Interactions Between Obsessional Symptoms and

Interpersonal Dynamics: An Empirical Single Case Study

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Abstract

Background: Both classical and contemporary psychoanalytic theories stress the importance of interpersonal dynamics in treating neurotic symptoms. Associations between the symptomatic and interpersonal level were formally represented in the symptom specificity hypothesis (Blatt, 1974, 2004), which linked obsessional symptoms to an autonomous interpersonal stance. Findings from cross-sectional group studies on symptom specificity, however, don’t converge, possibly indicating that the complexity of associations is underestimated. Aim and method: This paper presents a ‘theory-building’ case study specifically aiming at refinement of the classical symptom specificity hypothesis by quantitatively and qualitatively describing the longitudinal clinical interplay between obsessional symptoms and interpersonal dynamics throughout a psychodynamic psychotherapy. Interpersonal functioning was assessed by means of the Core Conflictual Relationship Theme method (Luborsky & Crits-Cristoph, 1998). Results: Findings affirm a close association between symptoms and interpersonal dynamics. However, obsessional symptoms proved to be determined by profound ambivalences – manifesting both withinand betweenrelationships – between dependent and autonomous interpersonal behavior. Psychodynamic interventions focusing on interpersonal conflicts were associated with symptomatic alterations. Conceptual and methodological considerations, limitations and future research indications are discussed.

*Keywords:* Obsessional Symptoms, Interpersonal Characteristics, Psychodynamic, Empirical Single Case Study, Core Conflictual Relationship Theme.

Interactions between Obsessional Symptoms and Interpersonal Dynamics: An Empirical Single Case Study

Psychoanalytic theory has always stressed the centrality of interpersonal dynamics to the emergence and maintenance of psychic illness. An important focus of psychodynamic research has consequently been on the identification and description of specific relationship patterns, and their associations with symptomatology. In this respect, the symptom specificity hypothesis (Blatt, 1974, 2004, p. 155-157) discerns two major interpersonal styles that are distinctly associated with different types of neurotic symptoms. On the one hand, the *autonomous* style is hypothesized to be associated with obsessive-compulsive symptoms (e.g., obsessional ideas, compulsions, pathological doubt, inhibition), which are viewed as exaggerated attempts to install a sense of self-definition and separation from others. The *dependent* style, on the other, is related to bodily symptoms (e.g., somatization and conversion reactions) and phobias, considered as exaggerated attempts towards closeness to significant others. Over the past decade, Blatt’s symptom specificity hypothesis has been put to the test in several cross-sectional group studies, which yielded markedly inconsistent findings, both in clinical and in nonclinical samples (for a review, see Desmet, 2007).

The lack of converging results might be due to several conceptual and/or methodological issues related to the nomothetic research designs of these studies. *Conceptually,* the classical symptom specificity hypothesis has necessarily been reduced to less complex statements that were suitable for testing in cited designs. Hence, the tested operationalizations potentially yielded an underestimation of the complexity of associations (see also Desmet, 2013). Importantly, Blatt’s theory primarily aimed at defining complex clinical interplays between symptoms and interpersonal characteristics over time. *On a methodological level*, therefore, pertinent investigation into these dynamics actually requires longitudinal clinical data, in which co-variations between both levels can be observed over time or in the course of a therapy process. Still, up until now, all studies on symptom specificity (1) were cross-sectional in nature (i.e., relying on measurements of symptomatic and interpersonal features at one single time point) and, consequently, described static associations; (2) defined average, invariant tendencies in (large) groups of participants, resulting in rule-based, abstract knowledge that disregards intra-individual variability and (potentially relevant) contextual factors as confounds; consequently, it is unable to readily capture the multiple and dynamic factors operating in real-world clinical practice (e.g., Vanheule, 2014); (3) used solely quantitative, patient-reported measurement of participants’ symptomatic and interpersonal functioning, which are known to be subject to a variety of biases (e.g., Desmet, 2007; Schwarz, 1999).

Hence, rather than aiming at additional statistical testing of the classical symptom specificity hypothesis, there might first be need to *refine* it on some points. Empirical case research specifically allows for hypothesis-refinement, as it covers important areas that might be overlooked in nomothetic designs (Iwakabe & Gazzola, 2009). In order for theories to be clinically useful, they need to account for (1) *patterns* amongst the complexity of psychotherapeutic processes, and (2) specific *variations*, and the applicability of group-based findings to *idiographic* contexts of every-day clinical practice, where multiple dynamic factors operate in ongoing processes (in which research consumers prove to be particularly interested, e.g., Flyvbjerg, 2006; McLeod, 2013; Stiles, 2009). In integrating (intra- and extra-therapeutic) contextual influences into thick descriptions of naturally unfolding processes over time, empirical case studies provide a distinctive, unique way of contributing to scientific development and the advancement of clinical knowledge (McLeod, 2013).

**Aims and hypotheses**

Addressing the methodological and conceptual issues raised above, the aim of the present ‘theory-building’ case study (Stiles, 2009) is to suggest areas where the classical symptom specificity hypothesis (Blatt, 1974, 2004) possibly needs to be *refined*, in order to be closer to both the complex theoretical underpinnings as to clinical dynamics. Symptom specificity is tested, therefore, in an empirical case study of a patient with obsessional complaints, who was treated in a real-world clinical practice by means of supportive-expressive psychodynamic therapy (Luborsky, 1984). The aim of the study is two-fold: (1) to test concrete operationalizations of the classical symptom specificity hypothesis (see below), and (2) to thoroughly investigate the dynamic unfolding of associations between the patient’s symptomatic and interpersonal functioning throughout therapy. The additional discovery-oriented nature of the study thus scopes for the detection of distinctive, unexpected findings, which could indicate where the classical hypothesis possibly needs to grow. In doing so, we address both recommendations of earlier research on symptom specificity to make use of longitudinal designs (e.g., Pilkonis, 1988) in mental health clinical settings (e.g., Huprich, Rosen, & Kiss, 2013; Werbart & Forsström, 2014), and broader claims in psychotherapy research to direct research endeavors towards the increased use of idiographic research (e.g., Barlow & Nock, 2009; Dattilio, Edwards & Fishman, 2010; Hill, 2012; Iwakabe & Gazzola, 2009; McLeod, 2013; Stiles, 2009; Vanheule, 2014).

In order to enhance the ‘credibility’ (Morrow, 2005) and ‘trustworthiness’ (e.g., Elliott, Fischer, & Rennie, 1999; Hill, 2012) of the study, Consensual Qualitative Research for Case Studies (CQR-c; Jackson, Chui and Hill, 2011), was used as an overarching data-analytic approach. This well-established, systematic method was specifically developed to assess clinically rich and complex material, by addressing the data through different perspectives in a team of researchers. During multiple team meetings, systematic, in-depth discussion between team members on how different data sources complement and/or contradict each is explicitly installed, until all team members agree on the best representation of the data (Hill, Thompson, & Williams, 1997). The consensus process thus serves as a means of triangulating the researchers’ understanding of the data. Moreover, critical intercommunion between theory (deductive) and data (inductive) results in a more meaningful understanding of the studied phenomena (Dattilio, Edwards, & Fishman, 2010), which is pivotal to high-quality case reports (McLeod, 2013).

To systematize empirical investigation of interpersonal behavior, ‘Core Conflictual Relationship Theme’ methodology (CCRT; Luborsky & Crits-Christoph, 1998) was used. This method is specifically based on Luborsky’s (1962) theory that an individual’s relational exchanges are underpinned by a typical ‘core conflict’. As symptoms are claimed to be rooted in this core conflict, Luborsky (1962, 1984) theorized that psychotherapeutic endeavours aiming at transforming this conflict will bring about symptomatic changes; as previously evidenced by e.g., Grenyer and Luborsky (1996), Luborsky and Crits-Christoph (1998), and Slonim, Shefler, Gvirsman, and Tishby (2011). Hence, in line with the supportive-expressive therapy under study, CCRT-methodology provides conformity between the treatment as conducted by the therapist, and the researchers’ method of analyzing the narrative data extracted from this treatment. Moreover, it allowes for reliable and systematic analyses (e.g., Wilczek, Weinryb, Barber, Gustavsson and Asberg, 2000), while staying close to the complexity of clinical experience.

In order to optimize the possibility of capturing intended complexities, and to illuminate distinct aspects of (the broad spectrum of possible changes in) the variables under study (e.g., Hill, Chui, & Bauman, 2013), extensive multiple method and multiple source data sets were gathered. Symptomatic and interpersonal functioning, and their associations, were assessed regularly throughout treatment and during follow-up, in both a quantitative and qualitative fashion, from the perspectives of patient, therapist and researchers (see ‘Procedure’). Symptoms and associated mental distress were additionally mapped via saliva cortisol concentrations (i.e., biomarker of distress) and health care costs (i.e., all mental and physical health related expenses, and job absenteeism; see Method). As such, clinical judgment, which is primarily based on the patient’s (face to face) narratives and non-verbal conduct during treatment sessions (“the most direct and observable changes”; Hill, Chui, & Baumann, 2013, p.75), could importantly be nuanced by the gathering of additional, more ‘objective’ information on therapeutic progress. Quantitative measurements offer insight into the amount of symptomatic, general and interpersonal problems at various moments during therapy. Yet, predetermined items on standardized measures are at risk of not accurately reflecting a patient’s subjective experience of well-being (Hill, Chui, & Baumann, 2013), which does not always coincide with a mere reduction in symptomatic and/or interpersonal problems. In this respect, qualitative study of the patient’s narratives during sessions rendered additional, contextualized documentation.

Consequently, operationalizing interpersonal characteristics by means of the CCRT-method, the classical symptom specificity hypothesis (Blatt, 1974, 2004) leads up to the following expectations with respect to symptomatic-interpersonal associations in the patient under study:

1. Before therapy (during the intake phase) we expect the obsessional symptoms to be accompanied by an autonomous interpersonal style, expressed in an exaggerated emphasis on self-definition and separation from others. (1a) Quantitatively, we expect the patient will show an autonomous sub-profile on the Inventory of Interpersonal Problems (IIP-32), rather than a dependent sub-profile (see Desmet, Meganck & Vanheule, 2013); (1b) Qualitatively, we expect the following CCRT-components (Luborsky & Crits-Cristoph, 1998) to underpin the patient’s relational exchanges: Wishes (with which he enters exchanges) = independence, self-control, self-assertion, being acknowledged and respected, achieving; Responses of Other (i.e., his appraisal of how the other person responds to these wishes) = critical, controlling, opposing, not respectful; Responses of Self (i.e., his own subsequent responses) = anxiety, self-doubt/uncertainty, guilt, feelings of failure, (struggles with) aggression, vengeful fantasies.
2. Throughout the therapeutic process, we expect that the supportive-expressive therapy will reduce the exaggerated strivings towards autonomy and that, as a consequence, obsessive-compulsive symptoms will diminish. (2a) Quantitatively, we expect that scores on the IIP-autonomy profile will decrease progressively throughout therapy and that the decreasing IIP-scores will be correlated with decreasing scores on symptoms and general distress; (2b) qualitatively, we expect that changes in the autonomous CCRT’s throughout therapy (particularly in the RO- and RS- components, e.g., Crits-Christoph & Luborsky, 1990; Grenyer & Luborsky, 1996) will be accompanied by changes in the obsessive-compulsive symptoms.

**Method**

**Participants**

**The patient** was a 29-year old Caucasian man. He was a secondary school graduate and a blue-collar worker, who was referred by his general practitioner due to intrusive obsessions. Patient provided written informed consent (approved by the University Ethics Committee) to participate in the study and to publish the individual case materials. All possibly identifying information has been changed to protect confidentiality.

**The therapist** (third author) was a 36-year old Caucasian, man, who held a PhD in clinical psychology, received three-year postgraduate training in Freudian-Lacanian psychoanalytic psychotherapy, and had six years of clinical experience at the start of therapy.

**The research team** consisted of one female assistant professor, two postdoctoral researchers (one male, one female), and two PhD students (one male, one female). They were all Caucasian, ranged in age 24-35 years, and were trained in Freudian-Lacanian psychoanalytic psychotherapy.

**Therapy**

Patient received 22 (40- to 60-minute) sessions of supportive-expressive psychoanalytic psychotherapy (Luborsky, 1984) over 11 months, conducted in the therapist’s private practice without interference of the research team. Session frequency varied between once a week and once every month, with an average frequency of one session every two weeks (see Figure 1). In-depth discussion of the therapeutic process, including specific examples of supportive and expressive techniques, is provided in Results Step 3.

**Measures**

**Symptoms and general well-being.**

***Idiosyncratic item on specific obsessional symptom.*** Constructed by the research team to specifically assess the severity of the patient’s obsessional symptom. This item was named “obsessional thoughts”. The patient was instructed to score the extent to which he suffered from these thoughts in the past week on a Likert scale from 0 to 10 (0 = did not bother me at all/did not occur at all; 10 = it troubled me intensely).

***The Symptom Checklist - 90 - Revised*** (SCL-90-R; Derogatis, Lipman, & Covi, 1973) is a 90-item self-report questionnaire assessing general psychological and physical functioning with good psychometric qualities (Derogatis, 1994). Items are scored on a 5-point Likert scale.

***Global Assessment of Functioning*** (GAF; APA, 2000) is a widely used clinician- or researcher rated measure of psychiatric symptom severity and functioning on a psychological, social and occupational level. The scale can be used to track clinical progress of individual patients in global terms. The overall GAF scale scores range from 0 to 100 and are divided into ten deciles of functioning.

***The General Health Questionnaire - 12*** (GHQ- 12; Goldberg, 1972; Koeter & Ormel, 1991) is a 12-item self-report questionnaire used to assess general psychological distress. Items are scored using a 4-point Likert scale. The GHQ’s validity and reliability was demonstrated by Koeter and Ormel (1991), and by Vanheule and Bogaerts (2005) for the Dutch version.

***Saliva stress hormone levels****.* Concentrations of cortisol (μg/dl) were measured in saliva samples by means of mass-spectrometry, following the standard practice in salivary hormone research (e.g., Kirschbaum, Bartussek, & Strasburger 1992). Cortisol is considered a biomarker of an activated stress response. It plays a key role in numerous models that link (chronic) stressors to psychiatric as well as medical disease (Miller, Chen, & Zhou, 2007).

***Health care costs.*** Via the patient’s health insurance fund all health care costs were retrieved, spanning from two years before intake until follow-up 7 months after treatment termination. Costs include medication use (i.e., psychotropic and other), medical consultations (excluding the psychotherapy discussed in this paper) and job absenteeism.

***Semi-structured Change Interview*** (SCI; Elliott, 1999; Elliott, Slatick, & Urman, 2001) is an in-depth qualitative outcome interview, used to assess the way the patient experienced the therapeutic process, the changes that occurred during therapy, and the processes that might have brought about these changes.

**Interpersonal functioning.**

***The Inventory of Interpersonal Problems - 32*** (IIP-32; Horowitz, Alden, Wiggins, & Pincus, 2000) is a 32-item self-report questionnaire with eight subscales reflecting different interpersonal problems. Items are scored on a 5-point Likert scale. Psychometric properties of the Dutch version were positively evaluated by Vanheule, Desmet, and Rosseel (2006). Desmet et al. (2008) developed a scoring system for an anaclitic/hysterical and an introjective/obsessional IIP profile.

***The Core Conflictual Relationship Theme (CCRT) Method*** (Luborsky & Crits-Christoph, 1998) is a qualitative, systematized and reliable measure of the central relationship patterns that pervade self-other interactions (Wilczek, Weinryb, Barber, Gustavsson, & Asberg, 2000). Within the patient’s narratives, two researchers selected Relationship Episodes (RE’s), i.e., discrete episodes in which the patient spontaneously spoke about concrete relational exchanges, decomposed in (see Introduction): (1) ‘Wishes’ (W), (2) ‘Responses of Other’ (RO), and (3) ‘Responses of Self’ (RS). The most typical W’s, RO’s and RS’s constitute the final CCRT-formulation.

**Procedure**

Data collection happened according to the following procedure: (1) therapy sessions were audiotaped by the therapist, and transcribed verbatim by a postgraduate research assistant; (2) after every session, the patient completed IIP-32, GHQ-12, and the idiosyncratic item in the therapy room in the presence of the therapist; (3) after every session, the therapist made a brief session report in which he summarized important dynamics at the level of symptomatology and interpersonal functioning; (4) after the first session, after every eighth session, after the last session, and at follow-up (i.e., 4 and 7 months after treatment termination, respectively), the patient completed a more extensive set of questionnaires at home (i.e., IIP-32, GHQ-12, idiosyncratic item, SCL-90, BDI-II) and provided a set of 8 saliva samples (gathered on 4 consecutive days prior to the day questionnaires were filled out; one morning and one evening sample each day); and GAF-scores were administered by a research team member (except for second follow up); (5) during first follow up, SCI was administered by a research team member, and health care cost information was retrieved.

**Data analysis**

Data-analysis included three steps: a quantitative and qualitative outline of evolutions in patient’s symptoms (Step 1), interpersonal functioning (Step 2), and their associations, embedded within a broader description of therapy process (Step 3).

In Step 1, one member of the research team (referred to below as ‘researcher 1’) constructed graphs on quantitative evolutions in all outcome measures of symptoms and general well-being (see Figures 1 and 2). To assess significance of change, the ACORN Toolkit (specifically designed to help clinicians and researchers calculate change related statistics for a variety of outcome measures; Brown, Simon, Cameron, & Minami, 2015) was used to calculate Reliable Change Indices (RCI; identical to RCI formula of Jacobson and Truax, 1991, but with one-tailed 95% confidence intervals; see Brown et al., 2015) and severity adjusted effect sizes (SAES; Brown et al., 2015). Next, two research team members (i.e., ‘researchers 1 and 2’) attentively listened to audiotapes and read the transcripts. Both were equally informed of relevant patient demographic information and therapy characteristics (see Hill, 2012), but researcher 2 was blind to quantitative graphs. Both researchers separately identified all events where the patient explicitly referred to his obsessional symptom, and marked symptomatic evolutions throughout therapy with respect to intensity, content or form. Through subsequent discussion on the most profound changes, consensus was reached on identification of the main ‘tipping points’ (i.e., specific moments in the chronicle of events that turn out to be crucial for further development; Tarrow, 2004). In case of divergence, members engaged in discussions in which they questioned each other on their ideas, so that every opinion was fully expressed and understood (see also Jackson, Chui, & Hill, 2011; Schielke, Fishman, Osatuke, & Stiles, 2009) until both members agreed on the best representation of the data (Hill, Thompson, & Williams, 1997). A concise qualitative description of symptomatic evolutions was provided by researcher 1, reviewed by a third team member (familiar with the raw narrative data), and consequently refined.

In Step 2, researcher 1 constructed similar graphs on evolutions throughout therapy in interpersonal characteristics (see Figure 3), measured by IIP-32 total scores, and dependent and autonomous IIP-32 sub-profiles (see Vanheule, Desmet, & Rosseel, 2006). Again, RCI and SAES were computed using the ACORN Toolkit (Brown et al., 2015) to assess significance of change. Next, researchers 1 and 2 conducted CCRT analyses for the first therapy sessions, the ‘tipping point’-sessions selected in Step 1, and the last sessions. In a first phase, both researchers attentively re-read transcripts of the identified sessions, individually selected all RE’s that were suitable for CCRT coding (i.e., RE’s that contained W’s, RO’s and RS’s), and gathered to select by consensus the 10 most informative RE’s. When sessions yielded less than 10 informative RE’s, additional RE’s were selected from the preceding and/or following sessions. In a second phase, selected RE’s were then written down in a separate document and coded using the standardized coding system (Standard Category List, Edition 2; Luborsky & Crits-Christoph, 1998, p.26). In line with Hill et al. (2011), judges distinguished between (a) RE’s describing interactions with *specific people*,and with *people* *in general*, (b) W’s, RO’s and RS’s occurring in *all* RE’s (General, G), in *at least half* of RE’s (Typical, T), and in *less than half, but at least two* RE’s (Variant, V). Researchers strived towards consensus on identified RE’s (phase 1) and CCRT-codes of identified RE’s (phase 2). In case of divergence, researchers engaged in extensive discussions (see Step 1), and gradually refined initial ratings by integrating valuable contributions of the other until consensus codes were reached (see Hill, 2012). Judges’ proportions of agreement (RE’s: .88, W’s: .80, RO’s: .83, RS’s: .80) indicated acceptable correspondence for initial ratings. Finally, researcher 1 organized consensus CCRT-codes in Tables 1 – 4, which were checked for accuracy and comprehensiveness by researcher 2.

In Step 3, researcher 1 calculated longitudinal intra-subject associations (i.e., correlations between two series of repeated measures within the same subject) between evolutions in patient’s symptomatic and interpersonal level of functioning. Next, researcher 1 engaged in a ‘thick description’ (Pontoretto & Grieger, 2007) of the longitudinal, clinical interplay between both levels throughout therapy, in which changes in quantitative measures were linked to the treatment narrative (Dattilio, Edwards, & Fishman, 2010) and significant therapist interventions and extra-therapeutic events were discussed. Several precautions were taken to reduce researcher 1’s biases and expectations and to present a ‘truer’ account of the data (see Hill, 2012): prior to writing, researcher 1 orally presented provisional analyses to a third research team member (familiar with the raw narrative material) and a colleague (uninvolved in the research project, but familiar with theoretical orientation and phenomena of interest, and informed about research questions), who extensively questioned her in order to focus findings more clearly in response to research questions; during the writing process, researcher 1 continually returned to raw materials to stay close to the patient’s narratives, including sufficient detail and literal quotes of the patient to validate presented findings; and the manuscript was reviewed several times by the team member and colleague described above, to identify areas in need of further attention, which were subsequently refined.

**Results**

**Step 1: Evolutions in Obsessional Symptoms**

**Analysis of outcome data.**

[Insert Figures 1 – 2 here]

Figure 1 shows a generally descending trend over the course of the therapy (session 1-22) on self-report measures, idiosyncratic item, and cortisol concentration, and generally increasing GAF-scores. Decreases in self-reports reached significance when assessed by means of RCI (GHQ-12: RCI = -2.82, *p* < .05; SCL-90: RCI = -6.495, *p* < .05), and large SAES were observed (GHQ-12: *d* = 1.69; SCL-90: *d* = 1.59).At follow-up, changes are maintained, except for cortisol concentrations that rise again to exceed pre-treatment levels.

Several peak values can be noted during treatment (addressed Results, Step 3, qualitative description). Scores on the idiosyncratic item peaked during sessions 2, 3, 8, 15, and 16; and largely coincide with similar peaks in GHQ-12 scores.

The top two graphs of Figure 2 show that the patient’s main health costs are due to frequent consultations of the primary care physician, six ambulant hospital admissions, and two residential hospitalizations (which were all due to medical conditions, of which one was “stress-related”, i.e., stomach infection). Eight months after treatment termination, the patient started taking antidepressants again. The bottom graph of Figure 2 depicts the total sum of health costs added with two periods of job absenteeism. The first period (two weeks, May 2012) was due to bronchitis (for which his employer covered expenses). The second period spanned two months (June-July 2012, see first peak in bottom graph) just before the onset of treatment, and was due to a diagnosis (made by his primary care physician) of “depression and fear” (for which the patient received a disability allowance from his health insurance company of approximately €1000 per month). In terms of average health care costs per month, costs were highest during the treatment period. Post-treatment costs prove to be similar to expenses prior to the pre-treatment crisis in June/July 2012.

**Qualitative description of evolutions.**

Note: literal wordings of the patient (indicated by double quotation marks) are quoted to illustrate researchers’ remarks, as natural language “more closely represents the psychological reality of human experience” (Camic, Rhodes, & Yardley, 2003).

At the onset of therapy, John’s complained of obsessional “thoughts” or “images” that “suddenly jump into my mind” several times a day, and that pictured him stabbing his girlfriend Lisa with a knife. His attempts to ward off the images and to hide his intense confusion and anxiety for his surroundings, absorbed so much energy he was exhausted and irritable during most part of the day, felt depressed, and had difficulties concentrating at work (see two-month period of job absenteeism, Figure 2). In addition to alterations in symptom intensity throughout therapy (see Figure 1), several changes occurred in the content/form of the obsessional scenery: the described scene was “suddenly replaced” by intrusive images of past sexual interactions with his best friend Greg (session 7, *tipping point 1)*; by continuous “flashes” of Greg’s genitals (session 9), provoking a major increase in suffering (see Figure 1); by commanding and prohibiting “thoughts” or “voices” (sessions 10-11); again by “flashes” of Greg’s and male genitals (session 14); and anew by the original knife scene, accompanied by intense fears of “actually stabbing Lisa this time” and subsequent withdrawal to his parents’ place (session 15, *tipping point 2*); after which “thoughts about the knife” only “occasionally popped up” and “disappeared rather quickly” (sessions 16-22); and negative “counter thoughts” temporarily flickered again (sessions 18-19). In the last session, John declared he no longer found it necessary to continue therapy: symptom frequency and intensity had decreased significantly, it no longer inhibited him in living peacefully together with Lisa, and he felt much more energetic. During the follow-up interview, maintenance of improved symptomatic and general well-being (see Figure 1) was affirmed.

**Step 2: Evolutions in Interpersonal Functioning**

**Analysis of outcome data.**

[Insert Figure 3 here]

Similarly to Figure 1, Figure 3 shows a generally descending trend in IIP-32 scores throughout therapy and during follow-up, which reaches significance when assessed by means of the Reliable Change Index (RCI = -2.68, *p* < 0.05) and corresponds with a large severity adjusted effect size (*d* = 1.07). Scores for the dependent sub-profile are overall higher than for the autonomous sub-profile. Peak values are observed in sessions 4, 9, 13 (specifically for dependent sub-profile), 15 (coinciding with *tipping point* 2, Step 1) and 17; and are further addressed in the qualitative description of Step 3.

**Analysis of CCRT-codings.**

[Insert Tables 1 – 4 here]

***CCRT’s in RE’s with specific others.***

*With parents.* In early sessions, John generally wished (W) to be loved and to be guided in making choices; generally experienced them (RO) as over-controlling, but attributed this overprotection to their love and best interests for him. He usually considered himself (RS) too dependent of them, but felt highly uncertain when faced with autonomous choices. Throughout therapy, John increasingly wished (W) to free himself from his parents’ control; current RE’s decreased significantly, whilst past, frustrating RE’s with his mother increased; and he progressively succeeded in making independent choices (RS).

*With best friend Greg*. In early sessions, John typically wished (W) to be independent and respected, but experienced Greg (RO) as controlling and untrustworthy, making him feel (RS) dependent, uncertain and anxious. Throughout therapy, John increasingly wished (W) to be opened up to and to be close, but typically experienced Greg (RO) as punishing and distant, arousing (RS) guilt and uncertainty, and leading to a steep decrease in RE’s.

*With girlfriend Lisa.* In early sessions, John typically wished (W) to be loved by Lisa but felt rather disappointed (RS) due to frustrating RO’s. Around *tipping point 1*, he began to voice (unexpressed) anger (RS) towards her. Throughout therapy, RE’s increased, accompanied by new W’s to achieve, and a greater variety of positive RO’s and RS’s.

***CCRT’s across all interaction patterns.***

In early sessions, John typically wished (W) to be his own, self-assertive person, and to be loved; but he typically experienced others (RO) as un-respectful and controlling; provoking feelings of (RS) dependency, uncertainty, anxiety, and disappointment. Throughout therapy, John increasingly wished (W) to achieve and better himself, experienced more positive RO’s of cooperation and the granting of independence (except for RE’s with parents and Greg), and described RS’s of self-confidence and happiness.

**Step 3: Associations between Symptomatic and Interpersonal Level**

**Analysis of outcome data.**

Longitudinal intra-subject correlations between IIP-32- scores on the one hand, and ‘Obsessional Symptom’-, GHQ-12-, SCL-90- and GAF-scores, on the other, affirm a positive association between the patient’s interpersonal dynamics and his symptomatic and general well-being (*r* = .260 with Obsessional Symptom, *ns; r* = .695 with GHQ-12, *p* < .01; *r* = .866 with SCL-90, *ns*; *r* = -.555 with GAF, *ns*). Although observed correlations were high (medium to large effect sizes), they did not reach significance due to the small number of measuring points.

**Qualitative description of association.**

Note: in referral to Luborsky’s (1984) manual of supportive-expressive therapy, concrete therapeutic interventions are italicized and designated as ‘expressive technique’ (‘ET’) or ‘supportive technique’ (‘ST’), including the related page in the manual. Literal wordings of patient or therapist are indicated by double quotation marks (“…”).

John entered therapy feeling greatly distressed and confused (visualized in the peaking SCL-90 and low GAF-score in Figure 1) due to obsessional ideas that had “suddenly come out of nowhere” two weeks before the onset of treatment, after “three lovely months” with Lisa, his first girlfriend ever, and which had since then daily “jumped into” his mind at various, unexpected moments during the day. *Incited by the therapist (ST, p.87)*, John described during the first therapy session that these obsessional ideas generally appeared as “images” that pictured himself in the act of stabbing Lisa with a knife. Noteworthy, as John’s symptom depicted the performance of an aggressive act by himself on another person, the interpersonal factor had right from the start of treatment been present in the content of the symptom itself. *When the therapist pointed this out to* *John* *(ET, p.94)*, the latter immediately appended that he experienced his symptom to stand “between me and Lisa”, “inhibiting me to fully engage in our relationship”, and thereby “spoiling our happiness” (session 1); again indicating a certain function of the symptom within an interpersonal relationship.

Yet, during the initial sessions, John repeatedly passed over *the therapist’s repetitive queries to provide more details (ST, p.87, p.89)* on this specific scene, by hastily adding very empathetically that he experienced the aggressive content of this scene to be in great contrast with both his complaisant nature and his tender feelings towards his girlfriend. Hence, reflecting his incapacity to recognize these “images” or “thoughts” as his own thoughts, he invariantly referred to them as “those black/bad thoughts” or most often “that knife” (e.g., “I saw that knife again”, session 1), thus placing the symptomatic appearances outside his conscious self, explaining their fear-inducing and intrusive nature.

Yet, denying any aggressive feelings towards his girlfriend, but *encouraged by the therapist to elaborate* *(ST, p.87, p.89;* session 2) on the aggression staged in the symptomatic scenery, John alluded to his best friend since childhood, Greg: “When you cite aggression, the first person I think of is Greg”. *Again egged on by the therapist to expand (ST, p.87, p.89)*, John explained that, as a child, he had longed - but also dreaded - to break out of his parents’ safe - but suffocating - boundaries, and had thus become attracted to Greg’s audacious spirit. Spending all their free time together, Greg had generally taken the leading role in deciding what to do, and John had followed. However, over the past two years, Greg had become increasingly more dominant and possessive over John, and had even regularly persuaded him to engage in sexual activities together, to which John had each time very reluctantly consented (i.e., he masturbated Greg, but never allowed Greg to touch him). Feeling ashamed, he had always kept this a secret for others. Hence, the therapist embodied the first person he had ever (though deeply embarrassed) confided in; an act that indicated the patient’s experience of a *supportive alliance* and which immediately yielded a feeling of “great relief”.

Yet, despite his resulting frustration and to his own amazement, he was reluctant to “let go of” Greg (session 2), unaware of the motives for his submissive behavior. Having met Lisa three months before the onset of therapy, he had seen an opportunity to break free from Greg’s tight grip, had engaged in a relationship (with her), and had moved in with her shortly afterwards. Since then, he had met Greg only occasionally and when he had done, the latter had always reacted distantly and dismissively, which – *as specifically asked for by the therapist (ET, p.121)* – had made John feel confused and disappointed (see also Tables 1-4).

However, not seeing “what on earth this [contextual elaboration] had to do with Lisa”, John initially (sessions 1-3) kept hitting the same two questions, which also occupied him “day and night” outside of therapy: (1) “Why on earth would I want to hurt Lisa, what has she ever done to me?” and (2) “Why am I unable to let go of Greg, now I am finally free from his dominance and engaged in such a good relationship?”; while his narratives continually circled within the same rigid framework of (a) Greg as a dominant, non-respectful man towards whom he only felt frustration, (b) Lisa as a sweet girl towards whom he only felt love, and (c) himself as a complaisant, non-aggressive man.

In session 3, therefore, *the therapist interrupted John’s repetitive moans* about the on-going strangeness of his symptom (also reflected in the first upsurge in GHQ-12- and ‘Obsessional Thought’-scores in Figure 1) and *explicitly directed him to contextualize his remarks by asking him to illustrate the specific situations in which symptomatic flares occurred (ET, p.94, p.131)*. Next, as *the therapist indicated a possible common denominator apparent in John’s recited examples (ET, p.110, p.118, p.131; ST, p.89)* (i.e. “the knives” predominantly “popped up” at those moments when Lisa unpredictably changed their plans - e.g. to do an extra shift at work or to go out with friends - leaving him “alone at the house”) this immediately brought about ruptures in the above mentioned framework.

First- in reference to (a) – it opened up John’s discourse to a theme that would frequently re-appear throughout the whole therapy, i.e.: he was not used to being home alone, as either his mother or Greg had always wanted him around. Elaborating on the subject in the following sessions, he gradually started to recognize that their habitual dominance over him did not solely arouse resentment (as he had stressed thus far), due to frustrated longings towards autonomy, but also made him feel familiarly safe, protected and loved. *In response to further inquiries of the therapist (ST, p.87, p.89; ET, p.131)*, he began recollecting memories of past amusing interactions with Greg, who had not always been as manipulative as during the past two years, but could also be a very enjoyable person, who had reliably guided him in his attempts to break the conservative boundaries set by his parents. While reminiscing, it began to dawn on John that the fear, uncertainty and confusion he felt lately, was induced by the recent absence of Greg’s familiar bossing around, which confronted him with a void. (see also Tables 1-4).

Simultaneously - relating to (b) - John cautiously started to acknowledge some irritation towards the unpredictable, and thus, unreliable Lisa. When (sessions 4-6) *the therapist introduced a possible distinction (ET, p.110, p.114, p.121)* between this resentment and his previously uttered (fiercer) frustration towards Greg and his mother, John steadily realized that (on the up side) Lisa, unlike the latter, did respect him in his longings for autonomy and positively stimulated him in exploring and developing his own interests and ambitions, which generated his caring feelings stressed thus far. However, as she never instructed or guided him in this process, he alsobelieved she left him “too independent”, which made him feel anxious and unloved (see Tables 1-4). John suddenly perceived that his resulting resentment was rooted precisely in those feelings. This “understanding” immediately generated a feeling of “relief”, as “linking” the initially alienating feelings to this interpersonal determinant made them less frightening.

Next – relating to (c) – *as the therapist suggested that (ET, p.114, p.121; ST, p.82)* (session 3) in contrast to the (thus far sketched) portrait of “John, the complaisant man”, shared by both others and himself, there did seem to lurk some aggression in him, John surprisingly started to disclose about bottled up frustrations that frequently led to “outbursts of anger” when no one was watching (e.g., hitting something in the backyard), though startled by these late frustrations. *Incited by the therapist to elaborate on this newly raised theme (ST, p.87, p.89; ET, p.114)* of aggression (sessions 4-6), John gradually started to distinguish a pattern of which he had previously been unaware, i.e. in his tendencies to never communicate any of his wishes and needs to others, nor the resulting irritation and disappointment whenever they frustrated these (unexpressed) wishes. As *the therapist further inquired after (ST, p.87, p.89; ET, p.114, p.131)* determinants for this behaviour in the light of his autonomous longings, John reminisced that on those rare occasions when he had acted against the will of either his mother or Greg (e.g., buying the car he always wanted), each time something bad had happened (e.g., a car accident), of which his mother and Greg had repeatedly reminded him in an angry, cold and punishing manner, (see Tables 1-4). Thereupon, *the therapist paraphrased that (ET, p.107, p.114, p.118; ST, p.89)*, based on these experiences, John’s pursuit of personal choices and desires had progressively become linked to conflict and to others’ rejection and withdrawal of love, shedding light on an apparent competition between these longings towards independence, and wishes to be cherished (see ‘ambivalence’ discussed in Results Step 2). Committedly enunciating that he had “never looked at it that way”, John now recognized he had generally chosen a conflict-avoidant, submissive position towards others – even to the point of repeatedly consenting to sexual activities he profoundly disgusted – out of deep-seated uncertainty and fear; an (newly gained) understanding he named “very interesting, it enlightens a lot of things”.

Yet, intensified focus on the theme of ambivalence during sessions incited climbing agitation levels outside therapy and entailed a first intense symptomatic shift. In session 6, preceding the first symptomatic ‘tipping point’(see Results Step 1), John intensely struggled with the ambivalence “Should Greg stay or go?”, feeling he had to choose between him and his girlfriend. Prompted by the experienced contrastbetween Lisa’s stimulation and Greg’s “total lack of respect for him”, he ended this session with the decision to “break contact with Greg and put Lisa in first place”. The following session, however, John exclaimed in panic that the obsessional images of “the knives” had disappeared, but had suddenly been “replaced” by intrusive images of past sexual activities with Greg, which likewise “jumped into” his mind several times a day, “standing between Lisa and me”. *As the therapist took up this symptomatic shift as a point of departure for encouraging John to disclose about these gruesome memories (ET, p.94, p.97, p.114; ST, p.87, p.89)* the panic decreased during the session (reflected in low GHQ-12- and ‘Obsessional Thought’-values in Figure 1) yet, steeply rose again in session 8 (together with increased IIP-32-scores in session 9, see Figure 4), reflecting John’s frustration about his persisting inability to let go of Greg. Initially reluctant, but *egged on by the therapist to resume narration about the latter (ST, p.87, p.89; ET, p.94, p.131)* (session 8), John was positively surprised by new revelations his narratives associatively brought about, i.e.: fears (1) that spending less time with Greg would make the latter so angry he would reveal “their secret” to Lisa, thereby causing an end to their relationship (i.e., choosing Lisa would actually imply losing Lisa); and (2) that the absence of Greg’s familiar guidance entailed “doing everything all alone now”. *Incited to concretize (ST, p.87, p.89; ET, p.9, p.131)* what he meant by “everything”, John began to explore his ambitions and desires during therapy (sessions 8-9) while increasingly acting upon them between sessions**.** Synchronously, he started to feel more self-confident and happy, he no longer felt the urge so much to seek out Greg’s company (see the decrease in RE’s in Table 2), engaged in more positive interactions with Lisa, and experienced a relatively stable period in terms of symptomatic burden (mirrored in the steady decrease in ‘Obsessional Thought’-values in sessions 8-11, Figure 1).

However, in the week preceding session 10, Greg had angrily blamed John for “abandoning” him and “destroying everything”, which had immediately made John feel extremely guilty. During that week, he had been constantly bothered by highly intrusive ‘commanding’ and ‘prohibiting’ thoughts “jumping” into his mind (e.g., “you must go to Greg” and “you can’t stay with Lisa”). The intense confusion and the struggle to “push away” these thoughts resulted in a temporary increase in suffering (see rise in GHQ-12- scores, Figure 1). In response to the *therapist’s question whether these thoughts possibly resembled “voices of someone else” (ET, p.94, p.114)*, John promptly linked them to (1) Greg’s wish “to have me all for himself and Lisa gone”, a wish, he now realized, he had ‘staged’ in the initial symptomatic scenery “of the knives”; and to (2) his mother’s warning voice he “heard in his head” each time he wanted to pursue an ambition or desire, which had always and still caused intense self-doubt, hampering him to “fully engage” in excelling at work or in enjoying himself. “Like something is constantly holding me back,” he repeatedly phrased.

Following this “new, interesting link”, sessions 10-14 encompassed a more stable phase in the therapeutic process (resonated in decreasing scores for symptomatic burden and interpersonal problems, and increasing rates of general well-being, see Figures 1 and 4) in which John mainly proceeded on discussing his autonomous ambitions and encountered hindrances.

Then, at ‘tipping point’ 2(sessions 14-15), John’s interpersonal, symptomatic and general well-being complaints climaxed (as clearly visible in Figures 1 and 4). Due to unwilling practical circumstances, there had been a longer time lapse between these and the previous sessions, in which the inability to talk about what bothered or upset him to “a neutral person bound by professional secrecy” had resulted in a building-up of pressure (thus reflecting how *the scheduling of regular appointments, as part of the treatment structure, function as inherently supportive, p.11*). During the preceding week, “the knives” had abruptly returned in such ferocity that John had been terrified to “really” stab Lisa this time and had fled to his parents’ place, resulting in “a break-through”: “It was as though I suddenly woke up, and thought by myself ‘What the hell am I doing? This is not what I want, this is what Greg wants. But it is my turn now!’” Resolutely, he had returned to Lisa, “the knives” had diminished instantly, though “still popping up from time to time”, but in a less alienating and frightening fashion. Accordingly, during therapy John now referred to his symptom as “the obsessional thoughts” and even casually uttered “obsessions are actually quite trivial, aren’t they?”. Non-verbally, he became notably less agitated, talked calmer, laughed more and increasingly initiated discussions on interpersonal topics spontaneously, thus *requiring less incitation from the therapist, who mainly took on a supportive stance* (sessions 16-22*), i.e. paraphrasing and encouraging John to further elaborate on his disclosures (ST, p.87, p.88)*. As such, John started to report profound interpersonal changes: both during work and leisure activities, he increasingly wanted to achieve and to compete with other men, and he started to “notice beautiful women” (“I no longer have my eyes in my pockets”). Simultaneously, the cited ‘break-through’ started to steady (see decreasing and stabilizing values on all measures in Figures 1 and 4), He increasingly felt more “liberated” and energetic, and invested this fresh energy in new leisure activities (e.g., indoor snowboarding). Incited by the thrill these new experiences gave him (“It feels like everything is coming to life again”, see also the rise in RS’s ‘happy’, ‘confident’ and ‘independent’ in Tables 3 and 4), he also started to be more assertive in interacting with Greg and Lisa. He finally found the nerve to confront Greg with his fears that their secret would be leaked. Reassured to hear the latter also wanted to keep it quiet, John was finally able to “leave it all behind” him and to peacefully choose for “a grown-up relationship with Lisa”, while enjoying less, but more enjoyable interactions with Greg (see Tables 3 and 4). In addition, instead of biting his tongue whenever he felt frustrated with Lisa, he progressively engaged in arguments. “I can still be angry with her, but now *without* the knife,” he laughed. Based on these constructive arguments and on increasingly pleasurable interactions with *as well as* without Lisa, John gradually discoveredthat the ambivalence – even collision – he had always experienced between his autonomous longings and his wishes to be loved, could actually co-exist, though still not in interactions with Greg or his parents, further ensuring him in his “choice for Lisa”.

Elaborating on a last symptomatic ‘spasm’ in session 19 (see temporary rise in GHQ-12- and ‘Obsessional Thought’-scores in Figure 1) – in the form of “negative counter thoughts” during pleasurable activities – John suddenly channeled the former warnings of his mother with the recognition that he was the one who put a spoke in his own wheels.He had since long inhibited his own happiness, precisely by obeying this interiorized negative voice of his mother. During the last sessions (21-22), the negative counter-thoughts had disappeared and John mainly started to reflect upon all the changes he had gone through during the last months, *integrating them with the help of the therapist* *in a coherent, meaningful ‘story’* *(ST, p.87, p.89; ET, p.94, p.114)* (which lessened their frightening load), until he longer found it necessary to continue therapy. During the follow-up interview, John ascribed his maintained therapy to “having worked through a number of conflicts in my relationships” (e.g., the feeling he had to choose between Lisa and Greg, questions about the precise nature of his relationship with Greg, the feeling of being “caged” in this relationship with Greg, and fears of cutting himself adrift from his parental home).

**General Discussion and Conclusion**

The classical symptom specificity hypothesis as conceptualized by Blatt (1974, 2004) formalizes psychodynamic approaches of neurotic symptoms and associated mental suffering as grounded in typical interpersonal functioning. Starting from conceptual and methodological considerations with respect to conflicting observations from previous nomothetic research, the present paper aimed at refinement of the classical hypothesis, by examining its applicability in a longitudinal case design.

In line with expectations based on the classical symptom specificity hypothesis (Blatt, 1974, 2004), longitudinal intra-subject correlations showed a close association between the patient’s symptomatic and interpersonal level of functioning. Compared to the more extensive questionnaires, the correlation between interpersonal problems and ‘Obsessional Symptom’-item was relatively lowest. On the one hand, this might be due to low reliability of a one-item instrument. On the other – in contrast to the idiosyncratic item, which specifically assesses obsessional symptom intensity – both self-reports measuring symptomatic/general well-being, *as* self-reports measuring interpersonal well-being, are known to be sensitive to the subject’s broader negative emotionality (see Meyer et al., 2001). The shared ‘error variance’ might be responsible for (artificially) larger correlations between both types of questionnaires.

The clinical material (therapy transcripts) further affirmed close associations. Although at the onset of therapy, the patient could not link his symptom to any determining factors, interpersonal components proved to be already present (1) in the content/form of the symptom itself, and (2) in the patient’s primal wordings concerning his symptom (“It stands *between* me and Lisa, (…) *inhibiting* me to fully *engage* in our relationship”). Also in line with expectations and consistent with findings from earlier studies (e.g., Grenyer & Luborsky, 1996; Luborsky & Crits-Christoph, 1998; Slonim, Shefler, Gvirsman, & Tishby, 2011), repeated therapeutic focus on these interpersonal associations (as supportive-expressive therapy prescribes) revealed a series of past and present contexts. The linking of recurrent incidents within these contexts led to clarifications of similarities between the patient’s experiences of these events and his subsequent positioning in it. In the course of this process, remarkable changes started to take place in his formerly rigid obsessional imagery, further incited by the gaining of new, non-familiar and thus dissimilar relational exchanges with the therapist. Contextualizing these changes further led to the surfacing of new, unprocessed elements in the patient’s narratives, e.g., repressed desires and ambitions, which at times also raised fears that obstructed him in the realization of these desires, and led to temporary symptomatic increases. As the patient progressively managed to link the start and evolutions in his symptom to the interpersonal positions he occupied towards significant persons in his life, he gradually started to organize and symbolize all these determinations in a coherent story, thereby recounting the initially enigmatic experiences in a meaningful framework. Hence, the symptom started to make sense again and was no longer experienced as alienating, overwhelming and frightening.

Further in line with expectations relating to the patient’s interpersonal functioning, the predicted CCRT-components (Luborsky & Crits-Cristoph, 1998) as based on the classical symptom specificity hypothesis (Blatt, 1974, 2004) were observed in this patient. Consistent with findings from previous studies (e.g., Crits-Christoph & Luborsky, 1990; Vinnars, Dixon, & Barber, 2013; Wilczek, Weinryb, Barber, Gustavsson, & Asberg, 2004), the patient’s main CCRT’s did not alter substantially throughout the therapeutic process, but higher flexibility arose in his use of different wishes and negative responses from others, as well as an increase in positive responses from others and self. According to expectations, these changes were accompanied by transformations in symptoms, as previously evidenced by e.g., Grenyer and Luborsky, 1996; Crits-Christoph and Luborsky, 1998; and Slonim, Shefler, Gvirsman, and Tishby, 2011.

In contrast, however, to the classical symptom specificity hypothesis, quantitative analysis of self-reported interpersonal problems, demonstrated it was *not* the autonomous tendency that came to the fore in this patient, but the dependent interpersonal profile, characterized by nonassertive, overly accommodating and self-sacrificing behavior; which explains the patient’s initial perplexity with his aggressively laden symptom. Correspondingly, qualitative CCRT-analyses showed, in addition to the predicted autonomous components, persistent dependent W’s to be loved by and close to significant others, and RS’s aimed at avoiding losing their love.

Here proves the added value of triangulating data that is gathered from various (quantitative and qualitative) sources and studied from multiple perspectives within a team of researchers (Jackson, Chui, & Hill, 2011; McLeod, 2013). Complementing the context-independent, pre-fabricated quantitative measurement tools and standardized CCRT-categories, with extended qualitative analysis of narrated relationship episodes, granted the opportunity to identify factors (i.e., contextual elements and specific aspects of the patient’s subjective, dynamic functioning), in which his symptomatic and interpersonal functioning proved to be intrinsically embedded. This analysis revealed that the patient’s issues with dependency of others were actually rooted in frustrated, highly prominent longings towards autonomy. Dragged back and forth between two pressing wishes (i.e., to be loved and to be independent) which he, based on past interpersonal exchanges, experienced as opponent, he found himself ‘stuck’ in a dependent position towards others, from which he simultaneously tried to escape. Repeatedly during therapy, obsessional complaints proved to be grounded in the unbearable tension associated with this conflict. Profound *ambivalence* manifested both (1) *within* relational exchanges with his girlfriend (e.g., alternations between “she is the woman I want to be with” and “she is not a girl for me”), and with his best friend and mother (e.g., alternations between “secure” obedience and “uncertain” revolt); (2) and in alternations *between* choosing for his girlfriend “versus” choosing for his best friend.

**Conclusions and contributions to psychotherapy theory, research and practice**

At the conceptual level, the present study did not document a mere interpersonal tendency towards autonomy in this patient, but documented profound *ambivalences* between dependent and autonomous interpersonal behavior, manifested both within and betweendifferentrelationships; thereby suggesting a higher complexity than originally assumed by the classical symptom specificity hypothesis. Previous studies, which used cross-sectional group designs to test symptom specificity, and thus focused on modal tendencies and static associations, did not reveal this ambivalence. In accordance with our findings, however, both classical (e.g., Freud’s and Lacan’s) and contemporary psychodynamic theories (e.g. Blatt’s and Luborsky’s) describe more complex interpersonal dynamics for patients with obsessional complaints: out of fear of losing the love of significant others, separating tendencies are usually accompanied by feelings of ambivalence (e.g., Blatt, 2004; Verhaeghe, 2001). It would be valuable for future research efforts (discussed in more detail below) to further examine this suggested complexity.

At the methodological level, we believe that single case research, in which extensive multiple method and multiple source data sets on one patient are analyzed, is necessary to grasp the complex clinical interplay between symptoms and interpersonal dynamics, and, consequently, to indicate on which points the classical symptom specificity hypothesis needs refining. Additionally, in accordance to previous research (e.g. Stiles & Shapiro, 1989; Hill, 2012, p.39; Luyten, Blatt & Mayes, 2012), the present study showed that important changes at the level of symptomatic and interpersonal functioning could best be understood as non-linear functions. As evidence-based case studies enable researchers to observe and analyze complex materials and have the additional advantage of avoiding specific types of measurement error frequently occurring in group designs (see Desmet, 2013), they are key to understanding the complexity of therapeutic change.

Importantly, the present study draws attention to the difficulty of univocally determining therapy outcome in terms of successful or not. The patient’s narratives and self-report questionnaire scores showed significant improvements throughout therapy, both in the patient’s symptomatology and interpersonal functioning as in his general well-being. Evolutions in these areas as described by patient and therapist, both during treatment and during follow-up assessments, are even more pronounced than depicted by the outcome measures. In accordance to findings in Randomized Controlled Trials and other large-scale studies on the efficacy of psychodynamic therapy (see recent reviews of Fonagy, 2015, and Leichsenring et al., 2015), these improvements were maintained at follow-up or even increased. However, findings were somewhat contradicted by saliva stress hormone measurements and health care cost information. In line with the positive evolution in self-report data, cortisol concentrations decreased during treatment and post-treatment costs proved similar to costs prior to the pre-treatment crisis (June/July 2012). Yet, in contrast to self-report measures, cortisol levels went up again during follow-up and even exceeded pre-treatment levels. Further, despite affirmation of maintained improvements in symptomatic and general well-being during the follow-up interview, health costs revealed that eight months after treatment termination the patient had restarted antidepressant medication.

Hence, in applying a “multimethod, multiperspective approach on assessing outcome” (Hill, Chui, & Baumann, 2013, p.75), a more differentiated assessment of therapy progress appeared and areas were made visible that are not readily accessible through other techniques. Assessing a wider range of outcomes is viewed to be important, as (the patient’s and/or therapist’s and/or researchers’ notion of) change does not always equal symptom reduction (e.g., Blatt & Auerbach, 2003). Scientific documentation proved to be a beneficial addition to a sole reliance on clinical judgment in assessing treatment response, as it warrants against premature clinical optimism. Independently from the clinician’s perception, self-report questionnaires, saliva cortisol and/or health care information can identify areas in which improvement is limited or even absent, and which are not readily revealed to the therapist in a direct, oral fashion. Previous research (e.g., Hill, Chui, & Bauman, 2013) has pointed to possible divergences between therapists’ and patients’ perspectives on process and outcome in psychotherapy. Hence, carefully weighing various (divergent) pieces of evidence against each other seems advisable.

For this patient we propose the following interpretation. As explicitly stated by the patient at the end of treatment and during both follow-up assessments, he got rid of the symptoms he suffered from at the onset of treatment, and prominent changes took place in his broader (inter)subjective functioning. Once the symptoms disappeared, however, the patient stopped therapy and “fled into health” (Freud, 1978 [1905e]; Freud, 1978 [1909d]). Consequently, important aspects of subjectivity might not be worked-through and, during the follow-up phase, new intra- and inter-subjective conflicts could have manifested, inducing distress that could have made cortisol levels rise again. Resistance might have prompted the patient to ignore these conflicts, trying to deal with the distress by taking anti-depressants again. Other interpretations are very well possible; follow-up contact with the patient could bring clarity into this findings.

**Limitations and Future Research Indications**

The present study aimed to address several methodological limitations intrinsic to statistical hypothesis-testing research in cross-sectional group designs in an effort to further enhance a rich understanding of symptom specificity. Accordingly, however, restrictions apply in statistical generalizability of the results to broader populations of obsessional subjects. Therefore, the applicability of the proposed refinement (i.e., ambivalent rather than autonomous interpersonal behavior) should be critically tested in larger scale studies of obsessional subjects. These studies should include (1) *cross-sectional* analyses of co-occurrences of autonomous and dependent interpersonal tendencies within these subjects, measured both (1a) *quantitatively*, based on a variety of patient-, therapist-, and researcher-rated outcome and process measures, as (1b) *qualitatively*, with respect to the according CCRT-components, and (2) *longitudinal* investigations of their dynamic interactions with symptom alterations over time, (2a) *first* in *individual* (clinical) contexts (i.e., series of single and multiple case studies), using *quantitative* intra-subject correlations, and *qualitative* examinations of change processes (e.g., CQR-c, Grounded Theory methodology,…). (2b) *Subsequently,* it would be valuable to *aggregate* these findingsover groups of subjects to make statementsabout group-level *patterns.* In this way, findings can be contrasted as to whether (dis)similar patterns can be found in underlying processes responsible for interpersonal and symptomatic alterations that led up to the discussed treatment outcome (see also Iwakabe & Gazzola, 2009). Finally, quantitative-qualitative examinations of change processes occurring in psychotherapies from alternative treatment schools, grant the possibility of yielding (distinctive) observations that fail to correspond to the classical theory, thereby stimulating further theory improvements (e.g., Stiles, 2015).

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Table 1

*Patient’s wishes (W), responses of other (RO), and responses of self (RS) in first three therapy sessions*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Target of interaction | # | W | RO | RS |
| Across all interactions | 16 | Be own person/independent/ assertive (T), be respected (T), be loved/close (T) | Negative*:*  Doesn’t respect me (T), controlling (T) | Negative*:*  Dependent (T), uncertain (T) anxious (T) |
| Greg | 7 | Be own person/independent (T), be respected (T), avoid conflicts (V), be close (V) | Negative*:*  Doesn’t respect me (T), controlling (T), not trustworthy (T) | Negative*:*  Dependent (T), uncertain (T) anxious (T) |
| Lisa | 4 | Be loved/close (T), have stability (T), be own person (V) | Negative*:*  Not understanding (V), distant (V), gives independence (V)  Positive*:*  Happy (V), loves me (V) | Negative*:*  Disappointed (T) [not expressed], angry (V) [not expressed], depressed (V) [not expressed]  Positive*:*  Happy (V), loved (V) |
| Parents | 3 | Be loved (G), not be responsible (G), be helped (G) | Negative:  Controlling (G)  Positive:  Love me (G) | Negative:  Uncertain (G), dependent (G) |

*Note*. # = number of events; G = general (occurred in all events); T = typical (occurred in more than half of the events); V = variant (occurred in at least 2 events); W’s, RO’s, RS’s are ranked from most to least frequent.

Table 2

*Patient’s wishes (W), responses of other (RO), and responses of self (RS) in therapy sessions 6 - 8*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Target of interaction | # | W | RO | RS |
| Across all interactions | 18 | Be opened up to (T), be own person/ independent (T), be respected (T) | Negative*:*  Not respecting (T), not trustworthy (T), punishing/opposing/rejecting (T), distant (T) | Negative*:*  Uncertain (T), dependent (T), guilty (T), disappointed (T) |
| Greg | 13 | Be opened up to (T), be close (T), be own person/ independent (T), be respected (T), avoid conflicts (V) | Negative*:*  Doesn’t respect me (T), not trustworthy (T), punishing (T), distant (T) | Negative*:*  Dependent (T), guilty (T), uncertain (T), disappointed (T) |
| Lisa | 3 | Be loved (G), be close (T), achieve (V) | Negative*:*  Not respecting (V), distant (V)  Positive*:*  Understanding (V), respectful (V) | Negative*:*  Disappointed (T) [not expressed], angry (T) [not expressed]  Positive*:*  Loved (V) |

*Note*. # = number of events; G = general (occurred in all events); T = typical (occurred in more than half of the events); V = variant (occurred in at least 2 events); W’s, RO’s, RS’s are ranked from most to least frequent.

Table 3

*Patient’s wishes (W), responses of other (RO), and responses of self (RS) in therapy sessions 13 - 15*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Target of interaction | # | W | RO | RS |
| Across all interactions | 18 | Be opened up to (T), be own person/ independent (T), be respected (T) | Negative*:*  Not respecting (T), not trustworthy (T), punishing/opposing/ rejecting (T), distant (T) | Negative*:*  Uncertain (T), dependent (T), guilty (T), disappointed (T) |
| Greg | 5 | Be own person/ independent (G), feel good about self (G) | Negative*:*  Doesn’t respect me (G), rejecting (G), punishing (T), opposing (T) | Negative*:*  Dependent (T), guilty (T), uncertain (T) |
| Mother | 3 | Be own person/ independent (G), feel good about self (G) | Negative*:*  Doesn’t respect me (G), rejecting (G), opposing (G), controlling (G) | Negative*:*  Uncertain (G), anxious (G), disappointed (G) |
| Lisa | 5 | Be close (G), be loved/taken care of (T), be respected (V) | Negative*:*  Distant (V), not respectful (V), gives (too much) independence (V)  Positive*:*  Respectful (V), loving (V) | Negative*:*  Disappointed (V) [not expressed], angry (V) [not expressed]  Positive*:*  Loved (T), happy (V), self-confident (V) |

*Note*. # = number of events; G = general (occurred in all events); T = typical (occurred in more than half of the events); V = variant (occurred in at least 2 events); W’s, RO’s, RS’s are ranked from most to least frequent.

Table 4

*Patient’s wishes (W), responses of other (RO), and responses of self (RS) in last three therapy sessions*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Target of interaction | # | W | RO | RS |
| Across all interactions | 20 | Feel happy/good about self (T), be my own person (T), be respected/understood/ opened up to (T), achieve/better myself (T) | Negative:  Controlling (T), oppose me (T), not understanding/ respectful (T), rejecting (T)  Positive:  Helpful/cooperative/ understanding/ respectful (T), gives independence (T) | Negative:  Uncertain (T), anxious (T), dependent (T), angry (T), disappointed (T), guilty (T)  Positive*:*  Independent (T), open (T), self-confident (T), happy (T), comfortable (T) |
| Parents | 7 | Feel happy/good about self (G), be my own person (G), be respected (G) | Negative:  Oppose me (G), doesn’t understand (G), controlling (G), rejecting (T) | Negative:  Uncertain (G), anxious (G), dependent (G), angry (G), disappointed (G), comfortable (T), guilty (T)  Positive:  Independent (T) |
| Lisa | 6 | Achieve/better myself (T), feel happy/good about self (T), be loved (V), be opened up to (V), be understood (V) | Negative:  Distant (V), rejecting (V)  Positive:  Helpful/cooperative (T), understanding (T), gives independence (T) | Negative:  Uncertain (T), angry (V)  Positive:  Open (T), self-confident (T), happy (T) |
| Greg | 5 | Be respected (T), feel happy/good about self (V), be my own person (V) | Negative:  Controlling (T), doesn’t respect me (T)  Positive:  Helpful/cooperative (T) understanding (T) | Negative:  Angry (T), disappointed (T)  Positive:  Independent (V), comfortable (V) |

*Note*. # = number of events; G = general (occurred in all events); T = typical (occurred in more than half of the events); V = variant (occurred in at least 2 events); W’s, RO’s, RS’s are ranked from most to least frequent.



*Figure 1*. Evolutions in patient- and researcher-rated well-being and saliva cortisol concentrations from intake to follow-up. GHQ-12 = General Health Questionnaire-12; SCL-90 = Symptom Checklist-90; GAF = Global Assessment Functioning; T1 = Tipping point 1; T2 = Tipping Point 2; cortisol values: µg/dl.



*Figure 2*. Evolutions in patient’s health care costs (euro) from two years before treatment until follow-up.



*Figure 3*. Evolutions in patient-reported interpersonal problems from intake to follow-up. IIP-32 total = Inventory of Interpersonal Problems-32 total scores; IIP-32 dep = Inventory of Interpersonal Problems-32 subscores dependency; IIP-32 aut = Inventory of Interpersonal Problems-32 subscores autonomy; CCRT1 = Conflictual Relationship Theme codings of first three sessions; CCRT2 = Conflictual Relationship Theme codings of Tipping point 1 sessions; CCRT3 = Conflictual Relationship Theme codings of Tipping point 2 sessions; CCRT4 = Conflictual Relationship Theme codings of last three sessions.