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THE SEMANTICS GRID OF THE DYADIC THERAPEUTIC RELATIONSHIP (SG-DTR)

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The article introduces the Semantics Grid of the Dyadic Therapeutic Relationship (SG-DTR), a coding system for the analysis of the therapeutic relationship. It is inspired by the systemic and cognitivist therapeutic field of research on meaning and psychopathology and make testable the concept of family semantic polarities, developed by Ugazio (1998, 2013). The SG-DTR identifies the interactive semantic polarities, that is, the semantic oppositions inferred by how the patient and therapist position themselves in the here and now of their mutual interaction. The grid captures the specificity of the psychotherapeutic relationship and identifies four main ways of relating and positionings between patient and therapist, expression of the four semantics — freedom, goodness, power and belonging — identified by Ugazio. The SG-DTR is a research and a clinical reliable tool. Knowing the meanings and the position of the therapist in his/her interaction with the patient is essential also to plan the therapy.

Key words: Coding system; Therapeutic relationship; Systemic therapies; Family semantic polarities; Semantics.

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AS MANY DIFFERENT THERAPEUTIC RELATIONSHIPS AS THERE ARE SEMANTICS?

Research on the therapeutic relationship has concentrated on the alliance between patient and therapist. Although relevant for the outcome of the therapy and understood in a dynamic and procedural sense (Safran, Crocker, McMain, & Murray, 1990; Safran & Kraus, 2014; Safran & Muran, 1996, 2000, 2001; Safran, Muran, & Eubanks-Carter, 2011), the alliance is only one aspect of the therapeutic relationship (Gelso & Hayes, 1998). Other components are equally important if not more. For example, the patient-therapist relationship and the possible dysfunctional interpersonal cycles are essential for the diagnosis and treatment process as has been recognized by many researchers of different approaches (Dimaggio, Carcione, Salvatore, Semerari, & Nicolò, 2010; Dimaggio, Semerari, Carcione, Nicolò, & Procacci, 2007; Fassone et al., 2012; Liotti & Monticelli, 2008; Safran, 1998; Safran & Segal, 1990).

Ugazio (2013) has recently suggested that the meanings through which the patient and therapist read the therapeutic experience and position themselves, shape the therapeutic relationship and any dysfunctional interpersonal cycle. "We don't have — Ugazio (2013) maintains — a single way of building up the therapeutic relationship, but have as many different ways as the number of semantics" (p. 263). She also adds: "There are as many differences in the therapeutic

alliance, the rifts created within it, the dysfunctional circuits, as the number of semantics that prevail" (p. 263).

Meaning and meaning making are at the core of the intersubjective model of personality and psychopathology developed by Ugazio (1998, 2013). According to this model, each family constructs conversation within antagonistic meanings — called "family semantics polarities" — such as cheerful/sad, generous/selfish, intelligent/dim-witted. They form a shared plot within which each family member has to take a position in the conversation. Take for example the polarity "intelligent/dim-witted," which often constitutes a semantic dimension around which conversation is organized inside a family of scholars and intellectuals. When this happens

> the members of these families will position themselves with people who are intelligent or very intelligent but will also be surrounded by people of limited intelligence or who are actually stupid. They will marry people who are intelligent, bright, stupid or painfully deficient. They will strive to become intellectually brilliant or will help those who are unfortunately less bright to become so. They will fight and compete to ensure that their intellectual abilities are recognized; they will end marriages and friendships when intellectual problems arise. Some members of these families will be intellectually brilliant, or regarded as such, while others will prove to be intellectually lacking. One thing is certain: everyone in these families will have to *position themselves* within the polar dimension in question and each member, in order to maintain his/her own identity, will need those positioned at other points in this semantic dimension. (Ugazio, 2013, p. 24)

And we can often find children with some learning disabilities in these families. In other families, though belonging to the same cultural background, the semantic polarity "intelligent/dim-witted" will be irrelevant and the conversation will be organized for example around episodes that put the dimension "diplomatic-outspoken" at stake.

Some of the polarities, made prevalent by the conversational practices of families, are organized around a specific and coherent group of family semantic polarities that Ugazio, Negri, Fellin, and Di Pasquale (2009) called "family semantics." A central thesis of Ugazio's (1998, 2013) model, supported now by substantial evidences (Castiglioni, Faccio, Veronese, & Bell, 2013; Castiglioni, Veronese, Pepe, & Villegas, 2014; Ugazio, Negri, & Fellin, 2011, in press; Ugazio, Negri, Zanaboni, & Fellin, 2007), is that people with eating, phobic, obsessive-compulsive disorders and depression will have grown up in families, where certain specific semantics predominate. For example, in a family where one member has a phobic disorder, conversation will be characterized by what is dubbed a "semantic of freedom," a dynamic driven by the emotional polarity fear/courage. Since the most relevant semantic polarities of the members of such a family are freedom versus dependence, or again exploration versus attachment, conversations in the family will tend to focus on episodes where fear and courage play a central role. As a result of these conversational processes, members of these families will feel, and define themselves as, fearful and cautious or, alternatively, courageous, even reckless. They will marry people who are fragile or dependent, or on the other hand free and unwilling to commit. They will try in every way to gain their independence and defend it tooth and nail. Admiration and contempt, friendships and conflicts, love and hate will all be played out around issues of freedom and dependence. In families where a member has a different kind of disorder conversations will revolve around quite different sets of meanings. The obsessive-compulsives live in contexts where the "semantic of goodness" with the conflict between good and bad is dominant; for those with an eating disorder, family conversations are organized by the "semantic of power" where some win

and some lose, some are successful while some others give up; the "semantic of belonging," where some are excluded and marginalized whereas others are filled by belongings, possessions and honor, characterize the contexts of people prone to chronic depression. Each of these semantics are characterized by its own specific emotions and ways of feeling.

The prevalence of these semantics in the family conversation is not enough in itself to favor the development of the related psychopathologies. The eventual appearance of one of the mentioned psychopathologies is favored by the reciprocal positioning assumed by the patient and their relatives in the conversation within the dominant semantic. According to Ugazio's (1998, 2013) model, it is therefore the position more than the semantic that plays a central role in the transition from normality to psychopathology.

Semantics instead play a fundamental role in the construction of the therapeutic relationship and consequently for the therapeutic process. "The crucial variable that shape the therapeutic relationship is not so much the psychopathology but the dominant semantic in the patient's conversational contexts" (Ugazio, 2013, p. 263). The semantics of power, goodness, freedom and belonging

> offer quite differing constraints and possibilities for therapy because they shape the therapeutic relationship in particular ways. Certain therapy stories that are possible in one type of semantic — in the sense of being productive, easy to implement, boding well for change — are forbidden in another, in the sense that they are difficult to develop, incapable of making best use of personal resources, destined to encourage dropping out or dysfunctional circuits. (Ugazio, 2013, p. 275)

The identification of the semantic can thus be a guide for setting the therapeutic process. The instrument presented here — The Semantics Grid of the Dyadic Therapeutic Relationship (SG-DTR) — allows us to precisely identify the semantics through which patient and therapist build their mutual relationship and to distinguish the contribution of each.

THE SG-DTR: GENERAL FEATURES

The SG-DTR derives from the Family Semantics Grid (FSG; Ugazio et al., 2009). The FSG allows us to identify and classify the "narrated semantic polarities" (NSPs), defined as the *verbal* meanings inside which the patient places him/herself and others within the therapeutic narrative. The narrator is the patient — he/she talks about him/herself and his/her world — but his/her narrative is also the result of the therapist, who will trace the plot through questions and comments. The FSG concerns the "narrated story" in therapy, extractable from transcripts of psychotherapy sessions, but it can also be applied to other texts, including literary ones. The SG-DTR presented here, instead, concerns the "lived story" between patient and therapist. Its purpose is to identify and classify the "interactive semantic polarities" (ISPs) understood as the meanings expressed by the mutual positionings between patient and therapist.

The concept of "family semantic polarities" elaborated by Ugazio (1998, 2013) includes essentially two types of different polarities (Ugazio et al., 2009): the NSPs already mentioned, and the ISPs, which deal with what is actually done rather than with what is said. These two types of polarities express the meanings extractable from positionings similar to those which Lucius-Hoene and Deppermann (2000) consider relevant in biographical interviews.

ISPs express meanings that are mostly implicit, identifiable in video recordings of the sessions. They are discursive phenomena of performative order and concern how patient and

therapist position themselves in the ongoing interaction. They represent much more closely than the NSPs, the conversational meaning of the concept of polarity provided by Ugazio (1998, 2013). "Polarities are not considered as something in the mind of each individual, but a discursive phenomenon" (Ugazio, 2013, p. 21). They are arrays of meaning fuelled by emotions, and created through the ongoing relationship with the other speaker. The construction of the SG-DTR required both the operationalization of the ISP concept, indispensable for their detection, and the identification of the specific way of relating between patient and therapist of the four semantics described by Ugazio (1998, 2013).

THE PATIENT-THERAPIST INTERACTIVE SEMANTIC POLARITIES: CONCEPT AND OPERATIONALIZATION

The SG-DTR identifies ISPs with the semantic oppositions inferred by how the patient and therapist position themselves in the here and now of their mutual interaction. These polarities can completely leave aside the verbal content of the interaction. The meaning they express is mainly based on non-verbal communication and only secondarily on verbal expressions. Each ISP is treated as a "way of relating" that underlies a specific emotion to be taken into account when classified.

Ways of relating and emotions are, from a constructionist point of view (Cronen, Johnson, & Lannamann, 1982; Harré, 1986; Harré & van Langenhove, 1999), together with the definitions of oneself/others/relationships and values, the semantic areas inside which patient and therapist position themselves, and at the same time the social realities that communication creates. ISPs are primarily ways of relating defined according to the emotions that support them. They also contribute, although indirectly, to the definition of oneself/others/relationships and the construction of the values.

Imagine a patient who overwhelms the therapist he/she just met, with a long list of questions about his/her working method and that this therapist, taken by surprise, tries to come up with some answers. The nonverbal behavior expressed during the exchange can give rise to very different meanings. For example, if the tone of the patient is assertive, while the therapist looks uncomfortable and hesitant, the exchange will qualify as an attack by a patient, putting the therapist in the one-down position. In another case, the exchange will appear as an anxious request for reassurance from a patient, disoriented by an unfamiliar context, to a therapist who is not able to reassure. The way of relating in play in the first case will be of "imposition/submission," with the patient being the imposer and the therapist the submissive, while in the second case, the way of relating will be coded as "looking for reassurance/disorienting," where the patient seeks reassurance and the therapist disorients him/her, deactivating his/her expectation of being guided. Both of these ways of relating lead to different definitions of the two interlocutors. In the first case, the patient will qualify as overbearing, while the therapist will appear submissive; in the second case, we have a fearful patient, struggling with a distant therapist, indifferent to the emotional state of the patient or firmly anchored to his/her position. The exchange that we have examined also refers to specific values: victory/defeat in the first case, security/risk in the second. As this example shows, the definition of self/other and the evincible values are very inferential and leave the hermeneutical field open to different alternatives. In fact, the meaning changes drastically also if the coder takes on the point of view of the therapist, the patient or an external observer, who, of course, will not be totally neutral.

Generally, the external observer tends to look at the interaction from the point of view of the patient, whose emotions during the conversation are stronger and more visible than those of the therapist; however, there are also observers who identify themselves with the therapist.

Also for their high inferentiality, which reduces the inter-rater reliability, we think it is better to limit the application of the SG-DTR to the ways of relating and underlying emotions. Researchers interested in extending the analysis to the definitions of self and values can refer to the original version of the FSG (Ugazio et al., 2009) for their classification.

The ISPs can be codified and distinguished based on whether they characterize relatively stable positioning or only briefly modify the emotional climate of the session. The most interesting ISPs are those evincible from ways of relating in which the patient and/or therapist move away from their allocated roles, because they express better the personal ways in which patient and therapist build their therapeutic relationship. We hereby list the six ways of relating that divert from allocated roles which we encountered most frequently.

1. Ways of relating where the patient and the therapist are directly called into question, both in their specific roles as well as interlocutors.

Example

T (therapist): How did you come to the decision to call me?

P (patient): Well, I was looking for, how can I say this, someone I could somehow ... mm ... I don't know ... I mean ... [the patient, who seems anxious, almost frightened, looks at the therapist].

T: [with a reassuring tone] Rely on.

P: Yes, exactly! Someone... someone that helps you and I've thought of you. I saw you at a conference and you... yes you sounded reassuring. And then... [the patient stops as suspended and blocked, then with a gesture indicates that it is there].

T: And then you called me and here we are.

2. Ways of relating where the patient and the therapist are called into question in an indirect way. This is what happens for example when the patient comments on the setting and its rules, speaks of other therapists or past treatment experiences, reports on other therapists or other judgments, which are significant for the therapist, and so forth.

Example

T: Here is a microphone and camera, which we also use for individual therapies.

P: [looks at T with evident disappointment].

T: If you don't mind [hesitantly].

P: Why are you recording?

T: Obviously, recordings are protected by the professional oath...

P: [interrupting] Heavens! With all the treatments I've done, I've never seen something so complicated!

T: [in obvious embarrassment] Of course, if you don't agree ...

P: [with assertive tone] Yes, if I don't agree you cannot tape me... I know it well, God forbid!

3. Ways of relating in which the therapist and the patient meta-communicate on the therapeutic relationship.

Example

P: I like working with you...

T: [pleased] I'm glad.

P: It's amazing, I'm very reserved, but I feel I can talk about everything with you... It's as if I've always known you.

T: [with evident satisfaction] I am very happy, I'm very pleased!

4. Ways of relating where mostly the therapist, but also the patient, meta-communicate their feelings toward each other, their personal characteristics, their relational strategies and what these aspects arouse in them.

Example

P: ... I don't know what kind of father I am... I don't think I'm that good in this as well... [sounding very sad]

T: ...From what I understand you did a good job with the twins, right? It seems they have come out very well, or am I wrong? Twins are also difficult to raise...

P: Well, yes; in the end I have to recognize that they have come out well, despite the separation...

T: It seems that you have been very good with them. You can be proud of them and yourself... [the tone is encouraging]

5. Ways of relating through which the therapist and the patient position themselves toward one another, on request or spontaneously, regardless of their roles or interpreting them in a very personal way. For example, it often happens that the therapist, when presenting the rules of the setting and negotiating with the patient the methods, time and format of the therapy, takes a personal position that goes beyond allocated roles.

Example

T: How can I help you?

P: I do not know, maybe listen to me...

T: Okay; but what are your goals for this therapy?

P: I would just like to be happy...

T: You've already done many therapies that unfortunately were unsuccessful. We must therefore clearly understand what your expectations are. I would not like to be the hundredth useless therapist!

6. Ways of relating in which the therapist, as conductor of the session, takes on interactive approaches that imply a definition of the relationship between the interlocutors, through the adoption of behaviors or expressions that transcend the technical aspects of the conduction.

Example

T: Oh no! Wait a second! There is a great contradiction in what you are saying! You pose yourself as a child, saying that without them (parents) you are lost, instead you do all this to protect them! No, I'm not going to let it pass! [laughing] It's too much!

P: Actually it's true... I helped them... I didn't even think about it... now I wonder...

THE FOUR GRIDS OF THE DYADIC THERAPEUTIC RELATIONSHIP

The grid of the patient-therapist ways of relating, characterizing the four semantics and the emotions that support them (see Figures 1-4) originates from Ugazio's (2013) theory of semantic polarities and the clinical literature concerning the therapeutic relationship. The identified

polarities are similar, but they do not coincide with those presented in the previous version of the FSG for what concerns the ways of relating.

Despite a certain degree of intimacy, the patient-therapist relationship is a professional interaction and presents specific features. Those who turn to a psychotherapist have in mind a socially shared patient-therapist relational pattern which differentiates, although ambiguously, this relationship from interactions among family members, friendships or other professional relationships.

Although social definitions of the therapeutic relationship vary, the asymmetry of roles is recognized and emphasized by the presence of a payment. The patients and their problems are also at the centre of the conversation. It is patients who talk about themselves, their problems, emotions, history, family, relations, while the therapist helps them to express themselves, to modulate their emotions, define their problems, their points of view, to understand themselves and the significant people in their world, to change behaviors and beliefs, to transform constraints into resources.

The majority of psychotherapeutic models have abandoned the idea of a therapist acting as a "mirror," firmly maintaining a neutral position. However, the therapist tends to avoid marked positioning. Especially during first sessions, his/her primary goal is to gather information, identify the problem, explain the setting and the working method and create a therapeutic alliance. The patient is certainly more free than the therapist to position him/herself and, consequently, to position the therapist; however, he/she also keeps him/herself anchored to allocated roles. At times, the patient's positioning toward the therapist emerges overtly in the form of questions, requests, meta-narrative observations that often violate the implicit and explicit rules implied in the psychotherapeutic model at the base of the treatment.

Despite the fact that the patient-therapist relationship is deemed a treatment instrument by many therapeutic approaches, it is still "task-oriented": the goals that legitimatize its existence are in the foreground. These features tend to reduce the range of the possible positionings between patient and psychotherapist, although to a lesser extent than in other more "aseptic" and predefined professional relationships. The grid shown in Figures 1-4 captures the specificity of the psychotherapeutic relationship. We describe below the main ways of relating and positionings between patient and therapist within the four semantics identified by Ugazio (1998, 2013).

Careful Tutor or Dangerous Guide?

The semantic of freedom is characterized by two polarities: "freedom/dependence" and "exploration/attachment," fostered by "fear/courage," the fundamental emotions of this semantic. Because of dramatic events that take place in personal or family history, or for reasons that are difficult to pinpoint, the outside world is built as threatening by who position themselves within this semantic. Also emotions can be experienced as a source of danger because it is difficult to control them. On the contrary, family members are deemed as protective and reassuring. Nonetheless, individuals feel free, independent and, consequently, admirable, if they are able to face the world and its perils on their own, without the help of others.

Freedom and independence "are understood in this semantic as freedom and independence *from* relationships and *from* their restraints" (Ugazio, 2013, p. 83). As a rule, in the therapeutic setting the patient is not free from the relationship and its restraints. On the contrary, he/she is in a dependent position. Even if, in the past, he/she was placed within his/her contexts of belonging

among those who are free and able to fend for themselves, the symptoms and/or situation that causes him/her to seek a therapy, position him/her within the dependant pole, that in this semantic, has a negative value. Even if the patient needs to rely on a reassuring therapist, he/she looks for a free and independent person when seeking therapy. The hope is that a free and independent therapist will be able to emancipate him/her from the bonds of dependency in which the symptoms have placed him/her now and from which he/she had freed him/herself more or less easily. In some cases, as for example with agoraphobics, even if before the onset of symptoms they are far from being free and independent, they nevertheless want the therapist to reduce their dependence.

> When the semantic of freedom dominate, (…) therapists, especially at the beginning of treatment, will find themselves positioned in the "freedom" pole. Like it or not, they will end up in the position of someone, for example, who encourages the patient to break away from oppressive ties and widen their horizons. (Ugazio, 2013, p. 264).

But because of this, the therapist will solicit the fear in the patient who wants to break free of the constraints but is afraid to be alone in a dangerous world.

The therapy often oscillates between two opposite situations. It is a "secure base" from which to explore the world and deal with its dangers, under the supervision of a careful tutor to whom the patient can come back to when the exploration becomes too risky. But it is also a "springboard" from which the patient can be challenged by a reckless therapist-guide at the risk of falling into situations for which he/she is not equipped (see Figure 1). Consequently, the patient will oscillate between "trusting," "opening to the therapist" and "closing the therapist out," "distancing." Like a crayfish, he will make three steps forward by relying on the therapist, opening up to him/her, immediately followed by four steps backward. The distancing of the patient may be expressed as a closure, mostly cordial, but nonetheless hermetic or as physical distancing: the patient will postpone the session in order to catch his/her breath, will arrive late or warn the therapist that the meeting will have to be shorter than expected due to an urgent commitment, or will end the therapy always leaving the door open to return, which often happens within a few months, or even years. Dropouts are frequent in the semantic of freedom but are often temporary.

The patient's expectations, that the therapy will help him/her overcome fears and break away from oppressive ties, make three ways of relating to be particularly frequent: "encouraging/limiting," "exploring/protecting," "scaring/reassuring." The therapist encourages the patient to explore and overcome his/her fears, becoming autonomous from the therapist. However, the therapist can also limit the patient, thus increasing his/her dependence. The patient tends to consider the therapist as either a daring guide — whom he/she should keep distance from — or a caring tutor who protects his/her. The same patient tries to face one's anxieties and fears, wants to break away from oppressive ties, to explore new horizons and to become self-reliant, to gather the courage to be more independent. But the patient may relay on the therapist for safety becoming dependent on him/her. Especially because fear and anxiety dominate the scene, "scaring/reassuring" are ways of relating that are very frequent in therapy. Usually, it is the therapist that calms, guides, reassures, while the patient is frightened, asks for reassurances, is disoriented or even alarmed by, for example, the interpretations of the therapist. The positions may be reversed, however. The therapist may be driven to an excess of caution by the anxieties and fears of the patient. It is then the patient that reassures the psychotherapist, realizing that he/she has alarmed the therapist unnecessarily.

CODE	WAYS OF RELATING		CODE
130	CLOSING OTHER OUT Distancing oneself Keeping distant	TRUSTING Opening to other Getting close	131
132	ENCOURAGING Emancipating Getting free from other	LIMITING Relaying on other Depending	133
134	EXPLORING Venturing Taking risks	PROTECTING Staying put Safeguarding	135
136	SCARING Disorienting Alarming	REASSURING Guiding Calming	137
CODE	EMOTIONS AND FEELINGS		CODE
140	**COURAGE**	**FEAR**	141
142	DISORIENTATION	CONSTRAINT	143

Note. The first digit of the three-digit code indicates the semantic (1 = *freedom*, 2 = *goodness*, 3 = *power*, 4 = *belonging*), the second digit refers to the semantic areas within patient and therapist position themselves (1 = *values*, 2 = *definitions of self/other/relationship*, 3 = *ways of relating*, 4 = *emotions and feelings*), the third digit refers to the specific pole of a semantic polarity.

FIGURE 1
The SG-DTR of the semantic of freedom.

Judge or Accomplice?

The polarities at the centre of the semantic of goodness, that we usually find in the therapeutic conversation with obsessive-compulsive patients, are "good/bad" and "dead/alive." This last polarity confers a dramatic pathos to this semantic because life is on the side of evil. Goodness played by this semantic is the absence of evil.

> Good people are *not* those who are helpful, friendly, polite, and generous toward others but those who renounce all expression of personal desire or defence of personal interests, who sacrifice themselves, who distance themselves from all *instinctual* urges. Bad people are those who express their own sexuality and their own aggressive impulses. (Ugazio, 2013, p. 131).

Innocence and guilt, disgust and pleasure drive this semantic.

When this semantic prevails patients oscillate between seeing therapy as a source of liberation from guilt, from the scruples and the moral dilemmas that torn them and the anguish that the therapy will corrupt them. The social perception of psychotherapy as an experience that tends to favor the freedom of sexual expression often leads patients to place the psychotherapist in the vital, but also forbidden pole, of this semantic. The therapist, if not properly immoral, is therefore suspected to be permissive. On the other hand, psychotherapy is considered a pro-social and vocational activity, chosen by people who are more interested in their work than in the earnings that

derive from it, thus having high ethical values. The therapist can hence become an accomplice for the forbidden desires of the patient, but also a judge, albeit an often-permissive one.

"Following the rules/trespassing" is the way of relating that characterizes the here and now of the therapeutic conversation (see Figure 2). Patient and therapist can scrupulously fulfil their respective allocated roles, asking the other to respect rules rigorously, or, on the contrary, break rules more or less overtly, to claim rights or take advantage of the availability of the other. The patient may for instance resent the fact that the therapist ends the session a few minutes before the agreed term, but also worry if he prolongs the session: is the therapist falling in love with him/her? Or is the therapist trying to increase the agreed cost of the sessions? The therapist may also end the session abruptly, not allowing the patient to conclude his/her discourse. Demanding a preferential treatment, claiming rights or taking advantage of the interlocutor's availability are also typical ways of relating of patients positioned within this semantic. The patient may ask to have sessions at an unusual time, but comfortable for him/her, a reduction on the fee and so forth. Obviously, the therapist has to take position within this polarity either maintaining more or less rigidly the rules set or becoming a potential transgressor.

CODE	WAYS OF RELATING		CODE
230	FOLLOWING THE RULES Fulfilling one's duties Abstaining from demands	TRESPASSING Claiming rights Taking advantages	231
232	JUDGING Disgusting Blaming	RENDERING AN ACCOMPLICE Seducing Demanding preferential treatment	233
234	MAKING ONE'S CONFESSION Assuming one's responsabilities Declaring one's (malicious) purposes	MANIPULATING THE FACTS Feeling/making other guilty Concealing	235
236	RESISTING Repressing emotions Intellectualizing	LETTING OFF STEAM Using vulgar language Getting rid of	237
CODE	EMOTIONS AND FEELINGS		CODE
240	**INNOCENCE**	**GUILT**	241
242	DISGUST	PLEASURE	243

Note. The first digit of the three-digit code indicates the semantic (1 = *freedom*, 2 = *goodness*, 3 = *power*, 4 = *belonging*), the second digit refers to the semantic areas within patient and therapist position themselves (1 = *values*, 2 = *definitions of self/other/relationship*, 3 = *ways of relating*, 4 = *emotions and feelings*), the third digit refers to the specific pole of a semantic polarity.

FIGURE 2
The SG-DTR of the semantic of goodness.

The "judging/render an accomplice" polarity often implicitly characterizes the therapeutic relationship. Both the therapist and the patient may situate themselves within the judging pole — thus feeling a sense of disgust toward the interlocutor and blaming the interlocutor for his/her

immorality — as well as they may corrupt the other and induce him/her to become an accomplice. The patient is often the one who tends to "corrupt" the therapist making the therapist his/her accomplice. The patient leads the therapist to allow the expression of one's "forbidden" or morally inappropriate behaviors (at least from the point of view of the patient) and/or criticize parents or partner, considered too strict and oppressive. Sometimes the patient seduces the therapist. A first step consists in trying to shorten the distance for example through e-mails and text messages. Naturally, also the therapist can more or less overtly "corrupt" the patient, leading him/her to distance from one's values and principles, or searching for complicity in developing a therapeutic project that acquires, within the session, a dubious moral connotation. In both cases, the therapist will be in the position of helping the patient express one's forbidden needs. Therefore, the latter may side with the positive pole of his/her semantic, resisting his/her enticements, or positioning him/herself within the negative pole allowing the patient to be led down a dubious road.

Therapist and patient may also turn the session into a confession, where events have to be reported precisely and both the patient and the therapist feel responsible for what is happening, or, conversely, one of them can manipulate the facts by presenting a personal version of the facts or by concealing important information. They can blame themselves or one another or one can forgive the other, putting them in a indulgent position. Patient and therapist can "resist" more or less passively, but also "let off steam." Intellectualization and repression of emotions will dominate the scene. The sessions will nevertheless see the patient give vent to emotions, by using for example vulgar language or getting rid of oppressive burdens. Also the therapist can give vent to emotions with some planned or unplanned enactments.

Rivals or Allies?

When the semantic of power takes over, shame and pride generate an interaction that produces "winners" and "losers." Therefore, "the crucial winner/loser semantic polarity renders the definition of the relationship between members of the family unit and their relative conflicts central" (Ugazio, 2013, pp. 184-185). Of course, the therapeutic relationship is not immune to this dynamic.

The patient tends to ask for therapy because he/she thinks or fears that he/she has lost power and feels like a loser. Although he/she hopes to regain or find a winning positioning thanks to the therapy, the patient is challenged by the asymmetry of the patient-therapist relationship, which he/she interprets through the metaphor of power. Feeling humiliated, the patient considers the therapist as a rival and the setting and its rules as a plot to put him/her in a one-down position.

According to Ugazio (2013), the semantic of power may turn the therapist's position into the more promising one of an ally: "*The patient, to win over an ally, is prepared temporarily to accept a relationship that is disagreeable because it is asymmetrical*. (…) This, unfortunately, is an alliance that is very different from the kind the therapist wants, since *it is an alliance against someone else*" (p. 273).

It is highly unlikely that those who are or try to be in a winning position, like for example anorexics, turn to a "loser" therapist, or supposedly so. On the contrary, they will choose a prominent professional psychotherapist, even better if known by the media. Those who are chronically positioned in a losing position — such as patients suffering from obesity — or those

who feel they have no self-confidence whatsoever to gather the courage to confront themselves with a "winner" psychotherapist, may go for a "loser" psychotherapist.

The ways of relating that characterize the therapeutic relationship within this semantic are summed up in Figure 3. "Adapting/resisting" is the most common way to relate to others according to the semantic of power. However, in a therapeutic relationship such modality displays specific features. In this relationship, "adapting" means "submitting to the setting and its rules" and "questioning oneself," whereas resisting stands for "rejecting the setting and its rules" and "imposing one's own point of view."

CODE	WAYS OF RELATING		CODE
330	ADAPTING Submitting to the setting and its rules Questioning oneself	RESISTING Rejecting the setting and its rules Imposing one's own point of view	331
332	WITHDRAWING Losing ground Giving up	BEING A MATCH FOR OTHER Gaining space Prevaricating	333
334	ALLYING Enhancing Showing off	COMPETING Belittling Criticizing	335
336	CHALLENGING Making an impression Boasting	HUMILIATING Making a poor impression Patronizing/discrediting	337
CODE	EMOTIONS AND FEELINGS		CODE
340	**BOAST**	**SHAME**	341
342	SELF-EFFICACY	INADEQUACY	343

Note. The first digit of the three-digit code indicates the semantic (1 = *freedom*, 2 = *goodness*, 3 = *power*, 4 = *belonging*), the second digit refers to the semantic areas within patient and therapist position themselves (1 = *values*, 2 = *definitions of self/other/relationship*, 3 = *ways of relating*, 4 = *emotions and feelings*), the third digit refers to the specific pole of a semantic polarity.

FIGURE 3
The SG-DTR of the semantic of power.

Despite manifesting themselves also in other relationships, three other ways of relating are particularly frequent in the psychotherapeutic relationship. "Withdrawing/being a match for other" refers primarily to the way the patient and the therapist interact in the here and now of the conversation. The winner seems to set the rhythm, keeps on questioning the other person, reports on events, presents diverse topics, he/she gains more and more space and leads the conversation, he/she takes over the conversation, leaving no space for the other to interact. On the other hand, the person who withdraws, loses ground and gives up in the end, leaving to the other the task of leading the conversation and to prevaricate (at least temporarily). "Allying/competing" is a strategic and intentional type of relational co-positioning guided by the goals that both the patient and the therapist set. By allying with the therapist and presenting the story so that the therapist takes a stand, the patient seeks most of all to win those who are in a superior position within the

contexts he/she belongs to. Also the therapist seeks the patient's alliance without which it would not be possible to continue the therapeutic project. Like the patient, he/she can cooperate with him/her interlocutor or side with him/her, against his/her rivals and detractors.

In this semantic "challenging/humiliating" implies an opposite positioning of the interlocutor. Those who challenge the other, implicitly acknowledge that the other person has a similar or superior status, whereas those who humiliate consider their conversational partner as inferior to them and want him/her to acknowledge his/her inferiority. "Making an impression" and "boasting" mean here to be aware and show one's own privileged social status, whereas "making a poor impression" entails feeling one's own position threatened by the interlocutor.

Ideal Partner or Fake?

The polarities of "inclusion/exclusion" and "honor/dishonor" are prominent in the semantic of belonging, which is generally found in the treatment of chronically depressed patients. Fuelled by the emotional opposition "anger, despair/joy, cheerfulness," the semantic of belonging generates a conversation where being included in the family, in one's lineage, and in the community is the most important thing.

> Expulsion from the group, or not belonging to a family, is seen by such people as an irreparable disgrace, whereas the greatest good is to be well-established and respected within the groups to which they belong, including family and community. Yet it is often in the name of dignity that permanent rifts occur. Honor in these families is therefore a value just as fundamental as belonging. (Ugazio, 2013, p. 228).

Therapy with the people who have lived in contexts where this semantic prevails normally starts when they feel excluded from their contexts. Often the therapeutic request is preceded by a painful breakup of a relationship: the patient through the break feels he/she saved his/her honor, but the price to pay is despair and depression. Other times the patient is afraid of not being able to contain aggression toward a person that is important to him/her and risks losing him/her. More often the reasons are unclear but the patient is no longer able to control anger or has fallen into depression.

By asking for psychotherapy, the patients' goal is to save at least their integrity, rather than recovering an inclusion, which is desperately sought but considered unreachable. These patients generally choose a therapist whom they consider honorable and included in their professional and familiar world and therapy oscillates between being a happy oasis, where the patient can finally share his/her world with someone, and being an illusory space, where hopes, that are destined to be disappointed, are cruelly solicited. The therapist becomes often, especially in the early stages of therapy, "the ideal companion," the only one capable of understanding the patient, but may end up in the position of the impostor.

The most characteristic ways of relating in the therapeutic relationship are "sharing/claiming one's own uniqueness" and "repairing/provoking" (see Figure 4). The patient — who has mostly isolated him/herself from everyone else — not only shares thoughts, emotions, ways of feeling with his/her therapist, but very quickly elects him/her to be his/her privileged or even unique interlocutor, constructing with him/her a sort of "we." This "we," with the same speed with which it was built, can dissolve. The patient detaches him/herself emotionally from the therapist, offers during the session a narrative that highlights his/her uniqueness and the inability of people (therapist included) to understand him/her. The patient often provokes the therapist, for example by

skipping appointments without letting him/her know. The provocative behavior does not necessarily mean that the patient is disappointed with his/her therapist. He/she simply believes that nothing can help him/her and protects him/herself in view of the inevitable disappointment. But when the disappointment is real, the patient may attack the therapist, insulting him/her more or less overtly. These people, however, are able to "fix" the fractures they caused in the therapeutic relationship by expressing gratitude and medicalizing: attacks are attributed to their disease or bad luck.

CODE	WAYS OF RELATING		CODE
430	SHARING Involving (we) Enthroning	CLAIMING ONE'S OWN UNIQUENESS Cutting off Deposing	431
432	RESPECTING/CLAIMING RESPECT Idealizing Honoring	DISHONORING Discrediting Defaming	433
434	REPAIRING Medicalizing Being grateful	PROVOKING Attacking Insulting	435
436	ENTHUSING Amusing Providing clinical materials	DESTROYING Cancelling Demolishing	437
CODE	EMOTIONS AND FEELINGS		CODE
440	**JOY**	**ANGER**	441
442	CHEERFULNESS	DESPAIR	443

Note. The first digit of the three-digit code indicates the semantic (1 = *freedom*, 2 = *goodness*, 3 = *power*, 4 = *belonging*), the second digit refers to the semantic areas within patient and therapist position themselves (1 = *values*, 2 = *definitions of self/other/relationship*, 3 = *ways of relating*, 4 = *emotions and feelings*), the third digit refers to the specific pole of a semantic polarity.

FIGURE 4
The SG-DTR of the semantic of belonging.

The patient, just as he/she wants to be treated with respect by his/her therapist, shows for the most part respect for the therapist and the rules of the setting. Always punctual in paying the sessions, does not ask for a favorable treatment, does not seek to extend the sessions, nor telephones outside the agreed times. The patient often idealizes the therapist, gives her/him the credit for having eventually reached some results, rather than crediting him/herself: if he/she is feeling better it is because the therapist is exceptionally good. When he/she removes the therapist from the throne where he/she placed her/him, the attack always presupposes infamy: the therapist is in substance a crook. The underlying accusation is to have been deceived, to have pointlessly been given hope.

When the therapeutic conversation is dominated by this semantic, the polarity "enthusing/destroying" plays a central role in the therapeutic process. The sessions can be marked by the enthusiasm of the patient who provides a lot of material to his/her therapist. Very often the therapist enjoys him/herself: the narrative of the patient, even if it presents very painful contents, is brilliant, ironic, grotesque. In short, the patient does everything to present her misfortunes so as not to weigh emotionally on the therapist and provides him/her with the material that he/she wishes

for. Of course, all this beautiful structure can fall apart very easily. And the therapist can witness the work of many sessions being cancelled abruptly. Ending the therapeutic relationship, cancelling it, demolishing it are therapeutic ways of relating that are allowed among those who construct the relationship with the therapist with this semantic.

IDENTIFICATION AND CODING PROCEDURE

It consists of two steps. Firstly, it entails the identification of ways of relating in compliance with the supplied operational definition and, secondly, their codification. Both parts imply the comprehension of the conversational context where ways of relating and meanings originate. The entire video recording of the session must be observed at least a couple of times before starting. The phone chart and all communication (emails, letters, text messages, phone calls, etc.) that occurred between patient and therapist before the first meeting, and between sessions should also be analyzed. Of particular importance is the initial phone call, which, although it is not usually recorded, must be examined carefully in case the therapist will take note. The possibility to include the positioning emerging here and the related polarities in the coding depends on the accuracy with which the therapist takes note of the contacts preceding the session.

Step 1
Identifying the Ways of Relating

The identification process is carried out by two coders. They work at first autonomously and later jointly, in order to reach an agreement (see Hill et al., 2005; Hill, Thompson, & Williams, 1997) on the selection of the sequences where a way of relating appears.

Phase 1
Selection of Sequences and Transcription

The coder identifies the sequences where the six ways of relating can be found, in compliance with the definition provided in the paragraph titled “The patient-therapist interactive semantic polarities: Concept and operationalization,” transcribing the verbalizations that express them and defining their duration. Should the transcript of the session be available, the indication of turn-takings may substitute the duration (Angus, Hartdke, & Levitt, 1999). If the coder is uncertain if a way of relating is present or not in a specific sequence, this sequence is not taken into consideration.

Phase 2
Annotation of the Meta- and Extra-Narrative Indicators

The coder annotates both meta- and extra-narrative indicators (nonverbal and paraverbal) found in the sequence (cries, laughter, posture, tone of voice, glance and eye contact, facial and emotional expressions, etc.) which are deemed necessary to identify the way of relating.

Phase 3
Comparing Findings between the Coders

Once the dyadic sequences are independently identified, the two coders compare their findings in order to reach an agreement on the identification of the sequences and their classification. The sequences where a disagreement persists are excluded from the analysis.

Step 2
SG-DTR Application

The SG-DTR is fully implemented by the coder.

Phase 1
Semantic Analysis of the Interactive Sequence

The coders express in writing the meaning that they attached to each ISP between patient and therapist, explaining the verbal and nonverbal, implicit and explicit, indicators on which they base their attribution and summarizes it with a label.

Phase 2
ISP Coding

The coders evaluate whether each ISP analyzed and labelled in the previous phase is among those provided by the grid and takes note of the corresponding code. If it is not, it is included and annotated in the category "other semantics," which has a unique code (530).

Phase 3
Identification of the Agent

The coders identify the agent of each interactive positioning, that is, the person to whom the way of relating is attributed*:* Patient = 1; Therapist = 2

Phase 4
ISP Classification on the Explicit/Implicit Axis

Three different types of positionings (Figure 5) are identified according to the degree of explicitness:

a) Explicit ISPs: the agent involves the interlocutor explicitly, for example by commenting on his/her way of narrating, his/her personal characteristics or his/her professional rules. Here is an example:

T: If I am not mistaken, at that time you used to come back home and growl, because something vital had gone wrong and you opened your eyes…

P: There you go! Excellent! You do have a point there!

Complimenting the therapist for his/her perspicacity, the patient takes an explicit positioning.

b) Explicit ISPs with explicit reference to the interlocutor: the agent directly addresses the interlocutor, yet the positioning and its meaning remain mostly implicit. Here is an example:

P: I've decided to pick up the phone and call you because I realized I'm about to die. I thought I could manage by myself, but time is running out. I hope it's not too late [looking down and whispering, as if he were talking to himself]…

The reference to the therapist is clear, whereas the movement with which the patient alarms the therapist he/she just met is implicit (this occurs in the first session).

c) The ISPs and the interlocutor are implicit: their meaning and real targets are evincible only indirectly. Here is an example:

P: You know, Doctor, I'm a very reserved person; before talking about... mm... my problems with someone, I mean, it takes time... I don't know where all this comes from, but I'm always afraid that if I say too much I will regret it...

Is not therapy a context where it is possible to talk about one's problems, in which we open ourselves to another in the hope that it will be helpful? The patient is expressing one's difficulty in relying on the therapist in an implicit way.

ISP type	Code
Explicit	1
Implicit, with explicit reference to the interlocutor	2
Implicit, with implicit reference to the interlocutor	3

FIGURE 5
ISP types and corresponding codes.

Phase 5
Classification of ISP According to Person/Role Axis

Both patient and therapist can position themselves in agreement with their role or their personal characteristics. Naturally, role and person coexist. We have provided four codes that indicate the prevalence of the role or the person (Figure 6).

P: Don't leave me doctor, please! I'm drowning! Help me solve my problems!

T: I'll do everything I can... During this first session we've seen a few things. Next time we'll try to figure out what the problem is and see which road we should follow together.

The roles predominate over persons and neither of the two seems to deviate from it, even on a nonverbal level.

In the following example we see persons prevailing instead, with their physical and psychological characteristics against the roles from which both patient and therapist temporarily deviate. The patient, an anorexic woman weighting 23 kg, is ranking her relatives on the basis of

their weight. She, together with her sister and an aunt, are the skinny members of the family, while her mother belongs to that category of people who, weighting more than 50 kg, are, according to her definition, "whales."

T: Was your mother as slim as your sisters or was she well-built?

P: She was a beautiful lady!

T: How beautiful?

P: A beautiful lady [with emphasis; reaching out, drawing a circle] I mean... like you! [smiling].

T: Don't worry. I won't be upset if you say that I belong to the "whales"!

P: No, no! No, no, no! You look beautiful [she laughs]! No, no!

Role label	Code
Patient as patient	1
Therapist as therapist	2
Patient as a person	3
Therapist as a person	4

FIGURE 6
Role labels and corresponding codes.

Phase 6
Identifying the ISP Degree of Polarization

The coder assigns a code that defines the degree of polarization of the positioning assumed by each party in each ISP (Figure 7). We suggest using a 3-point scale because it is difficult to determine the intensity of the ways of relating, especially those implied in a context such as the therapeutic one, where roles are largely predefined. In addition, the therapist does not generally assume marked positionings.

ISP degree of polarization	Code
Slight	1
Moderate	2
Marked	3

FIGURE 7
ISP degrees of polarization and corresponding codes.

Organization of Data

All data collected and codes collected during the coding process are entered and organized in a spread sheet (see Appendix) which provides the basis for a statistical analysis. Depending on the objectives of the study, some codes may be omitted whereas others may be added.

APPLICATION AND RELIABILITY

The SG-DTR has so far been applied to the first two consultation sessions, conducted according to the systemic-relational approach with 60 patients (mean age = 34.9; range = 17-59). Forty-eight of them are equally distributed according to the four psychopathologies envisaged by Ugazio's (2013) model: disorders of the phobic spectrum, obsessive-compulsive, eating and depressive disorders. These are prototypical cases, with a documented psychopathological diagnosis, with no co-morbidity. The remaining 12, constituting the comparison group, are patients who required treatment for existential problems and show no diagnosis provided by the DSM-5 (American Psychiatric Association, 2013).

The coding was applied to all the video recordings of the sessions (N = 120), which last between 60 and 90 minutes (M = 73). The average number of interactive semantic polarities for each single session is 13.71 (SD = 9.64; range = 1-44). Being the first two sessions, where the majority of patients adhere to their allocated roles, only the six most distinctive positionings of the therapeutic relationship indicated in the paragraph titled "The patient-therapist interactive semantic polarities: Concept and operationalization" were coded. The inter-rater reliability of all steps in the procedure is indicated in Table 1.

TABLE 1
Inter-rater reliability

Type of coding	Cohen's K
Selection of interactive positioning	.94
Semantics	.75
Way of relating	.61

The agreement on the selection of the sequences is high. The second coder performed analysis on 50% of the interactive positionings detected in each session. As expected the inter-rater agreement is lower for what concerns the meaning attributed to each way of relating than for the classification of semantics. A full coding, including all the positionings, even those totally adherent to the ascribed roles, was carried out on the video-recordings of single cases, one of which is in press (Ugazio & Fellin, in press).

CONCLUSION

The SG-DTR enables the empirical identification of ISPs, the polarities that best express the distinctive features of the concept of semantic polarity introduced by Ugazio (1998, 2013). For Ugazio (2013) "polarities are not considered as something in the mind of each individual, but as a discursive phenomenon" (p. 21) expressed mainly by emotions, therefore on a nonverbal level. The FSG (Ugazio et al., 2009) has provided a working definition and a method to identify and codify the narrated semantic polarities that do not fully capture the specificity of the concept

of semantic polarities, because they concern the narrated story, rather than what is done. Thanks the SG-DTR, the family semantic polarities theory will then be verified in a reliable way.

Although provisional, and subject to revision, the definition of ISP introduced by the SG-DTR offers therapist-researchers the opportunity to understand the semantics with which the patient is interacting with them. At the same time, it allows them to understand how they positions themselves, often unknowingly, in the interaction with the patient and how to change it if it proves to be unproductive. The SG-DTR is an instrument with significant clinical value, useful to clinicians too.

The SG-DTR has excellent reliability with regard to the identification of the six interactive sequences defined as ISP distant from allocated roles. Its reliability is satisfactory also for the classification of ISPs in the four semantics. However, it is low for the classification of each ISP in one of the specific ways of relating characteristics of each semantic (see Table 1). Overall its reliability is lower than in the original version of the FSG (Ugazio et al., 2009). This is a predictable result. The SG-DTR has a high degree of inferentiality, superior to that of the FSG. Although the ISP definition we have provided also includes verbal aspects of the conversation, the interactive positionings and their possible meanings are mostly evincible from implicit aspects of the interaction, thus more inferential.

From our point of view, the main value of the SG-DTR is that it is capable of identifying the characteristic ways of relating between patient and therapist, that is, the core of the therapeutic relationship. In addition, it provides the ISP characteristics of each of the four semantics. From this point of view, the SG-DTR is a research as well as a clinical tool. Knowing the meanings and the position of the therapist in its interaction with the patient is essential for planning therapy.

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APPENDIX

The SG-DTR spread sheet (extract)

P's ID	Time/ Turns	Sequence	Semantic analysis	Agent		Way of relating		SG-DTR code		Kind of positioning		Role		Degree of polarization	
				A	B	A	B	A	B	A	B	A	B	A	B
Marco, 37 years old, musician. Diagnosis: Panic Disorder 300.01 (F41.0)															
10101	78-80	T: How did you come to the decision to call me? P: It was when I had the last (panic) attack. It was very strong and I thought: "I've to phone her immediately, because I can't manage it! I can't go on like this! I really need someone who can help me." And then [he leans forward, clearly upset] I took the phone and I called you. Fortunately you answered, because just talking with you made me calm down and... So I believe that you can *really* help me [he looks at the therapist with a needy expression] T: Yes, I understand...	The patient positions the therapist as a professional that can help him. While describing the episode of the phone call, he looks very agitated, but he also tells the therapist that just after the conversation with her he calmed down. His help-requesting gaze and the emphasis on "really" are very eloquent and the positioning is explicit and marked: the patient trusts the therapist, because he is not able to cope by himself.	1		Trusting		131		1		1		3	

(appendix continues)

Appendix (continued)

10101	501-505	T: Ok, let's schedule the next appointment [she takes the agenda] P: Mm… I beg your pardon [he sinks back in the chair]… by the way [pause]… I don't know what you are thinking, but I don't… I didn't think about regular sessions (his voice trembling) I didn't think about… strict therapy… I thought: "Let's go and see what she says to me, about my problem." I came here because I think I can't manage it by myself. When you said you're a bit busy this month, I thought "Whatever! We can decide not to start immediately." T: Mm, mm P: I can wait, if you... [in a whisper, moves his hand nervously] If I think about an intensive work, I'm a bit scared... T: [calm tone] Yes, I understand. Generally, during the consultation, I plan two or three sessions in a closer lapse of time, just to better focus on the problem, better understand the client's needs and define together some possible goals. I think you shouldn't worry about this: we won't meet every week and we can always define the frequency of the sessions, ok?	The verbal and non verbal behavior of the patient indicates he is trying to safeguard himself from a possible therapy. He looks scared, pulls away from the therapist and his voice trembles, especially when he is talking about "a strict therapy." He attempts to postpone the next session and he says that he felt relieved when the therapist told him she was rather busy (it is the opposite of turns 78-80). Is he afraid of a close relationship with the therapist? The therapist feels the patient is worry and tries to reassure him and calm him down: some session in a closer lapse of time is just a praxis of the consultation phase. It will not be an "intensive" therapy and they will plan the frequency of the sessions together.	1	2	Safeguarding	Reassuring	135	137	1	1	1	2	2	2
10101	506	P: Ok, Doctor. If you think so, it's ok. This is your job, so I trust you [smiles].	At this point the patient trusts the therapist as an experienced professional. His expression is still a bit hesitant, but now, reassured, he can even smile…	1		Trusting		131		1		1		1	

(appendix continues)

Appendix (continued)

Renato, 49 years old, economist. Diagnosis: Obsessive-Compulsive Disorder 300.3 (F42)															
20702	430-433	P: Perhaps I was wrong [low and gloomy face]… but the anger overpowered me and I literally exploded! Sometimes I feel I'm not a good person [silence] T: Mm… P [lifts his face, looks at the camera and then at the therapist] Do you think I behaved badly? Do you think I am a...? T [interrupting him] Well, I cannot answer a question like that... Goodness! I'm not here to discuss if you have done right or wrong.	The patient is describing the episode with a sad and gloomy tone, when, in an explicit way, he asks the therapist to judge him from a moral point of view ("Do you think I..?"). He looks at the camera: does he feel that a third eye is watching and judging him? The therapist abstains from any judgment and positions herself as a therapist, meta-communicating that the therapy room is not the place for moral judgment.	1	2	Judging	Abstaining from demands	232	230	1	1	3	2	2	3
Lucia, 37 years old. Diagnosis: Bipolar II Disorder 296.89 (F31.81)															
40402	55-58	P: Doctor, in general I'm not as you see me now… You see me at ease with you, right? T: Yes. P: Well, also in our previous session, I felt… [looks in the therapist's eyes, with an almost adoring expression] I really want to tell you that it is you who makes me feel this way, as I've known you for twenty years [big smile]. I feel good here and I wanted you to know this! T: [a bit embarrassed] Hm, yes...I...I... You told me that recently you feel better, it's not a bad period for you [laughs]. I think you've been able to take a breather…	The patient's facial expression is almost adoring. Just after a few minutes of the second session, she positions the therapist as someone with which she can build an emotional sharing, as she has known her for many years. The emotional climate is positive and the client's eyes are shining, idealizing the therapist. There is no seductive intent in her words or the attempt to appraise the therapist. The therapist feels a bit embarrassed and responds to this idealization, ascribing the client's well-being during the session to another reason.	1	2	Idealizing	Belittling	432	335	1	2	1	2	3	1

(appendix continues)

Appendix (continued)

Giovanna, 24 years old, actress. Diagnosis: Binge-Eating Disorder 307.51 [F50.8]															
30801	5-6	T: As you can see, there is a microphone and a camera… P: [interrupting and talking with a challenging tone] Yes, yes, I know how it works here! I looked on your website! And in fact I need some more information about your working method [swigs from the bottle]. But maybe you've some question for me... You can start with your own questions and then I'll ask you...	We are at the very beginning of the first session and the patient, in an overbearing way, interrupts the therapist as if to clarify that she intends to lead the session. She also takes on a meta-complementary position: "I'll let you ask me some questions." The normal client-therapist relationship is overturned.	1		Prevaricating		333		1		1		3	
30801	235	P: Before this, I had lots of experiences! I went to different specialists, psychologists and so on. My father calls them "sorceresses, witches, fortune-tellers" and so on and so forth! [laughing with his arms open].	Though in an indirect and implicit way, referring to her father's words, the patient compares therapists (including the one sitting in front of her) to charlatans and fakes. She is humiliating the therapist, as her final self satisfied laugh shows.	1		Humiliating		337		3		2		3	
Silvia, 21 years old, student. Diagnosis: Anorexia Nervosa, restricting type 307.1 [F50.01]															
30401	134-135	T: Do your parents know that you are here? P: Sure, Doctor! When I told him I was looking for a therapist, my father said: "So be it! But you've to find someone worthwhile, really capable!" And here I am, Doctor! [bright smile].	The patient's tone is artificial and overly sweet. Her gaze and her smile seem fake. Through her father's words, the client defines the therapist as a capable person, appraising her from the professional point of view.	1		Enhancing		334		2		1		3	