

## **Application of the Jones' Psychotherapy Process Q-Sort**

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### **Abstract**

Recent research in psychotherapy was focalised on the efficiency of interventions and on the change process. Throughout the years, numerous techniques were used to accomplish this study. The Jones' (1985) Psychotherapy Process Q-sort (PQS) was used to describe the therapeutic processes, to evaluate the relationship between processes and result and to analyse the nature of the change processes over time. With the application of this instrument, the present research has confronted three types of psychotherapeutic approaches: the systemic-relational therapy (SRT), the cognitive-behavioural therapy (CBT) and the brief strategic therapy (BST). Through the use of this instrument it was possible to identify differences and similarities between the three approaches.

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## **Introduction**

From the research about outcomes and about psychotherapy processes could be recalled certain significant phases. About fifty years ago, Eysenck (1952) carried out the first investigation regarding efficacy of psychotherapy and introduced the problem of spontaneous recovery. In reality, this quest had been already indicated in 1937 by Landis and even before that, Rosenzweig (1936) had carried out certain observations regarding the common factors of psychotherapy- which are normally attributed to Luborsky- brought up by the metaphor of “dodo bird verdict”: all have won and all deserve a reward.

In the 1970s important economic questions were interweaved with the exercise of psychotherapy: gradually doubts and mistrust seemed to diminish: to undergo therapy one should no longer be very wealthy or very crazy. With the arrival of the meta-analysis of Smith and Glass (1977) and of Smith, Glass and Miller (1980), always more convincing factors, regarding the positive and consistent efficiency of psychotherapy, were obtained.

Starting from the mid 1990s, particular attention was given to the movement of Empirically Supported Treatments (ESTs), aimed at identifying clearly specific psychological treatments, which proved to be efficacious in the light of control researches regarding a well-outlined population (Chambless & Hollon, 1998). Such movement represented the attempt -only the future can tell how fruitful this will be- to propose detailed and experimented intervention protocols regarding specific disorders and specific patients.

While the debate between various theory models, operative praxis and investigation approaches still remain vigorous, one can note that recent research regarding psychotherapy has shifted its attention particularly on two areas and on their interrelationship: outcome research- that aims to compare efficacious relative to psychotherapeutic interventions- and the process research that has tried to identify specific phases and change dynamics. With particular references to the second point, certain researchers include in the process, all issues that take place in and between patients and therapists in their reciprocal roles, that is, that which the patient and the therapist effectively do, feel, think and want, in the changing context of the treatment circumstances and conditions. Such a definition might create a series of contextual and semantic uncertainties, however, for a better clarification, a distinction between technique and relationship variables could be of help.

Generally it is assumed that the (specific) technique factors differentiate procedures of a certain type of treatment, while the relationship between patients and therapists is always present, whatever the chosen approach and represents common variables (not specific). The therapeutic alliance results to be a pervasive construct that can be easily confused with the process treatment regarded as an overall process that fall to explain how therapy contributes in the improvement of the patient's conditions. Such construct, places at an extremely elevated level, the extracted processes that are presumably common to all treatments. In order to comprehend what these non-specific factors (such as therapeutic alliance) represent and how these can help the patient improve, it is above all necessary to describe such factors at a micro-analytic level (Ablon & Jones, 1999). Therefore, it seems particularly useful to hold an instrument that can be used widely, designed to describe empirically the therapeutic process in its complexity in terms of clinical relevancy.

Lately experimental, naturalistic and quasi-experimental, investigations and case studies are being used. The research design mostly used in the study of treatment process has been the naturalistic study, or better the observation of specific cases through out

different moments of therapy. The described research in psychotherapy has been principally concentrated on events that take place and could be observed during the treatment session. Such events can comprehend interactions between patient and therapist and experiences that took place during a session, successively reported by the patient and therapist.

However, the traditional story recollections hold a limited scientific value, since they consist of anecdotic reports, relative to observations gathered in an uncontrollable and non-systemic manner. The limits of this method of studying cases could be contained by introducing methodological adaptations such as the standardised application of objective evaluations. Case studies can be used in more systemic researches, by adapting methods of analysis that (1) consent the translation of the 'rich' observations typical of the case studies, into quantifiable objective dimensions; (2) capture the uniqueness of the individual; (3) permit the confrontation between the observers of the same case, and even confrontations between cases (Jones, Cumming & Pulos, 1993).

Through out the years, numerous techniques had been proposed, such as: Vanderbilt Therapeutic Alliance Scale (Hartley & Strupp, 1983); California Psychotherapy Alliance Scale (CALPAS); Structural Analysis of Social Behavior (Benjamin, 1974); Psychotherapy Process Q Set, an instrument composed of 100 items, devised to describe empirically the therapeutic process in its complexity in terms of clinical relevancy (Jones, 1985). The precedent of PQS lies in the Q-sort technique proposed by Stephenson (1953) and developed and systemically verified by Block (Block, 1961; Block & Haan, 1971). It is a measurement technique with a wide-range of applicability, particularly suitable to describe qualitative data. It consists of a series of items, each describing a significant psychological or behavioural characteristic of the individual or of the situation. The Q-sort is an ipsative-technique, that is, the items are given order within a single case, starting from those who characterise mostly the individual or the situation to those less characteristic.

### **The Q Methodology in research of Psychotherapy: The Psychotherapy Process Q-sort**

The Q-sort Technique, proposed by Stephenson (1953) was developed and systemically verified by Block (Block, 1961; Block & Haan, 1971). This is a measurement technique with a wide-range of applicability, particularly suitable to describe qualitative data. It consists of a series of items, each describing a significant psychological or behavioural characteristic of the individual or of the situation.

The Q-set consists of a series of items, whose number varies according to the cases, each describing a psychological or behavioural aspect of the individual or of examined situation. As Jones, Cumming and Pulos (1993) have sustained, the content of the Q-set items might be renewed according to the objectives of the research, rendering a single standard form inexistent. The Q-sort is an ipsative measurement therefore the items are arranged within a single case- from those more characteristic of the person and the situation to those less characteristic- with the aim of capturing the specificity and discover change.

In the research regarding psychotherapy, the Q-sort technique was initially used to evaluate the outcomes of treatment, even though its use to study the psychotherapeutic process dates back in time (Jones, Cumming & Pulos, 1993). Although the results of its first applications were prominent, such technique was not so popular due to difficulties in the construction of adequate set items.

Starting off from these problems, Block proposed a construction method of the Q-set based on the operation of the concepts relative to the variables of interest and to the construction of items through the use of variance analysis to evidence the observed characteristics (Block, 1961; Block and Haan, 1971). The aim of such a methodological approach is that to offer a set of items capable of capturing in the most comprehensible way, the critical dimensions of variance through the study of the various cases under examination.

An example of such a methodology is presented by Jones' (1985) *Psychotherapy Process Q-sort* (PQS), used to describe the therapeutic processes to evaluate the relation between the processes and results, so as to analyse the nature of change over time in various processes. Even though it was constructed on a general assumption that reads that psychotherapy constitutes an interpersonal process, whose aim is to remain neutral to every particular therapeutic theory and offers a wide spectrum of therapeutic interactions. The general aim of this instrument is to offer a significant frame for the therapeutic process, that can be used in comparative analysis or studied in circumstance that evaluate situations prior or successive to therapy (Jones, 1985). The PQS can be applied to recorded videos, audio and transcriptions of entire psychotherapeutic sessions and one of its strong points resides in the fact that it is a pantheoric instrument.

The Q-set is composed of 100 items, each representing a variable clinically relevant to describe the interaction between the patient and the therapist, the PQS gathers three fundamental aspects of the psychotherapeutic process:

- attitude, behaviour and explicative experiences of the patient;
- actions and attitudes of the therapists;
- the nature of the dyadic interaction, the environment and atmosphere of the session.

For a correct application of the instrument, it is necessary that the observers maintain a certain detachment from the therapy, attest to concrete facts, be as objective as possible and avoid being influenced by theoretical pre-conceptions or by personal reactions towards the patient or therapist. The items should be divided into 9 categories- distributed along a continuum from the less characteristic (number 1) to the most characteristic (number 9). In the central category (number 5) are placed the definitions retained as irrelevant in the evaluation of the session. In each category, there are a definite number of items so as to mirror the normal distribution. In the following table, we will see the meaning given to each category.

**The distribution of the 100 items in the provided nine categories**

Category	N° of the item	Meaning
9	5	Extremely characteristic
8	8	Completely characteristic
7	12	Quite characteristic
6	16	Rather characteristic
5	18	Relatively neutral or not important
4	16	Rather non characteristic
3	12	Quite not characteristic
2	8	Completely not characteristic
1	5	Extremely not characteristic

These are examples of the items relative to the three aspects of the process.

**Example of an item relative to the patient**

***Item 1***

The patient verbalises negative emotions to the therapist  
(vs. comments of approval and admiration )

- *Place towards **characteristic** if the patient verbalises feelings of criticisms, antipathy, envy, contempt, anger and antagonism towards the therapist (for e.g. the patient reproaches the therapist for not having given sufficient guidance during therapy.*
- *Place towards **not characteristic**, if the patient shows positive and friendly feelings towards the therapist such as giving him/her compliments.*

**Example of an item relative to the therapist**

**Item 9**

The therapist is cold and detached

(vs. *soliciting and emotionally involved*)

- Place towards **characteristic** if the attitude of the therapist towards the patient is cold, formal and detached or characterised by emotional withdrawal.
- Place towards **non characteristic** if the therapist is truly responsive and emotionally involved.

**Examples of an item relative to the interaction**

**Item 4**

*Therapeutic aims for the specific patient are discussed.*

- Place towards **characteristic** if in therapy is discussed what the patient desires to have as an outcome of therapy. These desires might refer to personal changes or "internal" (e.g. "I started my therapy to overcome depression") or to life-linked changes (e.g. "I question whether therapy can help me to get married").

**Place towards non characteristic, if there are no references and allusions made by the therapist or the patient regarding the possible consequences of therapy.**

The PQS seems to have challenged with discrete success the limits attributed to the Q-sort technique. The reliability between tests in various studies and treatments has reached a correlation that varies from .83 to .89 for two observers and from .89 to .92 when the number of observers is from three to ten (Jones, Cumming & Horowitz, 1988; Jones & Windholz, 1990; Pulos & Jones, 1987). The mean reliability between three different types of treatments have reached .82 (Jones, Parke & Pulos, 1992).

As regards to validity, results have demonstrated that the PQS has gathered differences between the Rational-Emotive and Gestalt Approach, Rational-Emotive and Client Centred Therapy (Jones, Cumming Pulos, 1993), Psychodynamic and Cognitive-behaviour (Jones & Pulos, 1993). In various studies, the PQS has demonstrated to be able to identify the process aspects relative to the therapeutic alliance but also to elements broadly descriptive of the therapeutic process such as behaviour, thoughts and feelings of the patient and also more interactive aspects of the therapeutic process (Ablon & Jones, 1998; Ablon & Jones, 1999; Ablon & Jones, 2002; Price & Jones, 1998).

In literature the data gathered through the use of PQS were treated along an ordinary scale but also along an interval scale. In the first case, the possible elaborations refer

uniquely to a median and correlation coefficient between the above (Giani, 1998; Paganucci, 1998). When working with interval scales, or better on the means of the categories to which an item is added, there is the possibility of showing, for example, the performance of the same item within the same therapy (examining its modality over time) or confront its performance in different therapies (Miller, Luborsky, Barber, Docherty, 1993).

### **Research in progress regarding the evaluation of psychotherapy processes**

In Italy the empirical research in psychotherapy, even though its importance was rather neglected, with limited investigations regarding the efficacy of psychotherapy and in certain meta-analytic studies (Di Nuovo, Lo Verso, Di Blasi & Giannone, 1998; Migone, 1996, 1998; Sirigatti, 1985, 1988, 1994), in these last years there seemed to be always more interesting studies regarding this argument (Costantini, et al., 2002; Dimaggio, Salvatore, Azzara, & Catania, 2003; Di Nuovo, & Zingales, 2000; Fava, 2001; Finicelli, Colombo, & Verga, 2001; Freni, Azzone, Bartocetti, Verga, & Vigano, 2000; Piasentin, Azzone, Vigano, & Freni, 2000; Ortu, et al., 2001). It seems however necessary to carry out systemic investigations in this field, particularly according to the process prospective.

In order to reply to the request for the systemisation of what happens within psychotherapy and to try to comprehend the mechanisms that bring at least to resolve the problem presented by the patient, a research was carried out with the collaboration of the guided groups of Valeria Ugazio of The Bicocca University of Milan and the University of Florence. The aim of the study was to relate the outcome data (comparison between the efficacies relative to the psychotherapeutic interventions) and those regarding the processes (in order to try to identify specific processes of change) so as to integrate in a constructive way both aspects of psychotherapy.

It was considered important to identify technical variables (specific factors) that differentiate the procedures of a particular type of treatment, rather than the relational modalities between patients and therapists, always present whatever approached is used, which present the common variables (non-specific factors) of treatment. It seemed of particular importance to have a widely-applicable instrument which is designed to empirically describe the therapeutic process in its complexity in terms of clinical relevancy: an instrument such as the Psychotherapy Process Q Set (PQS) (Jones, 1985) which has been used till now very little in our country.

### ***Objectives***

In connection with the concrete possible finding of the documentation to be analysed, the objectives of the research were further specified as the following:

- identification of differences and similarities in the processes relative to the systemic-relational therapy (SRT), and the cognitive-behavioural therapy (CBT) and brief strategic therapy (BST);
- individuation of the processes as outcome predictors of the examined psychotherapy;

- detection of differences and similarities in the processes in relation to psychopathological differences.

### ***Method and Techniques***

The research was carried out according to an osservative systemised approach.

### *Participants*

49 sessions of therapy were used (15 SRT, 4CBT, 30 BST)- in each case, there was the initial sessions, intermediate sessions and final sessions- audio recorded or video recorded and transcribed- 17 participants (8 Males and 9 Females), adolescents and adults. Their psychological profile can be described according to the Diagnostic Statistical Manual of Mental Disorders (DSM-IV Axis I) as follows:

- 4 cases affected of mood disorder: 3 treatments (2BST, 1 CBT) with a positive outcome and 1 (BST) with a negative outcome;
- 5 cases affected of anxiety disorder: 3 treatments (2BST , 1SRT) with positive outcome and 2 treatments (BST) with negative outcomes.
- 3 cases affected of eating disorders: 2 treatments (BST) with positive outcomes and 1 (BST) with negative outcomes.
- 5 cases (SRT) which lack indications regarding the disorder and the outcome of therapy and have been included so as to identify the differences and the similarities in the processes relative to the diverse therapy.

### *Instruments*

The psychotherapeutic process was evaluated through the use of the Psychotherapy Process Q-Sort (PQS), elaborated by Jones (1985) and it was appropriately adapted for this research. The objective of the 100 items that compose the PSQ is to provide a basic language for the description and the classification of the therapeutic process. Even though it was constructed according to a general assumption that psychotherapy constitutes an interpersonal process. The aim of this instrument is to remain neutral to each specific therapeutic theory and to consent a wide spectrum of therapeutic interactions. The use of the language and of a previously standardised evaluation has permitted us to characterise in a systemic way the interaction between patient and therapist, evaluating entire therapeutic sessions and classifying the impressions gathered through the process. The PQS is made up of three types of items: (a) items that describe patient's attitudes, behaviour and experiences; (b) items that put the therapist's actions and attitudes in the lime light; (c) items that are relative to the encounter itself. A code manual- with detailed instructions together with examples so as to minimise the variability of the interpretation of items- was prepared inspired by Jones' original manual.

### *Procedure*

The evaluations were carried out by a pool of five observers, composed of psychology researchers and Ph.D. students, participants to a program of clinical psychology. All the

observers were accurately prepared for the application of the PQS. For every patient, from two to four audiovisual recordings and their transcription relative to the first part, intermediate and final part of the treatment were examined. All the recordings and the transcriptions were randomly chosen and verdicts were expressed independently of the three observers (K Median of Cohen approximately .60): an arithmetic median was calculated for the three evaluations. The congruency between the evaluations presented by the observers was monitored.

In order to determine the descriptors of the process that best characterise each treatment, the items that characterise at a maximum and minimum level the therapeutic process were identified. Finally, in order to individuate if and in what measures process factors, that represent the items of the PQS, might differentiate and communise various therapeutic approaches, predict treatment outcomes and characterise the therapy of specific disorders, mono and multi-variant statistical analysis were conducted.

## **Results and Discussions**

### *Psychotherapeutic Approaches: differences and similarities*

Through the auxiliary of the one-way ANOVA, concerning the 100 points of PQS attributes of each session of the three psychotherapeutic approaches, 18 well-characterised processes were individuated. A successive discriminative multiple analysis have confirmed that even compressively these indicators are able to adequately differentiate the three approaches (Wilks' Lambada: .0123;  $F(36.58) = 12.9160; p < 0001$ ).

The SRT outstands in relation to the other two approaches for various peculiar attitudes and behaviour of the therapists. This shows the capability to perceive the "private world" of the patient as if it was his/hers, sensible to the general feelings of the patients and in specific situations and that he/she can communicate this comprehension in an empathic way to reflect gentleness, consideration and attentiveness. The interpretations refer to particular persons known to the patients, who play part of the patient's life. Various discussions and dialogues regarding this argument seem highly diffused; themes regarding patient's feelings, attitudes, concepts and perceptions both negative and positive regarding oneself are discussed; romantic relationships and loving feelings towards the partner are discussed. The patient seems hopeful and not suspicious, feels revealed when disclosing the suppressed and suffocated feelings, he/she communicates to the therapist that he /she feels better after having expressed such feelings.

With regards to the CBT the coming notes must be considered entirely preliminary, due to the limited number of sessions observed. The dialogue established between therapist and patient is centred on cognitive themes, on systems of ideas and beliefs, which are used to evaluate oneself, others and the world. While there are no frequent expressions of suppressed and suffocated feelings. No particular reference is made to important persons in the life of the patient. During the session the therapist does not tend to reformulate the ideas that the patient expresses nor tries to accurately perceive the experience the patient holds of the therapeutic relationship. The patient, who is quite worried about the therapist's judgement, tries to acquire the approval, the affection and the consideration of the latter; frequently asks questions, shows a certain resistance in examining thoughts, relationships

and motivations correlated to the problem faced. The patient is not diffident or suspicious and does not refuse comments or observations made by the therapist.

In BST the interaction is focalised on very few crucial elements, and it tends to concentrate on ideas or constructs used to evaluate oneself and others. Intimate or romantic relationships rarely emerge as arguments to be discussed. One does not observe comments from the therapist regarding the significance of certain behaviours shown by the patient. A peculiar aspect is the reformulation of the declarations and ideas of the patient in a more comprehensible form, so as to render in some way, more evident their significance; all this is carried out in a context where the therapist's behaviour generally reflects gentleness, consideration and attentiveness. The therapist frequently interviews using comments to show a more accurate perception of the experience that the patient holds of the therapeutic relationship. However, the emphatic comprehension of the patient's experience and feelings, does not seem a characteristic aspect of the brief strategic therapy approach and it can be noticed that even the patient does not tend to transform the therapeutic relationship into a more personal and intimate one.

With the research regarding the common processes among the three approaches, various similarities are noticed. Firstly, the therapist intervenes systematically to facilitate the patient's communication; reformulate things which until that time were not explicitly acknowledged. Gives limited attention to non-verbal behaviour, does not tend to carry out interventions specifically directed to make clear the use of the patient's defensive manoeuvres, nor does he/she intervene systematically with interpretations relative to eventual control mechanisms used by the patient to avert threatening information, even though none of the three approaches seem to exclude the possibility to follow such an objectives. The patient does not seem to look for more intimacy and vicinity with the therapist; does not seem agitated, tensed or anxious; does not feel particularly inadequate or inferior; nor does he/she express guilt feelings and shame. He/she shows slight signs of discouragement but also of positive expectations regarding therapy; there seem no marked ambivalent feelings or conflict towards the psychotherapist.

### *Processes as indicators of the outcomes of the psychotherapies*

In order to individuate eventual processes that might act as predictors of the outcome of psychotherapy, an estimation regarding the associations between the expressed evaluations and the results of the treatment was carried out. These data that should be considered as rough indications show that the initial sessions do not offer elements that can help predict the outcome, particularly if one had to exclude the positive valence that seems to be assumed, an interaction that seems to take in consideration constructs used to evaluate oneself, others and the world.

The intermediate sessions proved to reveal more much fruitful information. One can expect with higher probability a positive result when the therapist does not make clear the use of the patient's defensive manoeuvres, because there is no competition between the patient and the therapist. Moreover, more favourable previsions seem to be linked to a series of attitudes and behaviours of the patient who: comprehends with ease the comments made by the therapists; comprehends the nature of the therapy and what to expect; be hopeful and not suspicious; relies on the therapist to solve one's own problems; holds positive expectations regarding therapy; works hard to follow the therapeutic work; feels helped and encouraged; expresses a sense of efficiency, superiority and/or triumph.

The processes that characterise the final sessions indicate with sufficient clarity, whether the treatment is concluded positively. Among the various process differences that emerged through the use of the one-way ANOVA, some are well marked. The patient that is completing a positive therapeutic experience, seems less subjected to emotions of defeat, bother, pain, shame or guilt feelings; he/she feels more hopeful and secure, more efficient, more happy and confident; he/she manages with more ease to express anger and aggressively, shows less resistance when examining thoughts, reactions and motivations relative to the problems. The patient puts forward with more ease questions; accepts comments and observations made by the therapist, who tends to be more reassuring. The patient relies on these so as to solve one's problems; establishes a collaborative relationship; puts effort in the therapeutic work; shows positive expectancies regarding therapy; he/she feels helped.

***Identification of differences and similarities in the processes with different psychopathologies.***

The analysis of the process modality- characteristics of the treatments concerning the patients diagnosed of suffering of mood, anxiety and eating disorders- lead to the identification of certain specificities. Taking in consideration all the sessions carried out with patients who suffer of mood disorders has permitted us to extract these specificities. During the treatments of these disorders (positively resolved), the therapist often: reassures, suggests to the patient to accept the responsibilities of his/her problems, comments the mood changes and patient's emotions, centres the discussion on cognitive themes and on systems of ideas and beliefs. The patient expresses less often guilt feelings or shame, has fewer difficulties in comprehending the comments of the therapist, relies on the therapist to solve one's problems, he/she feels helped, puts effort in the therapeutic work and holds positive expectations regarding therapy.

The patient suffering of anxiety disorder, who underwent therapy with positive outcomes: accepts with more ease the comments and observations of the therapists, who tends to maintain a neutral position; establishes a collaborative rapport; puts efforts in the therapeutic work; feels helped and holds positive expectations regarding treatment. Among the arguments tackled, we find the patient's interpersonal relationships and the expressed need to establish an affectionate rapport.

The patient that suffers of eating disorders, who is obtaining positive results, has relatively less difficulties in comprehending the comments made by the therapists, which offer guidance and explicit advice. During the session there are a less periods of silence, the therapist adopts a supportive attitude and one can note the use of humour. The patient is not worried about the therapist's judgement, seems quite adequate and does not desire to be dependent or disengaged from other persons.

**Conclusive Notes**

The significant literature review and the presented investigation results reveal that the Psychotherapy Process Q-sort is an important pantheoric instrument, able to offer valid elements for the analysis of therapeutic processes and to offer to further methodical scientific panorama for the analysis of the psychotherapeutic. In particular, it is an attempt

to systemise the study of psychotherapy so as to better comprehend the mechanisms that lead to the resolution of the patients' problems, overcoming the dichotomy between the processes and the outcomes and thus move towards an integration of the two that might offer a new key to unlock the a better comprehension of psychotherapy in its complexity.

The results of the present research hold a substantial indicative valence but however consent to identify certain indications and to offer guideline for the development of this field of study. In relation to a methodological profile- even though there are limitations linked to an even more limited casuistry and certain slip-ups in the systemic collection of protocols –one might note that the use of the Q-set in an Italian context, there is a possibility to obtain quite coherent results through without the need of expensive preparations and this requires acceptable time-periods for the completion of the evaluations.

The instrument proved to be quite flexible, able to consent evaluations of sessions of different durations. It is sensible in identifying process differences that characterise different psychotherapeutic approaches, by offering a relatively complete picture of the session. For the elaboration of data, it is possible to make use of statistic packages, even if sometimes one has to derogate, at least partially from the predicted conditions, so as to apply specific analysis. Finally, the indications obtained suggest a qualitative and quantitative broadening of the casuistry, so as to verify with further certainties the specificities and the similarities- in this preliminarily outlined circumstance- of the different psychotherapeutic approaches in relation to various psychopathological contexts and to positive and/or negative treatment outcomes.

## References

- Ablon, J.S., & Jones, E.E. (1998). How Expert Clinicians' Prototypes of an Ideal Treatment correlate with Outcome in Psychodynamic and Cognitive-Behavior Therapy. *Psychotherapy Research*, 8(1), 71-83.
- Ablon, J.S., & Jones, E.E. (1999). Psychotherapy Process in the National Institute of Mental Health Treatment Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology*, 67(1), 64-75.
- Ablon, J.S., & Jones, E.E. (2002). Validity of Controlled Clinical Trials of Psychotherapy: Findings from the NIMH Treatment of Depression Collaborative Research Program. [On-line] *American Journal of Psychiatry*, 159(5), 775-783.
- Benjamin, L.S. (1974). Structural analysis of social behavior. *Psychological Review*, 81(5), 392-425.
- Block, J. (1961). *The Q- Sort Method in Personality Assessment and Psychiatric Research*. Charles C. Thomas Publisher: Springfield.
- Block, J., & Haan, N. (1971). *Lives true time*. Bancroft: Berkeley, CA.
- Chambless, D.L., & Hollon, S.D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 66(1), 7-18.
- Costantini, A., Picardi, A., Podrasky, E., Lunetta, S., Ferraresi, G., & Balbi, A. (2002). Questionario sul Clima di Gruppo: validazione di una misura di processo per le psicoterapie di gruppo. *Rivista di Psichiatria*, 37(1), 14-19.
- Dimaggio, G., Salvatore, G., Azzara, C., & Catania, D. (2003). Rewriting self narratives: The therapeutic process. *Journal of Constructivist Psychology*, 16(2), 155-181.
- Di Nuovo, S., Lo Verso, G., Di Blasi, M., & Giannone, F. (1998). *Valutare le psicoterapie*. Franco Angeli: Milano.
- Di Nuovo, S., & Zingales, I. (2000). La valutazione dell'esito e del processo in terapia cognitivo - comportamentale: presentazione di due casi clinici. *Psicoterapia Cognitiva e Comportamentale*, 6(3), 287-302.
- Eysenck, H.J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology*, 16, 319-324.

- Fava, G.A. (2001). Physicians, medical associations and death penalty. *Psychotherapy & Psychosomatics*, 70(3), 168.
- Finicelli, C., Colombo, A., & Verga, E. (2001). La psicoterapia nel servizio sanitario pubblico. Orientamenti degli psicologi e caratteristiche del processo terapeutico in un'Azienda Sanitaria Locale Lombarda. *Minerva Psichiatrica*, 42(4), 285-297.
- Freni, S., Azzone, P., Bartocetti, L., Verga, M.C., & Vigano, D. (2000). L'esigenza di protocolli clinici adeguati a documentare i processi e gli esiti dei trattamenti psicoterapeutici in un servizio di psicoterapia istituzionale. Risultati preliminari di un'esperienza. *Ricerca in Psicoterapia*, 3(1), 90-116.
- Giani, P. (1998). *L'approccio terapeutico familiare con adolescenti: analisi del processo*. Tesi di laurea non pubblicata, Università degli Studi di Firenze.
- Hartley, D.E., & Strupp, H.H. (1983). The therapeutic alliance: its relationship to outcome in brief psychotherapy. In J. Masling (Ed.), *Empirical studies of psychoanalytic theories*. Analytic Press: Hillsdale, NJ.
- Jones, E.E. (1985). *Manual for the psychotherapy process Q-sort*. Unpublished manuscript, University of California, Berkeley.
- Jones, E.E., Cumming, J.D., & Horowitz, M.J. (1988). Another look at the nonspecific hypothesis of therapeutic effectiveness. *Journal of Consulting and Clinical Psychology*, 56(1), 48-55.
- Jones, E.E., Cumming, J.D., & Pulos, S.M. (1993). Tracing clinical themes across phases of treatment by a Q-Set. In N.E. Miller, L. Luborsky, J.P. Barber, & J.P. Docherty (Eds.), *Psychodynamic treatment research: a handbook for clinical practice*. (14-36). Basic Books: New York.
- Jones, E.E., Parke, L.A., & Pulos, S. (1992). How therapy is conducted in the private consulting room: a multidimensional description of brief psychodynamic treatments. *Psychotherapy Research*, 2, 16-30.
- Jones, E.E., & Pulos, S.M. (1993). Comparing the Process in Psychodynamic and Cognitive-Behavioral Therapies. *Journal of Consulting and Clinical Psychology*, 61(2), 306-316.
- Jones, E.E., & Windholz, M. (1990). The psychoanalytic case study: toward a method for systematic inquiry. *Journal of the American Psychoanalytic Association*, 38, 985-1009.
- Migone, P. (1996). La ricerca in psicoterapia: storia, principali gruppi di lavoro, stato attuale degli studi sul risultato e sul processo. *Rivista Sperimentale di Freniatria*, 120 (2), 182-238.
- Migone, P. (1998). I gruppi di lavoro per la ricerca in psicoterapia. In S. Di Nuovo, G. Lo Verso, M. Di Blasi, & F. Giannone. (1998). *Valutare le psicoterapie*. Franco Angeli: Milano.
- Miller, N.E., Luborsky, L., Barber, J.P., & Docherty, J.P. (Eds.) (1993). *Psychodynamic treatment research: a handbook for clinical practice*. Basic Books: New York.
- Ortu, F., Pazzagli, C., Cascioli, A., Lingiardi, V., Williams, R., & Dazzi, N. (2001). Ricerca concettuale e ricerca empirica nella psicoterapia psicodinamica: Una metodologia per lo studio del processo. *Ricerca in Psicoterapia*, 4(1), 29-48.
- Paganucci, C. (1998). *La molla della psicoterapia breve strategica: un'applicazione del Q-Sort per scoprire cosa avviene nel processo terapeutico*. Tesi di laurea non pubblicata, Università degli Studi di Firenze.
- Piasentin, V., Azzone, P., Vigano, D., & Freni, S. (2000). La siglatura dei meccanismi di difesa nel contesto della ricerca empirica sul processo psicoterapeutico. *Ricerca in Psicoterapia*, 3(1), 38-65.
- Price, P. & Jones, E.E. (1998). Examining the alliance using the Psychotherapy Process Q-Set. *Psychotherapy: Theory, Research, Practice, Training*, 35(3), 392-404.
- Pulos, S.M., & Jones, E.E. (1987). *A study of differential validity of the Psychotherapy Process Q-Sort*. Paper presented at the Annual Meeting Of The Western Psychological Association, San Diego, CA.
- Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry*, 6, 412-415.
- Sirigatti, S. (1985). Ricerca valutativa in psicoterapia e terapia del comportamento. *Terapia del Comportamento*, 8, 110-117.
- Sirigatti, S. (1988). La ricerca valutativa in psicoterapia: problemi e prospettive. In G. Nardone (Ed.), *Modelli di psicoterapia a confronto*. Il Ventaglio: Roma.
- Sirigatti, S. (1994). La ricerca sui processi e risultati della psicoterapia. *Scienze dell'Interazione*, 1(1), 117-130.
- Smith, M.L., & Glass, G.V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist*, 32, 752-760.
- Smith, M.L., Glass, G.V., & Miller, T.I. (1980). *The benefits of psychotherapy*. John Hopkins University Press, Baltimore.
- Stephenson, W. (1953). *The study of behavior: Q-technique and its methodology*. University of Chicago Press: Chicago.

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