Developing a prototype for relationship therapy psychoanalysis: an empirical study with the *Psychotherapy Process Q-set*

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ABSTRACT

A Psychotherapy Process Q-set (PQS) prototype characteristic of psychoanalytic relationship therapy does not yet exist. Experts in psychoanalysis of relationship therapy [from the Italian Society of Psychoanalysis of the Relationship (SIPRe)] used the 100-Item PQS questionnaire to rate an ideal SIPRe therapy. Agreement between rates was high (Cronbach's alpha=0.84). The prototype for SIPRe therapy showed a significant correlation to the psychoanalytic prototype (r=0.68, p<0.000) and to the short expressive-supportive therapy (r=0.69, p<0.000) prototype. Correlations with Cognitive Behavioural Therapy (r=0.28, p<0.005) and Interpersonal Therapy (r=0.22, p<0.031), prototypes were significant, but weaker. The correlation between the two SIPRe samples (junior and expert therapists) was highly significant (Spearman's rho=0.936; p<000).

Key words: Psychoanalysis of relationship-therapy; psychoanalytic prototype; Psychotherapy Process Q-sort.

Introduction

Prominent exponents of the international psychoanalytic scene have recently argued for the need for psychoanalytic associations to give greater importance to empirical research in their training courses, and to provide a realistic public image of interest in scientific contributions relating to the progress of the psychotherapeutic profession (Castonguay, Muran, 2015; Dazzi, 2006; Kernberg, 2014; McWilliams, 2013; Safran *et al*., 2011; Tasca *et al*. 2014). In a book published in Italy last year ("Psychoanalysis and Training"), Kernberg states that it is "urgent" for psychoanalysis to develop studies in all fields of historical research, clinical investigation and empirical and naturalistic research to avoid the risk of "being cut out of public mental health systems".

As Minolli (2021) wrote, in this diatribe "between the historical faith in the objectivity of knowledge and the discovery of the subjectivity of the observer, there is a strong risk of slipping towards a radical relativism or a reactive authoritarianism" (Minolli, 2021; p.362).

It is also true that the situation regarding the *scientific nature of psychoanalysis* can be said to have changed a great deal over the last twenty years or so (De Robertis, 2009; Ponsi, 2006; Fonagy, 2002). Today, scientificity does not consist only of experimental verifications, but also of the shareability of the assumptions and the inter-subjective comparison with other forms of knowledge. Moreover, it is acknowledged that "Relational" psychoanalysis itself has made an important contri-

bution to the turning point in the issue of "scientificity", leading to significant conceptual changes: not only has it reshaped clinical intervention in terms of new theoretical constructs, but by establishing itself with epistemic references of constructivist matrix, it has allowed us to "burn the bridges between psychoanalysis and scientism" (Richards, 2003, De Robertis, 2009). Besides, today we know that relationships are the most robust predictors of treatment outcomes in all forms of psychotherapy, so much so that research into relational factors and the therapeutic alliance has been the most prolific area of process research for at least twenty years (Norcross & Wampold, 2011). Returning therefore to the connection between research and psychoanalysis, from a relational and complex point of view Varela (1985) advocates a "middle way" between unbridled objectivism and solipsism, emphasising that scientificity lies precisely in the interaction between the observer and the observed. The guarantee of scientificity, therefore, is not found in the nature of its subject, but is given by the rigor and criticism of the procedures and method pursued by the observer (De Robertis, 2009). As Leuzinger-Bohleber and Burgin (2003) state, 'modern psychoanalysis should neither feel obliged to adapt to the criteria of "science" in terms of a unified science characterised by the natural sciences, as some researchers claim, nor should psychoanalysts situate their profession in a state of suspension between the arts and the sciences' (ibid, p.12). This is what we have tried to take into account at the SIPRe (Società Italiana di Psicoanalisi della Relazione: Italian Society of Psychoanalysis of the Relationship) Research Centre in the approach and methodology used in the research project presented below. Psychoanalysis of the Relationship is started with a small group of Roman psychoanalysts in Italy in the 1970s (Tricoli, 2020; Scano, 2020). The theoretical and methodological model takes its cue from the critical studies of Freudian psychoanalytic thought, rooted in Rapaport's epistemic methodology (Rapaport D. 1960). The small group focused on the name of Psychoanalysis of the Relationship. The theoretical and methodological paradigm poses emphasis on the relationship not as a relational matrix (Michell, 1993), but instead as an interaction between two I-Subjects (Minolli, 1917, 2021) in the here and now of the analytic relationship. In the former paradigm the emphasis is on two subjects in interaction, they change while entering in contact with one's own world. While in the latter paradigm the accent is on the relationship and the third, the relational dimensions are related much more to the ruptures and repairs of the therapeutic alliance (Benjamin, 2017). The importance of the therapist's tact, availability, sense of equality and absence of feelings of superiority and directionality are all equally stressed (Minolli, 2021). All this leads to a progressive importance of the observer, of the subject, in a continuous reciprocal interaction as pointed out by Ceruti (Ceruti, 1985). Ceruti actually defines an "inexhaustible constructive circularity between observer and observed system"; likewise, von Foester (cit. Ceruti, 1985) claims that "those properties that were believed to belong to the object, turn out to be properties of the observer".

From the point of view of complexity, described in the introduction, we at SIPRe Research Centre felt called upon to respond to the growing need in the Psychoanalytic Community to verify the theoretical, methodological and technical models in use. It seemed appropriate to investigate first of all the thoughts and representations of SIPRe analysts with respect to their clinical practice. In accordance with a research methodology oriented to complexity and inter-subjectivity, we chose a bottom-up approach (Westen, Novotny, Thompson-Brenner, 2004), asking the experienced SIPRe analysts directly what they considered as characteristic of their daily work with patients. In this regard, we chose to use Psychotherapy Process Q-set (PQS; Jones, 1985), one of the most widely used tools in psychotherapy research to investigate the technical and relational characteristics of patient-therapist interaction, through a trans-theoretical and naturalistic analysis of psychotherapy sessions and transcripts. The PQS consists of 100 items that describe actions, behaviours, and thoughts of the patient and therapist. Recovering a Q-sort methodology (Block, 1961; Brown, 1996; Davidson & MacGregor, 1996; Hauser, 2005; Stephenson, 1953), which allows for the integration of clinical complexity with the demands of quantification, the PQS can "maintain the integrity of subjective expression within a particular context" (McKeown, Thomas, 1988). It is thus an ipsative observational strategy in that it provides a way to "quantify subjectivity", the quality of the therapeutic process, and the uniqueness of each session, allowing for the assessment of similarities and differences between sessions and patients while compelling the evaluator to a fixed distribution (Block, 1961; Hauser, 2005; Stephenson, 1953). In our research project, we chose to use the PQS as a questionnaire, as we have done in other studies, to define in a pan-theoretical and bottom-up logic, "ideal prototypes" of psychotherapy, in other words characteristic descriptions of different theoretical and technical models. Ablon and Jones (1998, 2005) developed prototypes for Cognitive Behavioural Therapy (CBT), Interpersonal Therapy (IPT), and Psychoanalysis. Subsequently, prototypes have been created for Control Mastery Therapy (CMT) (Pole, Ablon, O'Connor, 2008) and most recently for Short-Term Psychodynamic Psychotherapy (STPP) (Leichsenring *et al*., 2015), Transference Focused Psychotherapy (TFP), and Dialectical Behavioural Therapy (DBT) (Goodman, Anderson, & Diener, 2014). In 2016, the Group of Schools for Psychoanalytic Psychotherapy (GSPP; Bonalume, 2019), which includes SIPRe, analysed through PQS the representations of 368 students (F=312; M=56) from 10 Italian schools of psychoanalytic psychotherapy. The students of the GSPP schools identified five factors in psychoanalytic psychotherapy: i) psychoanalytic/explorative process;[1] ii) loss of work alliance;[2] iii)

[1] Included in this factor are interventions or communications, such as processing and understanding the meanings of the patient's experiences, focusing on the therapeutic relationship, working on the past, dreams, and fantasies, identifying dysfunctional cyclical dynamics in the patient's reactions, and understanding love relationships and sexuality. Examples of PQS items that fall under this factor are: PQS97 "The patient is introspective, readily exploring thoughts and feelings"; PQS100 "The therapist makes connections between the therapeutic relationship and other relationships"; PQS90 "The patient's dreams or fantasies are reported or discussed"; PQS32 "The patient achieves new understanding or insight."

[2] The results revealed a focus in students' minds on failure to attune to the patient, the presence of conflicting positions on the part of the patient (ambivalent, dependent/contra-dependent), and resistance or attitudes of devaluation and rejection of the therapist's interventions. Examples of PQS items that fall under this factor are: PQS14 "The patient does not feel understood by the therapist"; PQS44 "The patient is distrustful or suspicious of the therapist"; PQS8 "The patient is concerned or conflicted about his or her dependence on the therapist"; PQS49 "The patient has ambivalent or conflicting feelings toward the therapist"; PQS20 "The patient is defiant, testing the limits of the therapeutic relationship."

support techniques;[3] iv) syntonization/work alliance;[4] v) negative affectivity in the patient.[5]

These results are in line with those obtained by Ablon and Jones (1998), who, investigating the characteristics of the prototype psychoanalytic psychotherapy, according to a group of psychoanalytically trained therapists with an average of 6 years of experience (range 1-19 years), identified four main components for their model: i) psychoanalytic technique; ii) cognitive-behavioral technique[6]; iii) resistance on the part of the patient; iv) negative affectivity in the patient.

However, no one has ever tried to build a prototype related to relational psychotherapy. In this regard, our aim was to investigate the representations of some SIPRe analysts with respect to attitudes and therapeutic interventions that they consider most characteristic of their therapeutic work, according to the theoretical and methodological model of Psychoanalysis of the Relationship. We therefore formulated the following research questions:

i. What is the work prototype in accordance with the model of Psychoanalysis of the Relationship?
ii. How does the SIPRe prototype correlate with other models of psychotherapy, *i.e.* what does the SIPRe prototype have in common with psychoanalytic, cognitive-behavioral, interpersonal models?
iii. What similarities/differences exist between the SIPRe model defined by senior analysts and the one described by SIPRe postgraduate students?

Materials and Methods

Psychotherapy Process Q-sort

PQS (Jones, 1985) consists of 100 items that can be grouped into 3 areas, items describing (i) the attitude, the behaviour or the experiences of patients; (ii) attitudes and behaviours of therapists; and (iii) the interaction between patients and therapists or the atmosphere of the exchange between patient and therapist. PQS uses an entire session as the unit of observation. Having listened to an audio or video-tape of the session, clinical judges sort the 100 items in the Q-set on a continuum from least characteristic or negatively salient (category 1) to most characteristic or salient (category 9). The middle pile (category 5) is used for items deemed either neutral or irrelevant to the particular session being rated. The number of cards sorted into each category of the Q-sort conforms to a normal distribution (forced choice), requiring judges to make multiple evaluations among items, thereby avoiding Halo-effects and response sets (Ablon and Jones, 2002). Judges rate the frequency, intensity, and estimated importance of each of the 100 items. A detailed coding manual provides the Q-items and their description as well as operational examples. PQS was developed pantheoretically to assess therapist actions in different types of therapy, so it is especially useful for comparing the process of different forms of therapy (Ablon and Jones, 2002; Fonagy, 2005; Jones, Cumming, and Horowitz, 1988). It has demonstrated both reliability and discriminant validity across a variety of studies and treatment samples (Ablon and Jones, 2002; Ablon, Levy, and Katzenstein, 2006; Jones *et al*., 1988; Jones and Pulos, 1993). In addition, Ablon and Jones (2002) developed prototypic ratings of different forms of psychotherapy by asking expert therapists to rate each of the 100 items of the Q-set in the form of a PQS questionnaire according to how characteristic each item was of their understanding of an ideally conducted course of therapy that adheres to the principles of their theoretical perspective. In the studies by Ablon and Jones, 10 experts were included to give a prototypic rating for CBT, 11 for interpersonal therapy (Ablon and Jones, 2002), and 11 for psychoanalytic therapy (Ablon and Jones, 1998). A high agreement among raters was demonstrated (Cronbach´s alpha: CBT: 0.95, IPT: 0.96, and psychoanalytic: 0.94) (Ablon and Jones, 2002, 2005). In a next step, the expert ratings were analysed by principal component factor analysis using the Q technique correlating a smaller number of subjects over a larger number of items (the 100 items of the PQS) (Ablon and Jones, 1998). For this purpose, the data matrix was transposed in such a way that the experts represented the variables to be correlated over the 100 items of the PQS, so that N=100 (Ablon and Jones, 1998). Using the transposed data matrix, a principal component factor analysis was performed, and factor scores were calculated indicating to which degree each PQS item contributes to the factor (Ablon and Jones, 2002). These factor scores represent the prototype of the respective therapy. Thus, the PQS can be used to rate actual therapies administered and to study their correspondence to therapy-specific prototypes (Ablon and Jones, 2002). Leichsenring, Ablon, Barber *et al*. (2016) developed a prototype for supportive-expressive (SE) therapy, by using the PQS questionnaire developed by Ablon and Jones (1998, 2002). The prototype for SE therapy showed a significant correlation with the psychoanalytic prototype, but with 28% of variance explained, the majority of variance of the former was not explained by the latter or *vice versa*. Furthermore, the SE prototype

[3] Some emphasis was also placed by learners on the use of more directive and supportive techniques including reassurance, advice, suggestions, and encouragement. Examples of PQS items that fall under this factor are: PQS66 "The therapist reassures the patient explicitly"; PQS30 "The contents of the session focus on cognitive issues"; PQS38 "Specific activities or tasks are discussed for the patient to try to implement outside of the session."

[4] Learners emphasized in this dimension the importance of the presence of tact and empathy, acceptance of what the patient brings to the session, techniques for facilitating clinical dialogue including reformulations and clarifications, good emotional involvement, and attempts by the therapist to repair any ruptures in the therapeutic alliance. Examples of PQS items that fall under this factor are: PQS6 "The therapist is attentive to the patient's feelings, is attuned and empathetic"; PQS18 "The therapist conveys non-judgmental acceptance"; PQS3 "The therapist's observations are aimed at facilitating the patient's speech"; PQS47 "At times when the interaction with the patient is difficult, the therapist engages in attempts to improve the relationship.

[5] Learners identified a factor that describes the role of the patient's experiences of shame and guilt, concerns about what the therapist thinks of them, and requests for reassurance and support. Examples of PQS items that fall under this factor are: PQS53 "The patient worries about what the therapist thinks of him or her"; PQS94 "The patient feels sad or depressed"; PQS71 "The patient accuses himself or herself, expresses shame or guilt"; PQS59 "The patient feels inadequate and inferior"; PQS84 "The patient expresses anger or aggressive feelings."

[6] Cognitive-behavioural techniques refer to all interventions in which the therapist, even if trained in psychoanalysis, tends to give explicit advice or reassurance to the patient, suggests tasks or activities to be carried out outside the session, and proposes behaviour or attitudes to be implemented in daily life. Examples of items belonging to this factor are: PQS30 "The content of the session is focused on cognitive issues"; PQS38 "Specific activities or tasks are discussed that the patient should try to implement outside the session", PQS27 "The therapist gives explicit advice and takes on the role of guiding the patient".

showed significant correlations with the cognitive-behavioural prototype and the prototype of interpersonal therapy by Ablon and Jones (r=0.69, 0.43).

To obtain comparable results, methodological and statistical procedures were analogous to the studies by Leichsenring, Ablon, Barber *et al*. (2016). Twenty-one experts (F=13; M=8) in SIPRe therapy rated an (imagined) ideally conducted session of SIPRe therapy. Most of them were psychologists (80.5%), graduated in SIPRe therapy (61.4%), trained therapists with an average of 22 years of experience years. They all provided major contributions to the development of and research on SIPRe model. About 57,1% of them were supervisor of SIPRe therapy. They were asked to fill an online questionnaire in Survey Monkey, composed by two parts:

i. Personal, professional and demographic details (age, gender, graduation, years of expertise in SIPRe therapy, supervision, lessons, associations, psychoanalytic training, personal analysis, patients).
ii. The Psychotherapy Process Q-Set questionnaire developed by Ablon and Jones (1998, 2002).

Although it contains the same 100 items, this questionnaire is not identical to the PQS as raters do not have to adhere to the normal distribution. Experts in SIPRe therapy were asked to rate each of the 100 items of the PQS questionnaire according to how characteristic each item was of their understanding of an ideally conducted SIPRe therapy. They were given the following instructions: the following 100 statements describe things that may or may not go on during therapy. We are interested in your understanding of what should go on in an ideally conducted course of therapy that adheres to the principles of SIPRe. Please rate each item, on a scale from −4 to +4, according to how characteristic it is of an ideally conducted SIPRe therapy.

Results

The agreement between the expert ratings of an ideal SIPRe therapy was medium (Cronbach's α=0.84).

According to the first research question, principal component analysis yielded one factor explaining 60% of the variance. The factor scores were calculated to gain a PQS-based prototype for SIPRe therapy. The 20 PQS items most and least characteristic of this prototype are listed in Tables 1 e 2.

According to the second research question, the SIPRe prototype showed a significant correlation to the psychoanalytic (r=0.68, p<0.000) and to the short expressive-supportive therapy (SE) (r=0.69, p<0.000) prototypes. Correlations with CBT (r=0.28, p<0.005) and IPT (r=0.22, p<0.031), prototypes were significant, but weaker.

It is of interest to compare the items most characteristic of the SIPRe prototype with those most characteristic of psychoanalytic and short expressive-supportive (SE) (Tables 3 e 4) prototypes, the most correlated prototypes to the SIPRe model. Of the 10 items most characteristic of SIPRe prototype, six are among the items most characteristic of the psychoanalytic prototype (90,100, 6,18,98,46). For the items shared by the two pro-

Table 1. Rank ordering of Q-items by factor scores on Italian Society of Psychoanalysis of the Relationship (SIPRe) therapy. Most characteristic items of ideal SIPRe therapy.

Item	Factor scores	Mean
Item 90. Patient's dreams or fantasies are discussed	1.521	3.38
Item 100. Therapist draws connections between the therapeutic relationship and other relationship	1.501	3.24
Item 98. The therapy relationship is a focus of discussion	1.396	3.19
Item 63. Patient's interpersonal relationships are a major theme	1.360	3.10
Item 18. Therapist conveys a sense of non-judgmental acceptance	1.318	2.76
Item 75. Termination of therapy is discussed	1.308	3.10
Item 6. Therapist is sensitive to the patient's feelings, attuned to the patient; empathic	1.289	3.00
Item 88. Patient brings up significant issues and material	1.252	2.95
Item 46. Therapist communicates with patient in a clear, coherent style	1.235	2.86
Item 69. Patient's current or recent life situation is emphasized in discussion	1.228	2.76

Table 2. Least characteristic items of ideal Italian Society of Psychoanalysis of the Relationship therapy.

Item	Factor scores	Mean
Item 51. Therapist condescends to, or patronizes the patient	-2.698	-3.45
Item 77. Therapist is tactless	-2.477	-2.90
Item 39. There is a competitive quality to the relationship	-3.347	-2.67
Item 37. Therapist behaves in a teacher-like (didactic) manner	-2.153	-2.57
Item 57. Therapist explains rationale behind his or her technique or approach to treatment	-2.069	-2.52
Item 27. Therapist gives explicit advice and guidance (*vs.* defers even when pressed to do so)	-1.873	-2.14
Item 38. There is discussion of specific activities or tasks for the patient to attempt outside of session	-1.776	-2.05
Item 9. Therapist is distant. aloof (*vs.* responsive and affectively involved)	-1.734	-1.62
Item 17. Therapist actively exerts control over the interaction (*e.g.*, structuring, introducing new topics)	-1.471	-1.48
Item 19. There is an erotic quality to the therapy relationship	-1.415	-1.38

totypes, the factor scores are at least partly different showing that the items contribute differently to the respective prototype. However, all items among SIPRe prototype with higher factor scores were shared with the psychoanalytic prototype; in sum, characteristic aspects of SIPRe therapy were linked to the psychoanalytic model: "Item 90. Patient's dreams or fantasies are discussed"; "item 100. Analyst draws connections between the therapeutic relationship and other relationships"; "Item 98. The therapeutic relation is a focus of discussion". However, the SIPRe prototypes are characterized by focusing more attention on relational dimensions and "the present" of the patient: Item 63 ("Patient's interpersonal relationships are a major theme"), which is the fourth factor score of SIPRe prototype (factor score=1,36), and item 69 ("Patient's current or recent life situation is emphasized in discussion"; factor score =1,228), were not among the list of psychoanalytic prototype. These two characteristic items among SIPRe models were shared with short expressive-supportive (SE) with similar factor scores (Table 5). Even if focusing attention on patient's feelings and empathy (item 6) were characteristic of the SIPRe model, its factor score was not so high as the psychoanalytic one. In sum, SIPRe prototype has a psychoanalytic grounded root in addition to attention to therapeutic relation, to interpersonal dimensions and to the "present" of the patient's life. However, the SIPRe prototype shared many PQS items with high factor scores with the SE ones, the factor structures were very different.

The SIPRe prototype shares only one item with CBT prototype (item 88 "Patient brings up significant issues and material") and two items with IPT ones (item 63 "Patient's interpersonal relationships are a major theme"; item 75. "Termination of therapy is discussed") (Figure 1).

To better understand the SIPRe prototype, an exploratory factor analysis with varimax rotation was carried out. Five factors explain about 58% of variance (Table 6). As described above, relational dimensions are essential in the SIPRe model: Attention to patient-analyst interaction is the theme of therapist

Table 3. Correlations between Italian Society of Psychoanalysis of the Relationship (SIPRe) prototype and the other prototypes.

SIPRe prototype	Psychoanalytic therapy	Short-term psychodynamic (supportive-expressive) therapy	CBT	IPT
Pearson	0.679	0.694	0.280	0.216
p	0.000	0.000	0.005	0.031
Correlation's strength	Moderate	Moderate	Weak	Weak

CBT, Cognitive Behavioural Therapy; IPT; Interpersonal Therapy.

Table 4. Most characteristic items of psychoanalytic prototype.

Item	Factor scores
Item 90. Patient's dreams or fantasies are discussed	1.71
Item 93. Analyst is neutral	1.57
Item 36. Analyst points out P's use of defensive manoeuvres (*e.g.*, undoing and denial)	1.53
Item 100. Analyst draws connections between the therapeutic relationship and other relationships	1.47
Item 6. Analyst is sensitive to the P's feelings, attuned to the P; empathic	1.46
Item 67. Analyst interprets warded-off or unconscious wishes, feelings, or ideas	1.43
Item 18. Analyst conveys a sense of non-judgmental acceptance	1.38
Item 32. Patient achieves a new understanding or insight	1.32
Item 98. The therapy relationship is a focus of discussion	1.28
Item 46. Analyst communicates with patient in a clear, coherent style	1.24

Table 5. Most characteristic items of short-term psychodynamic (supportive-expressive) therapy.

Item	Factor scores
Item 31. Therapist asks for more information or elaboration	1.58
Item 62. Therapist identifies a recurrent theme in the patient's experience or conduct	1.48
Item 69. Patient's current or recent life situation is emphasized in discussion	1.40
Item 75. Termination of therapy is discussed	1.39
Item 46. Therapist communicates with patient in a clear, coherent style	1.39
Item 63. Patient's interpersonal relationships are a major theme	1.39
Item 18. Therapist conveys a sense of non-judgmental acceptance	1.37
Item 6. Therapist is sensitive to the patient's feelings, attuned to the patient; empathic	1.36
Item 45. Therapist adopts supportive stance	1.32
Item 4. The patient's treatment goals are discussed	1.30

interventions (item 63); therapist creates connections between therapeutic relation and other relationships of the patient's life (item 100).

Finally, according to the third research question, the SIPRe prototype of 21 experts was compared to SIPRe prototype of postgraduates, collected in GSPP study, reported above. The correlation between the two prototypes was highly significant (Spearman's rho=0.936; p<0.000). It is of interest to compare the items among the two prototypes (Tables 1,2,4 and 7-9).

The two prototypes share many characteristic items, even if factor scores are lightly different. Most characteristic items of SIPRe experts (item 100, 90, 63) have factor scores lower than the ones of the postgraduate prototype. SIPRe students place in the first positions of factor hierarchy the most generic items, such as sense of non-judgmental acceptance, attention to the patient's feelings, empathy (items 18 and 6). However, more similar were factor scores and hierarchy of the least characteristic items of the two prototypes: experts and students agree on importance of the therapist's tact, availability, sense of equality and absence of feelings of superiority and directionality (item 51,77,39,37,27).

The comparison of factor structures of psychoanalytic prototype by Ablon e Jones (1998), GSPP prototype and SIPRe prototype shows that Factor 1 "Psychoanalytic process" is less relevant in the SIPRe model. On the other hand, it is interesting to note the presence of a new factor, called "Interaction inside the session/talking about relations". In the other studies, the relational dimensions are related much more to the ruptures and repairs of the therapeutic alliance. Like the GSPP students and contrary to analysts of Ablon and Levy study, "emotional attunement" is considered an important ingredient of the psychoanalytic approach, not only because of listening to negative feelings of the patients. The teacher-like (didactic) manner, typical of a CBT approach, is present as a factor in the SIPRe model, but it hardly explains the variance.

Discussion

One of the aims of this study is to stimulate the discussion about Psychoanalysis of Relationship working model, within the international overview of psychoanalysis. The starting point was the observation of what SIPRe senior analysts think of their own clinical practice.

As SIPRe theoretical and methodological paradigm emphasis, in our study, attention to patient-analyst interaction (item 63), connections between therapeutic relation and other relationships of the patient's life (item 100), current or recent life situation of the patient (item 69) are three of the most characteristic items of the SIPRe prototype.

According to the second research question, the SIPRe prototype showed a significant correlation to the psychoanalytic and the short SE prototypes. However, for the items shared with the psychoanalytic prototypes (90,100, 6,18,98,46), the factor scores are at least partly different, showing that the items contribute differently to the respective prototype. While the Psychoanalyst of Relationship model (Minolli 2021a; Minolli, 2020; Minolli & Tricoli, 2004; Tricoli, 2009; Corbelli, 2020) is more focused on the present (item 69), at the same time it is actively involved in the relationship with the patient (item 63) and poses greater attention to the complexity of the subject (item 6, 18). The results describe a double belonging of the SIPRe model: on the one hand, a strong link with the classic psychoanalytic approach, which sees in the past the explanation of the solutions that the patient adopts in the present and finds the main working technique in the analysis of the patient's dreams, depths and fan-

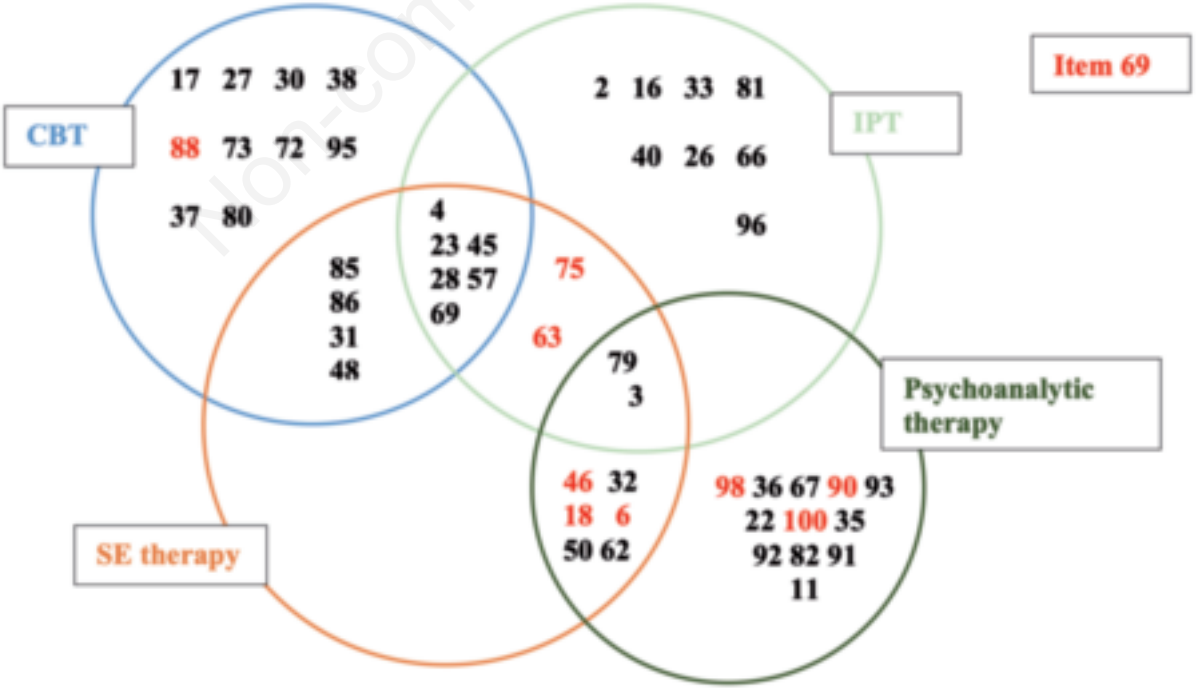

Figure 1. Overlap between psychoanalysis, short expressive-supportive therapy (SE), Cognitive Behavioural Therapy (CBT), and Interpersonal Therapy (IPT), with regard to the prototypic Psychotherapy Process Q-set items.

Table 6. Item of 5 factors of Italian Society of Psychoanalysis of the Relationship prototype.

Factor 1. Alliance with patient
Item 44. Patient feels wary or suspicious (*vs.* trusting and secure)
Item 56. Patient discusses experiences as if distant from his or her feelings
Item 82. The patient's behaviour during the hour is reformulated by the therapist in a way not explicitly recognized previously
Item 14. Patient does not feel understood by therapist
Item 43. Therapist suggests the meaning of others' behaviour
Item 49. The patient experiences ambivalent or conflicted feelings about the therapist
Item 21. Therapist self-discloses
Item 45. Therapist adopts supportive stance
Item 42. Patient rejects *vs.* accepts therapist's comments and observations
Item 5. Patient has difficulty understanding the therapist's comments
Factor 2. Interaction inside the session/talking about relations
Item 9. Therapist is distant, aloof (*vs.* responsive and affectively involved)
Item 100 Therapist draws connections between the therapeutic relationship and other relationships
Item 63. Patient's interpersonal relationships are a major theme
Item 90. Patient's dreams or fantasies are discussed
Item 99. Therapist challenges the patient's view
Item 27. Therapist gives explicit advice and guidance (*vs.* defers even when pressed to do so)
Item 65. Therapist clarifies, restates, or rephrases patient's communication
Item 91. Memories or reconstructions of infancy and childhood are topics of discussion
Item 98. The therapy relationship is a focus of discussion
Item 57. Therapist explains rationale behind his or her technique or approach to treatment
Factor 3. Emotional attunement (talking and sharing emotions)
Item 61. Patient feels shy and embarrassed
Item 59. Patient feels inadequate and inferior (*vs.* effective and superior)
Item 33. Patient talks of feelings about being close to or needing someone
Item 71. Patient is self-accusatory, expresses shame or guilt
Item 95. Patient feels helped
Item 55. Patient conveys positive expectations about therapy
Item 70. Patient struggles to control feelings or impulses
Item 94. Patient feels sad or depressed
Item 53. Patient is concerned about what therapist thinks of him or her
Item 36. Therapist points out patient's use of defensive manoeuvres, *e.g.* undoing, denial
Factor 4. Cognitive technique
Item 97. Patient is introspective, readily explores inner thoughts and feelings
Item 15. Patient does not initiate topics; is passive
Item 3. Therapist's remarks are aimed at facilitating patient speech
Item 26. Patient experiences discomforting or troublesome (painful) affect
Item 88. Patient brings up significant issues and material
Item 17. Therapist actively exerts control over the interaction (*e.g.*, structuring, introducing new topics)
Item 2. Therapist draws attention to patient's non-verbal behaviour
Item 38. There is discussion of specific activities or tasks for the patient to attempt outside of session
Item 28. Therapist accurately perceives the therapeutic process
Item 83. Patient is demanding
Factor 5. Psychoanalytic process
Item 40. Therapist makes interpretations referring to actual people in the patient's life
Item 22. Therapist focuses on patient's feelings of guilt
Item 66. Therapist is directly reassuring
Item 68. Real *vs.* fantasized meanings of experiences are actively differentiated
Item 32. Patient achieves a new understanding or insight
Item 31. Therapist asks for more information or elaboration
Item 67. Therapist interprets warded-off or unconscious wishes, feelings, or ideas
Item 4. The patient's treatment goals are discussed
Item 23. Dialogue has a specific focus
Item 19. There is an erotic quality to the therapy relationship

tasies; on the other hand, a closeness to a theoretical-clinical perspective that considers it important to work on the "here and now", on the "present" of the subject, on its solutions and on the complex interactions of events, emotions and relationships.

The SIPRe prototype shares only one item with CBT prototype (item 88) and two items with IPT ones (item 63 and 75), demonstrating important differences with these paradigms.

Finally, according to the third research question, correlation between the SIPRe prototype of 21 experts and the postgraduates, collected in GSPP study, was highly significant. Experts and students agree on importance of the therapist's tact, availability, sense of equality and absence of feelings of superiority and directionality (item 51,77,39,37,27). The two prototypes share many characteristic items, even if factor scores are lightly different. Most characteristic items of SIPRe experts (item 100, 90, 63) have factor scores lower than the ones of the postgraduate prototype. SIPRe students place in the first positions of factor hierarchy the most generic items, such as sense of non-judgmental acceptance, attention to the patient's feelings, empathy (items 18 and 6).

Compared with the trainees, the senior psychoanalysts would seem less distressed by the size of their role and therefore they are less focused on emotional tuning and above all on the effects of the patient's negative feelings in the session, which represents for the young SIPRe students and their colleagues from GSPP psychoanalytic schools an important factor in the clinical practice. Trainees and seniors are very clear on what the SIPRe model is not; instead, they deviate more from what the working model should be. Even if the technical aspects or the

Table 7. Most characteristic items of Italian Society of Psychoanalysis of the Relationship postgraduates prototype.

Item	Factor scores	Mean
Item 18. Therapist conveys a sense of non-judgmental acceptance	1.709	2.94
Item 6. Therapist is sensitive to the patient's feelings, attuned to the patient; empathic	1.519	2.63
Item 62. Therapist identifies a recurrent theme in the patient's experience or conduct	1.467	2.66
Item 63. Patient's interpersonal relationships are a major theme	1.428	2.56
Item 47. When the interaction with the patients is difficult, the therapist accommodates in an effort to improve it	1.412	2.53
Item 81. Therapist emphasizes patient feelings in order to help him or her experience them more deeply	1.322	2.41
Item 69. Patient's current or recent life situation is emphasized in discussion	1.261	2.34
Item 46. Therapist communicates with patient in a clear, coherent style	125.751	2.38
Item 100. Therapist draws connections between the therapeutic relationship and other relationships	125.633	2.34
Item 90. Patient's dreams or fantasies are discussed	1.521	3.38

Table 8. Least characteristic items of Italian Society of Psychoanalysis of the Relationship postgraduates prototype.

Item	Factor scores	Mean
Item 51. Therapist condescends to, or patronizes the patient	-2.647	-3.31
Item 77. Therapist is tactless	-2.621	-3.28
Item 39. There is a competitive quality to the relationship	-2.554	-3.16
Item 37. Therapist behaves in a teacher-like (didactic) manner	-2.319	-2.94
Item 38. Item 38. There is discussion of specific activities or tasks for the patient to attempt outside of session	-2.270	-2.69
Item 27. Therapist gives explicit advice and guidance (*vs.* defers even when pressed to do so)	-1.929	-2.38
Item 9. Therapist is distant, aloof (*vs.* responsive and affectively involved)	-1.864	-2.09
Item 19. There is an erotic quality to the therapy relationship	-1.653	-1.88
Item 58. Patient resists examining thoughts, reactions, or motivations related to problems	-1.568	-1.78
Item 89. Therapist acts to strengthen defences	-1.535	-1.69
Item 17. Therapist actively exerts control over the interaction (*e.g.*, structuring, introducing new topics)	-1.471	-1.48
Item 19. There is an erotic quality to the therapy relationship	-1.415	-1.38

Table 9. Comparison between factor structures of psychoanalytic therapy, Global Student Success Program (GSPP) and Italian Society of Psychoanalysis of the Relationship (SIPRe) experts.

Psychoanalytic therapy (Jones&Pulos, 1993; Ablon & Jones, 1998)	*GSPP students prototype (2019)*	*SIPRe prototype*
Psychodynamic technique	Psychoanalytic exploratory process	Alliance
CBT technique	Non-alliance	Interaction inside the session/talking about relations
Resistance	Supportive technique	Emotional attunement (talking and sharing emotions)
Patient's negative feelings	Attunement/alliance	Cognitive technique
	Patient's negative feelings	Psychoanalytic process

more supportive interventions seem to assume less and less importance with growth and experience, the SIPRe students show to have early on, in the years of formation, clarity around their role with the patient: the task is not to support, direct and guide, but rather to be in tune with the patient's solutions. The therapeutic relationship and its relationship with the patient's interpersonal relationships, which for the seniors are structural elements of the analytic work, does not seem to be so for the students. Students are more interested in other relational factors, such as alliance, recognition of one's role by the patient and empathy (item 18 and 6).

The comparison of factor structures of psychoanalytic prototype by Ablon e Jones (1998), GSPP prototype and SIPRe prototype shows that Factor 1 "Psychoanalytic process" is less relevant in the SIPRe model. Like the GSPP students and contrary to analysts of Ablon and Levy study, "emotional attunement" is considered an important ingredient of the psychoanalytic approach, not only because of listening to negative feelings of the patients. The teacher-like (didactic) manner, (item 37), typical of a CBT approach, for example, is present as a factor in both senior and trainees SIPRe model, but it hardly explains the variance.

Conclusions

Our study is part of the most recent research in the Community of the Psychoanalysis and aims to grasp the characteristics of the practice of Psychoanalysis of the Relationship, in order to identify differences and similarities with the other psychoanalytic models. It also takes into account the epistemic model of complexity, which is a theoretical reference to the SIPRe model. The progress of knowledge stems from a continuous and dialectical confrontation to get to the point where historicity and constructiveness replace absoluteness and neutrality (Ceruti, 1986).

In any way we realize that the study itself is not exhaustive to demonstrate that SIPRe psychoanalysts actually apply the model they claim to follow in their clinical practice. In this regard, in future studies we intend to compare the model that the analysts describe with a careful analysis of the clinical sessions.

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