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ORIGINAL ARTICLE

Patterns of change: tracking the therapeutic focus

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Abstract

Introduction: Brief dynamic psychotherapy has been increasingly important in the actual clinical practice. For its brevity, focalization must be accomplished. The work on focus consolidates the material, abbreviates psychotherapy, and is considered to be a change mechanism. Operationalized Psychodynamic Diagnosis OPD-2 proposes a concept of focus as the specific problem areas that are significant for patient's psychodynamics, in terms of relational pattern, inner conflicts, and structural vulnerabilities. The study on foci becomes a research and clinical imperative, where change on foci must be considered. **Aims & Methods:** This study aimed to (1) identify foci in change episodes and (2) establish the relationship between them during the process. A multiple single-subject design was used, considering the analysis of 13 outpatient psychotherapies done as treatment as usual (average of 18 sessions each process). OPD-2and Level of Presence of Foci were used to identify foci worked by therapist and patient during change episodes, already codified in a previous research usign the list of Generic Change Indicators. **Results & Discussion:** 208 change episodes were analysed. Conflict focus relates inversely with structural focus at the initial phase, and the latter appears to increase during the process. Some focus relates to different levels of patients change. Results are discussed in their clinical relevance.

Keyword: Focus; Change episode; OPD-2

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Introduction

The emergence of brief psychotherapy is probably better explained as an effect of the social, political, and economic changes occurred towards the end of the 20th century rather than as the result of progress in theory or research. Several authors (e.g. [1, 2]) highlight two elements identified as essential for the development of this approach. First, during and after World War I, it was necessary to provide large-scale, free analytic therapy. Secondly, due to an increased access to mental health services after 1980, people from different socioeconomic levels in the United States of America were able to receive therapy. The pressures for the existence of this service increased, which resulted in long waiting lists and a growing need to establish brief but equally effective treatment models. At the same time, the growing popularity of psychotherapy in the media increased people's awareness of such treatments, and thus their interest in them increased[3].

On the other hand, there is a significant and long-standing discrepancy between idealized theory and real-world practice that concerns the number of treatment sessions undertaken by most patients. Empirical studies have found that psychotherapy patients typically attend few treatment sessions[4]. This discrepancy is what Jiménez[5] has identified as "the clinicians' illusion".

Technically and theoretically, this demand had an effect specificallyon psychoanalysis, which up to that point it had mostly applied long-term therapies, employing techniques such as free association, free-floating attention, etc. The transformation of the "pure gold" of psychoanalysis into the "copper of direct suggestion" –in this case in the form of Brief Psychodynamic Therapy (BPT)–. As Jiménez[5] points out (alluding to Freud's metaphor), all golden objects have varying proportions of copper, because this alloy is harder and resistant to time. Focus is the pivotal difference between two treatment approaches which derive from essentially the same theoretical base[6].

Brief dynamic psychotherapy involves a psychodynamic comprehension of the patient and the form of his/her illness and psychic pain; thus, it requires specialized knowledge and training because it is neither a dehydrated long-term therapy[7] nor just less of the same[8]. In fact, this approach has led to the modification of theoretical assumptions and techniques which had been used for years, since requires, for instance, the therapist to be more active during the process. The central aspect of BPT is that the process unfolds around

a central therapeutic focus which is explored within a limited period of time[6]. The focus constitutes a main aspect of this type of psychotherapy, making it possible to be brief[1, 9].

Specifically, the task of focus selection is recognized as not only critical but as the aspect of brief therapy that is hardest to master[6]. In fact, therapists who have been trained in brief dynamic psychotherapy show better outcomes than those who have not[10-12], and trained clinicians feel that they are better skilled in brief therapy than are their untrained counterparts[13].

Using a therapeutic focus makes it possible to work on the patient's problem areas while at the same time limiting the length of the treatment.In general terms, focus can be identified early on[9, 14], it consolidates material and it abbreviates psychotherapy[6, 15]. On the other hand, focus gives shape and form to the patient's material and in doing so it makes a significant contribution to bringing the patient's inarticulate felt experience within the jurisdiction of form, and it also contributes in holding and containing that experience[16]. Therefore, the work on focus is considered as a mechanism of change[2, 15-19].

For this study focus can be defined as the area of the patient's problems, which underlies his/her current difficulties, or can best explain them[1, 20]. Therefore, is a thematic center of gravity, constructed in therapeutic interaction upon the basis of the material provided by the patient and the therapist's ability to understand and conceive it.Focus is not always the same, it is not rigid, and can change over time[1, 21, 22], enabling a sense of narrative cohesion which weaves together apparently unrelated sessions and helps to organize therapeutic experience.

Within the current field of psychodynamic research and practice, Operationalyzed Psychodynamic Diagnosis OPD-2[20] proposes a therapeutic focus' concept and operationalization that allows to systematically study foci's formulation and related mechanisms of change. For OPD-2, three are the areas that can become a focus; (1) dysfunctional relational patterns that considers the specific interpersonal constellations within which the behavioral modes of a patient and his/her interlocutor are limited to a rigid configuration, (2) internal conflictual configurations, that show a tension between two positions, motivated by a guiding affect, and (3) structural conditions considered as the expression of personality organization and the level on which this functions. Grande and colleagues[23] have shown that the selection of five foci has been sufficient to identify important aspects of a patient's psychodynamic profile. This study has also demonstrated that in every case the habitual dysfunctional relationship pattern should be defined as one of the foci. The remaining problems are selected from the areas Conflict and Structure.

When considering the psychotherapy process research reflections about the study of relevant episodes within session and throughout the process, it can be expected that foci may evolve, transform, or change. No studies have been found that look at foci, their relation and trajectory during the therapeutic process and not even their change during relevant episodes.One way of analyzing therapeutic process is to identify moments of patients´change. For this, change must be conceptualized. Krause, et al.[24], following the concept of Subjective Theory[25] which is cognitions about the view of the self and others in the world, and is usually an argumentative

structure which accounts for the way in which a person understands, explains, and functions in relation with the world and the self. Change is then subjective and is expected to evolve during the therapeutic process; that is, subjective change is sequential and can be regarded as a change in the representational sphere[26]. Krause et al.[24] produced a list of Generic Change Indicators which simplifies the identification of "markers" that can be selected from the session. From this markers change episodes can be delimited and therefore analyzed.

Study's aims

The aim of this study is to (1) identify foci in change episodes and (2) establish the relationship between them during the process. The hypothesis are that OPD foci can be identified and that they will relate in a way that relational patterns will be worked constantly and conflict focus will be present when structure focus is absent and vice versa.

Methods

Participants& units of analysis

13 outpatient psychotherapies done as treatment as usual (average of 18 sessions each process) where analysed. All of them were successful considering the Outcomme Questionnaire[27]. All therapies were done by clinicians with psychodynamic training with almost 10 years of experience. Therapists that participated didn´t knew about OPD-2 when delivering their psychotherapeutic processes. This project had the authorization granted by the Ethics Committee from Pontificia Universidad Católica de Chile and the Ethics Committee of Universidad Alberto Hurtado. Each participant signed a consent explaining the objectives of the study. The unit of analysis were the change episodes identified in each session. 208 change episodes were identified and analysed.

Measures and procedures

Operationalized Psychodynamic Diagnosis OPD-2[20]. Two expert clinicians trained in OPD-2 identified therapeutic foci in terms of: 1) relational pattern, 2) conflict and 3) structure for each patient through the observation of the two first interviews.

Level of Presence of Foci (LPF, [28]). The LPF was developed for the identification of foci in any segment of the process. It is a likert scale 0-4 (0=absence of the work on focus, 4=high work on focus).With the transcription of the change episodes (identified in a previous research) and the foci stablished by the two trained OPD-2 experts, two external judges identify which foci was being worked and its level of presence for each of the change episodes. Reliability was measured using the single Intra Class Correlation Coefficient (ICC,[29]), since the variables are continuous. For Focus 1 (relational pattern) ICCs ranged from .57 to .80. According to Fleiss[30]

they can be considered as fair to excellent. For Focus 2 (conflict) and Focus 3 (structure) ICCs ranges from .75 to .91 and from .72 to .82, respectively, both of them showing therefore excellent reliability[30].

Data analysis

A multiple single-subject design was used. Three generalized estimating equations (GEE) were used as data was nested within therapeutic processes. The three GEE had as a dependent variable, the level of foci presence, and were nested within Episodes of Change and Foci. As a predictor, the first GEE had the therapeutic phases, the second GEE had the foci, and the third GEE had the interaction between therapeutic phases and foci. Therapeutic phase (i.e., beginning, middle and final) was constructed considering the number of sessions of a therapy and dividing them by three. For example, a therapy that had 13 sessions: 5 were labelled "initial", 4 were labelled "middle", and 4 were labelled as "final".

Results

Identified foci in change episodes

As shown in Table 1, out of the 208 episodes of change that the 13 treatments presented, the most frequent was conflict focus (37,9%), followed by structural focus (31,5%) and relational pattern focus (30.6%).

Table 1. *Frequency of OPD Foci Identification in change episodes (N=412)*

	Foci Identified	
	F	%
Relational Pattern focus (OPD-2 axes 2)	126	30.6
Conflict focus (OPD-2 axes 3)	156	37.9
Structural focus (OPD-2 axes 4)	130	31.5

Relationships between foci during the process.

When analyzing the interaction among the phases of the process and the type of focus, results showed that there was a statistically significant interaction ($\chi 2$ (8 *df*)= 42.591, $p \leq .001$). Pairwise comparisons using Fisher's Least Significant Differences were conducted. Results showed that there was a statistically significant difference in the initial phase between Conflict Focus and Structure Vulnerabilities Focus ($p = .04$; see Figure 1). On the initial phase the more present the conflict focus, the less present the structure focus and vice versa.

On the other hand, when looking at the evolution of each focus during the process. There was a statistically significant difference in the Structural Vulnerabilities focus between the final and both the initial ($p = .04$) and middle phases ($p = .036$). This means that Structure Focus increases its presence during the process significantly.

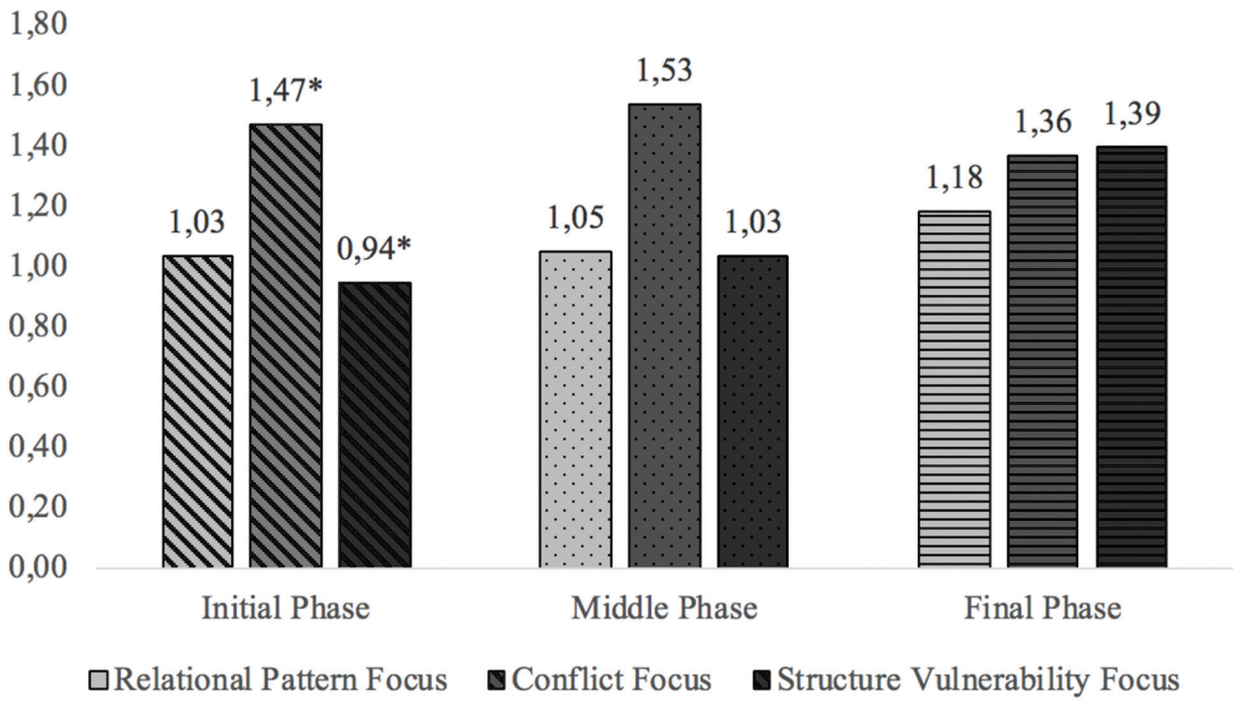

Figure 1. Interaction among the phases of the process and the type of focus. (p<.05)*

Conclusion and Discussion

Nowadays focus constitutes a central and defining aspect for the therapeutic work in the clinical practice, particularly for the brief psychotherapy model. This study searched for OPD-2 foci presence (relational patterns, inner conflicts and structural vulnerabilities) in 208 change episodes of 13 brief successful psychodynamic therapies. Results showed that OPD-2 system is able to describe what is really happening between patient and therapist, even in segments such as change episodes. Because these were therapists untrained in OPD-2, the successful identification of OPD-2 foci implies that the problematic areas defined by this system are really the core aspects of the therapeutic work.

When analysing the process differences were found, considering the relative presence of the different foci during the phases of the therapeutic process. At the initial phase of the processes conflict focus was significantly more present than structure functioning focus. In comparison, the presence of the foci on structure increases through the process and is higher in the final phase. As Rudolf and Grande[31] reported, foci constitute a gestalt between relational aspects, internal conflicts and structure. It is important to highlight that this were all successful psychotherapies. Results may imply, then, that to work initially on conflict allows to access the core features of patients´ problems rapidly. On the other hand, to increase the work on structural vulnerabilities may help the patient to sustain the change and to feel more ready to leave.

One of the limitations that must be considered to interpret these results is that patients' level of structural vulnerability were considered as middle-low, which suggests that their vulnerabilities were not a

huge impediment for the work on other foci at the initial phase of psychotherapy. It is hypothesized that this will be different on patients with more structural vulnerabilities.

This research has clinical implications, first it gives empirical validation to OPD-2 and a consolidation of the ability to identify and work on foci during the process. This system may help to train clinicians on the identification and work of foci allowing for brevity. This is important specially for public institutions were brief psychotherapy must be accomplished to fulfill the need of patients. By fostering close attention not to the whole session, but to the presence of foci in relevant segments, practitioners gain a 'royal road' to the way psychotherapy works on patients' problems[32]. Furthermore, as Greenson[33] said, the quality of the therapeutic intervention is an essential element, as long as the therapist knows what to say to the patient, when to say it, and how to formulate interventions in a helpful way.

Future research and limitations

The main limitation is the absence of patients with more structural vulnerabilities, this must be analyzed to see if there are differences in the way foci evolves during the process, but also because complex patients are the ones that mainly consult on public institutions. The other limitation lies in that these are successful psychotherapies and the analysis is done in change episodes. This also limits the results since it would be important to compare with other segments of the process (e.g. stuck episodes) or with unsuccessful psychotherapeutic processes. It would be interesting, for theory and clinical practice, to analyze the association between the presence and integration of foci during the different phases of the process and other elements of change, for example, the course of the alliance between patient and therapist.

In sum, it must be remembered that focalization arises from the need to abbreviate therapeutic processes, in order to deliver psychotherapy to people from different socioeconomic levels. Meanwhile, psychotherapies, even in private practices, tend to be brief. The results of this study, with its achievements and limitations, reveal the importance to continue studying therapeutic focus from a process view, since focalization and interventions on foci are central aspects when developing effective psychotherapeutic interventions. This line of research not only provides knowledge about psychotherapy as an effective tool, but also helps to develop orientations for the clinical practice.

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Appendix 1

Level of Presence of Foci LPF[28], based on the Heidelberg Structural Change Scale[20]

This scale allows us to describe the degree of foci presence in segments of psychotherapy. Alludes to an OPD-based foci definition and considers the foci as co-constructed between therapist and patient and is therefore a product of the dyad work.

Instructions: The evaluator must base his observation on the verbal interaction between therapist and patient during the segment of psychotherapy and must codify the level of presence of foci in each segment scoring the type of focus that the participants refer to. For this, the rater must consider the focus that has been established for the patient in particular. It is worth pointing out, that in one segment, several foci can be worked but at different levels so it is necessary to establish the level of presence for each of them (scoring the number of focus in the boxes on the right, e.g. on structure there may be three established focus for the patient, each of them will have a number that must be written on the box). In the case of Level 0, it can happen that patient and therapist are working on a topic that does not belong to the foci described for that patient, so if this level is scored, a small description of the talked theme must be written.
Rater: _____ _____ (First letter of mothers' and fathers' name) **Segment**: _____

Appendix 1 (cont.) Level of Presence of Foci LPF[28], based on the Heidelberg Structural Change Scale[20]

		Foci		
		Relational Pattern	**Conflict**	**Structure**
Level 0 Absence of work on the focus	Patient and Therapist do not refer to OPD focus. If the rater perceives that the focus is being acted (and not explicitly formulated) you must consider this level.			
Level 1 Vague reference to focus	Any of the participants refers vaguely the focus, that is to say that the rater has to be more inferential or go to higher levels of abstraction to deduce the focus, since this is not so evident. For example, in case of conflict focus the allusive theme is seen on third parties or in case of structural focus there is an unspecific reinforcement of structural themes.			
Level 2 Foci acknowledge and exploration	The focus is suggested explicitly, either by the patient or the therapist exclusively. The other dyad member acknowledges it but does not work on it. The other member of the dyad is able to recognize it but there is no work on it. Example, even though the therapists' discourse goes around the foci, the patient is only able to say, "yes, yes, it can be like that".			
Level 3 Work on the foci	Patient and Therapist refer to foci and their discourse goes around it, clearly both are working on it.			