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RESEARCH

Agreements and differences between psychoanalysts with regard to changes observed during a treatment. A quantitative exploration using the Three-Level Model (3-LM)

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ABSTRACT

The aim of this paper is to report the partial results of an exploratory investigation into how twelve psychoanalysts of different theoretical-clinical orientations perceive and use hypotheses about the phenomena of change in connection with selected material from a psychoanalytic treatment. The Three-Level Model (3-LM) was used for the observation of patient transformations and for the collection of data. This was followed by the statistical analysis of the behaviour and relationship of a set of variables relating to the type and degree of change perceived in the patient's mental functioning during the course of her treatment. The results reported here show that there was significant agreement among the participants, irrespective of their theoretical-clinical orientation, as regards the following: 1) the positive impact of the application of psychoanalytic treatment in diverse areas of the patient's mental functioning; 2) the explanatory hypotheses of the changes observed in the patient under consideration; 3) the usefulness of the experience of group exchange using the 3-LM in observing and understanding the changes in the patient.

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KEYWORDS
Psychoanalysis; empirical research; Three-Level Model; clinical common ground

Introduction

This paper reports the results of a pilot study into the way in which a group of psychoanalysts of different theoretical-clinical orientations analyse, discuss and cooperate in the production of hypotheses about the phenomena of change that are perceived and conceptualised during the presentation of clinical material from a psychoanalytic treatment, selected and presented according to the Three-Level Model (3-LM). The analysis of this type of group phenomenon is relevant for several reasons, including the need to generate legitimate channels of communication between professionals and to foster

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genuine scientific debate within our disciplinary field. We believe that the findings reported and discussed in this paper may encourage group exchanges about clinical material among colleagues, as well as inviting further reflection on the intersubjective agreements/disagreements that operate in the understanding of the processes of change that our clinical practice produces.

The problem of theoretical pluralism and the question of clinical common ground

The establishing of a single, official language that delimited the territory and epistemic identity of psychoanalysis responded to a foundational need in its historical origins. This enabled the hegemonic normalisation of forms of transmission and clinical practice, while at the same time marginalising other "impure" languages that were discredited and prohibited. But, over the years, "pluralism" was the best euphemism to speak of the ruptures and fragmentation of the Freudian movement, until it became a vehicle for the free expression of "heresies", previously unmentionable, without the risk of disavowal and rejection. In recent decades, "pluralism" has made it possible to covertly refer to the fragmentation of psychoanalytic knowledge and to a kind of truce between different schools of thought with the same ethnocentric basis (Bernardi 2003; Castillo and Mercadal 2020; Coderch 2006; Cooper 2008; Dahl, Kächele, and Thomä 2012; Fonagy 2002; Jimenez 2004; Leuzinger-Bohleber, Solms, and Arnold 2020; Wallerstein 2006). These same developments are recognised in different latitudes, including the River Plate region (Ahumada 1999; Aslan 2008; Bernardi 2001; Zukerfeld and Zonis Zukerfeld 2011).

This situation, which has already been analysed in detail by the aforementioned authors, has important negative implications for the development of our discipline. Without failing to acknowledge the importance of valuing diversity, the pluralism achieved in psychoanalysis nevertheless implies a series of underlying dangers: the hostility derived from *the narcissism of small differences* has led to a lack of effective communication between schools of thought, with the consequent absence of the controversies necessary to advance disciplinary knowledge within the framework of legitimate knowledge in the twenty-first century. Without this dialogue, scholarly debate and cooperative learning succumb to various forms of dogmatism and sectarianism, which are completely undesirable and unhelpful for any rational –and therefore collective – disciplinary development at this point in time.

The debate between Robert Wallerstein and André Green on the existence – or not – of *clinical common ground* has been the most significant public debate regarding the epistemological implications of contemporary pluralism in our discipline (Green 2000; Wallerstein 2005). A large proportion of the barriers to communication between analysts are raised when the examination of clinical material is based on theoretical principles that are considered the only admissible ones. This gives rise to the predominance of "top-down" deductive reasoning and the consequent exclusion of those phenomena that are imperceptible from each perspective. When this happens, agreements are only possible on condition that metapsychological principles are shared. However, if clinical common ground exists, it would offer a starting point to establish "bottom-up" inferential processes which would enable ascending progress from shared clinical experiences towards theoretical explanations with a higher level of abstraction (Bernardi 2017).

The use of theories in clinical practice and their investigation through systematic observation groups

Much has been investigated and written about the role played by the theoretical framework of reference for clinical practice in psychoanalysis. Some research has aimed to show how the same clinical material can be conceptualised from different theoretical perspectives, concluding that theory shapes technique (Hunter 1994; Pulver 1987). Other studies have suggested that adherence to a particular theoretical orientation is not reflected in the types of clinical indication selected by analysts, but rather in the way they organise and explain them (Leivobich de Duarte et al. 2002; Roussos and Leibovich de Duarte 2002). Other lines of inquiry have focused on the role that implicit and private theories play in the mind of the analyst during their work (Sandler 1983) and have drawn conclusions no less harsh than, for example, "psychoanalytic clinical practice is not logically deducible from currently available theory" (Fonagy 2006, 72) or "analysts do not do what they say (and believe) they do" (Canestri 2018, 157). Although this controversy remains active, there seems to be agreement that implicit theories assume the confluence of knowledge coming from not only the analyst's formal education, but also their own experiences as a patient and as a therapist, as well as from their personal life experiences and system of values (Bernardi 2016; Tuckett 1994). In summary, it can be said that these make up the core of the *conceptual, referential and operational schemas* that, according to Pichon-Rivière (1998), form the backbone of the work of each analyst.

Among the different strategies that have been developed in recent decades to address the questions raised in connection with "clinical thinking in action", *working parties* take prominence. These consist of the group discussion of clinical material using different procedures of data collection and analysis, providing alternatives for the production and transmission of psychoanalytic knowledge (Altmann de Litvan 2015; Faimberg 1996; Tuckett 2008; Vermote 2021). The systematic group approach to the psychoanalytic process centred around individual clinical cases enriches the understanding of the complex interaction between those therapist and patient variables that contribute to a better explanation of the changes which take place during treatments. This type of design is a necessary complement to traditional studies using populations with a control group and has been systematically integrated into psychoanalytic research (Bernardi et al. 2016; Eells 2011; Hinshelwood 2013; Kächele, Schachter, and Thomä 2011).

Among the group devices, the Three-Level Model for the Observation of Patient Transformations, which has been used here, constitutes a guide or a heuristic tool to observe the changes and transformations of the patient by means of three levels that gradually progress from clinical experience to theoretical inferences. In 2012 it was established as a psychotherapeutic research method in different parts of the world by the IPA Clinical Observation Committee (Altmann de Litvan 2015; Hanly, Bernardi, and Altmann de Litvan 2021). Originally intended as a model for discussion groups, with the aim of enhancing the complexity and intersubjective control of individual observations, it has progressively been consolidated as a tool for research in psychoanalytically oriented psychotherapies (Altmann de Litvan, Bernardi, and Fitzpatrick-Hanly 2021; Azcona and Zurita 2022; Garbarino, Luzardo, and Corti 2019; Rodríguez Quiroga de Pereira et al. 2018). Recent studies have highlighted its credibility, acknowledging its potential for clinical practice, training and research in psychoanalysis (Rodríguez Quiroga de Pereira et al. 2022).

The aim of this study was to investigate the opinions of a group of psychoanalysts of different theoretical-clinical orientations during their exchanges using the 3-LM, in order to provide empirical information about the levels of agreement and disagreement (implicit and explicit) with respect to changes perceived in a patient during her psychoanalytic treatment.

Method

Design

The design was exploratory-descriptive in terms of its objectives and quantitative, non-experimental in its approach (Hernández Sampieri et al. 2014). The results presented are based on cross-sectional data (see "Instruments") and, in some cases, are based on the written record and comparison of two different stages of a group discussion (paired data). This incorporates a longitudinal aspect to the design, which seeks to investigate changes in participants' clinical inferences before and after the group exchange about the clinical material.

Participants

Twelve psychoanalysts of different theoretical-clinical orientations working in public and private settings in the city of La Plata (Argentina) were selected to participate in the study on the basis of purposive sampling. Four participants self-identified as "Lacanians", four as "Bleichmarians" and four as "integrators".[1] Nine of the participants identified as female and three as male. The average age of the group was 42.3 years, and all participants had more than 10 years of previous clinical experience.

One of the participating analysts provided material from a case they had treated. The treatment modality was psychoanalytic psychotherapy of open-ended duration and its frequency was once a week. Transcripts of the session notes were used as material for the group exchange using the 3-LM. Specifically, two initial sessions, two sessions in the middle stage of the treatment and one session in the final stage of the treatment were selected. The case and session selection criteria were in accordance with the recommendations of the IPA Clinical Observation Committee (see Appendices 1–4 in Altmann de Litvan 2015) and in line with existing guidelines (Hanly, Altmann de Litvan, and Bernardi, 2021).

Instruments

The Three-Level Model for the observation of patient transformations

The 3-LM was used. This is a research tool that consists of presenting clinical material from a psychotherapeutic process in a face-to-face group setting of eight to fifteen participants, and then proceeding to critically analyse this material by means of three

[1] "Bleichmarians" is a term that here refers to psychoanalysts who predominantly use the theoretical-clinical model developed by Silvia Bleichmar (cf. Viguera 2019). "Integrators" refers to those who do not identify exclusively with a single theoretical-clinical model, but who use tools deriving from different theoretical approaches. In Argentina, integrationism in psychotherapy is a growing movement that represents a very significant sector of professionals (Muller 2008; Muller and Palavezzatti 2015).

consecutive steps or levels. Although the three levels constitute integrated parts of the clinical judgement, the model seeks to separate them temporarily in order to analyse them in detail (Bernardi 2015).

The first level, called the *Phenomenological description of transformations*, adopts a phenomenological perspective and seeks to describe the changes as they appear to the observer, whose perception is based on their previous experience. Participants are invited to share the "resonance"[2] generated by the material. This enables the identification of "anchor points" which the group uses to reflect on the patient's changes. Possible questions for group discussion at this level include, among others (Altmann de Litvan 2015, 359): Which aspects of the material suggest positive, negative or no change? Which are predominant? In which areas are changes observable (e.g. ability to love and sexuality, family and social relationships, work and leisure, interests and creativity, symptoms and well-being)? What is the patient's perspective on these changes?

The second level, called *Diagnostic dimensions of change*, seeks a more precise description of several operationalisable dimensions or categories that provide a more systematic profile of changes. To this end, it examines the possibility of identifying changes in: (a) a patient's subjective experience of illness; (b) their patterns of interpersonal relationships; (c) major intrapsychic conflicts; (d) structural behaviour; and (e) overall personality disorder or organisation. The questions at this level have been developed from three diagnostic manuals: the Operationalized Psychodynamic Diagnosis (OPD-2) (OPD Task Force 2008), the Psychodynamic Diagnostic Manual (PDM-2) (Lingiardi and McWilliams 2017) and the Level of Personality Functioning Scale (LPFS) from Section III of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (APA 2014). Among others, some of the questions suggested (Altmann de Litvan 2015, 360) are: What are the patient's beliefs about what is happening to them and their expectations about the treatment? What are the patient's interpersonal relationships like, especially with respect to bonds involving closeness and intimacy? What are the characteristics of the transferential–countertransferential relationship? What are the main conflicts (e.g. dependency vs individuation, submission vs control, need for care vs self-sufficiency, etc.)? Are defences adequate and flexible or predominantly dysfunctional, distorting or restricting internal and external experiences? Is the patient able to regulate impulses, affects and self-esteem adequately? Can the level of personality organisation be considered as neurotic, borderline or psychotic?

At the third level, possible interpretations or explanatory hypotheses about the nature of these changes are examined. The starting point is the foci on which the analytic work was based, according to the explicit or implicit conjectures of the psychotherapist. Finally, such conjectures are challenged using alternative hypotheses that may come from different clinical or theoretical approaches. Some of the questions suggested for group discussion at this level are, among others (Altmann de Litvan 2015, 362): What aspects were the analyst's interventions mainly focused on and what was the patient's response? Could there be other psychodynamic factors that should have been taken into account for the clinical work? What hypotheses or theoretical approaches can be perceived in the

[2]"Mutual resonance does not mean identical resonance. In physics, resonance occurs when one vibrating system causes another system to oscillate with greater amplitude within a certain frequency. In this sense, discussion groups act as a resonator, creating a multiplier effect between the different participants, but recognising that each of them reacts according to his or her own personal equation" (Bernardi 2017, 739).

analyst's work? What other hypotheses about the patient's problems and the way of addressing them could be formulated from other theoretical or technical perspectives?

In addition to the analysis and group discussion of the clinical material, the 3-LM includes the use of three forms containing different items referring to each of the three levels of the method, with response options on Likert-type scales. These forms are used to collect data related to the variables analysed with the 3-LM, thereby showing the modifications of implicit assumptions in clinical judgement based on the experience of group discussion. For example, these data relate to elements of the material or the determining variables that each psychotherapist initially identified to explain the therapeutic change and that were subsequently modified based on the exchanges of opinion with their colleagues (Altmann de Litvan 2015; Bernardi 2015).

The first form includes data on how each participant perceived the phenomenology of the changes in the clinical case which was presented (level 1 of the method). It is self-administered by the participants and consists of a double-entry table comparing the initial interviews with later stages of the analysis to measure the degree of change in three variables: "global changes", "changes in the patient's use of their own mental and bodily resources for treatment" and "changes in the patient's 'use' of the analyst and their interpretations". The scale provided for this evaluation consists of four possible values: "no change or worse", "slight positive changes", "moderate positive changes" and "marked positive changes".

The second form, intended for the moderator, aims to obtain information about the process of the group conversation, specifically about the characteristics of agreements and disagreements in the participants' arguments. It shows, for example, the number of participants who agree on a diagnosis or the level of organisation of the patient's personality.

The third form is self-administered and contains five parts, each of which aims to gather information on the perception and inferences of the participants and the impact which the group process has had on them. It is based on items with response options which have Likert-type scales:

1) The first part, which relates to level 1 of the method, replicates the measurement of the first questionnaire in a post-discussion group setting.
2) The second part relates to level 2 of the method and contains twelve items that elicit the participants' opinions about the patient's mental functioning at two different points in time during the treatment: "initial interviews" and "later sessions". Each participant scores these twelve items on a scale from 1 to 10, where "1" corresponds to maximum disturbances and "10" to minimal or imperceptible disturbances. A score of "0" is reserved for items where the participant feels there is insufficient information to answer or prefers not to answer. Some of these twelve items are: "relationship patterns", "experience and understanding of suffering", "impulse regulation", "bonds with others" and "internal communication and symbolisation".
3) The third part is concerned with each participant's opinion regarding the group's identification of the relationship between the treating analyst's interventions and the changes observed in the patient (level 3 of this method). It is structured in a double-entry table. The columns provide a scale broken down into 1 to 4 ("very little", "some", "quite a lot" or "a lot"), while the rows contain the items to be rated with respect to what the group identified: *1. types of interventions, 2. changes in the*

interventions over time, 3. changes in the patient's use of the analyst's interventions, 4. effects of interventions on observed changes, 5. parts of the material not addressed by the analyst, and 6. hypothesis about alternative interventions that address specific aspects of the material.

4) The fourth part relates to each participant's opinion of the group discussion and consists of applying the same four-choice scale ("very little", "some", "quite a lot" or "a lot") to the following three items*: 1. To what extent did you find the group activity useful in refining the observation of the material? 2. To what extent did you find it useful in conceptualising the dimensions of change? 3. To what extent do you feel that the theoretical explanatory hypotheses used are satisfactory for understanding the changes?*
5) An additional item was also added to the third form for each participant to show the theoretical-clinical orientation which they commonly apply in psychotherapy.

Summary of the clinical case

The following is a summary of the central aspects of the five treatment sessions selected by the treating analyst for presentation at the 3-LM meeting.

Parents who were separated requested a consultation because their daughter Mora, sixteen years old at the beginning of the treatment, was doing badly at school and was about to repeat the second year. They described their daughter as an introverted girl who hardly ever talked to anyone other than those in her intimate circle. Mora is the youngest of her sisters: she has one sister sixteen years her senior, who is the daughter of her father with an ex-partner; and she has another sister six years older than her, who is the daughter of her mother with an ex-partner. The father expressed concern because the oldest sister had found photos on social networks in which Mora appeared "half-naked" or smoking marijuana. Although, in the father's opinion, these actions meant that his daughter did not measure the risks of the situations, for the mother they were "things that kids get up to". She thought that Mora's father "is from the era of Cro-Magnon", that he "has no street cred" and that their daughter was "possessed by hormones". The father complained about not knowing or being able to enter Mora's world, and stated that he did not share either the use of technology or the mother's parenting criteria. However, they both agreed that Mora lied: she played truant and produced false sick notes with the stamp of a doctor who was a relative.

At the beginning of the treatment, it was difficult to establish the therapeutic relationship because Mora practically did not speak unless she was asked a question directly. The analyst suggested that she draw and, taking into account the patient's musical knowledge and interests, also invited her to rap. It is from the writing of rap lyrics that there came a more fluid communication with the analyst and, after a few months, these modes of expression began to develop into free association.

In one of the initial sessions, when asked by the analyst to draw a family, Mora, puzzled, asked, "What is a family?" Something similar happened when the analyst asked her to narrate something about this subject: "What is a life story, something real or made up?" She hesitated to draw her mother or father's family, unable to articulate a narrative of her place in relation to both parents.

In this initial period, what predominated was the patient's lack of awareness of what was happening to her: she barely registered her affective states or the reasons why she usually skipped school and lied to her parents. This disconnection that can be seen in

relation to her own affective mental states was in stark contrast to an exceptional degree of vigilance with respect to others: she was always attentive to the problems of friends and peers, and ready to think up solutions. This generated a strong feeling of discomfort.

The mother appeared to be represented by the patient as a series of significant contradictions between what she said and what she did, and repeatedly had episodes marked by an overflow of emotion caused by her angry feelings towards her daughter. She would repeat to her daughter: "You're my baby, I don't know what I would do without you", but when she got angry with her, would impulsively yell, "I can't live with you anymore", threatening to throw all of Mora's things out onto the street. After giving vent, her mother would become distressed and apologise for what had happened. She would cry and write letters of apology. Many times Mora ended up going to sleep with her mother so that she could calm her anxiety.

During the second year of analysis, Mora managed to pass all her subjects. She started going to rap competitions and began a project which involved cooking and selling food. After the summer holidays, she began a relationship with a boy and, at the same time, the lies and truancy returned. On several occasions she woke up at dawn and, without understanding why, left her mother's house, and without telling her, went to her boyfriend's house. This new link enabled analytic work related to the repetition of a relational pattern: Mora was attentive to her bond, ready to solve her boyfriend's problems. She was anxious because "he does not assess the consequences of his actions".

In that period, Mora described having panic attacks: she was short of breath feeling that "there was nowhere I could go", and that "I had to go". The analytic work made it possible to understand that these episodes were directly related to the behaviour of her mother. As a result, the patient began to feel openly angry with her mother, and made progress by discovering and working through the pain caused by the fact that the mother did not register what was happening to her daughter.

After two years of treatment, Mora was able to feel that her father's home was also her home. Around this time, certain scenarios took place which marked new beginnings: dinners with her father and her boyfriend, and having the power to be away from her mother without missing her. She also organised a physical space in her mother's house to start giving private music lessons. She no longer forged sick notes nor regularly skipped school; if she decided not to go for any reason, she would become upset and worry about the consequences.

Procedure

The participants were contacted personally and asked to provide informed consent. The group experience took place in a meeting in August 2019 at the moderator's home and lasted approximately 6 h.

The meeting began with the presentation of the clinical material by the treating analyst. At the outset, each participant received a copy of the material in which the lines of the text were numbered. After the presentation of the case and before any verbal exchange about the clinical material, the moderator asked the participants to complete the first form, marking with a cross the box that best represented their opinion. Subsequently, the group exchange continued at each of the three levels, based on recommendations and suggested questions (Altmann de Litvan 2015)

which were introduced opportunely by the moderator to guide the dialogue according to the method.

At the end of the group discussion, the moderator invited the participants to complete the third form. They were asked to mark with a cross the option that best represented their opinion in the first and third parts of the form, and they were asked to express their opinion by giving a score from 1 to 10 in the second part of this form. In addition, the moderator entered their opinion in the second form. This form enables the gathering of information from the group consensus regarding the type and degree of change in the patient – similar to form 1 – as well as the patient's personality functioning at the beginning and end of the treatment.

Data analysis

The information obtained from the 3-LM questionnaires was entered into a database and statistically processed. The behaviour and relationship of a set of variables of different kinds was analysed, as detailed below.

Given the size of the sample, the Wilcoxon signed-rank test for paired samples ($p < 0.05$) was used. This is a non-parametric test – an alternative to the Student's *t*-test – that enables the comparison of the mean rank of two related samples to determine whether there are differences between them. Given that the 3-LM enables the measurement of the participants' opinions regarding a series of variables (relating to the dimensions of change in the patient, level 2 of the method) with an ordinal scale from 1 to 10 relative to two different stages (at the beginning of the treatment and at later stages), this test was used here to analyse the difference in the measurement of the ranks, based on the comparison of the medians. Where statistically significant results were obtained, the size of the effect was calculated with the Wilcoxon two-sample paired test.

Given that participants could be grouped by theoretical-clinical orientation into three groups, a Kruskal–Wallis test (the non-parametric equivalent of a one-way analysis of variance [ANOVA]) was also used to determine whether or not there was a statistically significant difference between the median scores that each of these groups gave to the dimensions of patient change under consideration. Where there was evidence to reject the null hypothesis, a post-hoc comparison was performed using the Wilcoxon rank sum test to determine which groups there were differences between.

The degree of agreement between participants with different theoretical orientations with respect to the level 3 hypotheses was also analysed. For this purpose, the individual responses to the third part of the third form were averaged, thus obtaining scores by theoretical orientation for each ítem. The Fleiss kappa value was then calculated on the basis of these scores.

The Fleiss kappa index measures the degree of agreement between a number of raters who give categorical ratings to a set of items. It can be interpreted as the degree to which the number of agreements observed between raters exceeds what would be expected if all raters gave their ratings at random (Fleiss 1971). It has been used here to assess the level of agreement which existed, after the group discussion, among the participants of the different clinical-theoretical orientations with respect to six variables. These variables relate to the treatment of the explanatory hypotheses during the group work (cf. the third part of the third form).

Finally, Fisher's exact test was used (since the requirements for applying the chi-squared test were not met) to analyse the association between categorical variables: each participant's assessment of the model and theoretical orientation (the responses to the fourth and fifth parts of the third form).

All analyses were conducted using the RStudio programming environment, version 4.0.2.

Ethical aspects of the investigation

Prior to the implementation of the study, informed consent was obtained from the participating psychotherapists as well as the patient whose clinical material was used. This consent covered both the process of conducting the investigation and the publication of its results, ensuring anonymity and confidentiality, in accordance with the ethical principles and deontological standards integral to the field of research in this discipline.

Results

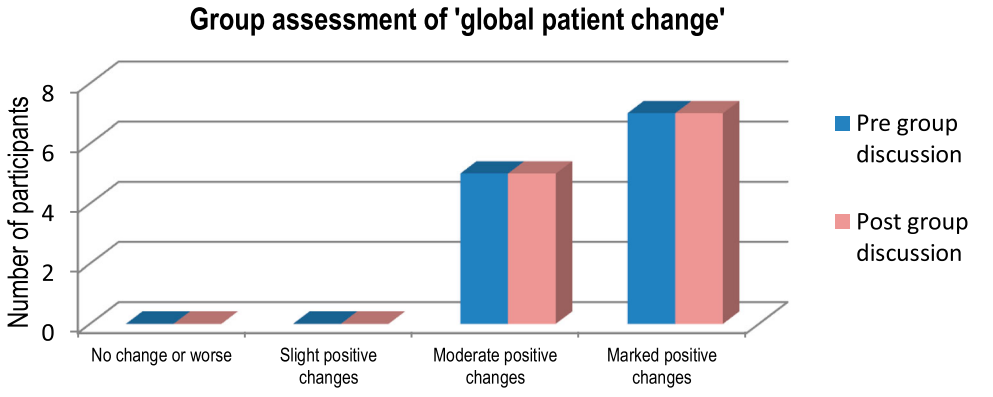
Level 1: Changes observed before and after the group discussion

The results of the pre- and post-group discussion measurements of the first form, which can be seen in Figure 1, show that, on the one hand, there was significant agreement among the participants as to the degree of change observed with respect to the three general variables, and, on the other hand, that the impact of the group discussion did not produce modifications in the variable "global change of the patient" but did produce modifications in the other two variables. For these variables, the post-group discussion measurement shows slight increases in the ordinal scale of values. Although the Wilcoxon signed-rank test did not yield statistical significance for this pre–post-group discussion comparison, it is considered that this result is worth reporting and will be discussed in the next section. Furthermore, the use of this statistical test in this case had considerable limitations due to the small sample size and a Likert scale with only four options. In addition, the resulting comparisons are reduced by omitting the "ties" in the pairs. As a result, the calculation of statistical significance may have been heavily influenced by the structure of our data.

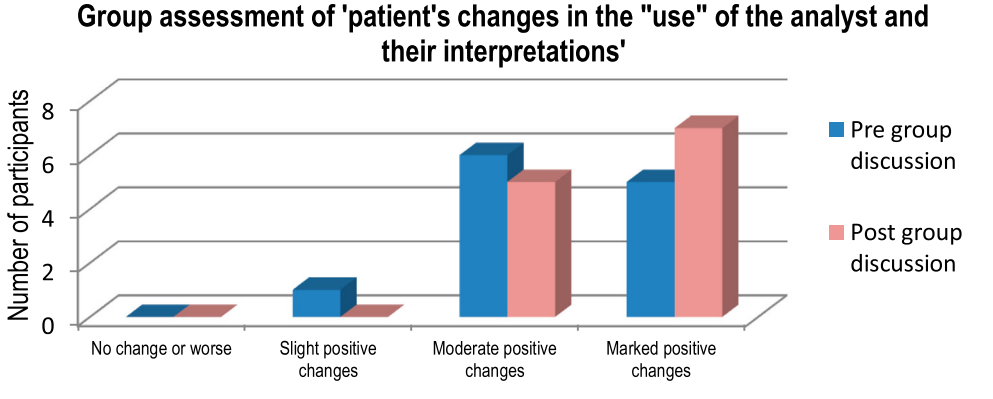
Level 2: Agreement with respect to the differences between the initial and later stages of analysis

Participants' opinions on a series of variables referring to dimensions of psychological functioning at the beginning and end of the treatment were analysed. For this purpose, participants were asked to score from 0 to 10 (1 corresponds to "maximum disturbances", 10 to "minimum disturbances" and 0 to "insufficient data/prefer not to answer") twelve variables, such as "relationship patterns with the analyst", "impulse regulation", "internal communication and symbolisation", etc.[3] The Wilcoxon signed-rank test showed statistically significant differences in all the pairs of variables measured ($p < 0.01$),

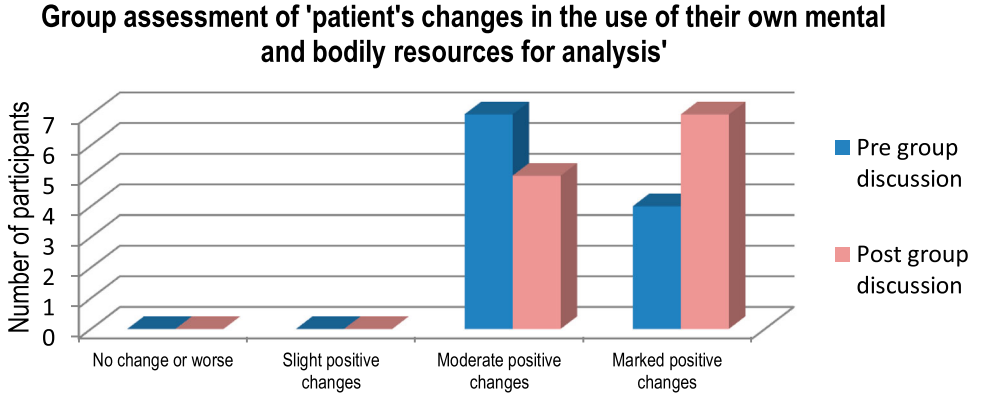
[3]For the form used, see Appendix IV in Altmann de Litvan (2015) and Appendix 15 (Hanly, Altmann) by Litvan and Bernardi (2021).



(a)



(b)



(c)

Figure 1. Pre and post group discussion measurements.

and the analysis of the size of the effect turned out to be large in all cases (>0.80). These results lead us to reject the null hypothesis, which postulates that there are no differences in the paired observations (in each of the twelve variables measured for the initial and

Table 1. Paired comparison – early and late stages of analysis – of the twelve level 2 variables using the Wilcoxon signed-rank test.

Level 2 variables	*p*-value	Size of effect
1. Experience of the illness: understanding the difficulties and seeing the potential for change	0.00372**	0.875
2a. Relationship patterns outside of analysis (before)	0.0036**	0.878
2b. Relationship patterns with the analyst (before)	0.00243**	0.887
3. Defences and conflicts (before)	0.00358**	0.878
4.1.a Self-perception, sense of identity and integrity of self (before)	0.00368**	0.876
4.1.b. Perception of others. Empathy (before)	0.00363**	0.877
4.2.a. Regulation of impulses, affects and self-esteem (before)	0.00235**	0.890
4.2.b. Regulation of the relationship with others (care of self and others, reciprocity) (before)	0.00232**	0.891
4.3.a. Internal communication and symbolisation (bodily and mental representation) (before)	0.00228**	0.892
4.3.b. Communication with others (depth and complexity of affects and representations) (before)	0.00235**	0.890
4.4.a. Links with internal objects (before)	0.00832**	0.829
4.4.b. Relationships with others. Ability to establish and end relationships, deal with separation, and the existence of a third party (before)	0.00216**	0.897

**p<0.05

subsequent sessions of the analysis) and statistically confirms that, for the discussion group, the application of psychoanalytic treatment made a significant difference in all areas of the patient's mental functioning (see Table 1).

The next question relates to whether the theoretical-clinical orientation of the participants has any influence on their evaluation of the patient's changes. According to the orientation with which they self-identified, the participants were divided into three groups: Lacanians ($n = 4$), Bleichmarians ($n = 4$) and integrators ($n = 4$). The differences between the medians of the scores assigned in all the patient change variables, for both the initial and later sessions, were then calculated. As the requirements for performing one-factor ANOVA were not met, for example because the level of measurement of our variables is ordinal (from Likert-type scales), the non-parametric Kruskal–Wallis variant was used. For the measurement of the scores related to the initial stage of the analysis, the test did not find a statistically significant difference between the three theoretical-clinical orientations (chi-squared = 5.8792, df = 2, $p > 0.05$), but differences were found for the scores which related to the final stage of the analysis (chi-squared = 20.852, df = 2, $p < 0.01$). To find out which groups were different, a post-hoc comparison was made using the Wilcoxon rank-sum test. Pairwise comparisons found differences between the Lacanian group and the other two groups ($p < 0.01$) (Figure 2).

Level 3: Agreement about the functioning of the patient and the usefulness of the group discussion

The aim was to ascertain the level of agreement in the group as regards the metapsychological hypotheses outlined to explain the changes observed in the patient.

The Fleiss kappa index is a statistical measure of the degree of agreement between a number of evaluators who assign categorical ratings to a set of items. It can be interpreted as the degree to which the number of agreements observed between raters exceeds what would be expected if all raters performed their ratings at random (Fleiss 1971). It was used here to measure the level of agreement that occurred, after the group discussion, among the participants of the different theoretical-clinical orientations with respect to six

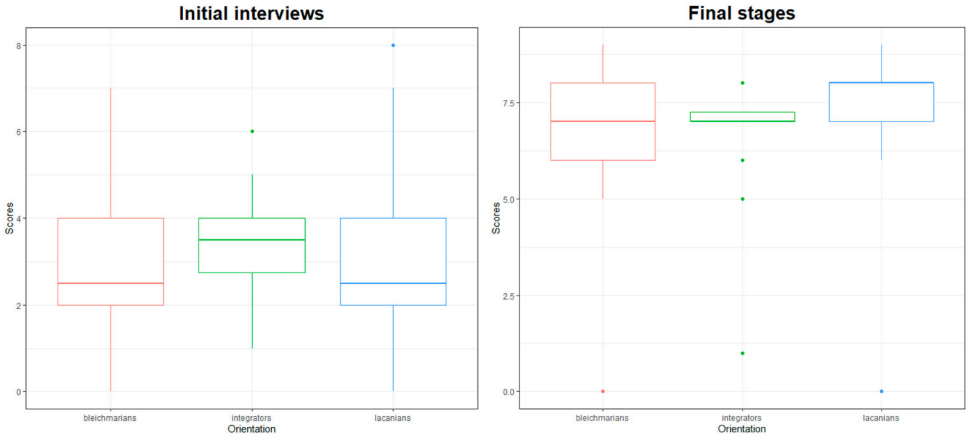


Figure 2. Participants' views on the patient's mental functioning, at the beginning and at the end of treatment.

variables that relate to the treatment of the explanatory hypotheses during the group work (see the third part of the third form).

By averaging the individual responses to the third part of the third form, it was possible to obtain scores by theoretical orientation for each item. The Fleiss kappa value was calculated using these scores and the following result was obtained: kappa = 0.783, $z = 3.86$, $p < 0.01$. This value shows a good level of agreement (Landis and Koch 1977), which can be interpreted as a significant degree of agreement between participants of different theoretical orientations as regards the group analysis of the explanatory hypotheses about the changes observed in the patient.

Finally, with regard to the relative frequencies of responses to the fourth part of the third form – concerning the usefulness of group discussion – it can be seen that most of the frequencies are concentrated around "quite a lot" or "a lot" (Table 2). A test of association was used to determine whether the theoretical orientation is related to the type of answers given in the fourth part of the third form, but no evidence was found to reject the hypothesis of independence between the two variables (Fisher's exact test, $p > 0.05$).

Discussion

Level 1

The results show that while there was significant agreement among participants as regards the degree of change observed in the three general variables, it is noteworthy

Table 2. Percentage of responses about the usefulness of the model.

Usefulness of the model to observe and understand changes	Very little or nothing	Some	Quite a lot	A lot
1. To what extent did you find the group activity useful in refining your observation of the material?	0%	25%	25%	50%
2 To what extent did you find it useful in conceptualising the dimensions of change?	0%	16.6%	41.6%	41.6%
3. To what extent do you feel that the theoretical explanatory hypotheses used are satisfactory for understanding the changes?	0%	16.6%	50%	33.3%

that the impact of the group discussion did not change the participants' views on "global patient change" but did change with respect to the other two variables ("patient's changes in the 'use' of the analyst and their interpretations" and "patient's changes in the use of their own mental and bodily resources for analysis"). Although this shift in some participants' opinions is not radical, since it is a matter of moving up or down a category on the Likert scale, it is interesting to highlight that this was mediated by the group discussion. A close look at Figure 1 shows that the changes of opinion have "grown" in the scale of options (in the post-discussion measurement, the categories denoting a greater degree of patient change show a higher frequency of opinions than those recorded in the pre-discussion measurement). This could be due to the fact that the exchanges between analysts enables, among other things, the broadening of the individual field of perception of the type of changes that have occurred in the patient. It may be that the sharing of alternative or complementary points of view has led to movements in the participants' appraisals. The following excerpt from the group discussion on level 1 illustrates this:

> Now that I hear you reflecting on how the patient became aware of the origin of her anger, of that "historical fury" as you say, I realise that this is a very important aspect of her modifications at the symptomatic level. (Participant 4)

> The same thing happened to me like you were saying. I was able to think about other aspects that changed in the patient as a result of what we were talking about. (Participant 11)

However, bearing in mind that the imposition of narratives is a phenomenon present in exchanges that generate collective memories (Muller and Hirst 2010), it is also worth questioning to what extent this slight modification in individual opinion could be motivated by the suggestive effect that the version of the most dominant figures in the group conversation has on the narrative subsequently agreed upon.

An important point for the group conversation at level 1 relates to those metaphors or images of the material that produce a greater shared resonance, as they form "anchor points" that drive the work of *clinical thinking* (Green 2010) with respect to the meaning of the changes under investigation. This type of resonance is a good testimony to the existence of clinical common ground which goes beyond the different metapsychologies (Bernardi 2017). In our case, the deliberate inclusion of analysts of different theoretical orientations did not prevent some of these anchor points from being quickly established. These constituted the nodes of the discursive network around which the group was interweaving throughout the experience in an attempt to capture the meaning of the evolution of the case presented. The following fragment illustrates the delimitation of one of these anchor points:

> I think that the place that the patient comes to occupy seems really remarkable, because she goes from passive silence to being able to show that she is actively angry. (Participant 2)

> I agree. She went from being overwhelmed by indifference at times or by the intrusion of the other, to being able to create a subjective distance thanks to the analytical space. (Participant 7)

> I have the impression that there was a high degree of engulfment on the part of the mother at the time of the consultation, which had been keeping her in silence until she could only run away, and that as a result of the analytical work she was able to start thinking and turning this around. (Participant 9)

> Yes, of course, because the mother's impulsivity and disorganisation seem to be the basis of her "drowning" and her need to escape. (Participant 4).

We believe that it is this work of clinical group thinking about anchor points that can best explain the differences that some participants showed in their opinions, before and after the group discussion, as regards the variables relating to the "use" of the analyst and their own resources for analysis.

Level 2

The results of the Wilcoxon signed-rank test show that, independently of what was verbalised during the group conversation, the perception of all participants coincides. They all agreed that the application of the psychoanalytic treatment made a significant positive difference in all areas of the patient's psychic functioning. It is important to highlight that this coincidence between the perceptions of intra-subject variability occurred in a group of psychoanalysts with different theoretical-clinical orientations and that this was recorded after a detailed discussion of the multiple dimensions of change in the patient (see Table 1). This degree of agreement not only provides information about the effectiveness of the treatment,[4] but seems to point to a high level of implicit agreement that is apparent despite the deliberations and conflicting views that the group dynamics openly displayed.

As regards the results of the Kruskal–Wallis test for the measurement of the scores relating to the initial stages of the analysis, the fact that no statistically significant difference was found between the three theoretical-clinical orientations can be interpreted as evidence of the agreement achieved by the group as regards the psychic functioning of the patient at the beginning of the analysis.

The fact that the Lacanian subgroup showed statistically significant differences from the other two subgroups with respect to the scores assigned to the final stages of the analysis does not necessarily mean that there is only one interpretation. If we analyse the box plot (Figure 2), we notice that the median of the Lacanian subgroup is 8 points, while for the integrators and Bleichmarians it is 7 points, which in conceptual terms is not a great difference. The arithmetic mean of the Lacanians' scores is somewhat higher than that of the other two subgroups: 7.47 for the Lacanians, compared with 6.79 for the Bleichmarians and 6.72 for the integrators, which indicates that, on average, they have perceived greater improvements in the patient than the other two subgroups have. However, the standard deviation (SD) shows a greater spread in the Lacanian subgroup (SD = 1.72) than in the others (SD for the integrators = 1.63 and SD for the Bleichmarians = 1.41), as this may be a subgroup with more variability in the clinical reading of the patient. In any case, due to the limited number of psychoanalysts per subgroup and the characteristics of the survey, it does not seem reasonable to draw further conclusions in this direction.

[4]We can here assume a distinction between the term *efficacy*, commonly referring to the results that a treatment achieves in the framework of a research trial, and the term *clinical effectiveness*, which refers to the outcome of a therapy in everyday practice (Fonagy 2002, 36). As regards the value that the convergence found could have for analysing therapeutic efficacy, it should be noted that the diversity in theoretical orientation still exists within the field of psychoanalysis in which all participants are included. As this is a group of psychoanalysts evaluating psychoanalytic treatment, it is important to question the extent to which certain kinds of bias may have been at work here, for example as a result of "loyalty to a model" (Leichsenring et al. 2017; Leykin and DeRubeis 2009). We elaborate on this aspect below, in the section on the limitations of this study.

An interesting future study would be to investigate, with larger samples and repeated measures, the extent to which the theoretical-clinical orientation of the analysts has an impact on the way in which changes in patients are evaluated. Bearing in mind that different psychoanalytic schools, with their different metapsychological models and technical orientations, have historically advocated maximum identity differentiation and, at the same time, the superiority of their own point of view over other theories and techniques, it would be interesting to measure the extent to which such openly proclaimed differences actually correlate with distinct ways of identifying and conceptualising patients' transformations using this device. The data collected in this study show that it is very difficult to differentiate theoretical orientations on the basis of what each participant expressed in the questionnaires.

Level 3

Complementing the findings above, the result obtained by means of the Fleiss kappa index allows us to interpret a significant degree of agreement between participants who identify with different theoretical orientations, with respect to the explanatory hypotheses of the changes observed in the patient (level 3). This level of agreement shows us that the diversity in theoretical affiliation does not prevent the identification of anchor points and shared resonances relating to some significant aspects of the clinical material under discussion, nor does it appear to hinder a consensus on hypotheses of greater conceptual scope.

This point is interesting for at least two reasons: first, because the inferential processes that lead to convergent or complementary explanatory hypotheses seem to be made possible by their basis in previously agreed clinical phenomena, evidencing a cooperative and bottom-up process that goes from shared clinical experience to the most convincing explanatory conjectures; and second, because of the problem of the relationship between the implicit theories used in clinical practice and the explicit theories that are commonly expressed in public scientific exchange. In line with Sandler's (1983) characterisation of the *elasticity* of our metapsychologies, the dialogue concerning the emerging explanatory hypotheses about the patient's transformations shows a flexible and partial use of metapsychological concepts and categories (Bohleber 2018). In the group exchange, it was noticeable how participants sometimes combined or sought to complement (perhaps as an effect of the reflective discussion) conjectures from different theoretical approaches, which contrasts with the public identity statements often made by the proponents of a theory, in which it is usually stated that there are a priori mutually incompatible theoretical postulates. The following is an excerpt from the group discussion that exemplifies this point well:

> The analytic work seems to have focused on the reorganisation of the identificatory postulates of the patient's ego at that stage of the treatment … (Participant 3)
>
> In line with your idea, I would say, using the approach I work with, that this operation of separation is what gives a new statute to the subject, allowing her to be armed in relation to the other, don't you think? (Participant 7)
>
> Yes, absolutely, because the adolescent reorganisation of those aspects of her narcissism enables her to take a fresh look at what the parental figures contribute … I think we are referring to the same thing but with different categories. (Participant 3)
>
> Absolutely! (Participant 7)

At times the conversation about the explanatory hypotheses of the previously agreed dimensions of change took place within the framework of *rigorous pluralism,* with the possibility of debating different ideas while understanding the alternative thinking of the interlocutor and accepting the possible modification of one's own thinking (Zukerfeld and Zonis Zukerfeld 2011).

A noteworthy aspect of group agreement relates to the technical procedure during the different stages of the analysis: despite the divergences that could be expected according to each theoretical orientation, all agreed, for example, on the general orientation that the analyst gave to the analytic process and also on the technical resources deployed (encouraging mentalisation and symbolisation of impulses, as well as the narration of the patient's own relationship history within the environment of her upbringing, intervening to enable the separation from the mother figure, etc.). This allows us to question how conceptual tools are actually used, since there are clear indications that this use differs from the declarative knowledge expressed in public communication connected to specific theoretical-technical schools of thought. Relatedly, the findings reported here seem consistent with the problem that "analysts may be using theoretical and technical ideas in their clinical work that differ in varying degrees from the ideas they consciously hold" (Hanly 2018, 40).

Although progress has been made in understanding the role of implicit theories in the generation of explanatory inferences in clinical practice, it is still not entirely clear how such knowledge is expressed in the shared dialogue until it converges into explanatory hypotheses about the observed changes. It can be said, on the basis of this study, that this convergence is perhaps, for the most part, independent of partisan affiliations to a theoretical orientation and is more related to what is shared at the level of the referential schemas operative in the clinical task.

Finally, the group's assessment of the experience of the 3-LM group exchange is positive, as most of the participants highlighted the usefulness of the model for observing and understanding the changes in the patient. The Fisher's exact test shows that this result is also independent of the theoretical orientation of each participant.

Some limitations of the study

One limitation of this study is that the theoretical affiliation of its participants was not representative of the totality of existing clinical-theoretical orientations. Another important limitation lies in the absence of process and outcome measures for the case used for the group discussion. Data collection, using specialised instruments relating to certain significant variables (therapeutic alliance, symptomatic evolution, mentalisation, etc.) at different stages of the patient's treatment, would have been useful to enhance the complexity of the type of research carried out. Finally, it would prove valuable to complement the analytical approach which was adopted with a qualitative phase, based on a systematic collection and analysis of complementary data, which could be triangulated in order to deepen the level of understanding of the phenomena under investigation. For example, it would be useful to investigate the narrative roles assumed in the group conversation and their moderating effect on the subsequent stabilisation of group memories, since it is these memories that are offered as input for discussion and as a basis for discursive consensus for the case under consideration (cf. Muller and Hirst 2010).

It is planned to replicate the design in the near future, overcoming some of the limitations mentioned above, in order to investigate the reliability of the results obtained.

Conclusion

The 3-LM experience made it possible to examine the group conversation and individual opinions about extensive clinical material, highlighting the generation of discrepancies and agreements with respect to the changes in the mental functioning of a patient during her psychoanalytic treatment. The clinical case presented led to the manifestation of shared resonances that made it possible to establish anchor points to guide the successive inferential processes regarding the operational dimensions of the changes and the most plausible explanatory hypotheses.

By placing an emphasis on a quantitative analysis of the data from the 3-LM questionnaires, it was statistically possible to establish that, for the discussion group, the application of psychoanalytic treatment made a significant difference in all areas of the patient's psychic functioning, and that the diversity of theoretical orientations did not hinder the dialogue or the cooperative work of clinical thinking. Furthermore, the emergence of explanatory hypotheses about the patient's transformations showed a flexible and partial use of metapsychological concepts and categories, as well as the possibility of combining and harmonising conjectures from different theoretical approaches. The existence of these coincidences, at the level of both the explanatory hypotheses and the technical procedures, contrasts with the public manifestations of identity usually made by the adherents of each psychoanalytic school, when they support, a priori, theoretical postulates and procedural strategies that they consider to be mutually exclusive.

Although several of the reported findings are consistent with previous reports that have analysed different variables related to group communication using the 3-LM, here we have added quantitative measures that enable their evaluation with statistical significance, assuming that such procedures complement the perspective gained from the available information and contribute to the provision of quality empirical data.

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Translations of summary

Accords et différences entre les psychanalystes au sujet des changements observés au cours d'un traitement. Une exploration quantitative au moyen du Modèle à trois niveaux (3 LM). L'objectif de cet article est de rendre compte des résultats partiels d'une recherche exploratoire sur la façon dont douze psychanalystes aux orientations théorico-cliniques différentes perçoivent et utilisent les hypothèses relatives aux phénomènes de changement, qui seront reliées à un matériel extrait d'un traitement analytique. Le Modèle à trois niveaux (3-LM) a été utilisé pour observer les transformations chez une patiente, ainsi que pour collecter des données, et a été suivi d'une analyse statistique du

comportement et de la relation d'une série de variables en lien avec le type et le degré de changement perçu au niveau du fonctionnement mental de la patiente dans le cours de l'analyse. Les résultats rapportés ici montrent qu'il y avait un accord significatif parmi les participants, indépendamment de leur orientation théorico-clinique, par rapport à : 1) l'impact positif de l'application du traitement psychanalytique à différentes parties du fonctionnement mental ; 2) les hypothèses explicatives des changements observés chez la patiente en question ; 3) l'utilité de l'expérience des échanges dans le groupe relatifs au 3-LM pour observer et comprendre les changements chez la patiente.

Übereinstimmungen und Unterschiede zwischen Psychoanalytikern in Bezug auf die während einer Behandlung beobachteten Veränderungen. Eine quantitative Untersuchung anhand des Drei-Ebenen-Modells (3-LM). Ziel dieses Beitrags ist es, die Teilergebnisse einer explorativen Studie darzustellen, in der untersucht wurde, wie zwölf Psychoanalytiker unterschiedlicher theoretisch-klinischer Ausrichtung Hypothesen über Veränderungsphänomene im Zusammenhang mit ausgewähltem Material aus einer psychoanalytischen Behandlung wahrnehmen und verwenden. Das Drei-Ebenen-Modell (3-LM) wurde für die Beobachtung von Patientenveränderungen und für die Datenerhebung verwendet. Darauf folgte die statistische Analyse des Verhaltens und der Beziehung einer Reihe von Variablen, die sich auf die Art und den Grad der wahrgenommenen Veränderung der psychischen Funktionsfähigkeit der Patienten im Laufe ihrer Behandlung beziehen. Die hier berichteten Ergebnisse zeigen, dass unter den Teilnehmern, unabhängig von ihrer theoretisch-klinischen Ausrichtung, eine signifikante Übereinstimmung in Bezug auf Folgendes bestand: 1) die positiven Auswirkungen der Anwendung der psychoanalytischen Behandlung auf verschiedene Bereiche der psychischen Funktionsfähigkeit der Patientin; 2) die Erklärungshypothesen für die bei den Patienten beobachteten Veränderungen; 3) die Nützlichkeit der Erfahrung des Gruppenaustauschs unter Anwendung der 3-LM bei der Beobachtung und dem Verständnis der Veränderungen beim Patienten.

Accordi e divergenze tra psicoanalisti rispetto ai cambiamenti osservati nel corso di un trattamento. Un'esplorazione quantitativa condotta con il Modello a Tre Livelli (3-LM). Il presente articolo si propone di riferire i risultati, ancora parziali, di un'indagine esplorativa circa il modo in cui dodici psicoanalisti di diverso orientamento teorico-clinico sentono e utilizzano ipotesi relative ai fenomeni di cambiamento presenti nel materiale clinico di un trattamento psicoanalitico. Il Modello a Tre Livelli (3-LM) è stato usato per l'osservazione delle trasformazioni dei pazienti e per la raccolta dei dati. A queste fasi ha fatto seguito l'analisi statistica del comportamento e delle relazioni di un insieme di variabili concernenti il tipo e il grado di cambiamento percepito nel funzionamento mentale del paziente durante il trattamento.

I risultati qui riportati mostrano una notevole convergenza di opinione tra i partecipanti, a prescindere dai rispettivi orientamenti teorico-clinici, relativamente ai seguenti aspetti: 1) l'impatto positivo dell'applicazione del trattamento psicoanalitico in diverse aree del funzionamento mentale del paziente; 2) le ipotesi esplicative rispetto ai cambiamenti osservati nei vari pazienti in esame; 3) l'utilità dell'esperienza dello scambio di gruppo quando si utilizza il 3-LM per osservare e comprendere i cambiamenti nel paziente.

Acuerdos y diferencias entre psicoanalistas sobre los cambios observados durante un tratamiento. Una exploración cuantitativa utilizando el 3-LM.. Se comunican resultados parciales de una investigación exploratoria sobre la manera en que doce psicoanalistas de distintas orientaciones teórico-clínicas perciben y utilizan conjeturas sobre los fenómenos de cambio en torno a material seleccionado de un tratamiento psicoanalítico. Se utilizó el Modelo de los tres niveles para la observación de las transformaciones del paciente (3-LM) para relevar datos, luego se analizó estadísticamente el comportamiento y relación de un conjunto de variables referidas al tipo y grado de cambios percibidos sobre el funcionamiento mental de la paciente durante el transcurso de su tratamiento. Los resultados que aquí comunicamos muestran que existió un acuerdo significativo de los participantes, independientemente del tipo de orientación teórico-clínica asumida, respecto de: 1) la incidencia positiva de la aplicación del tratamiento psicoanalítico en diversas áreas de funcionamiento mental de la paciente; 2) las conjeturas explicativas de los cambios observados en la paciente bajo consideración; 3) la utilidad de la experiencia de intercambio grupal con el 3-LM para observar y comprender los cambios en la paciente.

Palabras clave: psicoanálisis – investigación empírica – modelo de los tres niveles – terreno clínico común.

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