



Conceptions and Perceptions of Psychotherapy in the Eyes of Therapists and their Patients: Longitudinal Analysis by the Faceted Action System Theory (FAST)¹

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Abstract

Fifty-four pairs of patients and their psychotherapists were interviewed individually at three time points during therapy, exploring their expectations and perceptions of the therapy in which they were engaged. Depicting therapy as a Faceted Action System, variables were classified into four functioning modes representing: Implied therapy contract, Therapy interactions, Management of external factors, and Therapy outcome. Multivariate analysis of the data by Faceted SSA yielded conceptual maps representing the structure and progression of participants' expectation from therapy, as well as their perceptions of it. Findings revealed that with time, therapists' expectation-maps shifted from the archetypal systemic pattern towards a variation closer to that of their patients, interpreting some integrative-mode (internal) variables, such as therapist interventions, as playing an adaptive-mode (external) role. As therapy extended to eight months, patients completely re-structured their original conceptualization, exhibiting an astonishing pattern dominated by highly differentiated integrative mode, underscoring the profound significance patients attributed to the patient-therapist relationship. Cognitive maps revealed a parallel shift with respect to perceptions of actual therapy. Implications of the findings are explored, resulting in a new, empirically supported systemic interpretation of the therapeutic endeavor. The study illustrates the unique advantage of pictorial representations of complex multivariate data for gaining insights into the psychotherapeutic endeavor, and into the relational approach to psychotherapy, in particular.

Keywords: Faceted Action System Theory; Psychotherapy; Therapeutic Alliance; Systemic Quality of Life.

Background

Within a particular social environment, therapists and patients are likely to share similar conceptions and understanding of what therapy is, what it should involve, and what is expected to happen in therapy. Yet, therapists and patients play distinct roles in therapy, which may well be reflected in their conceptions of therapy. As professionals, therapists are bound by professional rules and laws. They have experience, a profound knowledge of what is “psychotherapy”, firm conceptions and a certain professional approach. Patients usually go to therapy voluntarily, but do not necessarily, or not fully, know what to expect from it. Patient and therapist perspectives are undoubtedly different [1]. In addition to conceptions of therapy, we also investigate therapists' and patients' perceptions of the actual therapy in which they participate.

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Citation: Amir Ezrachi, Samuel Shye. Conceptions and Perceptions of Psychotherapy in the Eyes of Therapists and their Patients: Longitudinal Analysis by the Faceted Action System Theory (FAST). *Journal of Psychiatry and Psychiatric Disorders*. 8 (2024): 287-302.

Received: October 21, 2024

Accepted: October 28, 2024

Published: November 12, 2024

The phenomenon of therapy, in the sense of general dynamic-psychoanalytic therapy with adult patients, when observed from a sociological-anthropological perspective, could be described, primarily, as a voluntary encounter between two people. One of them is the “therapist” and the other is the “patient”. The two individuals meet for timed sessions (usually for fifty minutes) on a regular basis, usually once or twice a week (sometimes more, as in Psychoanalysis, and sometimes less frequently), usually at the same location, in a closed and private room, typically the therapist's office. The patient contacts the therapist or a facility that refers or pairs the patient with the therapist and asks for help. The therapist consents to providing therapy according to certain rules: rules of ethics and confidentiality, a commitment to accept the patient nonjudgmentally, to focus solely on the patient during the sessions and to be fully available for these purposes. The two form an agreement that defines the framework of the therapy: the cost of the sessions, their timing, location, length, and so on. The patient comes to therapy with the purpose of finding relief for his or her emotional distress and promoting certain aspects of his or her quality of life. This is the therapeutic goal, which derives from the patient's needs. Therefore, therapy can be said to have a framework and a goal.

The therapeutic work is based on conversations between the two, which usually begins with the therapist inviting the patient to share and talk about anything that comes to his or her mind. The therapist is expected to listen carefully, to help the patient find meaning and understanding of the manifest and tacit elements conveyed in his or her words, and to assist the patient with different dilemmas and with the containment of his or her emotions. Following these conversations, the patient may be inspired by therapy to form new perspectives and make changes in his or her life, either with explicit encouragement from the therapist, or indirectly and unwittingly. Surely, the therapeutic endeavor is not based solely on conversations and their interpretation in therapy, but also on the formation of a close relationship between the two, which constitutes a meaningful and inspiring bond, that is, the transference relationship. The patient's trust in the therapist and in their therapeutic alliance is the basis for all their collaborative work in therapy. The nature of the relationship between the two is shaped by the therapist's theoretical approach and personality, the patient's approach, expectations and personality, as well as by the interaction between all these elements in therapy. The two form a unique bond, a system of relationships. Freud and others thought that the therapist should play a neutral and objective role, like that of the physician. In practice this does not and perhaps cannot happen in psychotherapy [2,3]. Although therapy initially involves a functional relationship between two strangers, the relationship eventually develops into a meaningful, unique, close and personal bond. According to

the relational approach, which has developed in the United States since the 1990s, therapy can be conceptualized as dialectic movement between one-person psychology (the patient) and two-person psychology (the therapist and the patient; [4,5, 6,7]). The two form a shared co-construction [8,9]. The unique relationship between the therapist and the patient is not detached from its environmental, social and economic surroundings. Therapy is influenced by various external factors, with which it interacts. Therefore, therapy can be said to involve two types of interactions. The first type of interactions consists of interactions within therapy; the relationship and dialogues that develop between the therapist and the patient. The second type of interactions consists of interactions of the therapy with the external environment; including therapist's and patient's interactions with their physical and social environment, which influence therapy. For example, the professional supervision that the therapist receives for the therapy in question, or the encouragement or discouragement that the patient receives from his or her social environment in relation to therapy.

Thus, it appears that in any therapeutic encounter a distinct entity is being developed. This entity, as described above, constitutes a behavioral action system. On this premise, we develop the research instruments and examine the conceptions and perceptions of the participants – therapists and patients –using the concepts and tools of Faceted Action System Theory (FAST).

What is an Action System?

Background

In the scientific context, general system theory was developed in the 1940s by a biologist [10] and a cybernetics researcher [11] as a method of studying complex “wholes”. The systemic approach has been adopted by numerous scholars from various disciplines, including sociologist [12] who developed the social action system theory. Theories in the field of system research aim to understand the whole based on the understanding of the relationships between its parts, and between them (and the whole), and their environment. The “whole” in each application, depends on an explicit definition of the system that one wishes to study. For example, if one refers to a human individual, the person is the whole; if one refers to a family, the family is the whole; if one refers to an organization, the organization is the whole. An entity is a system if it is a collection of defined elements maintaining among themselves interactions of a defined kind, which are stronger than their interactions (of that kind) with the entity's environment. A system is an action system to the extent it is stable (adheres to its defining features); organized (its members interrelate with each other); open (interrelates with its environment); and active (influences its environment). [13]. For developing a scientific theory, it is often useful to refer to a generic entity as a system. For example, to

consider the generic "individual" (represented by a sample of individuals of a given population) as the system. Parsons [12,14,15], who focused primarily on the study of social systems, identified four functions that are essential for the existence and development of a properly functioning social system: the pattern maintenance function, the goal attainment function, the integration function, and the adaptation function. His work was strictly conceptual (or 'theoretical' as he would put it), devoid of testable hypotheses and lacked systematic empirical support [16].

Faceted Action System Theory (FAST)

Since the 1970s, Shye [17, 18, 13, 19, 20] developed FAST as a testable scientific theory for any multivariate behavioral action system, not just social systems. This framework is based on fundamental axioms and allows for clear definitions, from which observed variables can be created, questionnaires can be developed for the assessment of the system's functioning, and clear hypotheses can be formulated and tested. Following a logical analysis that derives from the axioms, Shye [18, 13, 20] shows that every action system has four and only four modes of functioning: the expressive mode, the adaptive mode, the integrative mode and the conservative mode.

- a. **The expressive mode:** The system acts upon its environment, expressing its unique character and goals. The effectiveness of the system's functioning in the expressive mode increases as the similarity between the actualization of an action outside the system and the system's internal state increases (similarity relations).
- b. **The adaptive mode:** The system interacts with its environment, by which the system adapts itself to opportunities offered and constraints imposed by the environment; and adapts the environment to itself. In this mode the system manages to regulate external influences and coexist with them. The effectiveness of the system's functioning in the adaptive mode depends on the extent of complementarity (compensatory relations) it maintains with its environment (complementary relations).
- c. **The integrative mode:** Intra-systemic processes, by which mutual adjustments are made among components of the action system. The effectiveness of the system's functioning in the integrative mode depends on the extent of complementarity (compensatory relations) among its internal components (complementary relations).
- d. **The conservative mode:** The system adheres to its defining characteristics (identity) for maintaining its essential stability. These are constitutional elements that were externally endowed to the system upon its creation. Functioning in the conservative mode is more effective to the extent its defining features exhibit similarity over time. That is, to the extent the system maintains its stability and continuity (similarity relations).

Given FAST axioms, these four functioning modes are easily seen to be exhaustive. Moreover, they are also exclusive. That is, they are mutually disjoint (non-overlapping). A well-designed, "healthy" system, functions in all four modes with sufficient effectiveness.

Empirical validation of the Faceted Action System Theory (FAST): The axioms on which FAST is founded, imply specific structural hypotheses that may be tested by suitable data analytic procedures; specifically, by Faceted Smallest Space Analysis (FSSA). FAST assumes the following preliminary steps:

1. Defining the generic system to be investigated
2. Selecting or creating a rich set of variables that assess the functioning-effectiveness of the system in each of the four functioning-modes (defined in (a)-(d) above);
3. Observing the variables on a sample of objects that pertain to the generic system.

In the present study the generic system is psychotherapy and the objects studied are the specific instances of psychotherapy, each consisting of a specific pair of a therapist and a patient and a sequence of meetings between them. Faceted Smallest Space Analysis [21; 22, 23] involves the following steps:

1. Computing the pairwise correlation coefficients matrix among all observed variables;
2. Mapping the variables as points in a geometric space of the smallest dimensionality subject to the condition that the higher the correlation between two variables, the closer their points would be in space;
3. Partitioning the space into regions so that variables of any given class (a given functioning-mode in the present case) are in the same region;
4. Identifying a pattern of spatial orientation among the regions.

The general FAST structural hypothesis asserts that representative empirical variables of an action system can be mapped by Faceted SSA into a two-dimensional space that can be partitioned into four sectors, each containing the variables of one functioning-mode; and that the sectors would be circularly ordered such that the expressive mode would be opposite the conservative mode; and the adaptive mode opposite the integrative mode. See Figure 1.

In many applications of the systemic conceptual framework, using Faceted SSA this structural hypothesis was supported [e.g., 24, 25, 13, 19, 26,21].

The conservative and expressive modes, situated opposite each other, are polar to each other. The conservative mode represents the system's identity and stability. The expressive

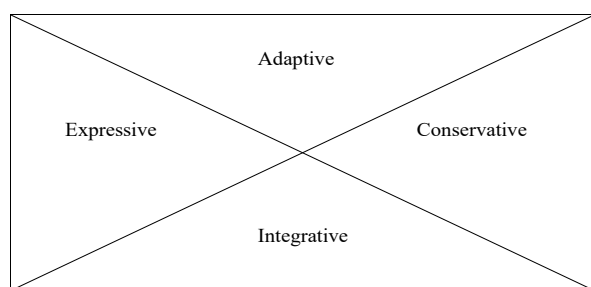


Figure 1: FAST Structural Hypothesis: SSA Space of Representative Psychotherapy Variables is Partitionable into Circularly Ordered Sectors Corresponding to the Four Systemic Functioning Modes Mutually Oriented as Shown: The Expressive Opposite the Conservative; the Integrative Opposite the Adaptive

mode represents specific system "behaviors" impacting on its environment, which may lead to system's transformation and growth. These two modes form the system's first polarity.

The integrative and adaptive modes are processive, representing respectively internal and external interactions. Situated opposite each other, between the conservative and expressive modes, these modes constitute a second polarity.

In this study, the Faceted Action System Theory (FAST) is applied to the Psychotherapeutic System, to test the general FAST structural hypothesis and to gain insights concerning the conception and perception of therapy held by its participants, the patients and the therapists.

Psychotherapy as an action system

Applying the Faceted Action System Theory (FAST) to psychotherapy as an action system, we now turn to the explication of its four systemic functioning modes. This will allow the testing of the FAST-structural hypothesis (Figure 1) in empirical data as well as exploring and interpreting structural variations observed in the empirical data.

The expressive functioning mode in therapy: The outcome of therapy.

The expressive mode of the therapy system refers to the beneficial influences of therapy on the patient's life. The expectations for such influences are shaped by the aims of psychotherapy as commonly understood: to improve patient's functioning as manifested by aspects of his/her quality of life, such as mental health, self-actualization and social relationships, and to alleviate troublesome behavior.

Beyond the various controversies, it is safe to say that the goal of therapy is to assist the patient in improving his or her quality of life, or some aspects thereof. Human quality of life itself has been modelled as an action system (SQOL. Shye, 19; 2014c) with 4^k functioning modes (where k is the resolution chosen in each application). If $k=2$ we get $4^2 = 16$ functioning modes or SQOL components. Table 1 present these components and concisely illustrates their contents.

Table 1: The 16 Systemic Quality of Life (SQOL) Components with Concise Interpretations. In bold the Seven Core Functioning-Modes Presumed to be the Target of Psychotherapy

Subsystem: Subsystemic mode ↓	Personality	Physical	Social	Cultural
Expressive	self-fulfillment	bodily skills	social influence	practice beliefs
Adaptive	recreation	goods & services	institutional ties	cultural ties
Integrative	mental health	bodily health	intimate friends	integrity
Conservative	stable identity	security	belonging/ trust	stable beliefs

Table 1 marks (in bold) the personality modes and the integrative modes of the human-individual system as likely foci for expected improvement in psychotherapy. In the context of the present study, patients' SQOL constitutes the expressive mode of the therapeutic system. The impact of therapy on the patient's quality of life, as well as on the evolution of therapist's and patient's expectations and perceptions of the SQOL subsystem during therapy, are addressed in a separate paper (Shye & Ezrachi, forthcoming).

The adaptive functioning mode in therapy: Interactions of the therapy with social and physical environments.

Therapy takes place in a certain social, economic and cultural context; it is not detached from its surroundings. The patient must pay for therapy and invest time and effort in the therapeutic process. The patient must also cope with external pressures, such as various attitudes towards therapy of people in his or her social environment, as well as his or her own hesitations regarding therapy. The therapist, too, must undergo various adaptations to make therapy possible. Occasionally, the therapist must intervene for the patient outside the therapeutic setting (e.g. send a letter, refer the patient to another professional, etc.), or modify or update his or her approach, at times with the help of supervision or a review of professional literature.

The integrative functioning mode in therapy: Internal interactions within therapy; the therapist-patient relationship.

The therapist and the patient must establish a trusting relationship and a common language. The therapist must "teach" the patient what therapy is and how to use it, but just as importantly, the therapist must learn and adapt to the patient. Thus, the therapeutic pair creates a special bond. Most of the therapist's interventions pertain to this functioning mode: the therapist asks questions, reflects, analyzes, interprets, reacts, falls silent, contains, states,

confronts, shares personal information, encourages, reassures, understands, invites the patient to contemplate or address certain topics, and more. Different therapeutic approaches, even within the psychodynamic sphere, vary in emphases given to these interventions. Sometimes, these differences stem from basic theoretical controversies. The atmosphere created in the therapeutic sessions is an essential part of the integrative mode. The concept of therapeutic alliance is the closest in its definition to the integrative mode. The literature on the therapeutic alliance points to both a distinction and a dialectic interaction within the therapeutic alliance, between the positive therapeutic bond and the therapeutic technique. For example, Hatcher & Barends [27] demonstrate how the technique, which includes all therapist's actions, creates the therapeutic relationship ("Good technique means good alliance", p. 294), but also how a positive therapeutic relationship enables the technique. Other studies [28,29] indicate a similar distinction, with the therapist actions on one hand, and the therapeutic atmosphere on the other hand ("technique is an activity, alliance is a way to characterize activity", [27], Likewise, Luborsky et al. [30] make a similar distinction in their description of the two axes of the therapeutic alliance: helpfulness and cooperation. Bordin [31,32] describes the development of the therapeutic alliance as a process that involves ongoing negotiations. Indeed, the integrative mode, by its very definition [19], consist in "a process that involves ongoing negotiations." While all its functioning modes are essential for the therapy system, there is a presumed emphasis on the integrative functioning mode; that is, on the developing a relationship between therapist and patient [33,34].

The conservative functioning mode in therapy: The therapeutic framework and the belief in therapy.

In therapy, the therapist and patient agree on the therapeutic method of work. They share the belief that therapy can benefit the patient and meet his or her needs. The two have a "therapeutic contract", parts of which are clearly stated. Other parts of the contract are implicit. Therapy requires a framework within which the therapeutic work is conducted. The therapeutic contract defines this framework: the timing, frequency and location of the sessions, the payment arrangements, vacations, etc. The therapeutic contract specifies the "rules of the game". Although the contract may change as therapy progresses, it forms the basis for the therapeutic alliance. The adherence to the therapeutic contract and its maintenance are features of the conservative mode. An essential part of the conservative mode is the belief in therapy. This belief manifests itself in holding on to the therapeutic setting despite various obstacles, including temporary doubts concerning therapy. Thus, difficulties in meeting regularly, tardiness and cancellations could be indicators of resistance to therapy and disbelief in it. Misaligned expectations, which

could indicate a personal incompatibility between therapist and patient, could sabotage therapy. Often, the importance of this mode is not acknowledged, much like the existence of oxygen in the air; its critical importance is understood only in its absence.

Method

To test FAST structural hypothesis in the case of the therapeutic system, two reflections of therapy are considered here: therapy as conceived, in principle, by participants; and therapy as perceived, in practice, by participants. In addition to the FAST-structural hypothesis testing, the Faceted SSA maps permit the study of structural variations, developments over time during the therapeutic process, and comparisons across participants (i.e., therapists vs. patients).

Assessing Conceptions and Perceptions of Psychotherapy: Questionnaires

Questionnaires were constructed based on the conceptualization of therapy as an action system, with reference to a sample of thirty-six conditions and actions that may characterize a given case. Participants, both therapists and patients, were asked to assess:

1. The importance they attribute to various therapy conditions and actions for the therapy's success, as well as their expectations regarding those conditions and actions. Together, importance and expectations were taken to indicate participant's conception of what therapy should be;
2. The realization of those conditions and actions in the therapy in which they participated; thereby recording their perception of what actually happened in the therapy; where those conditions and actions, viewed as therapy characteristics, were pre-classified into the four functioning modes of the therapy system.

Recorded assessments were analyzed to evaluate the extents of agreement between patients and therapists concerning:

- a. The cognitive structures of their conceptions and of their perceptions of the therapy,
- b. The compatibility between conceptions and perceptions within each of the two groups, patients and therapists.
- c. Similar questionnaires were administered to the therapists and to the patients at three different time points. Altogether, hundreds of variables were observed in this study, classifiable by five content-criteria or facets. The following five-facet mapping sentence [35,22, 21] provides a schematic presentation of the definitional system of observations for this study.

Mapping Sentence: The Quality of the Psychotherapy System

In therapy system (x), **participant** {*patient / therapist*} assesses the **attitude modality** {*conception / perception*} of a system characteristic pertaining to the {*conservative / integrative / adaptive / expressive*} **mode**, concerning **participant** {*Patient / Therapist / Both or Unspecified*} at **time point** {*before / 2 months after / 8-10 months after*} the beginning of the therapy → {*very high ... very low*} extent in the sense of the **attitude modality** {*conception (importance, expectation) / perception (existence, realization)*}.

Examples of questionnaire-items and their classifications by the mapping sentence

	Assessing participant	Attitude modality	Systemic functioning mode	Participant concerned	Time point
1. To what extent does the therapist ask you (the patient) guiding questions?	Patient	Perception (existence)	Integrative	Therapist	1 & 2
2. To what extent is it important, for the success of therapy, that it be preceded by a 'contract'?	Therapist & patient	Conception (importance)	Conservative	Both, therapist and patient	0, & 1, & 2
3. To what extent do you expect the therapy to improve your quality of life?	Patient	Conception (expectation)	Expressive	Patient	0, & 1, & 2
4. [patient's assessment of own SQOL aspect (x)]	Patient	Perception	Expressive	Patient	0, & 1, & 2
5. [therapist's assessment of patient's SQOL aspect (x)]	Therapist	Perception	Expressive	Patient	1, & 2

Questions 4 and 5 in the Table refer to patient's functionings as conceived in the Systemic Quality of Life model (SQOL; 19). This model includes sixteen components, which correspond to the four functioning modes within each of the four basic SQOL subsystems: the personality, the physical, the social and the cultural. SQOL was used as the assessment of the expressive mode in therapy and the influence of therapy on the patient's quality of life. In addition, it was used to assess the patient's quality of life before and after therapy.

Participants

Questionnaires for the evaluation of therapy as a system, and of the patient's quality of life conceived as the expressive mode of that system, were administered to 68 pairs of therapists and patients in several public treatment facilities in Jerusalem. The questionnaires were given to each of the therapy partners at three time-points: before the beginning of the therapy (Time 0), two months after the beginning of the therapy (Time 1), and 8-10 months after the beginning of the therapy (Time 2). Fourteen patients dropped out of therapy before Time 2. Therefore, results reported here are based on data collected from 54 pairs of therapists and patients.

Data Analysis

Agreements between patients' and therapists' conception- and perception- structures, as well as changes over time

in these agreements, are assessed using Faceted Smallest Space Analysis [23,21]. This procedure, which evolved from Multidimensional Scaling [36, 37, 38,39] and formulated within Facet Theory paradigm [35, 22, 21], incorporates logically structured research contents with the statistical data analysis, permitting instructive visual examination of complex multivariate data.

Like the familiar Multidimensional Scaling (MDS), Faceted SSA maps a set of observed variables as points in a geometric space subject to the condition that the greater the similarity coefficient (e.g., correlation coefficient or coefficient of weak monotonicity) between two variables, the smaller the distance between them in the map. However, rooted in Facet Theory (which integrates formal research contents with data), Faceted SSA differs from MDS in the following respects:

1. The set of variables included in a particular Faceted SSA application must all have a common meaning range, i.e., their score ranges are all similarly ordered from high to low with respect to a single concept (e.g., positive attitude, effective functioning, or response-correctness in intelligence test-items).
2. The set of variables included in a particular Faceted SSA application, are taken to represent but a sample from a much larger – possibly infinite – set of variables that constitute the domain investigated. Hence, clustering of variables in the geometric representation space is of no significance; it is just an artifact of the sampling of the variables.
3. Faceted SSA seeks to identify a 1-1 correspondence between regions in space and subsets of observed variables, defined by their contents. Such a correspondence between a conceptual aspect (classification of variables by their contents) and an empirical aspect (partition into regions of the SSA map) provides (a) empirical validation of the conceptual categories employed in the classification of the variables; (b) a geometric depiction of the relationships between validated conceptual categories. Space-partitions so obtained allow generalizations of these findings, from the sample of observed variables to the entire content-universe investigated. By taking observed variables for what they are – a sample from a larger content universe – and by being a more elaborate, yet softer, aspect of data than clustering, Faceted SSA leads to more stable research results, enhancing replicability.

Results

This section starts with a brief look at the satisfaction with the therapy, expressed by therapists and patients, noting the agreement between therapists' and patients' satisfaction assessments at Time 1 and Time 2. Also reported are perceived improvements in patient's quality of life during therapy. Then we turn to the main task of this paper, to elaborate on participants' conceptions and perceptions of therapy, as they emerge from structural analyses by Faceted SSA maps of variables observed in this study. These maps, often referred to as cognitive maps, portray how the analyzed content-universe (i.e., conception or perceptions of psychotherapy) is structured: what are its empirically verifiable components and how they are interrelated.

Satisfaction with Therapy: Change over Time and Patient-Therapist Agreement

Patients demonstrate some increase in their satisfaction with therapy from Time 1 (two months after the beginning of therapy, mean score 4.97) to Time 2 (8-10 months after the beginning of the therapy, mean score 5.13). Therapists perceive a significant increase in their patients' satisfaction with therapy (from 4.11 at Time 1 to 4.57 at Time 2). Patients' and therapists' evaluations of patients' satisfaction with therapy were positively correlated, and that correlation increased from Time 1 ($r = 0.22$) to Time 2 ($r = 0.38$), indicating a process of increasing agreement on this question between the two participants in the therapeutic endeavor. See Table 2.

Table 2: Patient's Satisfaction with the Therapy: Mean Scores and Correlations between Patients' and Therapists' Evaluations

	Time 1		Time 2	
	Mean Score on 1-6 Scale	Patient-Therapist Correlation	Mean Score on 1-6 Scale	Patient-Therapist Correlation
by Patients' own evaluations ¹	4.97	0.22 ($p < 0.05$)	5.13	0.38 ($p < 0.002$)
by Therapist's evaluations ²	4.11		4.57*	

1. To what extent are you (the patient) satisfied with the therapy so far?

2. To what extent do you (the therapist) believe that the patient is satisfied with the therapy so far?

* The difference between the two time points is significant at $p < 0.05$.

Does Therapy Improve Quality of Life?

At least some improvement in Patients' Quality of Life was recorded in all but one ("physical expressive") of the 16 SQOL variables. Of the seven SQOL variables presumed to be therapy's "core variables" (those assessing patients' functioning-effectiveness in the personality subsystem or in the of integrative mode, marked in bold in Table 3), five were statistically significant. Significantly, improvement in the integrative mode of the personality subsystem – covering

mental health, low anxiety and low stress – was the greatest (.82). It should be noted that, at the outset (and as anticipated), patients' evaluations of their functioning in this respect were the lowest, and expectations for its improvement were the highest, reflecting a well-recognized need as well as a good understanding of the main goals of therapy as noted above.

These initial findings suggest that, overall, the psychotherapeutic cases in this study represent effective therapy.

Table 3: Average Improvement in Patients' Quality of Life During Therapy
Differences in Patient Evaluations Between Time 0 and Time 2, on a Scale of 1-6

Subsystem: Subsystemic mode ↓	Personality	Physical	Social	Cultural
Expressive	.18	-.30*	.18	.09
Adaptive	.50*	.01	.11	.24
Integrative	.82*	.04	.40*	.43*
Conservative	.30*	*.35	.28	.37*

*Significant ($p < 0.05$) in a paired t-test

We now turn to structural analyses of the data, using the facet theoretic procedures described above with the objectives of exploring and interpreting patterns in the data and testing for the hypothesized systemic structure (Figure 1) in them. Our purpose is to determine the components of therapy and their interrelationships, where "therapy" is represented by two distinct universes of contents:

- Conceptions of psychotherapy in general, as indicated by participants' (patients' and therapists') expectations from it
- Perceptions by participants (patients and therapists) of the psychotherapeutic processes in which they took part.

Conceptions of Therapy

Conceptions of therapy are assessed by a series of questions inquiring into what each participant expects from the therapy or considers important in therapy.

Conceptions at the beginning of the therapy ($t=0$)

The following Faceted SSA maps, Figures 2 and 3, represent therapists' and patients' separate expectations from therapy before their acquaintance (Time 0), at the very beginning of therapy.

Therapists

Figure 2 demonstrates the structure found in previous studies of action systems. This structure, with minor deviations, concords with the archetypal (classic) pattern, hypothesized in FAST (see Figure 1), exhibiting a clear differentiation between the four modes of functioning, with the conservative region situated across from the expressive region, and the adaptive and integrative modes situated between these two regions and across from each other. This clear differentiation between the adaptive and integrative modes affirms the distinction between expectations concerning intra-systemic (integrative) and extra-systemic (adaptive) therapeutic processes.

Few deviations from the above-mentioned ideal pattern are observed. For example, variable 11 ("the importance of

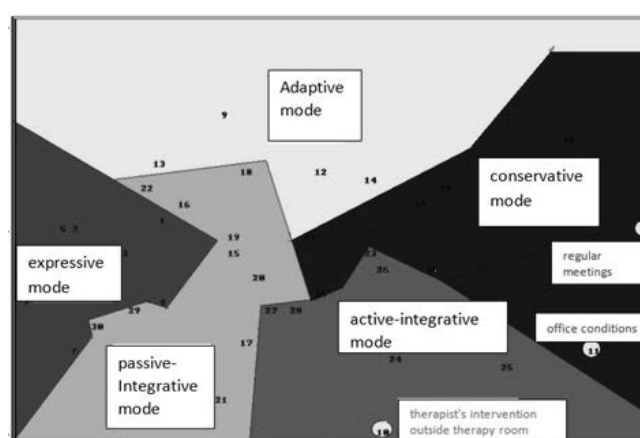


Figure 2: Therapists' Expectations from Therapy Before Therapy Starts (Time 0): A Faceted SSA Cognitive Map of All 36 Variables of the Therapy System (N=54)

room conditions") was found to be more compatible with the conservative mode than with the adaptive mode. Variable 10 ("the importance of therapist interventions outside the therapy room") was found in the region of the integrative mode, rather than the adaptive mode. Overall, the FAST-structural hypothesis (Figure 1) is well-supported in this analysis. Since the systemic structure exhibited in this map (Figure 2) is based on therapists' responses before therapy begins, representing their professional conception of therapy, it was termed the Institutional Systemic Conception of therapy. It is reassuring that such a conception, reflecting an a priori "in principle" conception of therapy, conforms to the archetypal (classic) structure of FAST.

The present analysis (Figure 2) also reveals a novel phenomenon: Within the integrative mode, a clear distinction is found between variables related to the therapeutic bond or atmosphere in therapy, and variables related to various forms of therapist interventions. These differentiated sub-modes were termed respectively passive integrative mode and active integrative mode.

Patients

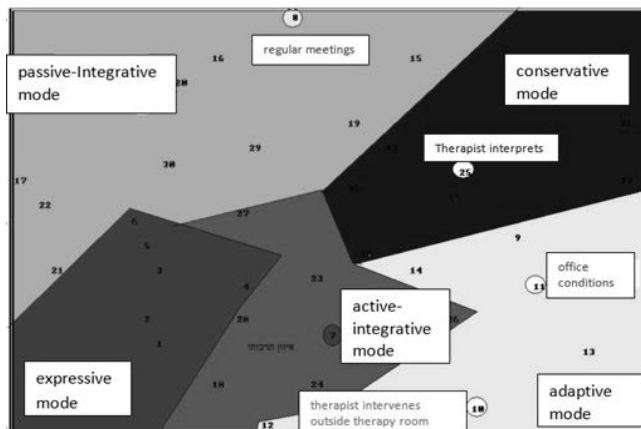


Figure 3: Patients' Expectations from Therapy Before Therapy Starts (Time 0): A Faceted SSA Cognitive Map of 36 Variables of the Therapy System (N=54)

This map demonstrates that patients, too, reveal a systemic view of therapy before it begins, as manifested by the clear differentiation between the regions pertaining to the four systemic functioning modes and the relative spatial orientation of the corresponding regions. However, this is so, provided the role of integrative functioning is assigned to the passive integration only. Indeed, patients like therapists, distinguish between the active and passive forms of integrative functioning, as attested by the distinct regions of these two forms. But, unlike therapists' conception where the integrative region is simply subdivided into passive and active sub-regions, here the active integration sub-region is realigned with the adaptive mode region. This structural difference between therapists and patients may be explained as follows: Therapists conceive of active integration (i.e., therapist interventions) as representing part of the internal therapist-patient interactions within the therapeutic relations. Hence, for them active integration is part – even if distinct – of the overall integrative functioning. In contrast, patients conceive of active integration as external occurrences with which therapy, and they as patients, need to deal. Hence for them active integration is more akin to the adaptive functioning mode. It is interesting that for patients, the question of room conditions was found in the adaptive region, in accordance with our a priori definitions. However, session regularity was found in the integrative mode region, rather than in the conservative region, suggesting that it was interpreted by patients as a matter of interpersonal relations, rather than part of the agreement.

Conceptions of therapy after 8-10 months (T=2)

Figures 4, 5 represent therapists' and patients' conceptions of therapy after 8-10 months.

therapists

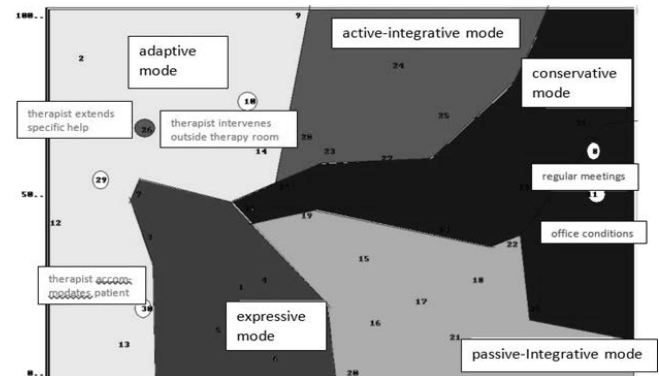


Figure 4: Therapists' Expectations from Therapy After 8-10 Months' Work with Specific Patients (Time 2): Faceted SSA of 36 Variables of the Therapy System (N=54)

Figure 4 demonstrates a complete separation between the passive and the active integrative regions with the latter being adjacent to the adaptive region. This unexpected pattern agrees with the classic action-systemic structure, provided active integrative mode is re-interpreted to be a variety of the adaptive functioning mode. Thus, at this stage of therapy, therapist actions intended to promote therapy are conceived by therapists as akin to environmental conditions that characterize the adaptive mode. Such an interpretation may well be substantiated if we consider that therapists' actions within therapy are partly guided by intervention theories and practices that are indeed part of the wider environment. In such a re-interpretation, the bond, trust relations and closeness (passive integration), representing the personal relationship that develops in therapy, remain within their originally formulated notion of the systemic integrative mode. Significantly, this therapists' expectation map bears a closer resemblance to the map of patients' expectations before therapy (Figure 3) than to the map of therapists' expectations before therapy (Figure 2).

Patients

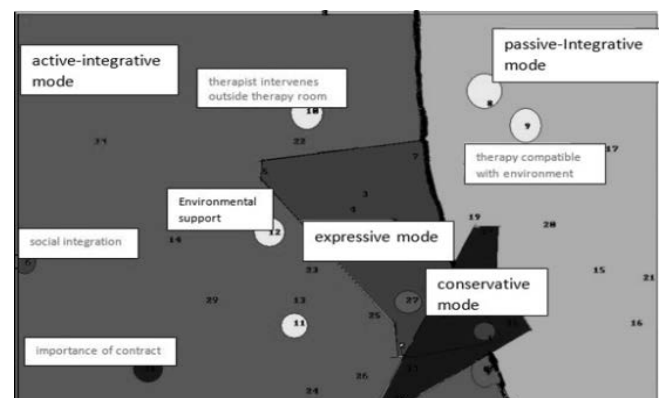


Figure 5: Patients' Expectations from Therapy After 8-10 Months' Work (Time 2): Faceted SSA of 36 Variables of the Therapy System (N=54)

Figure 5 demonstrates a radically new conception-structure among patients that evolved during the therapeutic work. Patients' expectation-universe is now dominated by the integrative mode, highly differentiated with respect to its constituent finer aspects, while the distinction between its active and passive forms, constitutes a major polarity in that universe. The adaptive mode of therapy virtually disappears as a distinct notion and its variables are dispersed over the two integrative regions. The conservative and expressive modes now occupy relatively small regions at the center between the two major poles. Although the conservative and expressive functioning modes retain their identity (occupy distinct regions), it may well be said that the classic "institutional" systemic structure of patients' expectation virtually collapsed by Time 2.

Elements of the adaptive mode are now dispersed over the integrative regions. For example:

1. The adaptive variable: "The importance of patient's environment being supportive and encouraging in regard to therapy" is in the active-integrative region.
2. The adaptive variable: "The importance of therapy's compatibility with social or religious factors" is in the passive-integrative region.

At Time 2, the space of patients' expectations from therapy (Figure 5) is distinguished by the wide spread of variables that represent relations – interpersonal relations and relations with the environment. Therefore, this structure was termed the Relational Expectational Therapy System. This system is governed by high discernability by the patients, within the universe of relations.

Therapists and patients together at T=0 and T=2

The Faceted SSA map in Figure 6 represents therapists' and patients' expectations from therapy at two time-points, T=0 and T=2. Here, as in all the SSA maps that include evaluations by both therapists and patients, there is a clear spatial division between the two sets of evaluations: those of the therapists and those of the patients. This finding reflects the existence of role-dependent differentiation between these groups. (Recall that the contents of the evaluation-variables were identical for the two groups.)

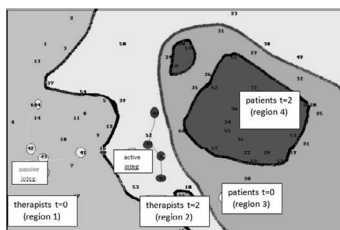


Figure 6: Therapist and Patients' Expectations from Therapy Over Time (T=0 & T=2): Faceted SSA Map of 72 Therapy-System Variables Representing the Four Modes of the Therapy System (N=54)

Four main regions may be discerned:

- Region 1 – Therapists' expectations before therapy (at T=0) are in the leftmost (gray) region. (This region was analyzed separately above in Figure 2.)
- Region 2 – Therapists' expectations after 8-10 months of work (T=2) are in a semicircular region (white), which partially encompasses the patient variables. (This region was analyzed separately above in Figure 4.)
- Region 3 – Patients' expectations before therapy (at T=0) are in an internal ring-shaped (gray) region. (This region was analyzed separately above in Figure 3.)
- Region 4 – Patients' expectations after 8-10 months of work (T=2) are in the innermost (black) disk. (This region was analyzed separately above in Figure 5.)

This map indicates a progression in therapists' expectations following their acquaintance with their respective patients. The phenomenon whereby, with time, the pattern of therapists' expectations follows that of their patients', was noted also above. Therapists' expectations approach patients' expectations and encompass them, as the former "move" from T=0 (Region 1) to T=2 (Region 2). The integrative mode of Therapists' expectations at T=2 (see eight individually circled variables) splits into two parts: The passive integration variables (Variable numbers 41-44, in white) remain in Region 1, meaning that for these variables, expectations do not shift towards those of the patients. In contrast, the active integrative variables of the therapist expectations at T=2 (variable numbers 45-48, in black), do shift – and even more so than other T=2 variables – towards patients' expectations at T=0 (Region 3). Patient expectations, on their part, become more concentrated (reflecting increased statistical correlations between variables), as they "move" from time T=0 to time T=2. (See corresponding Regions 3 & 4 in the map).

Perceptions of the Therapy

Participants' perceptions of the therapy-cases were recorded with respect to the same therapy-characteristics of the previous section, but with reference to their actual occurrence in the therapy, rather than with reference to expectations from therapy.

The Faceted SSA maps, depicting perceptions of Therapy at time T=2, are presented separately for therapists and for patients.

Therapists

This map demonstrates the archetypal (classic) systemic partition pattern: The therapists' perceptual structure reveals a clear distinction between the four systemic functioning-modes. And the modes are circularly ordered as anticipated by Faceted Action System Theory (FAST), with the adaptive mode opposite the integrative mode, and the expressive

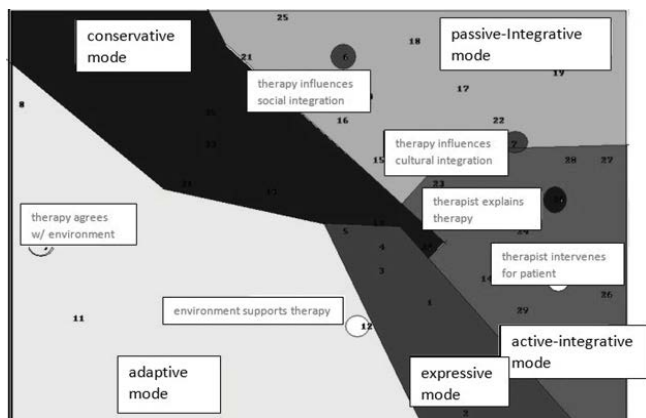


Figure 7: Therapists' Perceptions of Therapy After 8-10 Months of Work: Faceted SSA Map of 36 Variables of the Therapy System (N=54)

mode opposite the conservative mode. Thus, extra- and intra-therapeutic elements, i.e., the adaptive mode and the integrative modes are clearly separated into distinct regions. Within the integrative-mode region, here again, there is an evident distinction, between the active and the passive integrations.

Yet, Figure 7 also reveals few deviations from our prior definitions of the functioning modes:

1. The variable “The therapist intervenes for the patient outside the therapy room” appears in the (active) integrative-mode region, rather than in the adaptive-mode region, as hypothesized. That is, therapist's intervention is perceived by therapists as a matter of the therapist-patient relationship, not as interaction with the therapy's environment.
2. “The therapist explains the therapeutic process” is perceived by therapists as an active integration item -- a matter of therapist-patient relationship -- rather than a conservative-mode item, as we anticipated.
3. The variables “the patient's change of habits” and “coping with others' expectations” are not perceived as pertaining to the adaptive mode as pre-defined, but to the expressive mode, which may well be considered reasonable re-definitions.
4. Of the seven SQOL-based expressive-mode variables, two variables, patient's “social integrative” and “cultural integrative” functionings, appear unexpectedly in the region of the therapy-system-integrative, rather than expressive, mode. These deviations may be explained as follows: According to SQOL, “social integration” and “cultural integration” assess the individual's cultural and social compatibility with the individual's socio-cultural environment, of which the therapy system itself is a part. The location of these variables in the passive integration

region may well reflect their role in the bond between the therapist and the patient.

5. “The therapist analyzes and interprets” is found in the passive integration region, closer to the conservative region. Unlike the other active integration variables, analysis and interpretation are perhaps perceived as more basic elements that underlie the therapy system.

Patients

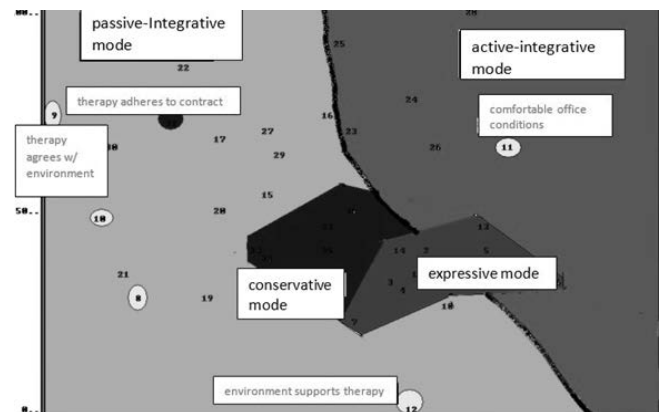


Figure 8: Patients' Perceptions of the Therapy After 8-10 Months' Work: Faceted SSA Map of 36 Variables of the Therapy System (N=54)

Figure 8 demonstrates that patients' perception-structure differs from that of the therapists. Patients do not distinguish between extra- and intra-therapeutic interaction items, as evidenced by the fact that the adaptive-mode items (variables 8,9,11,12,18; see white disks in the map) are mixed and widely spread within the integrative-mode regions. The interactive functioning modes (the integrative and the adaptive together) occupy a large area in this content space, indicating that they are highly differentiated, evidently reflecting patients' heightened concern with them.

The distinction between the active and passive integrations is clearly apparent in this map and constitutes the main polarity of the content-universe represented. The expressive and conservative modes occupy small regions in the center of the map and are adjacent to each other. This pattern of patients' therapy-perceptions resembles the pattern observed for patients' expected therapy at this stage (T=2. See Figure 5).

Therapy-perception maps presented in this section (Figures 7 and 8) serve as another example of the structural difference between therapists and patients. Therapists have a broad view of the therapeutic endeavor as attested by action-systemic perception-pattern, while patients view therapy mainly in terms of its interactive functioning-modes (i.e., the integrative and adaptive modes), the modes that concern the therapeutic relationships. The conservative mode (e.g.,

the therapeutic contract) and the expressive mode (e.g., therapy outcome) while clearly distinct, exhibit low internal differentiations. Located at the center of the universe of therapy perception, they provide the general (internally poorly differentiated) context for the therapy.

The Perceived Integrative Mode: The “Dyadic System”

In view of their prominent role in psychotherapy, we zoom-in and elaborate on findings related to the systemic integrative functioning mode. Results of the previous section point to the existence of a Dyadic System, consisting of the systemic functioning in the integrative mode of the perceived therapeutic system, and having a distinct significance for the therapeutic endeavor. In this section we analyze this Dyadic System. Following are the maps representing perceptions of integrative variables of the therapy system at an early stage of therapy (two months into therapy, Figure 9) and at a later stage (8-10 months into therapy, Figure 10).

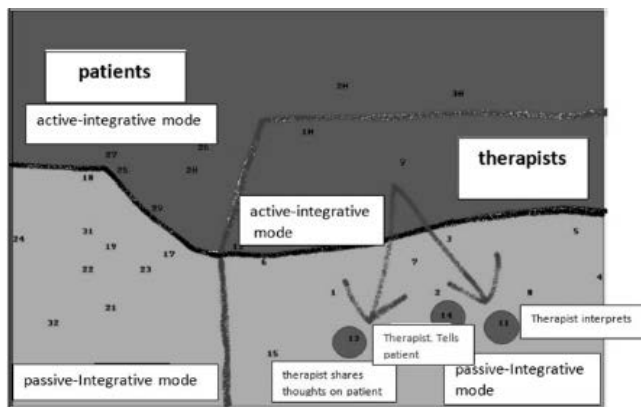


Figure 9: Therapist and Patients' Perceptions of Integrative-Mode Variables Regarding the Observed Therapy After Two Months' Work (T=1): Faceted SSA Map of 32 Variables of the Integrative Therapy Subsystem (N=54)

This map demonstrates a separation between therapist and patient perceptions as well as a separation between the active (top, black region) and the passive (bottom, gray region) items of the integrative mode. However, while for patients this separation is perfect, for therapists, some deviations are observed, and three of the active integration variables are found within the passive integration region. Deviations such as these occur in SSA cognitive maps, where they are often attributed to statistical errors that arise from stochastic fluctuations. Alternatively, deviating items are re-interpreted to conform to a re-classification. In the present longitudinal study, a dynamic explanation is afforded: the three deviating items may well be considered as heralding a shift in the Dyadic System, one that reached a fruition 8-10 months after beginning of the therapy (Figure 10). Indeed, the set of integrative-mode items observed at T=2, exhibit the map shown in Figure 10, where all therapists' active-integration

items change their relative location, to produce a clear yet puzzling new structure.

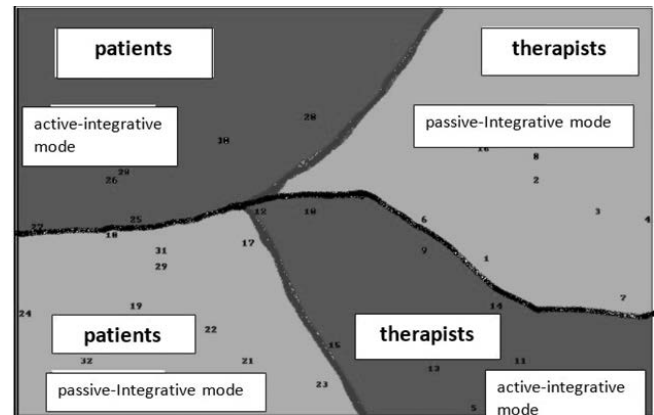


Figure 10: Therapist and Patients' Perceptions of Integrative-Mode Variables Regarding the Observed Therapy After 8-10 Months of Work (T=2): Faceted SSA Map of 32 Variables of the Integrative Therapy Subsystem (N=54)

After 8-10 a new perceptual structure of the dyadic system appears (Figure 10). Here, the therapist-patient distinction is clearly preserved, but the locations of therapists' active integration and passive integration switch places. While early in the therapy (Time 1, Figure 9), the dyadic system reveals a symmetry between therapists and patients, suggesting that both groups similarly understand the active/passive integration distinction, after six more months of work (Time 2, Figure 10), their perception of this distinction assumes a twist and becomes asymmetrical: The map in Figure 10 exhibits an affinity between one group's active integrative perception and the other group's passive integrative perception. One group's active integration region is located diagonally across the other group's active integration region. The two passive integration regions are similarly located diagonally to each other. Interestingly, the resulting structure places patient perception of positive therapeutic atmosphere (openness, common language, sense of belonging) diagonally across therapist perception of such an atmosphere. Thus, with time, perceptions of the integrative mode evolve to assume a new structure which calls for a novel interpretation of the dynamics that govern the dyadic relationship. Figure 10 may be presented schematically by Figure 11 below.

The Dyadic Action-System Interpretation: The dyadic relationship is governed by a network of complex interactions among all its four identified components: therapist passive integration, therapist active integration, patient passive integration and patient active integration. The four components have distinct systemic functions within the dyadic action system, expounded in the Faceted Action System Theory (FAST), as follows:

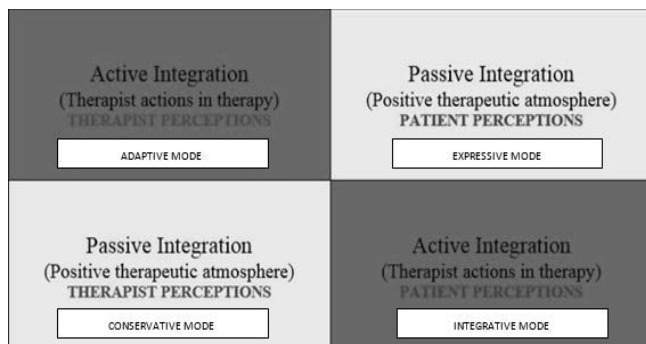


Figure 11: The Integrative Mode at Time 2: A Schematic Depiction of the Dyadic System

Therapist positive perception of therapeutic atmosphere derives from factors that are external to the therapy and are manifested within it (e.g., belief in therapy, confidence based on experience). Hence, this component represents the conservative functioning mode of the dyadic system. **Patients' perceptions of therapist actions in therapy** reflects how well those actions are received and interact with the patient. Hence, they refer to internal compatibilities within the dyad. As such they meet the definition of the integrative functioning mode of the dyadic system. **Therapist perceptions of own actions in therapy** represent materials brought by the therapist into the dyadic relationship from outside that relationship—therapist's personality and preferences – with which the dyadic relationship manage. These are defined as adaptive functioning mode of the system under study. **Patients' positive perceptions of therapeutic atmosphere** constitutes a desired outcome, in fact, the purpose of the dyadic relationship, as it facilitates openness to therapy, a necessary condition for its success. As such it represents the expressive functioning mode.

Specifically, FAST supports and often stresses a subset of inter-modal interactions, namely those that describe a progression from the conservative (which defines the system's capabilities), through the adaptive and the integrative (which determine external and internal conditions, respectively) to the expressive mode (specifying the system's intended impact). In meeting and getting acquainted with a new patient, the therapist gathers pieces of information and impressions that establish his/her confidence in dealing with the new therapeutic instance. This confidence is manifested by the therapist's inclination to report a positive therapeutic atmosphere (encompassing the entire passive-integrative content-universe, including items such as trust, mutual understanding, a common language, and the sense of belonging as well as open atmosphere). The positive therapeutic atmosphere, as perceived by the therapist, provides the basis for the ensuing therapist's actions in therapy -- interventions, analyses, and interpretations. These manifestations of active integration are recognized by both, the therapist and the patient, albeit these two universes (represented by sets of assessments) retain their

separate identity, as attested by their separate regions in the Dyadic System map. Therapists' actions, in turn, facilitate the perception of positive therapeutic atmosphere by the patients, an important factor in therapy success. With this processual interpretation, the dyadic system, as depicted in Figure 11, attests to the fact that the therapeutic process is mediated by the therapist's actions, providing a formal representation to previous studies [25, 31, 40, 21, 29,27] mentioned above, as well as to [41] who show that accurate therapist interpretations of patients' wishes lead to a significant improvement of the therapeutic alliance.

Scholars of the relational approach [e.g., 2, 42, 43, 8, 44, 45, 46] discuss the intersubjective relationship created in therapy. The therapist's interventions reveal her subjectivity to the patient, including her perception of the patient and her understanding of the situation. That is, the therapist's actions constitute a form of interpretation. Sometimes these actions are on the margins of therapy and the therapist's consciousness. Nonetheless, they have a profound effect on the relationship between the therapist and the patient. Ghent [7] discusses a clinical situation in which he felt that his patient was cold. In response, he got up from his chair and wordlessly handed her a blanket. The patient responded with a silent sob. After a while, the patient shared that she herself had not realized that she was cold. This is an example of an intersubjective interaction occurring in the subconscious of the therapist and the patient. A dynamic exchange unfolds between the therapist and the patient, fostering a profound sense of connection. This dialogue in action cultivates an atmosphere of intimacy, enabling both individuals to forge a genuine understanding, establish familiarity, and nurture a sense of belonging. Comparable concepts have been explored by scholars like Ogden [47,48, 49, 50]. Ogden describes the therapist's actions as interpretive actions, which the therapist uses deliberately or unwittingly as a way of telling the patient about himself or herself. Abargil & Tishby [50] believe that the therapist-patient duo forms a unique relationship, in which dyadic states of consciousness emerge in co-creative processes.

Discussion

In the pre-therapy stage, therapists use the "Institutional System Model" as their conceptual structure, while patients use the variant structure termed "the extended adaptive model". After 8-10 months, therapists adopt the patients' outlook, but patients transition to a new scheme called "the relational model". In this stage, patients focus on the integrative and adaptive aspects of therapy. As therapy progresses, patients shift their focus towards the interpersonal relationship with the therapist, leading to a more nuanced understanding of therapy, while therapists maintain a broader perspective within the therapeutic framework.

The relative reduction in the size of the sub-universe

of patient responses (technically, an increase in statistical correlations between patients' variables and hence less discriminating) reflects the patients assuming the "patient role" involving the expected "transference" and the positive regression that develop in therapy (cf. [52] "benign regression". Cf also Ghent's [6] concept of "surrender"). The therapists, on the other hand, maintains a containing attitude, reminiscent of Winnicott's concept of a "holding" or "facilitating" environment. The therapist's focus is placed of course on the patient, but also on the external world and the environmental context. Casement [53] points to the tension that the therapist experiences between the need to adopt an approach close to that of the patient, and the importance of keeping an appropriate distance from the patient. The patient surrenders to the therapeutic process and leaves the observation of the process to the therapist. The change in the patient's outlook from an "institutional systemic" to a "relational systemic" approach is what allows the patient to commit to therapy.

Finally, we focused on the developments within the integrative mode, which demonstrate the formation of the therapeutic dyad, as an expression of mutual adjustment and communication, both verbal and nonverbal, conscious and unconscious [53], or of a co-constructive process [54]. The dyadic relationship emerges as a new action system, where the therapist's perception of the relationship functions as the conservative mode of the dyadic system, endowing it with stability and continuity. The patient's perception of the relationship constitutes the system's expressive mode, by representing the realization of the essence of therapy for the patients. The therapist's actions are found between these two modes, functioning as the system's interaction and negotiation modes. Therapist evaluations of these actions constitute the dyad's adaptive mode, as they represent deliberate attempts to regulate the interaction between the dyad and the external environment. In contrast, patient evaluations of these actions function as the dyad's integrative mode. From the patient's perspective, the therapist's actions are part of the dyad's internal interaction.

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