BJPsychoterapy
Brazilian Journal of Psychotherapy
Volume 22, number 3, december 2020
www.rbp.celg.org.br

ORIGINAL ARTICLE

Psychodynamic Profile in an Early Dropout Case: Comparing Therapist's and External Judges' perspectives

Santiago Juan[a]

Rocío Manubens[b]

Luciana López Fediuk[c]

Juan Martín Gómez Penedo[d]

[a] Universidad de Buenos Aires – Buenos Aires – AR – Orcid – 0000-0003-1024-1337

[b] Universidad de Buenos Aires – Buenos Aires – AR – Orcid – 0000-0002-5582-1047

[c] Universidad de Buenos Aires – Buenos Aires – AR – Orcid – 0000-0002-2929-4773

[d] Universidad de Buenos Aires, CONICET – Buenos Aires – AR – Orcid – 0000-0001-7304-407X

DOI 10.5935/2318-0404.20200019

Instituição: Universidad de Buenos Aires – Buenos Aires – AR

Abstract

Introduction: contemporary psychodynamic therapy research supports combining clinical judgment with empirical evidences. Recent studies suggest that systematically analyzing single cases may contribute to such efforts. Also, current criteria for evidence-based case studies recommend different perspectives on therapeutic process and outcome, such as therapist's and external judges' ratings. Finally, client's dropout conforms a challenge for psychotherapy research. **Aims & Methods:** as part of a SPR Small Research Grant, this study analyzed and compared the psychodynamic profile proposed both by therapist and two external judges, for the same case of early dropout from focused psychodynamic psychotherapy, consisting of two diagnostic interviews

and five subsequent sessions, in a patient with an emotional disorder. Being blind to the rating process of the counterpart, Operationalized Psychodynamic Diagnosis (OPD-2) was used by therapist and judges to generate a psychodynamic profile including five therapeutic foci. External judges rating was achieved through consensus, following CQR's guidelines. **Results & Discussion:** similarities and differences among therapist's and judges' psychodynamic profiles were found. Result's contributions to the understanding of case's early dropout are discussed, along with OPD-2's usefulness for psychodynamic practice-oriented research.

Keywords: Focused Psychodynamic Therapy; OPD-2; Change Mechanisms; Dropout; Single Case Research; Practice Oriented Research

Introduction

Recently, there has been an increased need for psychodynamic clinicians and researchers in relation to: a) gather evidence that supports psychodynamic assumptions and procedures[1]; b) combine theory, empirical research and clinical judgment[2] and c) operationalize, register and evaluate therapy's process and outcome[3-6]. Recent studies[7, 8] suggest that to systematically analyze single cases may contribute to such efforts. In addition, current guidelines for empirical single case studies[9, 10] highlight the importance of including different views of the therapeutic process, combining, for instance, therapist's and external judges' perspectives. At the same time, the problem of psychotherapy dropout conforms a challenging field for both research and practice[11-13]. This phenomenon requires an in-depth analysis of the experience of abandonment, the different modalities it may present, and an understanding of whether, seen in retrospect, it explains patient's evolution[14].

It is within this framework that the aim of the present research was to study and compare the psychodynamic profile in an early dropout case of a focused psychodynamic treatment, proposed both by the therapist and two external judges. Given a case of early dropout was analyzed, the study sought to contribute to the understanding of this phenomenon. Thus, results and their discussion examine how the convergences and divergences in the vision of the external judges and the treating clinician would allow an understanding of the treatment's interruption. More broadly, this research is part of a mayor project aimed at investigating change mechanisms in psychodynamic psychotherapy's single cases, funded by the Society for Psychotherapy Research (SPR)*. Another study[15] presents results related to the evolution of the therapeutic foci of the same case analyzed in this study. We recommend considering both sets of results in a complementary way for a better understanding of the research conducted.

As it will be detailed later (see Procedures), the Operationalized Psychodynamic Diagnosis OPD-2[6] was used as the fundamental tool for analyzing the case and comparing therapist's and external judges' perspectives. In this way, the present work also aims to illustrate OPD-2's usefulness, contributing to the study of its theoretical

* "Therapeutic focus and mechanisms of change in a single case of psychodynamic psychotherapy". Project funded by Society for Psychotherapy Research (SPR), Small Grant 2017-2018.
Director: Dr. Santiago Juan, Co-director: Dr. Juan Martín Gómez Penedo.

validity and reliability, and collaborating with the diffusion of the instrument, still little known in our context, so that clinicians, researchers and students, interested in the field of psychodynamic psychotherapies, can benefit from it[16, 17]. Finally, the study aimed at a practice-oriented research[18], a paradigm of empirical research that aims to generate clinically relevant evidence, responding, through empirical procedures, to questions of clinical origin.

Methods

Patient

At the beginning of treatment, Angel (pseudonym) was a 30 years old single man, who worked in a store in the city of Buenos Aires. His reason for consultation was related to frequent anxiety crises he had been suffering on a daily basis after ending a relationship of several years. He had never consulted a psychologist. Despite having gone through a similar symptomatology a few years ago, he had improved without therapeutic help.

Therapist

At the time of the first interview he was 38 years old, was trained in psychodynamic psychotherapy and certified in the use of Operationalized Psychodynamic Diagnosis (OPD-2). He had 13 years of clinical experience and performed the dual role of therapist-researcher in the present study.

Treatment: focused psychodynamic psychotherapy following OPD-2 criteria

The treatment was based on the principles of transference and resistance, as well as on the theory of unconscious processes (see, for example: [19-21]). Being a focused therapy, the therapeutic work was concentrated on a pathogenic process of unconscious origin, generated by structural vulnerabilities and/or intrapsychic conflicts[22-25]. In this modality of therapy, different active ingredients of the psychodynamic field are combined, such as corrective emotional experiences, interpretation of unconscious conflicts, and supporting and repairing strategies of damaged structural aspects[6, 26, 27]. The process analyzed consisted of two diagnostic interviews and five weekly sessions, after which the patient decided to abandon treatment.

OPD-2 guidelines[6] were incorporated, in terms of case formulation and treatment planning. OPD-2 is a systematic tool for the diagnosis, selection and evaluation of therapeutic foci in psychodynamic therapy, and can be used for both research and clinical practice (see Materials). The multiaxial structure presented by the OPD-2 is used to delimit patient's problem areas (OPD-2 foci). The definition of these problem areas carries the status of a psychodynamic hypothesis, inferring that some level of change must take place in relation to these areas in order to achieve a significant change in patient's symptoms and complaints. Previous studies [28, 29] have indicated that the selection of up to five OPD-2 foci is sufficient to identify the psychodynamic profile of

a patient. In the present study, five foci were selected: one relation focus, two conflict foci and two structure foci (see Materials and Procedures). For more information, see Juan, Gómez Penedo and Roussos[30].

On the context of early dropout

After the fifth and final session, the patient contacted the therapist to let him know that he would not continue with the treatment and that he did not want to have a closing session. Despite this, he commented that the treatment had been very useful to him, but that he wanted to prioritize other activities. After six months he contacted the therapist to pay pending fees and recommend him to a friend, mentioning that in the future he could return to therapy himself.

Materials

Operationalized Psychodynamic Diagnosis OPD-2 (6). The OPD-2 is a diagnostic system that proposes an integrated articulation of different dimensions, allowing a therapeutic orientation for clinical practice and a systematic use for empirical research. It proposes five diagnostic axes: I) Experience of illness and prerequisites for treatment, II) Relation, III) Conflict, IV) Structure and V) Disorders according to DSM-CIE systems. Based on the information provided by the axes, up to five therapeutic foci are chosen to conduct the treatment.

Procedures

After being referred to the therapist, the patient was given details of the treatment and the research. In the informed consent he signed, possible risks and benefits of his participation were explained. In addition, confidentiality of generated clinical data was clarified and assured. Finally, it was explained that he could stop participating in the research without affecting his treatment's continuity.

All sessions were audiotaped and the first two were also transcribed. Treating therapist and two external judges, graduated in psychology, with more than 6 months of OPD-2 training, individually generated a complete OPD-2 profile for the patient. The same was obtained from the first two interviews, being blind to the coding of the counterpart. The judges agreed on a single profile following the CQR methodology[31-33]. Both resulting profiles (therapist's and judges') included five foci: one relation focus, two conflict foci and two structure foci.

Based on the profiles created by the judges and the therapist, a qualitative comparative analysis was carried out (see Table 1). The selected foci were also compared (see Table 2). The main goal was to consider convergences and divergences between the perspectives in the light of therapeutic early dropout.

Results

OPD-2 profile generated by external judges and therapist

Axis 1: Experience of illness and prerequisites for treatment. As shown in Table 1, therapist perceived a higher level of subjective suffering than the external judges. More convergences in the profiles were observed when coding patient's presentation of problems, concept of illness and change. Both therapist and external judges agreed on the presentation of physical symptoms (choking sensation, general vegetative activation) and psychic symptoms (fear and anxiety). They also agreed on a concept of illness oriented to psychic factors and, more slightly, to somatic factors. In the opinion of both perspectives, patient showed awareness of emotional involvement in the anxiety episodes. With respect to the patient's concept of change, therapist and judges agreed that Angel openly raised the need for psychotherapy, above medical or pharmacological treatment. Both perspectives on the patient considered the presence of personal resources and psychosocial support in Angel. Finally, in relation to psychotherapy indication, there was consensus between judges and therapist about Angel's orientation towards analyzing his problem in terms of internal conflicts, with some interest also in that treatment would reduce his symptoms. They saw no secondary benefits from the illness and the therapist assessed a greater degree of observation and mentalization capacity than the external judges.

Axis 2: Dysfunctional relational patterns. In this axis, OPD-2 proposes to evaluate the dysfunctional repetitive patterns in which a patient relates to his significant ones. Two perspectives are taken: A) that of the patient and B) that of the others. Thus, in this study, perspective A (patient's perspective) evaluated, on the one hand, how Angel consciously perceived himself in front of the others, and how he consciously perceived the response of the others in his relationships. Similarly, perspective B (the others' perspective) evaluated, on the one hand, how others repeatedly experienced Angel in relationships, and how they perceived themselves in their interaction with the patient. This B perspective dealt with what the patient was not necessarily aware of (his unconscious role-offering) and the response it induced in others, including therapist's counter-transference perception (role-induction). To make the codification, OPD-2 proposes a list of relational items, of which three must be selected for each aspect of each perspective (see Table 1).

Patient's perspective (perspective A). There were convergences in two of the three relational items, in terms of the conscious perception of Angel to want to control and dominate others, demanding freedom and autonomy. The third relational item was different: for the judges it was more about showing little need in front of others, while for therapist it had to do with showing a stubborn and oppositional attitude in relationships. Regarding patient's conscious perception of others, there was convergence in considering how Angel perceived reproaches from his significant ones. Then, the judges considered that the patient felt admired and controlled by others while the therapist considered that Angel perceived others in a polarity of distance and lack of space.

Other's perspective (perspective B). In considering the others' view of the patient there was a high degree of convergence between therapist and judges regarding Angel's relational offerings. Indeed, both the judges and the therapist agreed that Angel alternated between placing himself in the center of interest and

withdrawing from relationships, as a central part of his unconscious role offering. The third relational item was different but very linked: while the judges coded an attitude of dominance and control, the therapist coded an attitude of attack and harm. Finally, where the greatest discrepancies were obtained was in how the therapist and the judges experienced themselves in relation to the patient. Thus, the judges coded an induction on the part of Angel of a stubborn and reproachful attitude; while the therapist prioritized as a counter-transference record the fact of oscillating between wanting to control and challenge the patient, or protecting himself from his attacks and withdrawing.

Axis 3: Intrapsychic conflicts. Both perspectives converged in codifying "submission versus control" as the main conflict. This conflict is characterized by a non-adaptive polarity between wanting to control others or feeling subjected to their demands. In the secondary conflict the judges and the therapist did not agree on the codification. On the one hand, the therapist marked an "identity conflict" as a secondary conflict. The identity conflict implies, according to OPD-2, two different conflicting roles for the patient. In this case, the therapist considered the roles "employee-singer". On the other hand, the judges raised as a secondary conflict a "self-esteem-conflict", characterized in the OPD-2 as a non-adaptive polarity between valuing oneself versus valuing the other.

Axis 4: Structural functioning of the patient. This fourth axis proposes an evaluation of the basic structural functions of a patient, that is, how the patient: a) perceives himself and the others, b) self-regulates and regulates relationships with others, c) communicates emotionally with himself and others, and d) relates to internal and external objects. Using an OPD-2 profile, more and less preserved areas of the patient's structure can be evaluated, as well as the level of structural integration, on a scale from "integrated" to "disintegrated". As can be seen in Table 1, in general terms, therapist and judges agreed on a good level of structural integration in Angel, that is, they converged on seeing a patient with a structurally integrated functioning. They also agreed on taking the issue of self-regulation as a relatively less integrated structural function than the rest.

Axis 5: Descriptive diagnosis according to DSM system. Finally, both the judges and the therapist coded a "Panic Disorder without Agoraphobia" as a DSM-5 diagnosis[34].

Table 1. *OPD-2 profile generated by external judges and therapist*

AXIS	JUDGES' VERSION	THERAPIST'S VERSION
Axis I	Experience of illness and prerequisites for treatment	
	Presentation of physical and psychological symptoms Concept of disease oriented to psychic factors, and slightly to somatic factors Concept of change: psychotherapeutic treatment Model of change: conflict-oriented and symptom-reducing No secondary benefits	
	Subjective suffering: low Observation-mentalization: low	Subjective suffering: high Observation-mentalization: mid

AXIS	JUDGES' VERSION	THERAPIST'S VERSION
Axis II	Dysfunctional relational patterns. Patient's perspective (perspective A)	
	Patient perceives that he, in relation to others …	
	Dominates, controls Demands freedom and autonomy	
	Shows little need	Opposes
	Patient perceives that others …	
	Reproach and blame	
	Admire Dominate and control	Don´t allow freedom and autonomy Withdraw affect
	Dysfunctional relational patterns. Others' perspective (perspective B)	
	Others (including therapist) feel that patient …	
	Places himself in the center of interest Withdraws and leaves	
	Dominates and controls	Attacks, harms
	Others (including therapist) experience that they, with respect to the patient …:	
	Oppose Reproach and blame	Dominate and control Protect themselves from attacks Withdraw and leave
Axis III	Intrapsychic conflicts	
	Main conflict: submission versus control	
	Secondary conflict: self-esteem-conflict	Secondary conflict: identity conflict
Axis IV	Structural functioning	
	Overall structural functioning: high integrated Mid-integration structural dimension: self-regulation	
Axis V	DSM-5 diagnosis: Panic Disorder without Agoraphobia	

OPD-2 foci proposed for the case

On the basis of the OPD-2 profiles generated (see Table 1), both judges and therapist selected five foci to work on in the treatment of Angel. Guidelines by Grande and team[29], as well as those of the OPD Task Force[6], were followed to make this selection, choosing five OPD-2 foci including: a relation focus, two conflict foci and two structure foci (see Table 2). Table 2 shows the agreement between judges and therapist with regard to the relation focus, implying patient's maladaptive oscillation between withdrawing and placing himself in the center of interest. This means that both perspectives agreed on the importance of working with Angel on his

withdrawals from relationships and his self-centered way of relating. With respect to the primary conflict there was convergence in the perspectives analyzed, while in the secondary conflict's coding there was a divergence.

Table 2. *OPD-2 foci proposed for the case by judges and therapist*

OPD-2 foci	Judges' perspective	Therapist's perspective
Relation focus (role offering)	Places himself in the center of interest Withdraws and leaves Dominates, controls	Places himself in the center of interest Withdraws and leaves Attacks, harms
Conflict focus 1	Submission versus control	Submission versus control
Conflict focus 2	Self-esteem-conflict	Identity conflict
Structure focus 1	Self-regulation (affective tolerance)	Self-regulation (impulses' control)
Structure focus2	External emotional communication (empathy)	Regulation of relation to others (interests' regulation)

The submission-control dynamic was related to a self-esteem conflict in the view of the judges, while for the therapist there was a conflicting opposition of two identities in tension. When comparing the structural foci, a convergence was found in the self-regulation dimension. However, judges highlighted Angel's difficulty in tolerating unpleasant affects while therapist pointed out patient's difficulty in managing his impulses. In the second structural focus there was no coincidence in the dimensions chosen by the therapist (interest regulation) and the judges (empathy). However, a relationship between both could be thought of since the capacity to empathize is linked to regulating one's own interests and those of others.

Finally, OPD-2 generates a strategic orientation of psychotherapy, considering the poles of structural vulnerabilities and intrapsychic conflicts as part of a continuum. In this case, for both therapist and external judges a predominant conflict-oriented treatment was considered for Angel.

Discussion

The present study described and compared similarities and differences in the construction of a psychodynamic profile, posed by two external judges and the treating therapist, regarding the same early dropout case of a focused psychodynamic psychotherapy. Therapist and judges used Operationalized Psychodynamic Diagnosis OPD-2[6] as a tool to build the comparative profiles including five therapeutic foci. As already mentioned in the introduction, in another work[15] results regarding the evolution of the case's therapeutic foci are presented. It is recommended to consider both sets of results in a complementary way for a better understanding of the analysis performed.

Both the therapist and the judges agreed on the patient's unconscious role offering, on his main conflict and on the level of overall structural functioning. This convergence brings validity to the categories of OPD-2

in our context, while illustrating central areas of the case's psychodynamics to be worked on. On the other hand, if these results are considered in relation to patient's dropout, the question arises as to whether these areas were not very accessible to the patient. In this line, the therapist could have intervened prematurely on appropriate aspects of the case dynamics, contributing to the interruption of treatment. Another hypothesis refers to whether the identified dynamic foci (egocentric posture, tendency to control relationships) marked in themselves a limitation towards a good establishment of the therapeutic alliance, leading to the unilateral termination.

Regarding the differences found between the perspectives of the judges and the therapist, different secondary conflicts were observed: the judges prioritized the self-esteem conflict and the therapist the identity conflict. Does this result mean, then, that by not considering the self-esteem conflict, the therapist's interventions could have impacted on patient's self-devaluation, adding to the interruption of the treatment? In a similar sense, could divergences in the selection of structural foci (affective tolerance and empathy for the judges, and impulse control and interests' regulation for the therapist), indicate that the therapist made interventions that were difficult for the patient to tolerate, contributing to abandonment?

Some discrepancies observed for the codification of the patient's experience of illness can be added to this line of thinking, such as the level of subjective suffering and the capacity of mentalization. While the judges coded a low level of subjective suffering and a low capacity for mentalization, the therapist did the opposite: he coded a high level of subjective suffering and a medium degree of capacity for mentalization. Taken together, these data may support the idea that the judges considered a different indication for psychotherapy than the therapist. Thus, the former saw a patient with greater difficulties in connecting with suffering and his emotional world than what was codified by the treating clinician. Again, it is plausible that the therapist interpreted more resources into the patient than were available, intervening at a level that was difficult for the patient to sustain, which would partly explain the early dropout. It is also possible that the therapist's live presence provided him with subtle and implicit information, which may have manifested itself in counter-transference terms, difficult for the judges to perceive, through a delayed coding of the material.

This analysis could lead to the conclusion that the patient's perceived reality is not the same as that of the therapists or the judges', but that these visions are enriched by each other and facilitate the understanding of the patient's suffering and phenomenology. Thus, when analyzing convergences and divergences, early dropout can be interpreted in two different ways: one line oriented towards the patient's limitations and the other towards the therapist's interventions. The first one would allow us to suppose that Angel's dynamics contributed by themselves to the unilateral termination of the treatment. The second one could indicate that the judges identified important elements of the patient that the therapist did not consider, leading to an interruption.

Finally, it is relevant to consider that, once patient had finished the treatment, he made it clear that it had been useful to him, contacting the therapist afterwards to pay fees. This situation sheds light on the

phenomenon of dropout, showing that from the clinician's perspective it can be understood as an early termination, but for the patient it can be a successful process[35].

In short, we are interested in highlighting the clinical utility of considering different perspectives of the same process, with the expectation, even, that different types of feedback[36] can be incorporated into the psychotherapeutic practice of our region. Likewise, we hope to have been able to illustrate the possibilities that a tool such as OPD-2 has within the field of psychodynamic practice-oriented research

Limitations

Having analyzed one case of focused psychodynamic psychotherapy, the conclusions of this study should be applied with caution to long-term psychoanalytic treatments, although research indicates that changes achieved in shorter therapies are equally stable[1]. In addition, it is necessary to consider the bias that may represent that treating therapist has taken the dual role of clinician and researcher. Finally, having analyzed a single case, it is important to note that results found could be linked to inherent features of this patient/therapist dyad. Therefore, future research should employ other methodologies that allow for generalizable inferences to be made for patients treated with focused psychotherapy.

References

1. Barber J, Sharpless B. On the future of psychodynamic therapy research. Psychother Res. 2015; 25(3): 309-320.

2. Levy R, Ablon J, Kächele H. Psychodynamic Psychotherapy Research. Evidence-Based Practice-Based Evidence. New York: Humana Press, Springer. 2012.

3. Dagnin P. Focus in Psychotherapy: Characteristics and trajectories through the therapeutic process. Tesis de Doctorado, Universidad de Heidelberg: Alemania. 2013.

4. Dagnino P, De la Parra G, Jaramillo A, Crempien C, Padilla O, Gómez Barris E, et al. El Devenir del Cambio: Cómo es y hacia dónde se dirige. Rev Argentina de Clín Psicol. 2014; 23(1).

5. Juan S, Pozzi A. La importancia de la noción de "proceso" para la práctica clínica y la investigación en psicoterapia psicoanalítica. Aperturas Psicoanalíticas. 2016; 53.

6. Grupo de Trabajo OPD. Diagnóstico psicodinámico operacionalizado (OPD-2). Manual para el diagnóstico, indicación y planificación de la psicoterapia. Barcelona, España: Herder. (2006/2008).

7. Gottdiener W, Suh J. Expanding the Single-Case Study: A Proposed Psychoanalytic Research Program. Psychoanalytic Rev. 2012; 99(1): 81-102.

8. Tillman J, Clemence A, Stevens J. Mixed methods research design for pragmatic psychoanalytic studies. J Am Psychoanal Assoc. 2011; 59(5): 1023-1040.

9. American Psychological Association. Evidence-Based Case Study. (S.f)

10. Kazdin A. Drawing valid inferences from case studies. En A. Kazdin (Ed.), Methodological issues and strategies in clinical research. Washington, DC: American Psychological Association; 2002. pp. 655–678.

11. Linardon J, Fitzsimmons-Craft E, Brennan L, Barillaro M, Wilfley D. Dropout from interpersonal psychotherapy for mental health disorders: A systematic review and meta-analysis. Psychother Res. 2018; 1-12.

12. Roos J, Werbart A. Therapist and relationship factors influencing dropout from individual psychotherapy: A literature review. Psychother Res. 2013; 23(4): 394-418.

13. Swift J, Greenberg R, Tompkins K, Parkin S. Treatment refusal and premature termination in psychotherapy, pharmacotherapy, and their combination: A meta-analysis of head-to-head comparisons. Psychother Theor Res Pract. 2017; 54(1): 47–57.

14. Rodríguez-Quiroga de Pereira A, Borensztein L, Corbella V, Marengo JC. The Lara case: A group analysis of initial psychoanalytic interviews using systematic clinical observation and empirical tools. Int J Psychoanal. 2018; 99(6): 1327-1352.

15. Juan S, Manubens R, Chávez I, López-Fediuk L, Roussos A, Gómez-Penedo JM. Focos terapéuticos en un caso de abandono temprano: perspectivas del terapeuta y de jueces externos. Investigaciones en Psicología. En prensa.

16. De la Parra G, Gómez-Barris E, Dagnino P. Conflicto y estructura en psicoterapia dinámica: el diagnostico psicodinámico operacionalizado (OPD-2). Mentalización. 2016; 6.

17. Juan S, Chávez I, López-Fediuk L, Manubens RT, Gómez-Penedo JM. Mecanismos de cambio en un caso único sistematizado de terapia psicoanalítica. En Comastri S (Coord.), Psicología Clínica y Psicopatología/ Psicoanálisis. Simposio realizado en las VI Jornadas de Investigación en Psicología, Universidad del Salvador en Buenos Aires, Argentina. 2018.

18. Fernández-Álvarez H, Castonguay L. Investigación orientada por la práctica: avances en colaboraciones entre clínicos e investigadores. Introducción. Rev Argentina Clín Psicol. 2018; 27(2): 107-114.

19. Kächele H. (2010). Distinguishing Psychoanalysis from Psychotherapy. Int J Psychoanal. 2010; 91(1): 35–43.

20. Luborsky L. Principles of psychoanalytic psychotherapy: A manual for supportive-Expressive treatment. Unites States of America: Perseus POD on demand. 1984.

21. Sifneos PE. Short-Term Dynamic Psychotherapy. Evaluation and Technique. New York: Plenum Publishing Corporation.1987.

22. Fiorini H. Teoría y técnica en psicoterapias. Buenos Aires: Nueva Visión.1973.

23. Jiménez JP. El tratamiento psicoterapéutico de la depresión: una visión crítica integrada. Aperturas Psicoanal. 2003; 13.

24. Summers R, Barber J. Psychodynamic therapy: A guide to evidence-based practice. New York: Guilford. 2010.

25. Thöma H, Kächele H. Teoría y práctica del psicoanálisis. Barcelona: Herder. (1985/1989).

26. Alexander F, French T. Psychoanalytic Psychotherapy. New York: Ronald Press. 1946.

27. Barber J, Crits-Christoph P. Dynamic Therapies for Psychiatric Disorders (Axis I). Estados Unidos, New York: Basic Books. 1995.

28. Grande T, Dilg R, Jakobsen T, Keller W, Krawietz B, Langer M, et al. Structural change as a predictor of long-term follow-up outcome. Psychother Res. 2009; 19(3): 344–57.

29. Grande T, Keller W, Rudolf G. What Happens After Treatment: Can Structural Change be a Predictor of Long-Term Outcome? En Levy R, Ablon J, Kächele H. (Eds.), Psychodynamic Psychotherapy Research. Evidence-Based Practice and Practice-Based Evidence. New York: Humana Press, Springer. 2012.

30. Juan S, Gómez Penedo JM, Roussos A. Proyecto de investigación: foco terapéutico y mecanismos de cambio en un caso único de psicoterapia psicoanalítica. Diagnosis. 2017; (14): 41-51.

31. Hill CE, Knox S, Thompson BJ, Williams EN, Hess SA, Ladany N. Consensual qualitative research: An update. J Couns Psychol. 2005; 52(2): 196-205.

32. Hill CE, Thompson BJ, Williams EN. A guide to conducting consensual qualitative research. Couns Psychol. 1997: 25(4); 517-572.

33. Juan S, Gómez-Penedo JM, Etchebarne I, Roussos A. (2011). El método de investigación cualitativa consensual (Consensual QualitativeResearch, CQR): Una herramienta para la investigación cualitativa en psicología clínica. Anuario de Investigaciones. 2011; Vol. XVIII, Tomo I: 47-56. Ediciones de la Facultad de Psicología, Universidad de Buenos Aires.

34. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Estados Unidos, Arlington, VA: American Psychiatric Publishing. 2013.

35. Olivera J, Challú L, Gómez Penedo JM, Roussos A. Client–therapist agreement in the termination process and its association with therapeutic relationship. Psychotherapy. 2017; 54(1): 88–101.

36. Areas M, Roussos A, Hirsch H, Hirsch P, Becerra P, Gómez-Penedo JM. (2018). Evaluación de un dispositivo de investigación orientada POR la práctica para el desarrollo de un sistema de feedback en psicoterapia. Rev Argentina Clín Psicola. 2018; 27(2): 229-249.

Correspondence

Santiago Juan

drsantiagojuan@gmail.com

Submitted on: 25/06/2020

Accepted at: 25/09/2020