorie on trouve la façon dont le patient comprend les interprétations positives du thérapeute : comme une récompense d'avoir été «sage».

Ex: « I just didn't deserve to feel like a mental patient, I felt like killing myself, I mean, I wasn't going to do it but I was driving home and I was feeling really, really bad ».

Ex: T: « You certainly did your best in this situation and you were very assertive too »
P: « Thank you, it feels good to be recognized since nobody cares»

2. Le sujet décrit les autres comme étant gratifiants, maternants et capables d'apaiser leurs sentiments négatifs internes. Ces objets extérieurs ont pour fonction de réguler les conflits avec le Surmoi interne.

3. Le patient a tendance à s'auto-stimuler en prenant la parole, et à éprouver une difficulté à s'arrêter. C'est comme si les émotions se trouvaient de plus en plus nourries au fur et à mesure que le patient prend la parole et obtient l'attention.

4. Le thérapeute est vue comme un ami, il n'y a pas de différence au niveau des rôles dans le traitement.

Ex: "My last analysis didn't work because I felt that I was speaking about another person, not me. I think it happened because I read a lot about psychoanalysis so I couldn't put myself as a patient, I felt as I was a psychoanalyst telling another one about a case."

Caractéristiques Semantiques du Discours Lyrique

1. Les propos font référence à des changements dans l'estime de soi. Le patient utilise des mots pour se dénigrer. On peut inclure ici le « taper dessus » Il peut changer la valence de son estime de soi d'une phrase à l'autre ou à l'intérieur d'une même phrase.

2. En parlant, le sujet semble indiquer qu'il a peu de distance face à ce qu'il dit ou ce qu'il est. La source du message et le récepteur sont la même personne (le sujet qui émette le message).

3. Le sujet est très critique d'autrui.

4. Le sujet se sent aisément critiqué. Des interprétations de la rage ou des pulsions destructrices vont être senties comme une critique personnelle.

Ex : «My father said something he thought was funny, he said we had too many things in the house for only one marriage…it seems that his children molest him."

5. Autrui est responsable de la signification profonde de leur vie. Le désir d'être continuellement proche, un idéal de fusion totale avec l'objet (C'est une difficulté au niveau de la différenciation soi-objet). En conséquence "tout est insuffisant", que ce soient les activités ou les gens. Dans les activités le sujet se porte dans le « tout ou rien ».

Ex: P: « l'idéal ça serait que je trouve une belle et jolie jeune femme qui soit (pause) comme dit une phrase de Verlaine, une femme qui soit en même temps belle et intelligente qui m'aime et me comprenne et qui soit en même temps la même, et jamais la même ».

6. Il arrive que le suicide soit présenté comme une manière de se trouver réunifié dans l'amour (ou obtenir le bon objet) ou encore, d'être puni de quelque chose.

7. La signification des mots compte moins que le ton de la voix qui les énonce, et qui révélerait le sentiment d'être accepté ou non.

Caractéristiques Syntaxiques du Discours Lyrique

1. Le sujet passe d'un affect à l'autre.

Ex: "You know, every time I close my eyes I see some blues dots which reminds me of my parents' very beautiful bedroom when I was small, it was painted blue, but with time it lost its all its color which was so sad."

2. Le thème de prédilection du discours du sujet concerne ses propres émotions en utilisant parfois, une grande diversité d'adjectifs pour décrire ses émotions et sentiments.

3. Le sujet a des « tendances orales-cannibaliques » manifestées sur le mode auditif par le fait d'avaler les mots entendus, de les incorporer avec avidité, en plus d'incorporer ce qui est dit. La parole est rapide comme si elle cherchait à supprimer ses propres mots. Des fois on a l'impression que le patient pense plus rapidement qu'il parle, il « avale » des mots.

Thémes

1. Les thèmes premiers sont la culpabilité, l'amour, le pardon, le rejet et ces thèmes sont abordés d'une façon très personnelle..

Spécificités du Style Lyrique Pour le Thérapeute

Les caractéristiques du Style Lyrique sont les mêmes autant pour le thérapeute que pour le patient, cependant, le thérapeute a d'autres caractéristiques qui font partie de ce Style :

1. Le thérapeute par l'effet du contre-transfert peut faire des interprétations ou utiliser le patient afin d'apaiser ses sentiments négatifs internes. Ces objets extérieurs ont pour fonction de réguler les conflits avec le Surmoi interne. Le thérapeute peut sentir qu'il doit apaiser, réassurer, renforcer le patient. Le thérapeute peut utiliser des expressions comme : « Sure ! » Pour renforcer ce qui dit le patient.

2. Le thérapeute recherche l'attention et l'admiration par l'effet du contre-transfert.

3. Le thérapeute se montre très critique.

4. Le thérapeute se sent aisément critiqué.

Ex : P : my mother, she had a lady friend that went to a psychiatrist and, uh, all you do is go and lay there on the couch and do all the talking and cure yourself and that's; uh uh; that's sometimes what I feel I'm doing just, you know, doing all the talking, you know.

T : but I don't have the impression I'm sitting here not saying anything.

Style Schizoïde-Réflectif du Pacient et Style Réflectif du Thérapeute

La pensée, aux dépends des émotions et du contact émotif aux autres, consiste en l'aspect le plus investi et le plus important de ce style. L'anxiété n'est pas présente et le discours est philosophique, détaché et abstrait. Ce détachement est plus structural qu'il n'est défensif, ce qui contribue quelquefois à maintenir de bons liens entre la réception et la transmission des messages puisque la dissociation idéo-affective aide les personnes réflexives à ne pas se compromettre personnellement par leur message. Ils décrivent ainsi des situations émotives ou des faits importants dans leur vie comme s'ils décrivaient un documentaire scientifique. En ce sens, nous avons l'impression d'avoir accès à un bon rapport des faits où les émotions ne sont pas impliquées.

Ils sont très curieux mais ne montrent pas aux autres cette curiosité puisqu'elle fait partie de leurs plans d'espionnage cachés, espionnage sans affect. Quelquefois, le thérapeute faisant l'objet d'une identification projective importante de cette curiosité, peut devenir très curieux lui-même ou peut répondre à la curiosité du patient par des confessions contre-transférentielles.

Les patients qui utilisent ce style sont souvent sous l'influence de la méfiance ou de l'incrédulité et ils répondent par conséquent de manière très impersonnelle et très abstraite. Non seulement qu'ils croient en leur propre méfiance mais également en celle des autres, ce qui les rend froid et distant. Ils ne peuvent prendre conscience de sentiments transférentiels sans se sentir suffoqués ou envahis.

Liberman (1983) dit de ces patients qu'ils recherchent l'inconnu sans créer de suspense. D'après lui, ce sont les patients schizoïdes [en faisant référence à la définition de Fairbairn (1945)] qui ont fréquemment recours à ce style linguistique. En ce qui nous concerne, nous nous intéressons à toute personne qui, peu importe sa psychopathologie, sous l'influence des aspects paranoïdes et des affects dissociés, aurait recours à ce style.

Caractéristiques Pragmatiques du Discours Réflectif-Schizoïde

1. Le sujet est capable de recevoir les messages mais il ne peut extérioriser, ni exprimer de réponse. Les autres ne savent jamais s'ils ont été compris, ni si ce qui est communiqué est juste ou non.

2. Le sujet s'exclut lui-même de la situation autant qu'il exclut le thérapeute.

Ex : (patient asked to talk about his parents) P : « What are they like about people, people consider them, a lot of people, they like my parents, they are well respected ».

3. Le sujet se sentira, à l'occasion, observé, au lieu d'être l'observateur. Il se perçoit alors comme un objet de curiosité, mais d'une curiosité sans affect.

4. Le patient et le thérapeute se communiquent continuellement une incompréhension, dans la mesure où ils se parlent dans des registres différents. Ce n'est pas tant l'exactitude des propos qui est en jeu, mais plutôt le sens même qui est atteint. Le climat de la séance est ainsi empreint de mystère.

5. Le silence est utilisé comme moyen de se soustraire à la communication et de ne pas participer à la séance.

Caractéristiques Sémantiques du Discours Réflectif-Sschizoïde

1. Le discours du sujet est caractérisé par un écart, une séparation entre l'éprouvé (les émotions) et la pensée. Le sujet parle d'une situation joyeuse ou douloureuse sans démontrer aucune émotion.

2. Le sujet est intrigué par quelque chose. Le sujet est intrigué par les faits et cela lui sert à maintenir à distance les émotions. Le sujet se trouve avec quelque chose d'inconnu (un concept mystérieux, obscur, occulte, étranger) et pour essayer de comprendre ceux-ci, il utilise de concepts de plus en plus abstraites.

Ex: "I mean, how does a person lay here and say every thought that's supposed to come to his head to someone when they normally don't do that, you know. a lot of things a person keeps inside, they think but they don't say it and that's different too. that, uh; that's getting to be unusual. it, uh; I mean, some things you think and you say and the other things you think and you just don't say them like some concepts can be said, others don't".

Ex: "Usually when you talk to other people you talk about someone or something and you've got a conversation going back and forth but just to lay here and talk about yourself, that's different".

3. Le sujet discutera de sujets philosophiques tels que la vérité, la justice, la vie et l'origine du monde. Être en thérapie revient à trouver des réponses à ces questions.

4. Le sujet parle fréquemment des échecs dans les tentatives d'établir ou de maintenir des liens de proximité avec les autres, dont il n'a toutefois pas la nostalgie.

5. Il oscille continuellement entre certitude et incertitude.

6. Son idéal est d'être un observateur détaché, sans devoir se compromettre avec les lieux ou les personnes.

Caractéristiques Syntaxiques du Discours Réflectif-Schizoïde

1. La dissociation permet de préserver certains souvenirs intacts. Il arrive ainsi au patient de communiquer des faits remémorés avec précision.

2. Le sujet témoigne d'une perception microscopique des faits, des gestes, des situations et des émotions.

3. Il utilise des néologismes.

Spécificités du Style Réflexif Pour le Thérapeute

Les caractéristiques du Style Réflexif sont les mêmes autant pour le thérapeute que pour le patient, cependant, le thérapeute a d'autres caractéristiques qui font partie de ce Style :

1. Le thérapeute s'exclut lui-même de la situation thérapeutique en utilisant des interprétations objectives-rationnelles surtout quand le thème apporte des aspects contre-transferentiels.

2. La dissociation permet de préserver certains souvenirs intacts. Il arrive ainsi au thérapeute de communiquer des faits remémorés à propos du patient ou de choses qu'il a dites avec précision.

3. Le silence est utilisé comme moyen de se soustraire à la communication et de ne pas participer à la séance et des fois, laisser le patient associer librement. Dans ce code, il y a utilisation instrumentale du silence et parfois, une impossibilité de s'approcher de ce que dit le patient.

4. Le thérapeute est intrigué par quelque chose et utilise de concepts de plus en plus abstraits pour essayer de les expliquer.

5. Le thérapeute donne des noms aux contenus internes du patient. Ici, c'est plus une description de ce qui se passe dans le monde interne du patient et dans certains cas, le rapport entre ceux-ci et les symptômes ou entre ceux-ci et la façon dont le patient fait des rapports aux gens. Il peut aussi faire des questions « interpretatives » qui ont pour but faire l'autre penser plus sur certains aspects inconscients. EX : « Now you don't seem to be settled » ou « That's an issue inside you » ou « still uneasy about this » ou « you have a feeling you're suppose to like to come ? »

6. Le thérapeute fait des questions ouvertes afin de laisser le patient explorer ses contenus internes.

Ex : P: It feels degrading in a way.

T: How is that?

Style Concret, Personne Infantile Selon Ruesch

Ce mode de fonctionnement de la pensée est généralement caractérisé par une pauvre capacité de représentation, une élaboration symbolique minimale, une diminution dans la formation de rêves nocturnes et dans la capacité de fantasmer ainsi qu'une augmentation de la pensée concrète. C'est le résultat d'une déficience. Les désirs ou les fantasmes ne peuvent pas s'exprimer. Parallèlement, les aspects agressifs ne peuvent pas s'exprimer à travers le sadomasochisme interne. Ce type de fonctionnement diffère d'une forme de pensée crue, non cultivée et non raffiné qui est tout de même remplie de sens, d'une tradition passée ainsi que d'une vie interne. Voici quelques manifestations caractéristiques du mode concret de représentation et de communication.

Caractéristiques Pragmatiques du Discours Concret

1. Les mots ne sont pas utilisés pour remplacer les actes mais ils illustrent, répètent ou doublent plutôt l'action de façon «serrée». Les mots expriment des pensées qui peuvent soit précéder soit suivre l'acte, mais toujours au sein d'un champ temporel limité. La pensée concrète se fait à un niveau utilitaire de gestuelles et de fonctions, comme si elle était prise dans un présent immédiat ou une actualité, vue comme une succession de faits.

2. Parler est une forme de libération. Le sujet est incapable de contenir ou de tolérer les pressions affectives internes.

3. La relation est ressentie comme exempte de contact, une forme de relation «blanche». Elle est similaire aux événements et aux comportements qui se produisent dans la vie du sujet. Ces patients répondent aux questions du thérapeute mais de façon non satisfaisante. Ils ont beaucoup de difficultés à s'identifier face à la concrétude du matériel. On le ressent également par une forme de présence vide de leur part.

4. Les patients utilisant ce type de style sont incapables d'initier des actions et ne peuvent déchiffrer le dialogue d'autrui. Ainsi, ils ont une information incomplète de leur entourage (ce qui inclus les personnes), croyant que les actes doivent être initiés par les autres.

Caractéristiques Sémantiques du Discours Concret

1. Une telle forme de pensée comprend des pensées conscientes, qui n'ont aucun lien avec l'activité fantasmatique. Elle est reliée à des choses plutôt qu'à des produits de l'imagination ou de l'expression symbolique. Ainsi, ce discours n'a aucun pouvoir symbolique. Ce n'est pas un support à la sublimation.

2. Le développement de symptômes peut être lié à des preuves anecdotales spécifiques, mais le patient ne fait aucune autre association au-delà de cela. Cette pauvreté est reliée à

une connaissance matérielle et factuelle concrète et étroite. Cela se produit dans un cadre temporel étroit.

3. Il y a une connexion immédiate avec le monde sensori-moteur.

Ex: Le thérapeute demande à la patiente si elle se sent inquiète par rapport aux traitements et elle répond : «oui, la manière dont je me suis levée hier est inconfortable, c'est comme si je me suis levée trop vite». Ici, nous voyons que la patiente ne fait aucun lien entre sa perception d'être inconfortable et son monde interne.

Ex : P : Si vous permettez, je vais prendre mon traitement, je pense que je commence à être allergique.
T : Allergique à quoi ?
P : Au pollen d'arbres, c'est la saison. Je commence à éternuer, parce que je ne sais vraiment pas quand cela commence, j'ai pas de pilule encore.

Il semblerait que le patient s'impose quelque chose. Son existence se réduit à des proportions minimales.

4. On cote également ce type de style lorsque la personne perçoit ses relations à travers les mécanismes d'action chimiques et sensoriels (transpiration ou le fait d'être tendu).

5. Ce mode de fonctionnement de la pensée peut être complexe, même fécond à un niveau purement technique. Les personnes utilisant ce style peuvent occasionnellement utiliser l'abstraction, mais il manque une référence à un objet interne vivant.

6. Les autres sont perçus comme identiques à soi en termes d'état mental et physique. Les personnes utilisant ce style sont incapables de différencier et de se représenter l'intériorité des autres puisqu'ils ne peuvent le faire pour eux-mêmes. Ces patients perçoivent les autres comme parlant un «langage corporel» tel qu'ils le font eux-mêmes.

Caractéristiques Syntaxiques du Discours Concret

1. Ces patients sont conformistes. Ils utilisent les opinions des autres comme la leur. Le discours est rempli d'expressions stéréotypiques, de clichés et de matériel circonstanciel. Ils peuvent quelquefois utiliser certains jugements stéréotypés (il est bon de faire ceci et mauvais de faire cela). Une perception pauvre ou distortionnée des indices sociaux est compensée par des jugements stéréotypiques portant sur les valeurs.

Spécificité du Style Concret pour le thérapeute

Les caractéristiques du Style Concret sont les mêmes autant pour le thérapeute que pour le patient sauf que le thérapeute a d'autres caractéristiques qui font partie de ce style :

1. Il y a connexion immédiate avec le monde sensori-moteur. Le thérapeute fait des liens et pose des questions à propos de la santé physique du patient au lieu de se concentrer sur un contenu interne. Pour être coté Concret, il faut que cette préoccupation soit initiée par le thérapeute. Si c'est le patient qui initie le discours et le thérapeute suit en essayant plus tard de lier ce qui est dit à des contenus internes, nous ne coterons pas le style Concret. Cependant, si le thérapeute continue de parler dans ce mode, nous coterons Concret.

Meta-Styles

Les styles linguistiques sont le résultat des points de fixation dans le développement de l'individu. (Liberman, 1982, 1983). La rigidité dans l'utilisation d'un style par un individu démontre la rigidité de fonctionnement du moi et conséquemment, son degré de pathologie. Aussi, en restant pris à cette rigidité, l'individu n'est pas capable d'utiliser d'autres formes de communication ni de bien codifier ce que l'autre veut communiquer. Ainsi, des bruits constants sont retrouvés dans la communication qui ne peut pas bien se produire.

D'autre part, la plasticité idéale du moi est conçue par Libeman (1982) comme la capacité de perception, d'évaluation et de réponse. Plus spécifiquement, c'est la capacité de grouper des signaux verbaux, non verbaux et paralinguistiques, en donnant du sens à des signifiants partiellement linguistiques et non linguistiques tout en considérant les contraintes et les combinaisons de la langue afin de communiquer sans distorsion (Liberman, 1982). Cette capacité de groupement, de donner du sens, de faire des liens et de bien utiliser la langue et les signaux verbaux afin de communiquer sans bruits, caractérise la plasticité du moi et la capacité d'une «communication parfaite» ou encore, un non-style.

Ici, nous allons considérer comme *insights*, cette capacité de faire ces liens. Cependant, nous appelerons cette capacité, ce non-style, de *méta-styles*.

L'insight selon Rapaport (1942), est la capacité de connaître quelque chose au-delà des apparences. C'est une connaissance qui n'était pas disponible au sujet avant mais qui l'est au moment du relèvement du refoulement. Pour le même auteur, c'est un moment de création, de nouveauté. Ainsi, l'insight est essentiellement intellectuel puisque le sujet décrit en mots la compréhension d'un phénomène inconscient duquel il vient de se rendre compte, mais il contient par fois un aspect émotionnel vu que le sujet peut rentrer en contact affectif avec une situation psychologique particulière (Etchegoyen, 1991).

Cette capacité d'entrer en contact (de forme créative et nouvelle) avec les contenus inconscients liée à une situation soit externe ou interne, avec un contenu émotif ou avec une expérience émotive et de les exprimer en mots, nous appellerons d'insight. Nous considérerons que l'insight est prononcé sans style, dans une syntaxique parfaite puisqu'il reflète l'accès du sujet à son inconscient, sans la présence de défenses.

Nous voulons souligner la créativité dans le concept d'insight vu que ce commun que les patients aient une capacité d'auto-observation, mais ceci n'est pas considéré comme un insight. Par exemple : Patient (parle des ses enfants) : « , I feel guilty and then if something would happen, you know, and someone told me about it and suggested that they could get hurt and yet, they still got hurt, then I'd feel guilty and a failure that I should have

listened, you know. it's, uh - something minor but it's; and *I take my life a lot like that; very seriously; very over sensitive, you know* ».

La dernière partie du discours de cette patiente, nous pouvons voir qu'il existe chez elle une capacité d'auto-observation, mais ceci, est loin d'être considéré comme un *insight* formulé dans un méta-style. Il n'y a pas un contact et une reconnaissance des aspects inconscients liés à cette expérience. Il n'y a pas de découverte, de processus créatif. Par ailleurs, l'action des défenses et du retour de l'agressivité ver le soi dans le discours fait ressortir le style « plaignard » du style lyrique.

Un exemple d'un insight que nous considérons comme un méta-style est donné : « P: I've been feeling rather destructive again in terms of my not being able to just say--it's over--it's over--,and realizing that in an effort either to protect myself or Wife or both of us from--from the pain of making the separation, that I'm actually making things worse--for both of us (pause) ».

Dans ce cas, le patient se rend compte qu'il continue d'amener une relation avec son épouse car il a peur de la douleur qu'il allait ressentir au moment du divorce. Ceci a été dit après que tout au long il disait comment il se sentait déprimé car ses rêves ne pouvaient pas être réalisés avec son épouse et qu'il ne sentait plus l'attrait sexuel qu'il avait avant par rapport à elle et qu'il pensait beaucoup quoi faire pour rétablir son mariage. A ce moment nous considérons ce que a dit le patient comme un insight vu qu'il accède à son inconscient et reconnaît quelque chose de nouveau dans son expérience. Cette phrase est émise sans style, avec une syntaxe et un contenu clair.

Pour cette échelle nous allons en considérer deux méta-styles car nous considérons que les processus liés à l'insight sont tels qu'il y a plusieurs niveaux d'insight. Nous nos rapportons au concept de *régression au service du moi* décrit par Kris (1956) et exploré par Séguin & Bouchard (1996) dans le concept de contretransfert.

As Kris (1952) affirmed, in the process of the regression in the service of the ego, regressive contents are allowed to invade consciousness without the loss of superior mind functions that control inadequate regression. In that sense, the ego uses the primary process to reestablish strength and creativity. This process however, passes through different states and different levels of consciousness, which in Kris (1952) model corresponds to two states; the inspiration state and the elaboration. That is why we use in this instrument, two types of insight, one more on the "surface" where the patient get in contact with regressive contents by a decrease of censorship (001). The second phase, is the elaboration, where the regressive contents are organized by secondary thoughts (002).

Méta-style type 1 (001) : Insights de premier niveau, ceux-ci correspondent à des émergences et des immersions. Les émergences et les immersions peuvent aussi être par rapport au style.

Ex : (émergence) : « Je me sens irrité » ; « Pourquoi je me sens vide en ce moment ? ».

Ex : (émergence style) : « Comme je parle de détails aujourd'hui ! ».

Ex : (immersion) : « Je me sens nerveux devant vous » ; « Quand je vous ai dit que j'allais me divorcer j'ai pensé que vous alliez me blâmer ».

Ex (immersion style) : « Je sens que je dois vous ranconter des histoires intéressantes car j'ai peur que vous me trouverez plate ».

Méta-style type 2 (002) : Insights de deuxième niveau, ceux-ci correspondent à des cycles complets d'insight où le patient est capable de se rendre compte de son affect lié à des objets de sa propre histoire. Dans ce type de meta-style, le sujet se rend compte du style de communication qu'il utilise pour communiquer et les bruits qui surviennent comme conséquence de son style.

Ex : « En ce moment je me sens rejeté par vous exactement comme je me sentais avec mon père quand il partait en voyage pendant des mois, je me sens triste et rejeté ».

Ex : « J'ai besoin de décrire avec tant de détails les choses qui se passent parce que j'ai peur que vous disiez quelque chose à propos de la façon dont je m'habille, je me sens laide et je veux que vous ne remarquiez pas ça. Je faisais la même chose avec ma mère parce qu'elle était toujours en train de me regarder et de me blâmer ».

References

Edelson, M. (1973). Language and dreams. In The language studies if the child (Vol. XXVIIpp. 203-282). New York: Quadrangle Books/New York Times Book Co.

Edelson, M. (1975). Language and interpretation in psychoanalysis. New Haven: Yale University Press.

Etchegoyen, R. H. (1991). The fundamentals of psychoanalytic technique. New York: Karnac Books.

Jakobson, R. (1963). Essais de lingusitique générale. Paris: Ed. de Minuit.

Kreuz, R., & McNeally, M. S. (1996). Empirical approaches to literature and aesthetics. New Jersey: Ablex Publishing.

Kris, E. (1952). Psychoanalytic explorations in art. New York: International University Press.

Liberman, D. (1983). Linguistica, interaccion comunicativa y processo psicoanalitico tomos I e II. Buenos Aires: Kargieman.

Liberman, D. (1982). Psicopatologia. Rio de Janeiro: Ed. Campus.

Liberman, D., & Maldavsky, D. (1975). Psicoanalisis y Semiotica: Sentidos de realidad y categorizaciones estilísticas. Buenos Aires: Paidós.

Morris, C. W. (1946). Signs, language and behavior. New Jersey: Prentice Hall.

Peirce, C. S. (1931). Colected papers. Massachussets: Harvard University Press.

Rappaport, D. (1967). The history of the awakening of insight. In Merton M. Gill (Ed), Collected papers . New York: Basic Books.

Ruesch, J. (1957). Disturbed communications. New York: W. W. Norton & Company.

Séguin, M.-H., & Bouchard, M.-A. (1996). Adaptive regression and countertransference mental activity. Psychoanalytic Psychology, 13(4), 457-474.

Liberman Linguistic Style Measure (LLSM) Exemples cliniques

La présence dans ces pages de matériel clinique anonyme fait en sorte que la lecture et l'usage de ce matériel sont soumis à des règles déontologiques strictes. Ceci implique notamment de la part de l'usager, la signature d'un formulaire d'engagement à respecter ces règles. Le formulaire peut être obtenu à l'un ou à l'autre des adresses suivantes:

- Daniela Wiethaeuper, Departamento de Psicologia, UNISINOS. Av. UNISINOS – Centro2, São Leopoldo, Brasil. [redacted]

- Marc-André Bouchard, Département de psychologie, case postale 6128, Université de Montréal, succursale Centre-Ville, Montréal, H3C 3J7, Qc., Canada. [redacted]

LES STYLES – EXEMPLES CLINIQUES

Style Narratif

Exemples du Style Narratif Pour le Patient (en anglais) :

Ex 1 P: I don't know. I guess I did the other days and today was just so nice out there, I just wanted to stay home and get something done, you know.**1**

Ex 2 P: yeah. and, uh; but you explained it wasn't that way so it's something I have to keep remembering, you know; it's not going to be that way. this is, you know (laughs) I'm glad I'm off tomorrow. I've got a few things I want to do. I hope the weather is nice and, you know, just uh; **1**

Ex 3 P: mm; (pause) You know, it's; I guess when you hear like my mother of *nick saying things, you start wondering and you start feeling like this; I guess, like am I wasting my time, am I wasting his time; but, uh, I've got to; it's getting somewhere where it's like between you and me, really, uh; **1**

Ex 4 P: Uh, mm - you know, uh, I have to say my mind is kind of distracted. I've got a lot of things on it. both the kids are; they seem to be congested and I've been giving them aspirin and rubbing them down at night. the last two days; everyday, I figure I'm going to wake up and one of them's going to have a high fever and they're both going to be0Dhome from school. it'll probably happen tomorrow when I don't have to go anywhere and they'll both be home sick.**1**

Ex 5 P: well, I'm looking at the ceiling but, uh, you know, lots of times thoughts come through your mind automatically and now it sort of, you know, just, uh - must be part of being overtired honestly. **1**

T: part of what? **1**

P: being overtired. I was really tired yesterday. not so much today but I was really tired yesterday. **1**

Ex 6 T: a big what? **1**

P: palm tree. **1**

T: palm tree? **1**

P: a palm tree. **1**

T: oh, a palm tree. yes. **1**

P: yeah. like a coconut tree. and they were at the top and they were having a good time; it was really kind of funny, in a way, and, uh, *sparky had, I don't know, some canteens and a box or something and I told him to drop it, otherwise, he'd fall and lose his balance. well, he leaned over the drop it which was really; if he would have just dropped it straight down, it would have been different but he leaned down and he started falling and I

just woke up there; just, you know, I was almost ready to go into his bedroom and check and see if he was still there. **1**

T: it woke you up with a moan. **1**

P: yeah. it, uh; I went; uh:, and I woke up immediately, you know. all I could see was him starting to fall from the top and *ericka was still up there. other than that, I was yawning from 9 to 10 o'clock. I was so tired I went to bed at 10 and fell asleep almost instantly and then woke up with that dream, you know, and then I was wide awake, tossing and turning, the rest of the night too. **1**

Ex 7 P: I thought maybe you; I thought maybe looking back at the dream this morning and I was wondering why it was that type with the two children and I thought; well, maybe because they've been sick; sort of; the last two days; not seriously but enough where they fevered, you know; say, a hundred or so I didn't ever; I didn't take their temperatures, it wasn't that high but enough that they were warm enough and they did have these colds coming and thoughts are going through my mind like I'm going to get it, my husband's going to get it and it's going to go round and round in a circle all winter long, uh, I thought maybe the two of them up there was kind of like; and *sparky, he just got the symptom yesterday so; I thought; well, maybe that was part of it the two children; you know, worrying about them. **1**

T: well, if we take the individual parts of the dream; what does it make you think of that they were on a palm tree. **1**

P: I haven't (laughs) I don't know; I thought maybe; well, they were using that ramp with the bricks and a little board to go up and they were doing their bicycles and *sparky was doing his big wheel. and maybe the height part of it; **1**

T: *sparky was doing his big wheel? **1**

P: yeah. do you know what a big wheel is? **1**

T: I'm afraid I don't know that. **1**

P: it's, uh - it's a toy; it's not a tricycle but it has two big wheels on the back and a large wheel on the front; uh; **1**

T: how is it not a tricycle then? **1**

P: it's it's low and the wheels in the back are very wide **1**

Ex 8 P: and it's; I mean, he goes two forty on it and he spins it around and everything I mean, every kid in the neighborhood) has got one. it's advertised on t. v. by marx. **1**

T: he goes two forty? **1**

P: two for; fast. **1**

T: is that what two forty means? **1**

P: yeah. I thought it did. **1**

T: well, it may very well, it's just that I'm not familiar with that expression. two forty.**1**

P: I always thought that was just going extra fast. **1**

Ex 9 P: yeah. this wooden board and it's funny to see them going over it. they're not even taking off in the air, they're just going over it and, you know, I thought maybe that was; I

was starting to think; well, gee, I'm letting them do this tiny, little dangerous thing, you know, maybe they'll try something higher or more dangerous, uh,**1**

Ex 10 T: who was frowning on it? **1**
P: dad *carter; *nick's father and also his brother, *hank. **1**
T: I see. **1**
P: that the kids could get hurt that way. it wasn't that high. it just; they weren't flying over twelve cars or anything like that. they weren't even flying a foot off. they went over it and right on to the ground again. **1**

Ex 11 P: he's always got something. he's the type of little boy that has to have his car or his gun or paper of pencil or crayons or a game. you know, he's always doing something, uh, so, uh; well, canteens, they had; *franky next door; the little boy, he's; he just turned seven and, uh he has like a camping out backpack and they were; we have; we live on a corner house off *maple and there's a prairie in the back of the house and they play in there like they pretend they have, uh, logs that are fire and they're camping out, you know, and, uh; I don't know why the canteens but it was something *sparky had with him. **1**

Ex 12 P: well, I thought he'd lose his balance and he'd fall and, you know, he just had too much plus trying to hold his hands onto the tree so I told him to drop them and when I meant drop them, I just meant let them go and go straight down but being four years old, he leaned over to drop them and that lost his balance and all I could see was this; starting to fall and I woke up before he hit. I always wake up before anybody hits. I; **1**

Ex 13 P: uh, I thought maybe a tree that was higher than the tree we have in front of the house; the children are always climbing on that; it's not really that high; it's about a foot over my head the branch they sit on and they're always climbing that and *sparky's always in that more than *ericka is. I thought maybe that tree being smaller, I picked a higher tree, you know. something they could really fall from. I I; **1**

Ex 14 P: yeah. but I; I wanted to lay it there (laughs) but it's like like when you were up there before I thought maybe you disappeared and I didn't want this to disappear so I just wanted; it's such a force of habit; we live in a neighborhood on *th and *maple and; that the northwest corner is completely black and I'm so used to; when I'm carrying this, I'm holding it constantly because I've heard stories of women, uh, you know; they just grab their purse and run and knives have been pulled on some women down there. these are stories I've heard. I haven't, uh, you know; and so it's such a habit of carrying my purse, you know, because, uh; **1**

Ex 15 P: I mean, to me, he's been dependent upon my mom for all his clothes and his food. when he comes in, he eats; he sits down and eats and leaves. well, this to him, is going to be extra work. I'm sure he's busy enough trying to take care of himself. I; and I don't think he's out to hurt their feelings intentionally. **1**

Ex 16 P: how do you cut something like that off, you know? how do you not let it bother you so much? like *nick says; he don't give a darn what people think; he don't let it bother him. I envy *nick in a way. I envy he can go out and be happy and have a good time and, uh; how do you be a person like that; how do you cut off that oh, just caring so much or that; wanting to please everybody and wanting to be perfect or wanting to have everything right. how do you calm down and just take everything in your stride and not let it effect you? (pause) it's very hard for me to do that. **1**

P: I feel very comfortable with all those books out there because those are the kind I buy all the time. and it's kind of like being at home and relaxing and read articles or you look at the pictures **1**

Ex 17 P: I've talked to the teacher several times already about uh, ericka's tonsils being removed; in fact, today after school, I have a meeting with her where I would like to request that she stay in Monday until; lunch is 11:50; 11:45; we don't have to be at the hospital until 12:30 or 1:00 and I think she should stay in school and, uh it'll keep her busy rather than her being home and fretting and worrying about things and the teacher's pretty well, I can't use the word "strict" but she can put her foot down where she still keeps the kids occupied with whatever work they have in school. **1**

Ex 18 P: I don't know. I just - I keep; I blame myself that; geez, all I can remember is bad things can't I remember any good things growing up (sighs) **1**

Ex 19 P: I still didn't make up my mind if it's good or bad or what. (sighs) don't know if we've got a doctor with some old ways of doing things you knows take the tonsils out, that'll work. old schooling or something; that's what they call it. (pause) **1**

Ex 20 P: it is funny because just the other day, I read that word again and up to this point, I don't think I ever was aware of it. I have something that's bothering me about what you said. (sighs) maybe we should talk about it. one of the things you said Wednesday was; I was voicing my opinion that I got to stop drinking because my brain cells are being destroyed and I can't remember things and so forth and you said something about an attention span. I know that about kids, you know, that they; they don't have a very long attention span. they don't seem to have that; well, I start thinking if I don't have one, then I'm a kid and I don't want to be a kid. **1**

Ex 21 P: I don't know maybe I got to feel like I got to be really happy and outgoing and up to what I have standards to be and on days I don't feel like that, I shouldn't be around people. **1**

Ex 22 P: if if you look at it for a lifetime, it's it's like balancing things out. you could have half unhappiness or punishing yourself or sacrificing yourself or whatever, including things that naturally happen, but it's got to be; it can't be more than 50 percent of being happy.I mean, it can't; I mean, happiness can't be more than the punishment or the sacrificing. it can't

be more in your life. I mean, if you're going to die and get to heaven, you can't have spent your life, 100 percent or 95 percent, uh enjoying things and; **1**

Ex 23 P: yeah. I'll do something at home that I really don't like doing but I'll do. oh. boy - that's how my life seems to be running - oh, God, I haven't done this in a long time that I've been aware of. I use to be aware of it on a lot of occasions. uh, I; there would be times where we'll be going someplace and I'd say" oh, say, a Friday evening out; I don't know; to people's home or a show or something **1**

Ex 24 P: I'm trying to think of something in particular, you know, like when I was there this last week with my mother, I tried to enjoy it. I really, really did. as long as she didn't touch me, I was going to be okay. (sighs) but I still ratted her hair. that wasn't bad and I talked to her we loaded her dishwasher together, I am trying to do; but I just don't want to. I'm holding back. **1**

Ex 25 P: oh - that means like, uh - (sighs) I wish I would have brought that book in; if you like scrub the floor on your hands and knees; well, that's work; if you offer it up for your sins and the sins of the people in purgatory, you'll get to heaven and it'll take away some of the punishment you should get for your sins, you know, uh" like what I wanted to bring in was my, uh, communion book. this would be like when I was in fourth grade. and the questions they ask for each commandment. uh, did you get angry with your parents; that's a mortal sin. did you, uh, miss saying your prayers in the morning and in the afternoon; not afternoon, but evening. uh, did you eat meat on Friday, I didn't do any of that stuff, did you, uh, steal anything; like you go and take a nickel out of the; me use to have on the second shelf; I don't know what it was (laughs) a little cup" but it didn't look like a cup it was square with a little handle and we use to keep change in there they always did that for years, you know; kids use to take a nickel or a dime out. I didn't do it as often as donny and you did it but uh, I would every once and awhile to buy some candy at the store and that was a sin, geez - what is it? the sixth or seventh commandment, uh - they reworded this commandment so many times; I learned it one way, ericka learned it another way, I've read it different ways but, uh; about keeping yourself pure; I well, there would be questions after this commandment; did you think about anything that was not appropriate, you know. I have to bring these in because when I read them over, it was just so much. just - like it's so opposite of being just naturally human, you know. it just (sighs); **1**

Ex 26 P: but, you know, it's just; and nick's mother she still says the family rosary every night; whole family; she goes to church everytime you turn around. she tells us we should do things more or we're going to suffer. God knows everything we do. (sighs) **1**

Ex 27 P: oh. I can't; the only sex that ever comes into mind in the catholic church is when Christ went to that marriage feast and they ran out of wine and he told them fill up the jugs with water and the water turned into the wine. it was like he was acknowledging and saying

that marriage was fine; that was the only thing that had any sexual connotation to me (sighs) **1**

Ex 28 P: right and I keep using the same two words for our father and God, the father **1**

Exemples du Style Narratif Pour le Patient (en français) :

Ex 29 P: C'est euh c'est ressorti cette semaine parce que ma fille en, en revenant de la bibliothèque, elle est arrivée avec un livre qui s'appelle euh "Le poids réel et le poids memtal" puis euh elle dit lis donc ça, j'ai l'impression, elle dit, que il y a des choses qui pourraient peut-être t'aider là-dedans (toux). Alors, j'ai du temps donc je l'ai lu. (...) C'est qu'il y a des exercices à faire et puis euh c'est un livre qui a été écrit par euh docteur Larocque je pense qui se spécialise dans l'obésité depuis euh x années puis euh lui en est venu à la conclusion qu'il y a beaucoup de gens qui traînent un excès de poids, des fois un excès de poids léger et qui euh se comportent comme des obèses avec un poids beaucoup plus lourd et d'autres qui sont obèses puis qui euh ne perçoivent pas leur obésité comme telle puis moi je corresponds au cas qui euh d'après les exercices que j'ai vus dans ce livre-là, mon poids santé est cent-vingt-neuf, je pèse dans le moment centre-trente-six, cent-trente-sept, ça varie toujours autour de ça mais mon poids mental est cent-cinquante livres.**1**

Ex 30 P: C'était pas une relation très confortable puis d'après moi, c'est, ça a commencé là ce problème-là, qui s'est accentué quand euh j'étais jeune mariée puis euh un moment donné euh j'avais pris quelques livres à peine puis euh puis je, toujours, je me surveillais, j'avais toujours mon poids fixe, tout ça, **1**

Ex 31 P: puis euh mon mari à l'époque qui est lui-même a eu l'obsession de prendre du poids, il m'avait dit un jour, si jamais tu en, si jamais je me retrouve avec une grassette, il dit, je te le dis d'avance, c'est un cas de divorce, moi, il dit, je serais jamais capable de, de, arriver en public et puis d'avoir une femme grassette, il dit, j'ai, j'ai une répulsion épouvantable pour les grasses. Puis euh pourtant c'est pas quelqu'un avec qui euh pour qui j'avais tellement tant de sentiments que ça, je crois pas mais euh encore une fois, toujours pour être un peu à la hauteur ou pour être aimée, **1**

Ex 32 T: Pseudo-suicidaires? **1**

P: Ah euh pseudo-suicidaires et une fois carrément suicidaire (?). C'est un professeur à l'école euh que j'admirais beaucoup, c'est un professeur de mathématiques puis euh j'ai toujours eu énormément de difficultés avec les chiffres puis euh (s'éclaircit la gorge) cette année-là, ça allait vraiment mal à la maison, je sais pas si ça peut être une des causes mais enfin j'arrivais pas à me concentrer sur l'algèbre. Puis ce professeur-là a fait une dépression nerveuse, je l'ai su par la suite, en tout cas, à l'époque euh j'ai pas trop compris ce qui se passait puis euh un moment donné il a donné un examen réellement facile, tout le monde a passé dans la classe sauf moi puis là j'étais allée le voir puis je suis allée lui dire bien, écoutez, il y a sûrement des choses que j'ai pas comprises si tout le

monde a passé, pourquoi je passe pas, tout ça, j'ai, même encore aujourd'hui, même avec, en rétrospective, je comprends pas sa réaction sauf de me l'expliquer du fait qu'il était malade. **1**

Ex 33 P: S'il t'a dit ça, c'est parce que quelque part, tu l'as mérité, ça a toujours été leur explication en regard de l'école donc euh je me disais si je vais chez moi puis euh que je leur dis ça, ça donne quoi, tu sais, puis euh des amis j'en avais mais ils me connaissaient pas vraiment, je passais toujours pour la brave euh celle qui prenait des défis stupides comme ça comme par exemple euh traverser euh sur une planche euh pas plus large que ça euh l'espace qui sépare deux "blocs-appartements" à quatre étages. **1**

Ex 34 P: (?) puis euh (soupir) puis c'est ça, avec ma bicyclette bien j'ai vraiment failli me tuer cette fois-là, cette fois-là j'ai eu peur par contre (rire) parce que je me suis euh je me suis jetée en bas d'un genre de falaise mais c'était pas très haut mais j'aurais pu me blesser beaucoup plus puis euh ça a pas fonctionné parce que j'ai glissé puis j'ai juste réussi à me, à me, à m'érafler une jambe puis un bras mais quand je suis revenue à la maison, j'étais tellement euh tu sais, quand je dis des fois je me gèle d'anesthésie j'étais tellement débranchée que c'est la seule fois que j'ai vu ma mère inquiète, vraiment inquiète puis elle m'a demandé d'où je venais puis euh où j'étais puis j'ai pas voulu lui répondre, je suis allée dans ma chambre euh cette fois-là euh j'ai trouvé que j'avais été un peu trop loin. **1**

Ex 35 P: Il y avait un test dans mon livre là euh "Le poids mental, le poids réel", c'était euh bon il fallait donner les qualités de son père, il fallait donner les qualités de sa mère. Je me suis creusée la tête pendant (rire) à peu près une demi-heure puis les seules qualités que j'ai pu trouver à mon père c'est qu'il était propre sur lui-même puis autour de lui parce qu'il en est presque maniaque, il cherche les poussières, tout ça, ça puis il est travaillant, c'est un homme qui travaille, qui a travaillé fort toute sa vie, j'ai essayé de trouver est-ce qu'il est franc? non, est-il intègre? non, **1**

Ex 36 P: j'ai essayé de, de trouver euh le plus objectivement possible les qualités, j'en ai pas trouvées puis ça, ça m'a fait vraiment curieux, il me semble, je devrais lui en trouver, **1**

Ex 37 P: c'est ce que je trouve difficile dans le moment, c'est que je me suis convaincue avec les années que c'est trop facile de dire toutes les causes sont dans l'enfance, tous les problèmes que j'ai c'est à cause de mes parents, oui, ils ont eu leurs torts oui euh (soupir) mais il me semble que ils ont agi à, dans leur, à l'intérieur des limites qu'ils avaient et qu'ils ont encore. Eux-mêmes ont l'humilité de dire aujourd'hui, ma mère en tout cas m'a dit si c'était à refaire la façon dont on vous a élevés, elle dit je te jure qu'on le ferait autrement, elle m'a dit ça il y a deux ans mais elle a dit il est vraiment très tard, je m'aperçois de tellement de choses trop tard, je m'aperçois même que je te connais pas du tout puis qu'on n'a pas déteint sur toi comme on aurait pu. Ça, ça m'a vraiment euh étonnée quand ma mère m'a dit ça parce que c'est le genre de choses, c'est la personne qui

dit toujours que tout va bien, c'est peut-être là où j'ai appris à dire pas de problèmes, c'est euh, c'est la phrase de ma mère, pas de problèmes, **1**

Ex 38 P: Non, c'est simplement que, je vous trouverais fatigant si c'est vous qui m'ameniez à regarder mon enfance mais vous m'avez pas réellement guidé par des questions euh il me semble, à date, vous m'avez jamais ramené malgré moi dans ce cercle-là ou je m'en suis pas aperçue mais c'est moi qui, comme aujourd'hui je voulais vous parler de ce problème-là de poids, je pensais pas de parler de ce qu'il y avait en arrière, c'est encore sorti. **1**

Ex 39 P: Je serais, je serais peut-être devenue dépressive ou euh ou agressive ou amère ou je sais pas quoi, j'ai pas voulu faire ça, si j'avais pas eu les enfants avec moi probablement il y aurait eu toutes sortes de, de réactions différentes, je me serais pas sentie en charge de, déjà je, je le suis devenue financièrement mais je l'étais aussi psychologiquement euh d'une certaine manière puis euh il me semble que j'aurais pas pu me permettre ça. **1**

Ex 40 P: même si j'aime mon intérieur puis euh je lis beaucoup, j'ai mes études à faire mais ça me manque, ça fait tellement longtemps que, ça fait vingt-six ans que je travaille puis que j'étudie en même temps puis je suis impliquée dans d'autres activités en même temps, j'ai, j'ai fait trois vies dans une quasiment les vingt dernières et quelques dernières années puis là ça coupe carré depuis le mois de juin, c'est vraiment un arrêt là puis euh ça, ça commence à tomber en place, je commence à m'habituer à pas courir après un métro ou l'autobus euh me dépêcher à faire mon lunch le matin ou tu sais, toutes ces habitudes-là qu'on fait (?) **1**

Ex 41 P: puis je le comprends dans le fond mais je lui demande rien non plus, pour prendre son expression je lui demande même pas de "dealer" avec ça, c'est simplement que des fois c'est (?) puis je me dis bon si, si je me mettais à pleurer tout le temps, serait-ce une solution, **1**

Ex 42 P: puis qui, qui je suis parce que j'avais l'impression que j'étais juste un être là euh robot, c'est, c'est le, le sentiment que j'avais au printemps dernier, j'allais travailler, je faisais bien mon travail, je revenais de travailler bon j'allais voir mes amis, je faisais ci euh j'allais voir John la fin de semaine, tout était euh tout était automatique, tout était comme euh bien réglé comme, moi ça me fait toujours penser à un robot puis euh quand, quand au mois de juin tout a arrêté, la machine a brisé bien je pense que c'est ça, le robot a arrêté de fonctionner puis là j'essaie, j'essaie de, de, j'essaie de ramasser les morceaux, c'est long parce que des fois je suis follement optimiste, je m'étais dit deux mois là, je vais avoir tout compris puis euh ça va être parfait puis bon mais je m'aperçois que quarante-quatre ans dans une vie là euh tu peux pas régler ça en deux mois, c'est impossible puis vingt-six ans de travail que tu n'aimes pas puis de, de concessions que tu fais parce tu te dis que tu n'as pas le choix ou que tu te convaincs que tu n'as pas le choix puis tu arrêtes du jour au lendemain tu peux pas non plus (?) **1**

Ex 43 P: parce que dans les jours qui suivent, ça travaille en dedans puis euh des fois je comprends des choses suite à la rencontre, à partir de ce que je vous ai dit je comprends des choses ou des fois à partir d'une question ou euh ou même d'un court commentaire que vous faites, des fois je développe à partir de ça, je trouve des choses, c'est, c'est euh ça ça m'étonnait, ça m'a étonnée parce que je savais pas que d'une euh d'une séance à l'autre ça continue à travailler en dedans. Moi je pensais que dans une thérapie on travaille quand on est là mais c'est pas comme ça que ça fonctionne. **1**

Ex 44 P: parce que quand on fait ça l'écriture automatique comme ça en classe euh (s'éclaircit la gorge) on sait jamais qu'est-ce qui va sortir (toux). Le professeur nous met un thème au tableau puis on part à partir d'un thème, il faut pas réfléchir, on lève pas le crayon, quand il nous dit que c'est euh le temps est suffisant, on lui remet la feuille, il faut pas la relire puis d'une semaine à l'autre on oublie en plus ce qu'on a écrit parce que c'est vraiment fait au fil de la plume donc quand la semaine suivante on reçoit le, la feuille euh avec les commentaires du professeur, tout ça, au niveau de notre écriture ou des idées ou quoi que ce soit ou du ton euh du texte **1**

Ex 45 P: euh mon imagination dramatise et puis je pense que en tant qu'enfant je voyais ça tellement horrible que ça, ça a peut-être pris des proportions (?) puis euh c'est l'explication que j'aurais peut-être que si je me rends vulnérable, si je m'ouvre, on peut me faire du mal. Je, j'essaie toujours de garder (?) un certain contrôle. **1**

Ex 46 P: (rire) C'est ça, oui c'est ça. Il y a de ça aussi, je, si je me rends vulnérable euh qu'est-ce qu'on va faire avec moi, qu'est-ce, qu'est-ce que, ça va donner quoi, ça va, la seule personne avec, à qui j'ai pu le faire comme ça par petits morceaux c'est ce monsieur-là à qui j'avais demandé (?) à l'époque puis euh ça a pris quand même des années d'amitié avant que je lui fasse confiance puis euh j'ai, je lui ai fait vraiment une très grande confiance puis euh c'est pas seulement (?) la première fois je lui ai demandé (?) quand j'avais vu que ça avait pas fonctionné ou que peut-être à ce moment-là au moins ça pourrait me servir d'outil, j'ai réitéré ma demande, cette fois-ci je lui ai dit j'aimerais savoir, j'aimerais aller voir qu'est-ce que c'est qui s'est passé (?) puis ça a pas fonctionné, on a essayé une troisième fois pour voir, pour rien voir, juste voir s'il pouvait tout simplement réussir à me faire passer du niveau conscient à inconscient puis ça a pas fonctionné, là on a vraiment cessé de, d'essayer **1**

Ex 47 P: parce, je veux dire, j'aimerais ça avoir un écran puis vous l'ouvrir puis dire bon bien regardez c'est ça qu'il y a, qu'est-ce qu'on fait avec ça mais non, il faut que je le sorte, c'est plus difficile. **1**

Ex 48 P: ça reste encore actuel, je vois ça comme un espoir, c'est encourageant dans ce cas-là. De ce temps-là euh on dirait que je travaille sur tous les plans en même temps, sans le vouloir, je suis des cours de yoga actuellement, ça m'avait été conseillé par une amie qui a fait un "burn-out" puis elle dit que ça l'a beaucoup aidé ça fait que finalement

je suis ce cours-là. J'en ai déjà fait il y a longtemps tout ça puis je trouve ça difficile parce que c'est une discipline encore une fois puis euh c'est des exercices qui sont quand même pas euh naturels dans les mouvements qu'on va faire c'est toujours forcer le corps à se dépasser d'une façon ou d'une autre **1**

Exemples du Style Narratif Pour le Thérapeute (en anglais) :

Ex 1 T: hello. **1**

Ex 2 T: why? **1**

Ex 3 T: yes. this is different. **1**

Ex 4 T: you're right. people very often, uh, don't say certain things because if they they think the other person will have a reaction that they don't want them to have but here, you are being asked to say everything so I guess the only way you can do that with any comfort at all would be if you had some conviction that I'm not using what you say to judge you or be critical or whatever. **1**

Ex 5 T: to the best of my ability, I'll use it to try to understand you. **1**

Ex 6 T: that doesn't mean we may not, now and again, come to the symptom as such. **1**

Ex 7 T: no. I meant that you'll be talking about the symptom too directly. **1**

Ex 8 T: and as I also explained to you and; there are things one; you have to learn about this process as you go along. I do not intend to direct you in any way in so far as your behavior is concerned. what effects will come from the treatment will be applications you will make of what you have learned. **1**

Ex 9 T: you're right. one's mind never is a blank. **1**

Ex 10 T: part of what? **1**

Ex 11 T: it woke you up with a moan. **1**

Ex 12 T: yes. I think they do and, uh; and I suggest you; since I've suggested to you that you tell whatever occurs to you, if a dream occurs to you, then that's the thing to tell; just like you did. **1**

Ex 13 T: and we have a particular way of working with dreams which is really very similar to just the general thing you do; say whatever comes to your mind. that is to say, you take the individual parts of the dream; and just say whatever they make you think of and sometimes that brings light on it. **1**

Ex 14 T: well, if we take the individual parts of the dream; what does it make you think of that they were on a palm tree. **1**

Ex 15 T: when I express an idea, that's all it is, it's an idea. it could be right. it could be wrong and you'll react to it in one way or another. if you think it's right, you'll agree, if you think it's wrong and so on. **1**

Ex 16 T: another thing that gave me the idea was that when you said that, uh, some relatives of yours objected to the kids activities for fear they might go higher and higher and maybe fall and really hurt themselves. **1**

Ex 17 T: see, I did notice that in that article you brought yesterday. **1**

Ex 18 T: they just lay there? **1**
P: well, the actor or actress; you know. **1**
T: oh, I see. **1**

Ex 19 P: how could I forget that? that's what I wanted to say and then I forget it and a minute later, I remember it. **1**
T: how did you forget it? **1**

Ex 20 T: no. you never directly asked me but you are, I think, directly asking me now and I will answer it; yes. **1**

Ex 21 T: and these events are so few that they stand out in your memory so sharply. **1**

Ex 22 T: they're books? I thought they were magazines, **1**

Ex 23 T: how old were you when yours (tonsils) were taken out? **1**

Ex 24 T: again, it occurs to me that that might be some kind of a hint about the treatment. I was especially struck when you said earlier that you're not sure that her tonsils should come out, that maybe this is a doctor from the old school who just sort of does that automatically. I'm reminded of how you use to say sometime ago, it's true that you weren't sure that this was a necessary treatment for you. **1**

Ex 25 T: right. **1**

Ex 26 T: what do you think I said about your attention span? **1**

Ex 27 T: but somehow you took from what I said that I have the idea that your attention span isn't what it should be? **1**

Ex 30 T: he s going to be lucky? **1**
P: because I really not not rather be here because I'm just so; **2**
T:: how do you mean then, that I'll be lucky? **1**
P: (pause) I don't know if it's nice or not but it's that that rather than call up and say "I don't feel good. I'm not going to come. ' I show you I mean, you're lucky I don't call up and sap "I don't feel good today. " you know, I don't cop out.**2**
T: you mean, I'm lucky that you came at all. **1**

Ex 31 T: say that again. **1**

Ex 32 T: (both laughs) well, that's a prospect of real punishment, I agree with that. oh. you mean, if yo'd; if you have an enjoyable session here, then you got to go see your mother and have a miserable time so it's still fifty fifty. **1**

Ex 33 T: well, were you taught that everybody's life should be something like Jesus's? **1**

Ex 34 T: what does that expression mean, "offer it up? **1**

Ex 35 T: I noticed you said a while ago, that you think you understand that you punish yourself to make sure that bad things don't happen, so to speak, bad; but that you don't intend to give it up

Ex 36 T: I wasn't quite clear what you meant by saying, "possibly you'd done a injustice to the church. " you mean, they weren't as strict as you make them out to be? **1**

Ex 37 T: yeah, it's a little bit like you having said. from time to time, that you wish you had different parents. **1**

Ex 39 T: and what was the point you were going to make about if man is made in god's image? **1**

<u>Exemples du Style Narratif Pour le Thérapeute</u> (en français) :

Ex 40 T: Vous avez rien reçu? **1**
P: Non, parce que ça m'intrigue un peu bien que dans le fond je me dis ça, ça dérange en rien le, la psychothérapie comme telle. **1**
T: Non. **1**

Ex 41 T: Vous allez pouvoir leur demander quand ils vont... **1**
P: Ah oui? **4**
T: ...ils vont vous contacter. **1**
P: Ah ils vont me contacter? **4**
T: Ils sont supposés, oui. **1**

Ex 42 T: Par exemple. **1**

Ex 43 T: Ça c'était vos oncles? **1**

Ex 44 T: Pseudo-suicidaires? **1**

Ex 45 P : puis je savais (?) ça c'est euh j'ai l'impression que j'ai suivi un peu son modèle là-dessus. **001**
T: Pas mal. **4**
P: Oui. **1**
T: Pas mal. **1**

Ex 46 T: Bien, vous travaillez dans le présent parce que il y a une petite fille qui a été abandonnée et elle est encore là et vous savez pas si vous avez adopté une attitude envers elle si différente que ça, de celle que vos parents ont eue et de celle que vous avez eue. Si la petite fille qui a été abandonnée a été abandonnée par vos parents, oui c'est vrai, elle a été abandonnée par vous aussi. Tout le lisse, tout le lisse que vous présentez, de, de (?) bien c'est au prix d'une chose, entre autres c'est que celle de votre histoire de l'autre jour, elle est restée tout seul celle qui a vécu des émotions très fortes devant ses oncles, son père qui l'a sexualisée de façon trop tôt même si elle paraît quatorze ans, une façon trop tôt, d'une façon euh négative parce que ce que vous décrivez c'est que ça avait pas l'air très plaisant. **1**

Ex 47 T: Donc quand vous dites, on devrait travailler dans le présent, on travaille aussi beaucoup dans le présent parce que tout ce dont vous parlez c'est très, très présent à mon sens. **1**

Ex 48 T: Comme tantôt quand vous avez failli de pleurer, c'est très présent. **1**

Ex 49 P: Depuis le début, est-ce qu'on avance dans tout ça ou on tourne en rond? Il me semble que je trouve les clés, est-ce que ça avance, est-ce que c'est encore aussi lisse? **4**
T: Oui, c'est pas mal lisse. **1**

Ex 50 T: Bien regardez, regardez là où vous êtes partie depuis que j'ai parlé, vous êtes retournée dans le lisse aussi vite que possible. La première partie de la séance était pas lisse du tout. **1**

Ex 51 T: A votre surprise vous vous étiez rendue très vulnérable, très ouverte mais aussi vite que possible vous avez tout refermé de sorte qu'on pourrait dire quand on regarde la première partie de la séance, ça avance, ça avance puisque euh vous décidez de vous rendre plus vulnérable à moi et à vous-même, ça avance mais soyons patients parce que il y a d'autres parties de la séance où aussitôt que j'ai parlé, aussitôt que j'ai pu mettre le doigt là-dessus, hum, ça c'est refermé. **1**

Ex 52 T: Mais ça ressemble un peu à ce que je vous disais plus tôt dans la séance, que vous devez, je me souviens plus de la phrase, c'est dommage mais que vous deviez me trouver fatigant puis là à la fin de la séance comme ça vous revenez avec l'exemple du professeur de yoga... **1**

Ex 53 T: Mais c'est sorti pas longtemps après au cours de yoga. **1**

Ex 54 T: On va s'arrêter là-dessus aujourd'hui. **1**

Style Dramatique avec « Suspense »

Exemples du Style Dramatique avec « Suspense » Pour le Patient (en anglais) :

Ex 1 P : is that; is that part of finding out what the problem is. I mean, uh, is that the way, uh, you can find out maybe, possibly, what could be causing the other problem. **2**

Ex 2 P : I mean, how does a person lay here and say every thought that's supposed to come to his head to someone when they normally don't do that, you know. a lot of things a person keeps inside, they think but they don't say it and that's different too. that, uh; that's getting to be unusual. it, uh; I mean, some things you think and you say and the other things you think and you just don't say them, you know. you just, uh; they stay in but like the last two days or so, it, uh; I mean, everything that came to my head, I was saying and, uh, when you start thinking about saying everything you're thinking, it's; you know, you wonder; gee; mm. **2**

Ex 3 T: you're right. people very often, uh, don't say certain things because if they they think the other person will have a reaction that they don't want them to have but here, you are being asked to say everything so I guess the only way you can do that with any comfort at all would be if you had some conviction that I'm not using what you say to judge you or be critical or whatever. (E:WB)(6)(S:WB) **1**

P: are you using it to (sighs) maybe, in the long run, uh; **2**

Ex 4 P: to get back to that that one problem. it seems like we talk about everything else and I'm wondering if everything else has got to do with that problem, you know. it does and it doesn't because most of my life is, you know; I enjoy being a housewife, I love my kids and I like all that. the only part is that one part when I get very nervous, scared, upset to go somewhere **2**

Ex 5 P: no one else knows; I don't lay or talk to anybody like this (laughs) and tell them things I feel or things that go through my head and you talk with your husband and your mother or your sister but this is different; this is, uh, getting to take a different, uh; I don't know; something different in my life, that's for sure. (laughs) **2**

Ex 6 P: I thought maybe **2**

Ex 7 P: how am I going to tie this in? uh, oh, I had the trend of thought and it just; I don't know where it went. I was tying it in to what you had said; that personally; **2**

Ex 8 T: say that again. you take it; **2**
P: the failure like, you know. **2**
T: at what? **1**
P: uh, oh, I don't know. that when things; people, uh; **2**

Ex 9 P: right. and to myself, I really feel that way. I mean, if; even if it's something minor, it's, (sighs) **2**

Ex 10 P: no. I can understand now sort of why it has to take longer than I imagined, uh, it; you know, I'm beginning to understand that and I'm beginning that that time element I had set in my mind, doesn't really matter, uh; **2**

Ex 11 P: Mmm - like I told *nick, he he wanted to know what I was talking about, you know and I said, "it's hard to say, you know. you just can't explain what goes on here. " I said, "it's different. " in a way, **2**

Ex 12 P: in a way, but like you're reassuring when when you talk and, uh; I don't know, uh; I did tell *nick, "I don't know what I expected. I guess I expected some theories he'd pour out and make sense. " I said, "but it's not taking it on that way. " you know, I never went to a psychiatrist before, you know, and you see them in the movies they just lay there and talk and every once awhile, the doctor says; **2**

Ex 13 P: it's something that takes time, I guess. I guess I have adjusted; I guess adjusting to the daily, uh; not just the fifty minutes or the hour but just adjusting to the way things are going to be or (sighs) well, I don't know. I guess, what I was going to say was that; what was w expected of me but, uh; it's hard to put it in words, so; (sighs) just, uh uh, unusual. **2**

Ex 14 P: well, it seems like I think I remember asking you this once before or I've asked it so many times in my mind that I was going to ask you; **2**

Ex 15 P: okay. that's all I wanted to know. it hurts in a way and yet, it's good to know. uh; **2**

Ex 16 P: I know. but it just; **2**

Ex 17 P: can the subconscious and the conscious; I don't know; I'm not putting it right. uh, when I've got nothing else to do and I'm just sitting there or, you know - it gives my mind a chance to go get nervous or I don't know. I think I'm inadequate or don't have the confidence and then it brings it on. **2**

Ex 18 P: right. I expect a lot and when I don't live up to it or; **2**

Ex 19 T: they're books? I thought they were magazines, **1**
P: magazines. oh: ; (sighs) (sighs once more) I don't know. **2**

Ex 20 P: my ma; the time I did come home, I think I was even home a week and I remember someone knocking on the backdoor - I remember coming in the kitchen; my mother was already answering the door; and it was the truant officer wanting to know how come I wasn't in school, you know, when I look back on it now you know, like I mean, **2**

Ex 21 P: I think I'm just tired of thinking (sighs) and hm - I just wish this was over with for ericka's sake too and I guess just not letting ericka be aware of how I feel either; **2**

Ex 22 P: I'm probably coming down with something; probably. I don't know. (pause sighs) (sighs) **2**

Ex 23 : P: it's like if I can't be; and I says well, dr. johnson's going to be lucky, he's going to get me today, I don't want to go but he's going to get me today. " (sighs) **2**

Ex 24 P: because I really not not rather be here because I'm just so; **2**

Ex 25 P: (pause) I don't know if it's nice or not but it's that that rather than call up and say "I don't feel good. I'm not going to come. ' I show you I mean, you're lucky I don't call up and sap "I don't feel good today. " you know, I don't cop out.**2**

Ex 26 P: I don't think I'm very good company today for anybody (sighs) you know, other than my own family it seems like I can hide certain irritations or what I'm feeling from them ? cause I enjoy their company but I guess, strangers, I guess, I just don't feel like; **2**

Ex 27 P: and that I shouldn't have been so happy. I'm going to get punished for being happy. I'll get punished like that; **2**

Ex 28 P: yeah. and I think I have to work out something where I can balance it out again. I justify what I'm doing. **2**

Ex 29 P: I think I've I've I've done an injustice to the church by being sop uh (pause) you know but every single thing they said that it; you know, it's not a very good outlet but then they were reinforcing a lot of this stuff which confuses me. **2**

Ex 30 P: you know, if my parents would have been a little different. I think it would have helped a lot more like if they just would have bad friends; if they wouldn't have knocked people down so much and I think they're wrong for doing that, I think then they're; **2**

Ex 31 P: I don't even believe in Christ; some figure that was built up in history. but - and the same with the immaculate conception and how she was conceived, (sighs) **2**

Ex 32 P: questionable. very questionable to me, (sighs) same with the mystery of the trinity. all three are supposed to be, who knows involved with each other somehow. gods the son and the holy spirit. there are; there are things, you know, I have studied and I have read and there's so many, you know; you could believe them but (sighs) **2**

Ex 33 P: I don't know what you mean by that. I've got a bunch of I've probably got the wrong ideas. **2**

Ex 34 P: yeah. still carrying on - but sometimes I think other than this sexual stuff, uh; **2**

Ex 35 P: other than all this sexual stuff - implied and stuff; it's just that; o that you just can't be happy, you are just not allowed to be that way; you cannot - I mean, he was so strict about everything and; and and I mean, **2**

Exemples du Style Dramatique avec « Suspense » Pour le Patient (en français) :

Ex 36 P: euh (soupir) oui je, j'ai pensé cette semaine, il y a un sujet que j'ai pas encore abordé puis pourtant c'est, c'est un point qui me dérange beaucoup. **2**

Ex 37 P: C'est un livre un peu, qui m'a un peu dérangé parce que je m'y suis retrouvée beaucoup. **2**

Ex 38 P: Ça je voulais vous en parler puis euh j'avais pas trouvé l'élan encore pour le faire mais avec ce livre-là, ça, ça (rire) ça m'a permis de valider un peu le doute que j'avais, l'impression que j'avais, que je traînais dans le fond euh une image qui correspond pas à celle que je suis puis des fois que, que ça, ça dérange mon euh comment je me sens en public, ma façon d'être, ma façon euh de me sentir avec le monde. **2**

Ex 39 P: Puis déjà euh mon père euh puis ses frères euh quand ils venaient faire un tour faisaient beaucoup de taquineries parce que j'ai été euh j'ai euh j'ai commencé à avoir du buste euh évident très jeune puis ma mère en a à peu près pas alors ça on, j'avais toutes sortes de surnoms puis des quolibets. **2**

Ex 40 P: Non, j'ai jamais pensé ça parce que j'ai beaucoup de projets puis euh si je veux les (?) si je veux les réaliser, ça me prend du temps donc il faut que je vive quand même encore un peu donc ça j'ai pas euh j'ai jamais eu cette impression-là. Surtout que (soupir) j'ai été longtemps, longtemps euh peu attachée à la vie, à faire toutes sortes de, à avoir pris toutes sortes de paris stupides dans le fond. **2**

Ex 41 P: C'est le genre de folie que je faisais ou euh (soupir) ou je demeurais près de, des écluses qu'on appelle la dame à Laval puis euh à cinq heures pile euh ça ouvre et puis là bien ça tombe une chute d'eau (soupir) puis il y a des pierres puis euh à chaque, j'essayais toujours de me rapprocher de cinq heures pour, pour avoir juste à peine le nombre de secondes que ça prenait pour (?), **2**

Ex 42 P: une des, il y a sûrement eu des, des euh des phases aussi dans ma période adulte là euh à partir du moment où j'ai quitté ce foyer-là, il y en a eu des problèmes à l'intérieur de mon mariage, je vous en ai parlé euh (?) **2**

Ex 43 P: Mais d'un côté, je trouve ça encourageant parce que dans le passé, on peut pas les, je peux pas aller refaire les, les réactions que j'aurais dû avoir, je peux plus les avoir

aujourd'hui mais par contre, ce que j'ai traîné puis que j'ai en, le tableau que j'ai dans le moment, ça j'y ai accès j'ai l'impression. **2**

Ex 44 P: je pense pas, j'ai pas voulu élever mes enfants avec un, avec des réactions comme ça, souvent j'avais, j'aurais eu envie de pleurer ou de me fâcher ou quoi que ce soit mais je voulais, c'était tellement important pour moi de leur donner une stabilité, de leur donner au moins une impression d'équilibre quelque part puis euh il y a une partie de moi qui est encore convaincue aujourd'hui que c'est la seule issue que j'avais. **2**

Ex 45 P: mais j'ai pas envie de pleurer, ce que je ressens ces temps-ci c'est plutôt de l'impatience parce que là je commence à avoir vraiment hâte de trouver du travail puis euh faire quelque chose d'autre puis apprendre quelque chose d'autre puis apporter quelque chose (soupir) puis ça je trouve ça long, je trouve ça long (?) **2**

Ex 46 P: c'est là que j'ai réalisé que c'est devenu tout à fait naturel puis j'ai continué mon chemin puis j'ai dit quand c'est rendu que on sait d'avance dans le métro qu'on va recevoir un coup de coude ou qu'on va se faire frapper ou euh **2**

Ex 47 P: (rire) (?) Oui. Bien si à chaque fois il y a une brèche qui s'ouvre, ça avance, c'est comme ça je vois ça (rire), si c'était lisse à chaque séance tout le long de la séance (?) **2**

Ex 48 P: J'ai bien de la misère à pas faire ça, bien de la misère, c'est, c'est maître à moi, je vais observer vos titres de livres pour voir ce que, ce que c'est, qu'est-ce que c'est que vous lisez ou euh je vais voir le mot vulnérabilité, je vais voir euh tu sais, il y a un tas d'aspects, il y a un tas de choses qui vont me frapper, c'est euh ça marche tout le temps, tout le temps là-dedans, c'est euh, je suis beaucoup visuelle, tout ce que je vois euh tout ce que je vois amène d'autres choses mais comment est-ce qu'on arrête ça ce processus-là, c'est un automatisme chez moi, c'est pas facile (rire) arrêter ça du jour au lendemain. **2**

Ex 49 P: il y avait une nouvelle euh pas une nouvelle, un récit dans lequel la conclusion en arrière de ça là c'est que le personnage c'est comme s'il se disait dans l'histoire si je me rends vulnérable je vais mourir c'est aussi grave que ça puis euh ça j'ai pas aimé ça (rire) j'ai pas aimé ça euh cette histoire-là euh je, je pensais même euh d'avoir jeté ma feuille **2**

Ex 50 P: c'est pas des nouvelles choses, c'est toutes les mêmes peurs, la même peur qui fait que pourquoi il m'a laissée tomber, tu sais, **2**

<u>Exemples du Style Dramatique avec « Suspense » Pour le Thérapeute</u> (en anglais) :

Ex 1 T: yes. you are right. that's one thing that seems strange about this procedure. you have this major symptom and we don't attack it directly **2**

Ex 2 T: so naturally, you're wondering is all this going to (E:WB)(7)(S:WB) result in helping that. **2**
P: right. **1**
T: hopefully, yes. that's the idea. we go at it indirectly. **2**

Ex 3 T: yeah. but anyhow, it's it's; **2**

Ex 4 T: I have an idea about the dream. uh **2**

Ex 5 T: but I put it that way because I think you should know about this and a lot of other things. **2**

Ex 6 T: the idea I have comes partly from one of the things you said earlier today and what happened at the end of the hour when you were dizzy because when you talked about his losing his balance and falling possibly, I thought of that. **2**

Ex 7 T: and I put that together with your telling me that you have some sense that your parents don't exactly approve of this treatment. **2**
Ex 8 T: say that again. you take it; **2**

Ex 9 T: oh, you mean, your father treated you in such a way that if something goes wrong, **2**

Ex 10 T: I thought maybe the palm tree, uh; **2**

Ex 11 T: I'll tell you why I asked. I was trying to understand that business of carrying a canteen **2**

Ex 12 T: the toilet part? **2**

Ex 13 T: and maybe you're expressing some concern about how it's not working out like you want it to. I'm trying this, that and the other recipe but, **2**

Ex 14 T: oh:; **2**

Ex 15 T: say that again. **1**
P: is punishing and sacrificing and so forth **2**
T: you don't; **2**
P: I'm aware of it ; **2**
T: yes. **1**
P: but I refuse to give it up. **2**
T: oh. **2**
P: Tuesday won't work out right. **2**

T: mm-hm. I wonder if it could also find an expression here in the session. I notice you; I didn't quite understand what you meant; at the very beginning you said you were comfortable out there, uh ; **2**

Ex 16 T: you mean, you think my position is that it's really neurotic, uh, for a person to punish themselves this way and you agree but; **2**

Ex 17 T: there's another idea that I would like to suggest to you; although it doesn't tie in too concretely or immediately with what we're talking about but who knows who have said that your father's mistreatment of you had unconscious sexual meaning for you **2**

Ex 18 T: I think that the possibility that should be considered is that suffering does too; the kind of suffering we are talking about now **2**

Ex 19 T: sounds to me like this could be connected with the various things we've talked about in terms of a possible sexual interest that your father had in you. (pause) **2**

Ex 20 T: sometimes you think what, . , ? **2**

Exemples du Style Dramatique avec « Suspense » Pour le Thérapeute (en français) :

Ex 21 T: C'est parce que je me demandais si avec le fardeau mental, le poids mental, il y avait aussi l'impression que, ah il vous en reste pas tellement. **2**

Ex 22 T: ...mais dans le fond vous devez vivre ça ici aussi par rapport à la situation ici. **2**

Style Dramatique avec « Impact Esthétique »

Exemples du Style Dramatique avec « Impact Esthétique » Pour le Patient (en anglais) :

Ex 1 P: well, he asked me; *nick even asked me, he said, "what do you tell him? " I said; "did you tell him about your brother running away? " I said, "yeah. I told him that already. " I said, "there's a lot of things I haven't told him" you know. **3**

Ex 2 P: *nick's father was over Saturday when they were doing this and, uh, they had mentioned that there was a neighborhood boy that was doing it; but I don't know, I think they were doing it much more severely; higher up and getting up in the air; and he didn't land his bicycle right and his face went right into the pavement so, uh, you know, they were kind of frowning on the fact that *nick and *ericka; *sparky and *ericka were doing that. uh; **3**

Ex 3 P: I don't know if it's that; possibly, possibly. because he he if he would have seen the kids up that high, he would have had a conniption. **3**

Ex 4 P: it was; it was a type of security; like a teddy bear type of thing, you know. **3**

Ex 5 P: uh, like my brother's left home; I've mentioned and she gets on me and says, "doesn't he care about us; about our feelings? isn't he worried about us? I mean, we've done so much in our life for him> " and I'm trying to tell her, "mother, I don't know. I haven't talked to him. " you know, uh uh, I understand he went and stayed with my brother and my brother is in *colorado now; these two weeks; and, uh, *louis's kind of taking care of the house and his two german shepherds so - I'm sure *louis, himself, has enough to keep himself busy with with getting his own clothes ready; his own food; getting himself to work. **3**

Ex 6 P: I just think he got fed up with the situation and (E:WB)(32)(S:WB) left. he just doesn't like all that third degree which is, uh; I think a lot of that is uncalled for but, uh; **3**

Ex 7 P: (sighs) I; you can't get him to talk about something. if he doesn't agree with you, he flies off the handle and shouts and hollers real loud. like you can't really discuss anything with him. **3**

Ex 8 P: and, you know, it's just; it's really different. it's unusual for me. it's not a normal part of my life. it's something I've never done before I guess, like I explained before, it's not something cut and dry. **3**

Ex 9 P: before he used to always put us down, you know. he (E:WB)(49)(S:WB) never said anything; he really felt, just belittled us, in a way. and one other time was, uh, I, uh; I wonder if I did this just to please my parents too. I, uh; I decorate cakes; I bake and decorate cakes and I did a wedding cake for my brother and it was three tiers and I had the water

fountain and had it decorated with orange roses all over and we were at the wedding reception and I was a wreck; oh, gee I had such a pain in my chest, I couldn't move. I was just; my nerves were shot, I guess, and my father actually said that was a beautiful cake. I just; you know, I just, you know, couldn't believe he said something like that. he can, you know, but he just doesn't give it. uh; **3**

Ex 10 P: she said "you don't know what can happen. you can die under anesthesia. your heart can stop beating. (sighs) and that's what her biggest fear was and I keep hearing this over and over in my mind about what she said and **3**

Ex 11 P: I got it all figured out. I got it figured; I just; the dawn has just come; **3**

Ex 12 P: and I would bust my ass far two or three days before we'd go out. **3**

Ex 13 P: yeah. I wonder if this has got to do with anything with like Christ and suffering and being on the cross and three days, after, you know3D all glorious and you're supposed to set your life; you're supposed to carry a cross **3**

Ex 14 P: well, I feel that you feel it's a little farfetched to do things like that and I agree. **3**

Ex 15 P: uh; it depends upon the individuals too that who knows it's; I know; ohs at least, three or four nuns who aren't nuns anymore, you knows that that gets confusing too. I mean, when I knew them, they were so all holy and righteous and so forth and now you know, they're they're different, you know, they're completely they're mad with the church they're very angry with the church, (sighs) and the church looks at them and says they're going to burn in hell, so what's the difference, you know. thor say; it's (sighs) ; like even with birth control - I'm committing a mortal sin everytime I take one of those pills but yet I firmly would prefer not having anymore than two children. I mean, that's how I really feel. and yet, (sighs) oh, you can run into one individual priest who will say; well, the church will change and then you can run into another one who says, that I'm going to burn in hell (sighs) and like even my mother said the other days she said well, I always told you kids to make up your own mind. " and I looked at her and I says, "bull shit, you've only been saying that the last couple of years. " I says "growing up, there were many times when you said, who knows what we did was very wrong and if we didn't change our ways weld end up you know where. " and she said, 'no. I didn't" I said "ma, will you please stop to think about it. you weren't this way. it's just the last few years that you have changed a lot of your viewpoints. " and she she kind of hesitated and said, "I guess so, " you know. **3**

Ex 16 P: in fact, I wish there would have been, then it would have been a little bit more human which would; I mean, they went around covering everything up with fig leaves, for pete's sake, (sighs) **3**

Ex 17 P: I hope so. I really do, I believe that for God. I don't know about that but I believe that for God. it's got to be, dr. johnson. it's just got to be. (sighs) **3**

Ex 18 P: I mean, not one God damn sentence of encouragement; not; you know, not even an ounce; nothings you know, ; like I said, the first time I could ever remember was that time he came up and told me that the wedding cake I made for my brother's wedding was really beautiful and I thought I was going to fall through the floor, I mean, that's the first time in our whole life, he ever said anything nice and that that kills me. that really kills me. I can't understand the way he can't give any of that; has that got to be sexual? I mean, on his part; that you can't tell another human being that, yes, they did a nice job Dr even children growing up, couldn't he be parent enough to know that they need that. I mean, why was there always this degrading; no confidence in what your kids can do; none. I "I don't understand him for that, I don't. maybe it's hard for you to realize that that a person can be that restrictive about giving a good word to somebody but that's the way he was with me. I can't understand why he's that way and if it's sexual, that still doesn't make enough sense to me. even if it's sexual; that should hold him back so much as one person to another person; as a human being to another human being; not to give a kind word or a good word about something that that; **3**

Exemples du Style Dramatique avec « Impact Esthétique » Pour le Patient (en français) :

Ex 19 P: Ça fait que ça c'est un point qui se (soupir) j'essaie de, de, j'essaie vraiment de, comme je disais la dernière fois que je vous ai vu, d'y aller au bord du mur euh j'y vais un peu comme on va à la pêche, tu sais, je vais chercher ce qui, ce que je pense qui sont les clés pour ouvrir les tiroirs, puis ça ça en est une, puis j'ai essayé après ça de dire bon bien ça a commencé où ça cette histoire-là. Le plus loin que je peux me rappeler, c'est dans l'adolescence euh l'adolescence euh tôt là, douze, treize ans. Ma mère c'est une personne grande et mince euh qui euh était pour moi comme euh un modèle à l'époque, je la trouvais tellement élégante, puis belle, tout ça puis élégante. **3**

Ex 20 P: parce que je, je me sentais comme euh (soupir) à l'époque, c'est clair dans ma tête, c'est, peut-être comme si j'étais un bloc, tu sais, tout, tout pris ensemble, tout euh compact, c'est exactement l'image que j'avais de moi. **3**

Ex 21 P: puis pourtant, quand mon père buvait trop, là, je, pour l'adolescente que j'étais qui était jeune puis qui avait pas d'expérience, je comprenais pas qu'il me trouvait rien de positif puis euh dès qu'il buvait il m'amenait dans un coin puis il m'embrassait à pleine bouche puis ça, ça, ça me dégoûtait totalement. J'avais horreur de ça puis euh (soupir) je lui faisais payer un peu parce que euh souvent quand il buvait trop euh il venait me retrouver puis il pleurait, j'étais bien dure avec lui, je lui disais que ses larmes il pouvait les garder pour lui, que c'était la boisson qui lui sortait par les yeux puis (?). **3**

Ex 22 P: entre parenthèses, quand j'interprète ça, il me semble que c'est ça, euh je me suis privée toute ma vie puis c'est, en fait je mange jamais à ma faim, tu sais, c'est, c'est euh c'est embêtant. **3**

Ex 23 P: J'ai cent-trente quelques livres mais j'ai une vingtaine de livres de poids mental, c'est comme ça que je le vois, puis j'aimerais tellement m'en débarrasser, j'aimerais, pour le temps qu'il me reste à vivre, x années (s'éclaircit la gorge) me débarrasser de ça, un peu comme on prend un fardeau puis on le met par terre **3**

Ex 24 P: Il s'est mis vraiment en colère puis il m'a pris par le bras puis il m'a montée euh sur l'estrade en avant puis il dit euh il dit voici quelqu'un il dit qu'on appelle une personnalité euh de ratée typique puis là il s'est mis à, à me dire, à dire plein de choses dans la classe euh il dit on voit tout de suite c'est une personne qui veut pas s'aider, c'est une personne qui vaut ci, puis pourtant j'avais des notes fantastiques dans toutes les autres matières. Mais lui avait comme euh décidé que j'étais ou il s'était pas informé peut-être sur le reste du tableau que j'avais au point de vue scolaire mais il m'a, il avait dit ça euh ratée euh un moment donné je m'étais comme fermée puis j'écoutais plus puis euh puis quand il m'avait demandé de descendre de l'estrade j'étais gelée, j'étais plus capable de descendre. **3**

Ex 25 P: mais euh je me suis plus souvent souhaité que, que (?). Mais c'est toujours quelque chose qui m'empêchait de faire le pas, je pense que, je crois pas que je serais allée jusqu'au suicide, je frôlais toujours mais jamais aller jusqu'au suicide puis mes parents avaient tellement de médicaments à leur maison que j'aurais pu me faire un cocktail n'importe quand euh ça aurait pu remplir facilement euh quatre tablettes de la bibliothèque, c'est effrayant les médicaments qu'ils prenaient puis pour rien, puis non, j'ai pas été attirée à faire ça, **3**

Ex 26 P: tout ce qu'il y avait de positif c'est la relation que j'avais avec ma grand-mère puis ma mère l'aimant pas tellement, je la voyais pas beaucoup donc euh il n'y avait rien d'autre puis euh puis les garçons, les garçons, j'avais vraiment pas de difficultés à les avoir après moi puis euh (soupir) c'est leur amitié que je voulais, tout ce que eux voulaient c'était m'amener dans un coin (?), ça m'attirait pas plus que ça, je faisais la drague avec eux puis euh la difficile à obtenir, celle qu'on gagne pas (soupir) je jouais à disons l'inaccessible **3**

Ex 27 P: Par la suite bien euh ça j'avais quinze ans, après quinze ans, après cette fois-ci, peut-être j'ai réalisé que ça aurait pu fonctionner euh (soupir) je me, je me suis mise, parce que j'écrivais depuis l'âge de huit ans, j'écrivais beaucoup, beaucoup alors je me suis comme jetée là-dedans, ça puis le dessin, le dessin, la peinture, l'écriture, je pense c'est un peu ça qui m'a sauvée (rire) de, de, d'avoir des idées morbides, je me suis mise à avoir plus d'amis aussi euh je me suis euh j'ai été nommée présidente de ci, de ça euh j'ai dirigé beaucoup de choses puis euh je devenais plus créative euh j'étais tellement occupée que je voyais presque jamais mes parents, c'était l'idéal **3**

Ex 28 P: puis j'en cherchais puis après ça ma mère, je disais, ah elle je vais lui en trouver plein de qualités, je suis certaine, je dis, elle est propre, elle est travaillante puis elle a beaucoup de sang-froid dans les urgences, bon, puis là je cherchais (rire), je cherchais

mais j'ai vraiment pas rien trouvé d'autre puis là quand je suis arrivée à la section des défauts, je l'ai pas fait parce que j'avais comme l'impression que j'en trouverais cinquante mais je l'ai pas fait (rire) **3**

Ex 29 P: Puis euh (soupir) puis c'est pas, parce que je disais que ce qui me dérange le plus actuellement c'est que je suis obligée d'aller toujours chercher dans les mêmes tiroirs, **3**

Ex 30 P: A date là j'aurais pas pu vous parler sans être comme ça, tout le temps, jusqu'à temps que je me force puis ça m'a pris une discipline épouvantable (rire) (?), ça a été tellement difficile. **3**

Ex 31 P: Oui. Mais c'est toujours (?) (rire) quand, quand j'éclate en larmes, (?) c'est euh ça m'est arrivé quelquefois avec John mon ami (?) (soupir) on dirait qu'il s'attend pas à cette réaction-là de m1a part, c'est comme euh (rire) c'est comme pour lui euh une chute d'eau là qui, il sait pas, il sait pas quoi faire avec ça, il voit que, comme il m'a déjà dit, il dit il y a des gens qui pleurent mais il dit toi il dit quand ça, quand ça t'est, le peu de fois j'ai vu en dix ans où ça t'est arrivé, il dit c'est du désespoir que je vois, il dit ça je sais pas il dit comment "dealer" avec ça (rire) **3**

Ex 32 P: Aujourd'hui je pourrais, aujourd'hui surtout que j'ai beaucoup de temps toute seule, si je voulais euh pleurer sur (rire) mes misères là, ça serait le temps **3**

Ex 33 P: comme euh un moment donné dans le métro je me souviens, un peu avant que, que j'arrête de travailler au mois de juin (s'éclaircit la gorge), il y a un gars, seize, dix-sept ans, qui courait, je sais même pas pourquoi il courait, beau bonhomme puis il s'en venait dans ma direction puis euh il y avait plein de monde puis je voyais que s'il faisait pas attention il était pour m'accrocher, j'ai essayé de m'organiser pour qu'il m'évite puis finalement bien à la dernière minute il a comme fait un faux mouvement puis je l'ai vraiment reçu comme on reçoit (rire) ça me fait penser à un joueur de football qui va recevoir un coup, **3**

Ex 34 P: j'ai déjà vu des gens euh tomber par terre puis euh se faire à peine aider ou quoi que ce soit, quand on est rendu qu'on trouve ça normal parce que ça fait tellement d'années qu'on reçoit des coups, je pense qu'il est temps que j'arrête, il est temps que je sorte un peu de cette jungle-là pour savoir où je suis **3**

Ex 35 P: euh c'est toujours un peu une surprise pour la plupart des élèves ont cette réaction-là, ce qui m'a étonnée, c'est de voir comment c'était mon inconscient qui écrivait, qui parlait à ce moment-là, c'était pas mon conscient, c'était l'autre bord du mur puis j'aime pas toujours ce qu'il y a l'autre côté puis ça euh en, en les relisant euh cette semaine euh c'est ça j'ai euh j'ai vu que, un peu comme les morceaux de puzzle, tout commence à coller ensemble, les choses que je vous, que je viens dire ici souvent les mêmes thèmes

reviennent et reviennent aussi dans les textes, c'est la même chose dans le fond (?) j'essaie de, de coller ça ensemble. **3**

Ex 36 P: Quand mon père faisait des colères il disait euh j'étais toute petite puis il me disait je vais te passer à travers le mur ou euh je sais pas des choses de même, c'était surtout, surtout celle-là qui revenait parce que dans ma tête d'enfant là, je me voyais projetée à travers le mur puis en ressortir en bouillie, je trouvais ça absolument là euh horrible comme idée quand j'étais petite fille, il me disait souvent ça quand il était en colère ou je vais t'écraser, des affaires comme ça **3**

Ex 37 P: c'est, c'est dommage, c'est dommage qu'il n'y en a pas qui ont une baguette magique là puis euh ils peuvent tout aller voir d'un coup sec, tu sais, **3**

Ex 38 P: Si c'était passé puis je voyais ça comme euh comme un fardeau qui est soudé après moi là, je saurais pas comment l'enlever mais si le problème est actuel, si je le traîne de façon actuelle, active (?) comme ça, je peux le mettre par terre un moment donné, il est pas soudé après moi, je fais simplement le transporter, **3**

Ex 39 P: puis euh (soupir) hier bien il fallait euh faire euh cet exercice qui consiste à avoir la tête par terre puis les pieds en l'air (rire) je réussissais pas puis là le professeur un moment donné il dit écoutez euh faites de telle façon, il a pris mes pieds, il a mis mes pieds au mur, quand il a senti que j'étais stable, il m'a laissée et puis euh puis là bien me voir comme ça les deux fers à l'envers (rire) quelques secondes ça allait mais j'ai réellement paniqué un moment donné, le corps s'est mis vraiment à trembler puis je ne me rappelais plus comment descendre alors je me suis laissée tomber, je me suis fait très mal parce que ça m'a fait un coup comme euh tu sais, quand il y a un accident d'auto ce qu'on appelle un "whiplash" (rire) je suis tombée puis là bien je, là j'étais en colère, j'étais bleu marin (rire) puis là je, je demande au professeur à quoi ça sert votre exercice complètement stupide (rire) là j'étais vraiment fâchée puis euh c'est un indien, très calme il me répond que il dit euh ça sert tout simplement à vaincre vos peurs, il dit probablement il dit qu'il en reste encore beaucoup, c'est pas mêlant, je l'aurais frappé (rire) tu sais, je me disais même là, tu sais, je viens ici pour me détendre, je viens pas ici pour travailler, je viens bon puis même là je suis confrontée encore au même miroir. **3**

Ex 40 P: Ah oui, oui, c'est lui qui a écopé de ça parce que je me disais euh j'ai, je suis pas ici pour me faire faire mal, pour me faire mal, je suis pas ici euh pour me faire dire que j'ai des peurs, ça c'est, c'est un autre docteur (rire) ça a pas rapport au yoga mais dans le fond quand je disais tantôt, c'est toutes les, tous les mêmes euh c'est toutes les mêmes blessures dans le fond qui, qui, qui s'ouvrent puis qui essaient de se fermer en même temps, je sais pas trop comment l'expliquer, c'est tout les mêmes bobos qui se réveillent en même temps. **3**

<u>Exemples du Style Dramatique avec « Impact Esthétique » Pour le Thérapeute</u> (en anglais) :

Ex 1 T: yes. I think you may have the idea that that's what this is for; that you're supposed to fish out all the terrible things about yourself and I'm just waiting to hear them and then I'll be real critical. **3**

EX 2 T: all right. so there again, there are relatives disapproving of something that somebody is doing so the idea I have is that that may represent; the kids may represent you in the dream and that you are afraid about this treatment and you say to yourself; oh, my goodness, if I; if I do this, how do I know what I'm going to do next. I'm going to go higher and higher. if I tell dr. *johnson the intimate, personal things about myself and dig up all of this stuff; my God, how do I know what's going to come next and I'm afraid that I might; I might go too far and I might lose my balance and fall and really do myself some damage. **3**

Ex 3 T: I will be critical and scold you and say you're worthless and a nothing and wave my hand and heaven knows what else. **3**

Ex 4 T: drop those things that you carry around with you that that; for a kind of security and to make sure everything's; is okay, you know (laughs) be free, you know, and let her rip two forty (pt. laughs) and so (E:WB)(28)(S:WB) I thought maybe you clutched your purse like, uh; **3**

Ex 5 T: and here we are horsing around with dreams and; **3**
P: no; **1**
T: and talking about everything under the sun, huh? **3**

Ex 6 T: I think, maybe in a way, you forget it because it's so terribly, terribly important to you that you're almost afraid to say it; that you're scared; and so you're saying to me; look, this is new and I'm trying and I'm doing my best. now, don't get so impatient and don't be ready to write me off and say; oh, she's not suitable for this and whatever. **3**

Ex 6 T: you used a very dramatic phrase; you said, "I get instant diarrhea. " (both laugh) **3**

Ex 7 T: yes. I think that might even have something to do with the dream; that, uh, you have a feeling if you start to talk freely, you might say just terrible things, it would be awful. **3**

Ex 8 T: yeah. and maybe that's another reason that you have to sort of be miserable to make up for the sessions that you enjoy. **3**

Ex 9 T: you think you're stuck with it. **3**

Ex 10 T: I think you're right in what you implied; that the teachings of the church and the behavior of your parents really confined to put you in the hospital that you're in. (pt. sighs) they both gave you to understand that you were born bad and wicked and should suffer. **3**

Ex 11 T: perhaps that seems to you like a blasphemous idea. **3**

Ex 12 T: and, of course, you also thought of my sexual interest in you, **3**

Ex 13 T: my understanding is that, uh, you're playing it by ear about next Friday. **3**

Exemples du Style Dramatique avec « Impact Esthétique » Pour le Thérapeute (en français) :

Ex14 T: Je pense que vous vous ouvrez ici, vous vous ouvrez par petits morceaux euh vous testez à savoir si c'est vrai que je sais quoi faire avec quelqu'un qui se rend vulnérable. **3**

Style Épique

Exemples du Style Épique Pour le Patient (en anglais) :

Ex 1 T: so naturally, you're wondering is all this going to result in helping that. **2**
P: right. **1**
T: hopefully, yes. that's the idea. we go at it indirectly. **2**
P: indirectly to get it; that, uh; I hope it works. (laughs) really, I do. **4**
T: that doesn't mean we may not, now and again, come to the symptom as such. **1**
P: I wish it would happen. I doubt that it will because you could say, I'm not under that pressure or that, uh, situation, you know. **1**
T: no. I meant that you'll be talking about the symptom too directly. **1**
P: yeah. when it happens; when it comes out. 4

Ex 2 P : Do you think dreams have significance in things or they're just; I had a dream last night. it was kind of terrible. I woke up with a; with a moan. it didn't have any significance other than the two children; they were on top of a big palm tree and **4**

Ex 3 T: now let's take another part of it. you say he had canteens and things with him; **1**
P: well, he's always got something with him. (laughs) **4**
T: what did you say? **1**

Ex 4 T: and I put that together with your telling me that you have some sense that your parents don't exactly approve of this treatment. **2**
P: I don't think my mother does. **4**
T: in other words, my idea is; what? **1**

Ex 5 P: yes. it said some sense their direction but I think each one has their own way of doing it, don't they? **4**

Ex 6 P: oh. Like I want to ask you (sighs) gosh; that's hard to say. I'll say it anyway. do you really feel like I have a problem; I mean, like (sighs) that I'm not really like like wasting your time and my time; that there really is something there. if I have to ask you this everyday, that's going to be bad. **4**

Ex 7 P: and I don't know if you remember that time I told you my sister was going in the hospital when she was going to have some warts removed and so forth **4**

Ex 8 P: where the hell do I get this ideas from and I was about all that belittling ant; I want to use that word again; denigrate? **4**

Ex 9 P: yeah. ha ha - oh, God - typical. all right, my biggest worry is ericka and her tonsils right? **4**

Ex 10 P: maybe if I go and spend the afternoon with my mother. (laughs) **4**

Ex 11 P: (interrupt) questionable. very questionable to me, **4**

Exemples du Style Épique Pour le Patient (en français) :

Ex 12 P: ...sur quoi portait la recherche, c'est à quel sujet? **4**
T: Vous allez pouvoir leur demander quand ils vont... **1**
P: Ah oui? **4**
T: ...ils vont vous contacter. **1**
P: Ah ils vont me contacter? **4**
T: Ils sont supposés, oui. **1**
P: Bon, o.k., d'accord **1**

Ex 13 P : Depuis le début, est-ce qu'on avance dans tout ça ou on tourne en rond? Il me semble que je trouve les clés, est-ce que ça avance, est-ce que c'est encore aussi lisse? **4**
T: Oui, c'est pas mal lisse. **1**
P: Encore? **4**

Ex 14 P: Bien tant que ça reste actuel donc je peux m'en sortir, c'est comme ça que je vois ça. **4**

Exemples du Style Épique Pour le Thérapeute (en anglais) :

Ex 1 P: possibly. and, uh - and it; I just feel that a lot of things he has done and my mother had done, (sighs) really kind of changed my attitude about people and the way I do things. I'm; like it's always like I'm out for approval. uh, even in myself; out for my own approval; uh, it's; **5**
T(out of the blue): were you puzzled about what to do with your purse when you came in today? 4

Ex 2 P: yeah. you don't want; **2**
T(interrupts): don't give up on you; **4**

Ex 3 P: oh. Like I want to ask you (sighs) gosh; that's hard to say. I'll say it anyway. do you really feel like I have a problem; I mean, like (sighs) that I'm not really like like wasting your time and my time; that there really is something there. if I have to ask you this everyday, that's going to be bad. **4**
T: (laughs) (pt. laughs) you think you're going to have to ask everyday, huh? **4**

Ex 4 T: it's really; in a way, it; there's something interesting about this that I don't think we quite understand. I don't understand you're having to ask. it's so obvious that you have a problem. **4**

P: I know. but it just; **2**

T: (interromp) every time you try to go out, you have to run to the toilet, isn't that a problem? **4**

Ex 5 T: I'm sorry to interrupt you. I know you have much more to tell but the time is up. **4**

Ex 6 P: and I don't know if you remember that time I told you my sister was going in the hospital when she was going to have some warts removed and so forth **4**

T: now wait a minute, they were around her vulva, weren't they **4**

Ex 7 P: I got it all figured out. I got it figured; I just; the dawn has just come; **3**

T: just now? **4**

Ex 8 P: it can't be more than 50 percent of being happy.I mean, it can't; I mean, happiness can't be more than the punishment or the sacrificing. it can't be more in your life. I mean, if you're going to die and get to heaven, you can't have spent your life, 100 percent or 95 percent, uh enjoying things and; **1**

T: can't even have 52 percent apparently. **4**

Ex 9 P: yeah. but I'm afraid I wouldn't be punished; like on this lifetime; I'd be punished in the hereafter. **1**

T: oh that makes it even tougher. nothing much she can do about what's going to has there? **4**

P: mm mm. **6**

T: and we certainly can never demonstrate that that isn't going to happen so that's it **4**

Ex 10 T: let's sees maybe that's, uh; I know I'm interrupting you for a second; **4**

Ex 11 P: I don't even believe in Christ; some figure that was built up in history. but - and the same with the immaculate conception and how she was conceived, (sighs) **2**

T: not a hundred percent sure of that either? think she… **4**

<u>Exemples du Style Épique Pour le Thérapeute</u> (en français) :

Ex 12 P : je me suis mise à avoir plus d'amis aussi euh je me suis euh j'ai été nommée présidente de ci, de ça euh j'ai dirigé beaucoup de choses puis euh je devenais plus créative euh j'étais tellement occupée que je voyais presque jamais mes parents, c'était l'idéal. **3**

T: Quand est-ce que votre père a commencé à vous embrasser? **4**

P: Ah (soupir), à douze ans peut-être, treize ans mais à douze ans j'en paraissais carrément quatorze, j'ai jamais vraiment paru mon âge. 1

T: Pourquoi vous me dites ça? 4

Ex 13 P: C'est ça, exactement. C'est sa réaction aussi, quand elle est très malade ou euh que ça allait pas avec mon père euh "oh non, j'ai un excellent mari" moi je la voyais pleurer puis j'ai vu comment c'était, c'était, c'était un couple tourmenté qui se déchirait, qui s'engueulait, qui s'envoyait des bêtises par la tête des nuits complètes et puis euh quand euh qui que ce soit lui parlait de son mariage, moi je suis bénie du bon Dieu, j'ai donc un bon mari, j'ai donc un bon mariage puis je savais (?) ça c'est euh j'ai l'impression que j'ai suivi un peu son modèle là-dessus.**001**

T: Pas mal. **4**

Ex 14 T: Vous devez me trouver fatigant. **5**

P: Pas à date. **1**

T: Non? **4**

Ex 15 T: Bien vous en gardez encore des traits très forts, entre autres une habitude que vous connaissez peut-être pas, celle-là, vous êtes toujours en train de vous placer, donc c'est encore très, très présent. **4**

Ex 16 P: (...) C'est intéressant par exemple (rire), j'ai un, j'ai un côté observateur euh mais je parle on, on a plusieurs façons de voir (?) puis il y a un côté qui observe puis euh je dois dire que, que ça soit moi ou une autre personne je trouve ça intéressant de voir comment, comment ça réagit un être humain sous différents... **6**

T: Mais observez un peu moins. **4**

Style Lyrique

Exemples du Style Lyrique Pour le Patient (en anglais) :

Ex 1 P: that's that is different. it, uh; even I told *nick yesterday that I'm kind of tired going there and talking about myself, uh; just, uh you know, in a way it sort of feels degrading in a way. **5**

Ex 2 P: I don't know, it, uh; maybe because I'm only telling you all the bad stuff or or you know, I'm telling you things; I'm worrying about what you're thinking about me, I think that's what it is but; **5**

Ex 3 P: yeah. I agree with you there because like I don't want to talk about my mom and dad, you know; the bad things all the time but it seems like sometimes that's what happens. they were always; or my father mostly would, uh; was very over cautious and he used to call us stupid and idiots and we had no brains and no; just wave his hand like that at us; like give up, uh, and when you do things in your own life that you've made mistakes or something didn't work out the way he thought it should be, uh; **5**

Ex 4 P: I feel like a failure. **5**

Ex 5 P: right. Like if the kids; like; well, I start feeling guilty; like, well maybe they shouldn't be doing that but then I don't want to be like my father. I don't want to be overcautious. if the kids are having a good time and it's not that dangerous, I've got to make that judgment myself and let them continue doing what they're doing but make sure they don't, you know, overdo it and really end up doing something that may hurt. but if my father would have seen that; holy (?) it was *nick's father who had seen it, uh, the kids Saturday but I guess, I feel guilty and then if something would happen, you know, and someone told me about it and suggested that they could get hurt and yet, they still got hurt, then I'd feel guilty and a failure that I should have listened, you know. it's, uh - something minor but it's; and I take my life a lot like that; very seriously; very over sensitive, you know, uh; **5**

Ex 6 P: I just hope my mother doesn't get on the; I think she's taking it personally. I think she feels like she failed somewhere in her life and that's why I'm here and; I've read enough books and I've tried to tell her, it doesn't have to be her personally, it could be a situation I take differently or words I take differently. it's not necessarily what she's done, you know, and I'm trying to reassure her that nothing is her fault. it's mostly the way I took my life or the way I took words or things that happened and, uh, I just hope she doesn't; she can get awfully; mm; she can end up crying and screaming and saying; you kids this and you kids that; I just don't want to go through a scene like that. she's done that a few times. **5**

Ex 7 P: I should tape my father one time when he comes over and gets on his kids; you wouldn't believe it. mm I wish he'd talk about something else besides his kids. the other the only other thing he talks about is, uh; he was born and raised in *carolina the back; a little

town; and he's wanted a farm all his life, you know, and he's he's progressed from that a little, hill billy type place to getting himself and education; he got two years of college in and he was an accountant for a work at a time; he was a bookkeeper there, you know. he always brings up, you know like he's done this, he's done that, (E:WB)(33)(S:WB) you know. **5**

Ex 8 P: it, uh; I really wish he was different (laughs) because that would have made me different. **5**

Ex 9 P: well, he comes over and complains about yours and he doesn't keep his own up; and, uh, my mother isn't exactly the greatest housekeeper in the world, my dad collects junk to high heaven, I think if he had to throw out a piece of papers; he feels like he he saves everything like and, uh, you know, I see this; I see his faults and yet, he comes over and tells *nick and I what we didn't do or what we should do, you know. it; (sighs) you know, it just irritates. **5**

Ex 10 P: oh, I just, uh; I remember all the (sighs) - I don't know the yelling and the spankings. I don't remember anything, uh - I guess, I mean, I try to remember something in my youth or growing up that I've really liked my father for. hm - try to pinpoint, you know, maybe one (sighs) happening where the two of us laughed together and enjoyed it. I think there was only one time that I felt that he confided in me; that I was really shocked in a way; uh, and it was already after I'd had *ericka, my daughter. uh, and he went over to my uncle's house which is just down the block and he came back after being there a few hours and he was just so upset with my uncle; my aunt was already in her forties; almost fifty; and my uncle was complaining to my father about her not getting pregnant, you know, that, uh, he wanted her; and she had five children already; and my father just couldn't see that, you know. what was wrong with that man, you know, he was just so jealous of her and made her quit work and how come she's not getting pregnant and he let this out to me like like I understood, you know, uh, life then and that that that outstood in my mind that my father actually talked to me on his level, you know, **5**

Ex 11 P: oh, there were times when my mother just; wow, you know when you're pregnant and big and even afterwards, when *ericka was born, uh, she'd get on the subject and you know; what a bitch and whore and all this, you know, terrible words. **5**

Ex 12 T: I'm sorry to interrupt you. I know you have much more to tell but the time is up. **4**
P: (laughs) that's okay. tomorrow I'll work in my garden (laughs) I'm looking forward to that. okay. can I, uh; **5**

Ex 13 P: The last couple of days I've been flustered just call it being at wit's end. (sighs) I just am going through; I don't know where I'm getting this depression from (sighs) but, uh, I feel like I can't do anything right, I can't say anything right. have been fighting myself (sighs) telling myself it's not true. **5**

Ex 14 P: you know, what I'm trying to say is I don't see why my mother didn't contact the schools you know or why did she let me get away with so much which was wrong on a parent's part. if a child is jumping up and down "I don't want to go. I don't want to go that's you know, I mean, it's an easy out to say okay and the subject is dropped and each goes their merry way but that's not good for the child in the long run and I think I'm spoiled (sighs) **5**

Ex 15 P: I don't know. I'm thinking all sorts of dumb things; maybe I'm coming down with something or (sighs) just worrying too much (sighs) because I've seen ericka sometimes when she's sick and she's just fighting or when she gets scared she literally is so scared she can't control; it seems; like what she's doing. she; and she's just screaming and I really feel for her, and just the whole decision about having the tonsils out. **5**

Ex 16 P: a lot of the memories I have, have a turning point where I get mad the way I was treated - (sighs) or not loved in the way that I needed it and there are times I just want to pour it all out and then I think about the idea of pouring it all out and then I get terribly guilty that that's not fair; you're not supposed to be mad; even growing up; even as a child; you're supposed top uh, your parents know what's wrong and right; they're doing what's their best to their knowledge; so you have no right to be mid about, uh; I think I'm really afraid; I remember a lot of instances where I really am mad about a lot of things and I; it would have helped probably if I would have said them growing up; voiced them; but it was instilled in me to keep my mouth shut about everything and anything because I was dumb and stupid and didn't know anything anyway (sighs) **5**

Ex 17 P: (pause) it's getting depressing to try recipes lately. **5**

Ex 18 P: I don't know, I was supposed to go to my girlfriends house for dinner today with the kids and I canceled out. I just don't think I'm fit company for anybody because I'm so irritated inside.**5**

Ex 19 P: yeah, but I know you don't think that way that's why I'm here, but it seemed to impress me that, uh I shouldn't be with my girlfriend today because of the way I feel - so I canceled out, and the fact that the sun is shining and I want to do something today at home, I think I get depressed without the sunshine for several days too, (sighs) don't ask me what's going on because I don't know, I just feel like a miserable person today (laughs) **5**

Ex 20 P: just so that everything that day will be fine and and okay, I am really doing it, I really am. (close to tears) **5**

Ex 21 P: I would work on that house from top to bottom just working and working and, in a way, I would say that it would be; I'd get so tired that I wouldn't feel what I was doing, I just would be there; kind of numb; thinking about all I did or stuff like that. there really, it probably was my punishment, you know; my sacrificing and suffering. **5**

Ex 22 P: that, uh, it was wrong to do what you were doing; you'd; you should be giving up more; you shouldn't be enjoying whatever you're doing so much. you should offer something up. **5**

Ex 23 P: things have changed a lot even with, you know, louis growing up but his his ways of talking, I mean, he was; he's never happy I mean, most of the time being miserable; once and awhile, laughing and his never enco; there was no encouragement; whatsoever; which is; you know that hurts; that really hurts. **5**

Exemples du Style Lyrique Pour le Patient (en français) :

Ex 24 P: Ça fait que ça m'étonne, ça m'a pas étonnée de voir le résultat de l'exercice parce que dans ma garde-robe, j'ai toujours des vêtements trop grands, je me sens toujours grosse tout le temps, ça j'en souffre énormément puis j'essaie de pas trop me regarder dans les miroirs des vitrines quand je passe ou, j'ai un comportement de personne obèse, là c'est, c'est mieux qu'avant mais avant je portais beaucoup de vestons pour me cacher, beaucoup de grandes robes puis pourtant là, tu sais, c'est ridicule, **5**

Ex 25 P: Puis euh elle a pesé je pense cent-dix toute sa vie, elle a toujours pu manger tout ce qu'elle voulait puis, puis euh puis moi à l'époque j'étais pas un, une enfant grasse mais comparé à elle, je me sentais déjà mal dégrossie puis j'y ressemblais pas déjà puis tout ça puis euh (soupir) souvent euh dans la famille de mon père, ce sont des gens qui sont portés à l'obésité ou même euh mon père souffre un peu de ça puis, puis euh il me disait c'est donc dommage que tu n'es pas comme ta mère, il disait ça souvent, qui est, qui est mince, élégante (?) tout ça puis euh j'en souffrais énormément quand il, quand mon père me disait ça **5**

Ex 26 P: Bien euh (soupir) par orgueil je laissais rien voir et puis euh mais ça me faisait mal en dedans parce que il y avait déjà ce, ce, ce côté-là où je me sentais étrangère de toutes façons au milieu dans lequel je vivais euh c'est, aux deux familles euh paternelle et maternelle euh je trouvais personne à qui m'identifier, me dire je me sens dans une famille, il y a quelqu'un à qui je ressemble ou, puis en plus bien euh je me retrouve la seule qui avait de la poitrine euh ce sont tous des gens à petits traits, à lèvres minces euh moi j'avais des, des, des lèvres différentes euh puis ça, on taquinait beaucoup là-dessus. Puis euh un moment donné euh (s'éclaircit la gorge) ma mère a commencé à me conseiller de m'habiller euh pour me cacher le plus possible pour euh essayer de dissimuler ça ces seins-là qui étaient trop évidents puis bien surtout ne pas mettre de rouge à lèvres parce qu'elle a dit tu as déjà tout ce qu'il faut pour avoir l'air vulgaire. Puis ça ça, ça m'avait fait encore plus mal que les euh les stupidités que les hommes pouvaient dire quand ils prenaient un verre puis ce que je comprenais pas en plus, c'est que mon père jamais de ma vie m'a dit un compliment ou quelque chose (bouge) sauf, oui une fois il m'a dit que j'avais l'air propre, ça c'était le jour de ma graduation (rire) où euh j'avais une robe longue et tout ça là mais euh j'aurais aimé un moment donné qu'on me dise euh même pas un compliment euh un commentaire positif plutôt que de toujours entendre euh

(?) tu sais, ça, toutes sortes de stupidités comme ça euh j'avais, j'avais envie d'avoir un, un rayon positif là-dedans puis je n'en avais pas **5**

Ex 27 P: Puis euh finalement bien là j'étais, j'étais partie puis quand j'étais partie j'étais vraiment démolie par en dedans puis euh je savais pas où aller (tristesse) parce que je savais que si, si j'arrivais à la maison, on me dirait qu'il avait raison, c'est, c'est le genre de chose qu'on m'aurait répondu. **5**

Ex 28 P: par la suite euh mais euh c'est pas ça qui revient ces temps-ci depuis que j'ai commencé cette euh thérapie-là ici, c'est toujours l'enfance que, c'est toujours en arrière. **5**

Ex 29 P: puis il y a des choses qui m'atteignaient puis je le savais pas que ça m'atteignait comme par exemple faire mon lunch (?) je suis fatiguée de toujours euh apporter euh un lunch au travail parce que je pouvais pas me permettre le restaurant sauf à l'occasion puis euh on dirait que j'en ai, j'en ai euh j'en ai développé probablement une frustration à ça aussi puis euh **5**

Exemples du Style Lyrique Pour le Thérapeute (en anglais) :

Ex1 P: is that; is that part of finding out what the problem is. I mean, uh, is that the way, uh, you can find out maybe, possibly, what could be causing the other problem. **2**

T: sure.**5**

P: okay. **1**

T: but I don't have the impression I'm sitting here not saying anything. **5**

Ex 2 P : uh - it's like, uh, I don't want you to give up on me, you know, that's what it is. **001**

T: oh, yes. that's a better way to put it than I did. **5**

Ex 3 T: I'm sorry to interrupt you. I know you have much more to tell but the time is up. **4**

P: (laughs) that's okay. tomorrow I'll work in my garden (laughs) I'm looking forward to that. okay. can I, uh; **5**

T: sure. **5**

Exemples du Style Lyrique Pour le Thérapeute (en français) :

Ex 4 P : par la suite euh mais euh c'est pas ça qui revient ces temps-ci depuis que j'ai commencé cette euh thérapie-là ici, c'est toujours l'enfance que, c'est toujours en arrière. **5**

T: Vous devez me trouver fatigant. **5**

Style Schizoïde-Réflectif du Pacient et le Style Réflectif du Thérapeute

Exemples du Style Schizoïde-Réflectif Pour le Patient (en anglais) :

Ex 1 P: no. I don't, you know, I can't explain to her; the only thing I could explain to her yesterday was that like when I'm at a loss for words and I have a feeling about something, he can; he can understand and he says in the words, you know, when I can't find the words to say it and I says, "that's a great help. " I says, uh, you know, you can't expect a person to; you know, it's different; I don't know; when you talk to other people you talk about someone or something and you've got a conversation going back and forth but just to lay here and talk about yourself, that's different. (laughs) **6**

Ex 2 P: well, animals aren't supposedly. the only difference is supposed to be we have a brain and they don't and this is what the church has been implying all these years that it's the will to choose right and wrong which makes man the image of God, like the image of God; not the; but when I look at man or human beings, they're; there are so many feelings and emotions including sex, that God has to be like this, in a way too I mean, you have to have some kind of feelings of something or another. I don't know. this is way off the deep end maybe but more partly like the image and likeness of him I mean, because he procreated us in this way" (sighs) he could have done it some other way but it didn't. **6**

Ex 3 P: and uhm, the thing that struck me was that both of those cases, what, one of the things that I had emphasized when I was thinking of it yesterday, was that the people were saying something, and they thought they were saying something else, to me. or, uhm, one was to meinz, but uhm, I, I don't know, I guess – **6**

T: (interrupting) well, what does that mean to you? **4**

P: I, I guess I was wondering, well, what was I actually t--, saying to you that I really know I was, but that I was couching it in something else, so I was pretending I was saying something else. **6**

T: do you have anything in mind? **6**

P: uhm, I'm not sure if I did last night, I can't remember now, if I did, and, and now what comes to my mind, but uhm -- I mean, it isn't specifically answering what I think I might have been actually saying, but maybe it's just another part of it is, I think of uhm, that whole thing of my thinking about being a psychiatrist, or my interest in it. or uhm, (sigh) thinking about helping people, and your asking. and then the feelings I had about it. and uhm **6**

Ex 4 P: but I just talked about the fact that when I asked him to stop I knew he had sometimes a problem stopping -- but that when I asked him to specifically, I really meant for him to stop. and that I didn't like getting angry at him, but it did make me angry when he did that. and I knew it didn't make him feel good. and then he began to really, well I suppose it was maybe he felt more comfortable with me, so then he could express being unhappy. but then he started talking about not wanting to go up on the roof, which is where we're going

next. and that's where he has the most obvious social problems, because he can't get involved in his own projects, then **6**

Examples du Style Réflexif pour le Thérapeute (en anglais) :

Ex 1 T: still uneasy about it. okay. mm-hm. **6**

Ex 2 T: you have a feeling you're supposed to want to come? **6**

Ex 3 T: is a person supposed to enjoy going to a doctor? **6**

Ex 4 T: mm-hm. **6**

Ex 5 T: and why in the dream did you want him to drop them? **6**

Ex 6 T: you always feel it's your fault. **6**
P: right. **1**
T: or that you have failed. **6**
P: right. and to myself, I really feel that way. I mean, if; even if it's something minor, it's, (sighs) **2**
T: or you do something that other people would say is not your fault? **6**

Ex 7 T: so the idea of a palm tree is sort of associated with your father; **6**

Ex 8 T: one of the reasons I I was suggesting that maybe that's tied up with your father is that, as you know; as I said, I think that since the dream may have something to do with your own fear of what will happen here, that would be a connection too because you have already said a few things that indicate that you're afraid that I will treat you like he did **6**

Ex 9 T: and being told to drop it and so on and after all, a canteen is, how shall I say; it's something that a person needs in case there will be danger or he'll be hungry or thirsty or whatever, and I think you may be referring to the fact that you'd been asked to say everything that comes to your mind, which is sort of like saying; drop your inhibitions here **6**

Ex 10 T: you feel this is a scary situation because you're being asked to let go of those things and see what comes. **6**
P: no. I can understand now sort of why it has to take longer than I imagined, uh, it; you know, I'm beginning to understand that and I'm beginning that that time element I had set in my mind, doesn't really matter, uh; **2**
T: what is it that makes you feel it might have to take a little longer? **6**

Ex 11 T: are you afraid your parents may try to block your continuing with the treatment? **6**

Ex12 T: yes. but I; that article said that there are psychiatrists; as I remember the article; there are psychiatrists who don't say anything and don't help and don't give the patient any direction and so on and I wondered if one of the reasons you brought the article was that you were afraid that I'd be that way. **6**

Ex 13 T: I think; yeah; I think maybe you're also sort of wanting me to know that this is a strange and unusual and very new situation for you and you are sort of wanting me to know that I should have some degree of patience and give you time to get; to get used to do it. to know how to do it. you're perhaps afraid that I'll expect you to jump in and do everything exactly right the first minute and so on. **6**

Ex14 T: I think it's true if you're busy with something, you sort of have a little less time for for your mind to start dwelling on those thoughts but the real problem is; Why is it that when you're free, your mind goes to such thoughts. **6**

P: right. **1**

T: why do you have, essentially, this very poor opinion of yourself? **6**

Ex 15 T: you see, one way of putting that would be to say; you treat yourself like your father treated you. **6**

P: right. I expect a lot and when I don't live up to it or; **2**

T: you're always ready to criticize yourself like he did. **6**

Ex 16 T: sounds a little bit like you think I may be dissatisfied with your; with your performance as a patient here in the treatment **6**

Ex 17 T: whereas, your impulse was to cancel (session) and say you don't feel well. **6**

Ex 18 T: sounds that way, sounds as though you feel I don't want you here unless you can be happy and working hard at your problems or whatever **6**

Ex 19 T: so really what that boils down to is, that you are not supposed to have a satisfactory, happy life and after all, all sorts of things keep happening in a person's life so, uh there's always the possibility of something bad happening so you mill always have to be punishing yourself huh? **6**

Ex 20 T: yes. that's one possibility and another is I've had the impression that maybe you enjoy your sessions here too. **6**

Ex 21 T: it was almost as if you were saying to me; that you don't believe that can ever change or that you may feel that I would like to see that change in you but that it's hopeless or something. **6**

Ex 22 T: it occurs to me that this might be connected to - the way we have talked from time to time, who knows you came here with a phobia and you wanted to get rid of the phobia; or at least, just get it under control and that's enough, I seem to want more; maybe you feel this is an example of the kind of thing that I want, I want you get over this neurotic thing of feeling you're supposed to suffer and you're telling me that it's too; either it's too deeply rooted in you that it can't be or that; which is also a part of the same thing; you feel you could never take a chance - because you feel if you ever gave up punishing yourself, then you'd be punished, **6**

Ex 23 T: but you don't see how, how suffering and punishing yourself could be a kind of disguised form of sex like being hit by your father **6**

Ex 24 T: but maybe that's why; or maybe one of the reasons that the idea that there could be something; the hidden sexual nature in suffering , seems to you so implausible because that might suggest that there was something sexual in Christ's suffering **6**

Ex 25 T: right, and we have said that the way your father treated. you and was jealous and bit you sounded very much as if he might have had some sexual feelings for you that he thought was terrible and couldn't even let himself know he had and it came out in the disguised form of hitting you and being mean to you. my point is that it may be then that all these considerations about whether there is sex in gods are connected with the notion of whether there's sex in your father, **6**

Ex 26 T: well, you see, that comes back to my previous suggestion that it didn't seem to mean very much to you at the tine, that, perhaps, in your suffering and in your punishing yourself; which is in a way, being mean to yourself like he was mean to you no? **6**

P: yeah, **1**

T: that there may; that that could be also an expression of some hidden sexual something - in fact one could almost say that you become two people and you punish yourself like your father punished you **6**

Examples du Style Réflexif pour le Thérapeute (en français) :

Ex 27 T: Comment vous réagissiez en dedans? **6**

Ex 28 T: Vous cherchez à le (père de la patiente) protéger. **6**

Style Concret, Personne Infantile Selon Ruesch

Exemples du Style Concret Pour le Patient (en anglais) :

Ex 1 T: yes. but I; that article said that there are psychiatrists; as I remember the article; there are psychiatrists who don't say anything and don't help and don't give the patient any direction and so on and I wondered if one of the reasons you brought the article was that you were afraid that I'd be that way. **6**

P: possibly. uh - but it was something like I had read, uh; and I thought maybe if you read it, you'll know what I read, you know. uh, it's a bit of knowledge; 7

Ex 2 P: yeah. I guess it goes back to what we discussed too. uh; geez, my mind (laughs) I forgot. I think of something when you're saying and then then I forget it (sighs) must start taking up my vitamin pills again. 7

Les Meta-Styles

Examples du Méta-style type 1 Pour le Patient (en anglais) :

Ex 1 P: I guess not. especially since my mother said something yesterday that's really been, uh; everyday I go back to pick up my son and she asks me, "what happened? what did he ask? what did you say? " and you know, it's; you can't tell her. you can't explain what happens in an hour, you know; myself, I don't know. but,**5**
uh, she said something monday or Tuesday that (sighs) really; she says; you know, she had a lady friend that went to a psychiatrist and, uh, all you do is go and lay there on the couch and do all the talking and cure yourself and that's; uh uh; that's sometimes what I feel I'm doing just, you know, doing all the talking, you know, just whatever comes to my mind and; **001**

Ex 2 P: mmm - I've been trying to snip it in the bud so they don't get, uh, worse. they're sneezing and got nose fulls and, uh, kind of miserable. they get overtired earlier, uh mm - my mind is a blank. I can't believe it. **001**

Ex 3 P: uh - it's like, uh, I don't want you to give up on me, you know, that's what it is. **001**

Ex4 P**:** I know this and I know all my life, you know, like I think part of it, I always tried to please him, you know, and then when I didn't, I felt really bad about it and, you know, like you say I'm bringing it on into my own life. **001**

Ex 5 P: then to them and maybe that's why I sort of don't want to come here; don't want to talk about my mom or my dad in a bad way. (pause) it, uh; it hurts. **001**

Ex 6 P: I keep thinking; well, maybe this is all just a disguise fear for ericka having her tonsils removed or maybe I'm going through the same dilemma or the same memories of when mine were out and they weren't exactly very pleasant. I don't know. **001**

Ex 7 P: I don't know. I just - I keep; I blame myself that; geez, all I can remember is bad things can't I remember any good things growing up (sighs) why do those things irritate me the most? **001**

Ex 8 P: well, I remember far awhile, I was really beaming and (sighs) I was getting happy and I was getting out of the phobia and now it seems to, uh; to be so stagnant and it's occurring at times; this dumb fear; and it's aggravating. you know, like why, how come? I was doing so great and now it's it's (sighs) I don't understand I'm supposed to understand but I don't. take your time. just go along from day to day, it'll work out. in the meantime. I've got to live with it. I don't know. I just; I don't know, I just am very irritable. I noticed that last night, I was very irritable and I don't understand why. **001**

Ex 9 P: again I know what I got very mad about yesterday afternoon when I was thinking of all these - ah - I wasn't giving myself credit for anything I do. I don't look at myself objectively and say; you can do this; you can do that you know, I mean, so many thing I can do; I don't give myself credit for anything. I just keep thinking I could do mare; I could do better. I could do more. (sighs) then I get mad from like; **001**

Ex 10 P: (sighs) you know what I'm doing to myself so everything works out. I'm punishing myself. **001**

Ex 11 P: I enjoyed being out there but I know I got to punish myself ? cause I was out there enjoying it and I can't enjoy it in here, **001**

Ex 12 P: I can't put it into proper who knows like the church still had dances for eighth graders and high school; they had dances for grown ups. they put on plays. they had meetings and they got together and they laughed and joked about things but yet I still; live got this; like somebody that their; it goes back to my father; like they've got the belt in their hand and they're going to start beating if you don't behave (sighs) it's; you know, **001**

Examples du Méta-style type 1 Pour le Patient (en français) :

Ex 13 P: Ça fait que ça m'étonne, ça m'a pas étonnée de voir le résultat de l'exercice parce que dans ma garde-robe, j'ai toujours des vêtements trop grands, je me sens toujours grosse tout le temps, ça j'en souffre énormément puis j'essaie de pas trop me regarder dans les miroirs des vitrines quand je passe ou, j'ai un comportement de personne obèse, là c'est, c'est mieux qu'avant mais avant je portais beaucoup de vestons pour me cacher, beaucoup de grandes robes puis pourtant là, tu sais, c'est ridicule, je le sais que je suis pas obèse mais quelque part, ça bloque. **001**

Ex 14 P: Il y a une partie de moi qui est logique puis qui me dit bien voyons pourtant tu n'es pas obèse puis je fais beaucoup d'exercices puis tout ça puis une autre partie qui me dit oui tu l'es, tu traînes plein de poids, tu sais, c'est, mais ce fardeau-là, il est probablement pas en graisse, il est en, je sais pas, en frustrations, en émotions, en toutes sortes de, de "bibittes" que j'ai ramassées, **001**

Ex 15 T: Vous cherchez à le protéger. **6**
P: Comme d'habitude. Comme je protège celui que j'ai épousé (soupir), oui c'est ça. **001**

Ex 16 P: C'est ça, exactement. C'est sa réaction aussi, quand elle est très malade ou euh que ça allait pas avec mon père euh "oh non, j'ai un excellent mari" moi je la voyais pleurer puis j'ai vu comment c'était, c'était, c'était un couple tourmenté qui se déchirait, qui s'engueulait, qui s'envoyait des bêtises par la tête des nuits complètes et puis euh quand euh qui que ce soit lui parlait de son mariage, moi je suis bénie du bon Dieu, j'ai donc un bon mari, j'ai donc un bon mariage **3**
puis je savais (?) ça c'est euh j'ai l'impression que j'ai suivi un peu son modèle là-dessus. **001**

Ex 17 P: Ça m'a fait peur de voir ça, vulnérabilité égale mort, pourquoi, pourquoi, pourquoi quelque part dans mon inconscient j'aurais peur de mourir si je me rends vulnérable **001**

Ex 18 P: pourquoi il m'a, parce que lui avait jugé que j'avais la bonne position et que j'étais capable de rester stable quelques secondes mais pour moi il m'a, il m'a abandonnée là, pourquoi il m'a fait ça, pourquoi il m'a trahie, tu sais, c'est toujours la même chose qui revient puis euh puis là je me, j'ai paniqué donc perdu mon réflexe de savoir comment descendre, c'est simple pourtant puis là je me suis fait mal puis je l'ai pris comme étant le responsable, c'est à cause de lui que je me suis fait mal, mais dans le fond c'est à cause de ma panique et non à cause de lui. **001**

Examples du Méta-style type 2 Pour le Patient (en anglais) :

Ex 1 P: I've been feeling rather destructive again in terms of my not being able to just say--it's over--it's over--and realizing that in an effort either to protect myself or Wife or both of us from--from the pain of making the separation that I'm actually making things worse--for both of us (pause) **002**

Ex 2 P: But I think that, you know, yesterday indicated to me also that I--that I've not yet given up, uh, my own fantasies--that it still hurts to think about, uh, the kinds of plans we had at one time or fantasies about our marriage--what we would do and so forth and that are, obviously, not going to happen (pause). **002**