Freedom, Goodness, Power and Belonging: The Semantics of Phobic, Obsessive-compulsive, Eating, and Mood Disorders

ACCEPTED VERSION

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Abstract

Are the semantics of "freedom", "goodness", "power" and "belonging" characteristic of the stories narrated in psychotherapy by individuals respectively with phobic, obsessive-compulsive, eating and mood disorders? To verify this hypothesis, put forward by Ugazio's model of semantic polarities (1998, 2012/2013), the Family Semantics Grid (FSG) (Ugazio, Negri, Fellin, & Di Pasquale, 2009) was applied to the transcripts of 120 individual video-recorded systemic therapy sessions - the first two sessions carried out with 60 patients with phobic (12), obsessive-compulsive (12), eating (12) mood (12) disorders and asymptomatic patients (12) with existential problems who make up the comparison group. The results confirm the hypothesis. All but one patient were correctly assigned to their diagnostic group only by drawing on their narrated semantics. The semantics alone seem therefore capable of defining the correct diagnostic group to which the patient belongs. We suggest considering the semantics as contextual and cultural diagnostic dimensions, expressions of the bonds but also of the resources of people, and above all useful for a diagnosis aimed at fostering processes of transformation and change.

Keywords: meaning, phobic disorders, obsessive-compulsive disorders, eating disorders, depression

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An idea in search of data

The idea that the main psychopathologies are characterized by specific meanings, formulated for the first time by Guidano (Guidano, 1987, 1991; Guidano & Liotti, 1983), forms the basis of Ugazio's psychopathological model (1998, 2012/2013). Guidano and those inspired by his model focus attention on individual processes through which personal meaning is constructed. Ugazio, as Procter (1981, 1996, 2005), shifted attention onto conversational processes in the family and other social groups through which individuals build meaning, and therefore themselves and the worlds in which they belong. The proposition put forward is that people with a phobic, obsessive-compulsive, eating and mood disorder are members of families in which the conversation is dominated by specific meanings. It is suggested that four different configurations of meaning characterize the conversational contexts within which phobic, obsessive-compulsive, eating and mood disorders respectively develop: These are the semantics of "freedom", of "goodness", of "power" and of "belonging". Ugazio et al. (2009) have called these coherent sets of meanings "family semantics" because they come from the same emotional polarities, which typically originate within primary social contexts like families. In family contexts in which, for example, we find people with phobic disorders, the semantic of freedom would prevail, fuelled by the emotive polarity "fear-courage". By virtue of the relevance of this semantic, the conversation in these families tends to be organized around episodes where fear, courage, the need for protection and the desire for exploration and independence play a central role. In

families where obsessive-compulsive disorders are present, the semantic of goodness would dominate, whose driving-force is guilt and purity, and in those where we find people with eating disorders or chronic depression, the conversation would tend to give central place, respectively, to the semantics of power and belonging which, as we shall see, are fuelled by other emotive polarities.

The prevalence of these semantics in the family conversation is not enough in itself to favor the development of the related psychopathology. A family conversation can, for example, be dominated by the semantic of freedom without any member of the family developing a phobic disorder. But the eventual appearance of one of the psychopathologies mentioned is, according to Ugazio, favored by the reciprocal positioning assumed by the patient and their relatives in the conversation within the dominant family semantic. It can in fact happen that a member of the family, by reason of their very position within the semantic of freedom, experiences a conflictual situation definable as a "dilemma" (Feixas & Saúl, 2005) or a "strange reflexive loop" (Cronen, Johnson, & Lannamann, 1982) that can trigger a full-blown psychopathological disorder. According to Ugazio's model, it is therefore the position more than the semantic that plays a central role in the transition from normality to psychopathology.

The proposition put forward has been confirmed by studies carried out on one psychopathology alone or two maximum.[1] There is a lack of empirical studies to test this hypothesis where there is a joint presence of patients with a phobic, obsessive-compulsive, mood and eating disorders. This is what we have sought to do in this study. Before describing it, we will briefly illustrate below the four semantics we intend to investigate.

[1] See Castiglioni, Faccio, Veronese, and Bell (2013); Castiglioni, Veronese, Pepe, and Villegas (2014); Faccio, Belloni and Castelnuovo (2012); Negri, Zanaboni, and Fellin (2007); and Ugazio, Negri, Zanaboni, and Fellin (2007).

The semantic of freedom

In conversational contexts in which this semantic prevails, *courage* and *fear* dominate the emotive scene. The world is seen—often as a result of dramatic events in a more or less distant past—as a source of risk to health, to relationships and to the very survival of the individual. Even emotions, for the abrupt way in which they arise, can be perceived as threatening. The exploration of the outside world, but also of personal feelings and states of mind, is perceived as hazardous. Attachment to others, on the other hand, is a source of protection. Those who free themselves from the reassuring presence of protective relationships are considered courageous for the very reason that the real world arouses fear. Exploration often generates disorientation and can consequently lead members of these families to seek a closeness to each other that is seen as protective but also limiting. Being in a close relationship can therefore generate feelings of constriction, whereas moving away from protective ties can produce a sense of disorientation.

Freedom- dependence and *exploration-attachment* are the central polar meanings of this semantic. Freedom and exploration are experienced as positive values, whereas the bonds of attachment, the company of the other persons, are felt as an expression of the need for protection from a dangerous world. Love, friendship and every other relationship of attachment are consequently equated with forms of dependence, and therefore evaluated in partially negative terms. On the other hand, dealing with circumstances alone increases self-esteem, since it expresses courage.

> As a result of these conversational processes members of these families will feel, or be defined as, fearful or cautious or, alternatively, courageous, even reckless. They will find people who are prepared to protect them or will meet up with people who are unable to survive by themselves, who need their support. They will marry people who are fragile or dependent, but also individuals who are free and

> sometimes unwilling to make commitments. They will suffer for their dependence. They will try in every way to gain their independence. In other cases they will be proud of their independence and freedom, which they will defend more than everything else. Admiration, contempt, conflict, alliances, love and hatred will be played out around issues of freedom-dependence. (…)
>
> In the same family we will therefore have globetrotters as well as people who have never moved away from the area where they were born. And there will be those - like agoraphobic patients -who are so dependent and in need of protection that they will require someone to be with them to deal with the most ordinary situations in daily life, and those who, on the other hand, will be so independent as to seem self-sufficient. (Ugazio, 2013, p.84)

Interpersonal relationships are constructed within this semantic mainly through moving closer or further apart: regulating distances is a central theme where this semantic dominates. Closeness to the other is indispensable, because the individual often feels at the edge of a dangerous precipice, but it generates feelings of constriction that push the person to move physically away from others or to withdraw. When the individual senses danger or a personal fragility he moves closer to others to look for support; on the other hand, when he feels strong, he moves away, frees himself from others so as to explore.

Ugazio (1998, 2012/2013) has suggested that this semantic is present in the conversational context of individuals with a phobic disorder.

The semantic of goodness

Innocence-guilt and *disgust-sensual pleasure* are the emotions underlying this family semantic in which personal ambition and sexuality are perceived as violent, immoral or perverse. Their expression can therefore lead some members to experience guilt and disgust,

while in others it produces pleasure. Sacrifice and self-denial, on the other hand, are associated with purity and innocence.

The central meanings can be summarized in the polar opposites *good-bad* and *dead-alive*. The second gives a dramatic pathos to this semantic, insofar as life stands on the side of badness. Bad people pursue their own pleasure and personal fulfillment, whereas good people disregard their personal desires, objectives and ambitions, they make sacrifices, they take a step back from life instead of acting or doing their best for the good of themselves and of others. As a result of this 'abstinent'[2] conception of goodness, the chastity-vice polarity perhaps most faithfully expresses the central meaning of this semantic, but it would end up establishing a connection with sexuality that is not always present nowadays.

When this semantic prevails, the conversation in the family

> is organized preferably around episodes which bring into play the deliberate intention to do harm, selfishness, greed, guilty pleasure, but also goodness, purity, innocence, asceticism, as well as sacrifice and abstinence. As a result, members of these families will feel, and be seen as, good, pure, responsible or alternatively bad, selfish, immoral. They will meet people who will save them, improve them, or, on the contrary, who will initiate them into vice, lead them to behavior that will then make them feel guilty. They will marry people who are innocent, pure, capable of self-denial or, on the other hand, cruel egoists who will take advantage of them. Their children will be good, pure, chaste or alternatively will express their feelings without restraint, be aggressive in affirming themselves and their sexuality. Some of

[2] The adjective 'abstinent' defines a specific construction of goodness as *noluntas* (Schopenhauer, 1819/1969). In many Western cultures, the "self-denial/self-assertion" polarity does not convey a predefined moral order, but here self-denial and (abstemious) goodness express the positive pole by representing a step back from life, whereas self-assertion and badness qualify negative, although lively, habits (*voluntas in Schopenhauer's terms)*.

> them will suffer for the selfishness and malice of others, or for the intrinsic badness of their own impulses. Others will be proud of their own purity and moral superiority. And some will feel gratified by the satisfaction of their own impulses. There will be those, especially in families where this polarity dominates the conversation over several generations, who have so proven their particular self-denial as to seem ascetic, and those who have expressed their impulses with such selfishness as to be considered evil. (Ugazio, 2013, p. 129)

Abstaining-becoming corrupt and *self-sacrificing-taking advantage* are the two main relational alternatives available to those who experience contexts characterized by this semantic. The first polarity makes direct reference to the sexual dynamics; nonetheless every involvement in the relationship (even if sex plays no part) is perceived as a vehicle that corrupts personal moral integrity which, however, is preserved by abstinence and self-denial. Becoming corrupted and taking advantage of others is the negative pole of the second polarity, in that they create an exchange with the others in which personal interest and the achievement of personal pleasure prevail; on the other hand, those who position themselves in the opposite pole, which is generally regarded as positive, sacrifice their personal needs and their personal success.

According to Ugazio (1998, 2012/2013), this semantic prevails in the conversational contexts of those who develop an obsessive-compulsive disorder or personality.

The semantic of power

Pride and *shame* are the basic emotions in this semantic. They are emotions generated by the perception of personal social status, inside and outside the family, and the recognition given to personal position in competitive conflicts, which are always central in relational contexts in which this semantic is prominent. Those who feel they are in a superior position experience feelings of personal capability and competence, while those who regard

themselves as being in a lower hierarchical position have a sense of inadequacy, ineptitude and impotence. The scene is dominated by pride when personal superiority is recognized by other conversational partners or, alternatively, by shame or embarrassment when there is a feeling of defeat.

Winner-loser and *strong-willed/yielding* are the two central polarities. The second polar opposition is subordinate to the first under a means-end relationship: those who win do so precisely because they are strong-willed and determined while those who lose are incapable of asserting themselves. Winner-loser has a peculiarity that distinguishes it from all other polarities:

> its content is purely relational. People can only regard themselves as winners and losers in comparison to others…. [It] cannot be perceived, even during the course of immediate experiencing, in terms of an individual trait. It relates exclusively to the relationship. It is the result of a comparison. (Ugazio, 2013, p.182)

Significant people and their evaluations are consequently perceived by members of these families, *in every moment and every circumstance*, as central for the definition of their own self. This semantic generates a particular sensitivity to the judgment of others and criteria of social success, including the precepts of external beauty.

Since identities are defined through confrontation, competitive conflicts are the rule in couple and peer relationships. The object of contention is generally irrelevant; what matters is who gains the upper hand. The predominance of competition obstructs the process of externalization of individual characteristics: Differences are feared because they are not utilized for cooperation but for affirming personal superiority. Every difference is always drawn in reference to status: Those who are self-important are so in relation to their hierarchical position, those who are humble are so because they do not give themselves airs

despite their status, they feel humiliated because they are treated as belonging to an inferior class. The body is a prime place for comparison: there are those who are more beautiful and thinner and those who are uglier and fatter. Thinness and beauty are values within this semantic, not just because they are qualities that are socially admired in many westernized cultures, but because they are a symbol of the individual's determination. Those who can keep their instincts at bay will also be quite tenacious in fighting to keep their personal power in the relationship. On the other hand, those who give in to their needs will be much easier prey to being bullied by others.

Winning or losing in the relationship is crucial in contexts in which this semantic is central. In order to win, people may fall into line with those who hold a higher position so as to gain advantage from it or they may fight them to keep their own position of supremacy or undermine them. Those who do not think they can improve their own position may yield and back away from confrontation, or they may set themselves against the winners, seeking at least to delegitimize their superiority.

The semantic of power, according to Ugazio (1998, 2012/2013), is a characteristic of those families in which one or more members present an eating disorder.

The semantic of belonging

The emotions that permeate the experience of members of families in which this semantic is prominent are *joy-cheerfulness*, *despair-anger*. Joy-cheerfulness are experienced by those who feel accepted in the group to which they belong, whereas despair-anger affect those who are excluded, abandoned or cheated out of a belonging to which they feel entitled. Anger makes people active and reactive, whereas despair makes them helpless against a misery that cannot be avoided. Those who are accepted feel gratitude, whereas members of the group who are excluded, or are offered a form of inclusion that is seen to be a threat to their own dignity, feel resentment.

Inclusion-exclusion, *honor-shame* are the main dimensions along which conversation is developed in relational contexts where this semantic is prominent. Inclusion in the family, among relatives, the same stock, in the community or, alternatively, exclusion or ostracism from the group, are the background against which identities are structured. Those in the position of being excluded experience their expulsion from the group as a disgrace, an irreparable damage that harms their dignity, a subversion of a natural order that damages their personal sense of worth. Inclusion is felt to be an honor for which those members who take part in the conversation may or may not be worthy. Though they crave for belonging, some members can refuse it in the name of dignity: in certain circumstances, acceptance to being included can lead to a shame that is even worse that rejection itself.

In this semantic, moreover, belonging is not won by personal commitment but pertains to the individual through birth or election. Glory, like honor and dignity, cannot be directly linked to belonging: the person excluded and rejected has the possibility of preserving honor and dignity and even achieving glory. Certainly,

> when the semantic of belonging has a long history in a family, extending back over several generations, those who are black sheep, or have been disowned, defrauded or forgotten co-position themselves with individuals who are respected, or worthy of being remembered for their actions, or have simply been included by divine grace among the elect. Illegitimate births, desertions, abandonments are matched with fortunate events such as inheritances, fairytale weddings, professional honors, dazzling careers. Life for some seems to have been harsh, while for others it has been particularly kind. Some members of the family are adored and admired while others are ignored or become the object of aggression and violence". (Ugazio, 2013, pp. 232–233)

Including oneself or others in one's own family or community or, on the contrary, excluding oneself or others are the characteristic and central ways of relating in this semantic. Sharing in all its forms is always desired, even though people who have grown up in contexts where this semantic dominates often isolate themselves. Equally central are honoring, adoring or being adored, as are dishonoring, shaming or cheating. Partners who position themselves in conversations created by this semantic can be lavished with every kindness, praised, celebrated, but also cheated out of a position of belonging to which they are entitled, in the same way that they can fraudulently appropriate a name, a reputation, a status.

Ugazio (2013) has suggested that this semantic is characteristically dominant in conversational contexts where one or more individuals are prone to mood disorders. In actual fact, depression is present as a symptom in almost all the main psychopathological organizations.

> Anorexics are unlikely to suffer from it, but many obese people do. Phobic patients can also display depressive disorders, especially agoraphobics whose self-esteem is structurally low since they suffer through their dependence. Depression is particularly frequent among obsessives.… The main reason that brings people with narcissistic disorder into therapy is depression (Ugazio, p.228).

In addition to these inherent nosographic difficulties are many others caused by the *DSM*'s particularly unsatisfactory criteria for diagnosing depression (Wakefield, 2012). The label of major depression continues to be so broad in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association [APA], 2013) as to be undiscriminating. Included in it are people who are sad as a result of negative events in their life just as much as patients affected by actual unipolar depression, and sub-type II bipolar disorders is such as to include unipolar depressions. The semantic of belonging characterizes only some forms of depression, especially those nosographically defined as

chronic depression and sub-type II bipolar disorders. It helps to identify them and to differentiate them from the depressions we can frequently find within the semantic of goodness and, sometimes, in the semantics of freedom and power.

Hypotheses

The specific hypotheses that this study seeks to test can be summarized in the form of four questions.

1. Is each of the four semantics described above present in the therapy conversation with the patients for whom it is considered to be characteristic (the target group) more than it is in the conversation with other patients (the non target groups)?

   It is expected here that the semantic of freedom is more present in the conversation with phobic patients than with those who have obsessive-compulsive, eating or mood disorders, or with clients free of full-blown pathologies. The same trend ought to characterize the therapy conversation with patients who have obsessive-compulsive, eating or mood disorders, where it is expected that the semantics of goodness, power or belonging will respectively prevail;

2. In the conversation with patients belonging to each of the four psychopathologies – irrespective of the comparison with patients of another psychopathology -does the critical semantic[3] prevail over all other semantics?

   It is expected that the semantic of freedom in the conversation with phobic patients is more present than the semantics of goodness, of power and of

[3] By the expression "critical semantic" we mean the semantic considered by Ugazio (1998, 2012/2013) to be characteristic of a specific psychopathological organization.

belonging. The other three critical semantics ought to prevail in the therapy conversation with patients who present the other three psychopathologies under consideration;

3. Who is mainly responsible for the prevalence of the critical semantic in the therapeutic conversation? The patient or the therapist?

   The responsibility ought to fall mainly on the patient. In particular, we expect that:

   a. the majority of characteristic meanings of the critical semantic are introduced by the patient;

   b. the therapist tends to introduce more meanings extraneous to the four critical semantics (classified by our code system as *other semantics*) than the patient does.

Method

Participants

The study was carried out on the first two psychotherapy sessions conducted by the first author with 60 participants, aged between 17 and 59 (M = 35.2; DS = 9.5), of medium to high educational and socio-economic level, equally distributed into five groups. Four groups are formed by patients affected by the psychopathologies that are at the core of this study and one, for comparison, by patients who have requested psychotherapy for a wide variety of existential problems (conflicts with partner and/or children, sudden bereavement, work problems, relationship crises, etc.). Those taking part in the clinical groups present a psychopathology that respects the criteria of the *DSM-IV-TR*[4] (APA, 2000) whereas none of

[4] The DSM-5 had not yet been published when the study was carried out.

the patients in the control group presents symptoms or satisfies the criteria for inclusion in a diagnostic category.

We adopted a purposive sampling approach to the selection of the participants from an archive of over 600 individual systemic consultancies and psychotherapies, all video-recorded and carried out at the European Institute of Systemic-relational Therapies (EIST), a private institute based in Milan, Italy and recognized by the Italian Ministry of Education and Research. Firstly, all the cases archived with the diagnosis of one of the four target psychopathologies were extracted. Drawing especially on sessions 3 to 5—where symptoms are explored in more in-depth and in detail —the second and the third authors then excluded those with comorbidities or non-prototypical symptoms: Those chosen for each diagnostic group were patients who had no other disorders and for whom there seemed no possible doubt about diagnosis. Participants in the four clinical groups are therefore prototypical patients[5].

Procedure

Once the first two video recorded sessions ($N = 120$) had been transcribed verbatim, following the appropriate indications (Mergenthaler & Stinson, 1992), we coded the semantic oppositions in the middle third of the transcribed sessions, lasting an average of 26 minutes. The coding was carried out by five researchers independently. To check the coders' reliability, a second independent coding was carried out on 36 transcripts. Twenty-eight of these were equally distributed between the four clinical groups and the remaining eight belonging to the comparison group: 24 are first sessions, 12 are second sessions.

[5] Forty-five cases of this sample were already included in three previous papers, one of these published in English (Ugazio, Negri, & Fellin, 2009) and 15 are new. We eliminated five cases from the 50 of 2009 sample for two reasons: They were cases (2) treated many years ago (before 2000) or individual therapies preceded by couples consultation (3). So our current sample is more homogeneous than the previous one. The 2009 article presents only the reliability results of our coding tool (FSG). All the analyses, we will presented here, are new.

We chose to focus the study on the first two sessions since the influence of the therapist on the construction of patient meanings is less than in the later stages of the therapeutic process. The purpose of the first two sessions is in fact to understand and define the problem brought by the patient, to explore his or her current relational situation and the family history, and negotiate the effective possibilities of the treatment and its format (individual, couple and/or family sessions).

The analysis is restricted to the middle third of each session because the coding procedures applied are very time-consuming and the duration of the sessions varies from 60 to 90 minutes (M = 78 min). We feel that the central third best represents the meanings of the patient, since it is the phase that concentrates most on the patient's story. The beginning of the first session is devoted to explaining the setting, introducing those taking part, filling out forms about the use of personal information, and then completing the information on individual and family history which has already been partially gathered by telephone contact before the meeting. At the end of the second meeting the therapist—who previously confines herself to questioning—intervenes: She summarizes what has emerged, often gives an initial assessment and discusses a possible beginning of therapy. The end of the second session generally marks the end of the consultation phase and, if the circumstances are right, the therapy begins or the consultation is extended.

Coding

The Family Semantics Grid (FSG) has been applied to the transcripts: This is a system that makes it possible to code the semantic polarities present in dyadic therapy conversations (Ugazio et al., 2009). The FSG provides a working definition of the concepts of *family semantic polarities* and *family semantics*, a detailed description of the semantic polarities making up the four proposed family semantics connected to the psychopathologies

under consideration, and a standardized procedure for detecting and coding these polarities in the transcripts.

The *family semantic polarities* are operationalized in the FSG as semantic oppositions through which the patient and therapist position themselves within the following areas of the conversation: a) values; b) definitions of self/others/relationships; c) ways of relating; d) emotions.[6] These positionings can be detected at an explicit, implicit and interactive level, each corresponding to three types of semantic polarity: *Narrated, narrating* and *interactive.*

In this article we limit ourselves to presenting the results of the analysis of narrated semantic polarities, which are those that adhere most closely to the text and in which there is less difference between Ugazio's concept of semantic polarities and Kelly's personal constructs (1955). These are explicit semantic oppositions, which emerge from what is *said* by the two conversational partners. They may differ from the semantic polarities that can be inferred from the very act of narrating (narrating polarities) and from the interaction (interactive polarities). However, for the very fact that this type of polarity relates to what is said rather than what is done, its analysis has the advantage of being far less inferential.

Each family semantic is operationalized in the FSG as set of 36 coherent polarities, fuelled by one and the same emotional opposition, which defines the core meanings of each semantic in the four areas of the conversation previously described. The FSG sets out standardized procedures for identifying in the transcripts the polarities of the four semantics illustrated above and their subsequent categorization. The FSG also provides a fifth residual category—the *other semantics*— which groups together the polarities that do not relate to the four semantics under consideration.

[6] The theory of Coordinated Management of Meaning (Cronen et al., 1982; Pearce & Cronen, 1980) defines these areas (values, definitions of self/others/relationships; ways of relating and emotions) as social realities created by conversations and labels them "levels of context". The Positioning Theory (Harré & Langenhove, 1999) also identifies these areas as the principal realities created by the conversation.

Data analysis

Hierarchical log-linear analysis (Semantic x Diagnosis x Speaker)[7] was used to test the three hypotheses. As this analysis does not take account of the relative variability of each subject, we have also carried out the analyses per subject listed below.[8]

To verify the first hypothesis we have used the Kruskal-Wallis test for the multivariate level and the Mann-Whitney test for pair comparison between groups. To verify the second hypothesis we have used the Wilcoxon test. In these analyses we have considered only the polarities introduced by the patients, and in the second one we calculated the percentages of the total polarities each participant introduced. In this way we have made the data for each of the 60 patients comparable.

To complete the results from previous analyses, a hierarchical cluster analysis was carried out using the complete linkage between groups as a method for cases clustering and the Chi-square as a measure of the distances between them. Here again, for this analysis only the polarities introduced by the patients were considered. The limited number in the sample did not allow us to perform a discriminative analysis that would have enabled us to investigate the hypotheses in a manner more robust than the cluster hierarchical analysis.

Results

In the 120 sessions analyzed we identified a total of 7255 narrated semantic polarities (per session: $M = 60.5$; $DS = 25.63$; range: 18–184),[9] 73.9% are introduced by the patients

[7] The speaker variable indicates the person who has introduced the polarity into the conversation (patient or therapist), the diagnosis variable indicates the patient's diagnostic group (phobic, obsessive-compulsive, eating, mood or existential), and finally the semantic variable indicates the semantic to which the polarity is a part of (freedom, goodness, power, belonging). The response variable (that indicates the degree of sharing of the polarity with the interlocutor: accepted, rejected, corrected, disqualified) has not been introduced into the analysis due to the high number of empty cells or with an expected frequency of less than 5 units.

[8] We have chosen non-parametric analyses since we consider the frequencies as measures on an ordinal scale of variables.

[9] Out of 36 of the 120 sessions the agreement between the coders in the selection of texts containing the semantic polarities was 82.1% (83.7% for the first sessions and 79.0% for the second), whereas the Cohen's

and 26.1% by the therapist,[10] 97.4% are accepted by both of them, while only 2.6% are corrected, rejected or disqualified by one of the two speakers. Of 188 cases in which this happens, the therapist is responsible for only nine. In the remaining 179 cases, it is the patient who corrects, rejects or disqualifies a meaning suggested by the therapist. Moreover, of the 7255 narrated semantic polarities, 3323 (45.8%) relate to the *other semantics* category, namely those different from the four that our hypotheses regard as characteristic of the four psychopathologies under consideration.

From this descriptive analysis there is already a clear asymmetry between patient and therapist in the construction of meanings. Though the two conversational partners remain jointly involved, it is the patient who plays the leading role in constructing meanings, at least in the first two coded sessions. Predictably, the *other semantics* category is the most numerous.

Is the critical semantic more present in the target group than in the others?

The results of the log-linear analysis carried out on the polarities introduced by patient and therapist ($N = 7255$), set out in Tables 1 and 2,[11] indicate that the critical semantics proposed by the first and second hypothesis predominate in the four target groups of patients.

INSERT TABLE 1 & 2 HERE

The interaction Diagnosis x Semantic indicates that the probability of finding the semantic of freedom, of goodness, of power and of belonging in the conversation of patients respectively with phobic, obsessive-compulsive, eating and mood disorders is significantly higher than that of finding any other type of semantic. In the conversation with the

kappa relating to the classification of the polarities to the respective semantic is .79 (.82 for the first sessions and .73 for the second).

[10] The percentage includes both the polarities introduced into the conversation for the first time by the therapist as well as those that are taken from what the patient has said.

[11] The model selected is the general model, since even the higher effects are necessary to describe the data variability.

comparison group, on the other hand, there is a significant predominance of *other semantics*; the semantics of freedom, of goodness and of power are equally distributed whereas that of belonging is significantly underrepresented. The graph representation of frequencies in the groups summarizes these results (see Figure 1).

INSERT FIGURE 1 HERE

The first two hypotheses thus receive an initial confirmation: The distribution of semantics within and between the groups follows the expected direction.

A more robust confirmation of the first and second hypotheses was obtained from the analysis by subjects, carried out on the percentage of polarities belonging to the various semantics expressed by each patient (see Table 3). The polarities introduced by the therapist were excluded from this analysis since the log-linear analysis shows that her contribution was significantly less than that of the patient (see the Speaker main effect).

INSERT TABLE 3 HERE

The Kruskal-Wallis test, in fact, shows significant differences between the average percentages of the five groups in the semantics of freedom, of goodness, or power, of belonging and in the *other semantics,* respectively $\chi^2_{(4)} = 32.555$, $p < .001$; $\chi^2_{(4)} = 28.051$, $p < .001$; $\chi^2_{(4)} = 29.550$, $p < .001$; $\chi^2_{(4)} = 28.933$, $p < .001$; $\chi^2_{(4)} = 33.192$, $p < .001$. The Mann-Whitney allows us to clarify the direction of the differences. The average percentage of semantic oppositions pertinent to the semantic of freedom is significantly higher in the phobic disorders group compared with all the others, $U = 0$, $p < .001$ for all four comparisons. Likewise, the average percentage of the semantic of goodness is significantly higher in the obsessive-compulsive disorders group, $U = 0$, $p < .001$ for the comparison with the group of phobic, mood and eating disorders, $U = 3$, $p < .001$ for the comparison with the group without symptoms. The same happens for the semantic of power in the group of eating

disorders, $U = 0$, $p < .001$ for all four comparisons, and for that of belonging in the group of mood disorders, $U = 0$, $p < .001$ for all four comparisons. The *other semantics* are significantly higher in the comparison group, $U = 0$, $p < .001$ for the comparison with the group of phobic, obsessive-compulsive and eating disorders, $U = 1$, $p < .001$ for the comparison with the group of mood disorders. The first hypothesis is therefore fully confirmed by this analysis that takes account of individual variability: The target groups, if compared with each other, differ in the semantics introduced into the conversation, and the critical semantic prevails in each.

Does the critical semantic prevail within each clinical group over the others?

The Wilcoxon test allows us to give a positive answer to this question. In the therapy conversation of each clinical group, if we exclude the *other semantics*, the critical semantic prevails: That of freedom in patients with phobic disorders (freedom vs. goodness: $z = -3.059$, $p < .05$; freedom vs. power: $z = -3.059$, $p < .05$; freedom vs. belonging: $z = -3.059$, $p < .05$), that of goodness in patients with obsessive-compulsive disorders (goodness vs. freedom: $z = -2.746$, $p < .05$; goodness vs. power: $z = -2.824$, $p < .05$; goodness vs. belonging: $z = -3.059$, $p < .05$), that of power in patients with eating disorders (power vs. freedom: $z = -3.059$, $p < .05$; power vs. goodness: $z = -3.059$, $p < .05$; power vs. belonging: $z = -3.059$, $p < .05$), that of belonging in patients with mood disorders (belonging vs. freedom: $z = -3.059$, $p < .05$; belonging vs. goodness: $z = -3.059$, $p < .05$; belonging vs. power: $z = -3.059$, $p < .05$). In the conversation of the comparison group, on the other hand, the *other semantics* prevail overall, others vs. freedom: $z = -3.059$, $p < .05$; others vs. goodness: $z = -3.059$, $p < .05$; others vs. power: $z = -3.059$, $p < .05$; others vs. belonging: $z = -3.059$, $p < .05$. The second hypothesis is thus also verified.

Is it the patient who introduces the critical semantic?

The log-linear analysis, which we have just mentioned, shows that the patient's contribution in introducing semantic oppositions into the conversation is significantly higher than that of the therapist (see Table 2: Speaker main effect). It also emerges that the number of *other semantics* introduced by the therapist into the conversation is proportionately higher than that of the patient (see Semantics x Speaker). The third hypothesis is therefore also verified.

The data also show that the therapist contributes toward the prevalence of the critical semantic. There is in fact no significant difference in the extent to which patient and therapist resort to the critical semantic in four of the five groups (see Semantic x Speaker x Diagnosis). Only in the group of participants with mood disorders does the therapist introduce the semantic of belonging to a significantly lesser extent than patients. Looking at the 60 participants as a whole, it is interesting to note that belonging is the only critical semantic that the therapist introduces significantly more than the patients (see Semantic x Speaker). These data are obviously proportionate to the number of semantic polarities introduced by the therapist, which, as already stated, are significantly lower than those expressed by the patients. Moreover, the analysis does not differentiate the semantic polarities introduced for the first time by the therapist from those that the therapist takes from the patient.

Since all the hypotheses have been confirmed, we verified if it were possible to cluster the patients to their diagnostic group solely on the basis of the profile of semantics expressed by them in the conversation. Consequently, we carried out a cluster analysis on the frequencies of the various semantics presented by the 60 patients. The results show five clearly distinct groups (see Figure 2), completely overlapping with the diagnostic groups except in one patient, of those diagnosed as obsessive-compulsive, which is clustered along with participants from the comparison group. The cluster analysis confirms that it is possible,

in almost all cases, to distinguish the five groups on the basis of the semantic polarities expressed by them.

INSERT FIGURE 2 HERE

Discussion

Patients with phobic, obsessive-compulsive, eating and mood disorders introduce meanings into the therapy conversation that predominantly relate, respectively, to the semantics of freedom, of goodness, of power and of belonging. This result confirms one of the key aspects of Ugazio's psychopathological model (1998; 2012/2013). At the same time it confirms the connection between meaning and psychopathology, put forward initially by Guidano and Liotti (1983) and developed by Guidano (1987, 1991) and other cognitivists who were inspired by his model (Arciero & Bondolfi, 2009; Bara, 1996/2005; Neimeyer & Raskin, 2000; Picardi, 2003; Villegas, 1995, 1997, 2000, 2004). The link between psychopathology and semantics has in fact been demonstrated for the four most frequent psychopathologies in clinical practice, and not just for a single psychopathological organization, as other studies have already been able to demonstrate (Castiglioni, Faccio, Veronese, & Bell, 2013; Castiglioni, Veronese, Pepe, & Villegas, 2014; Negri, et al., 2007; Ugazio, et al., 2007; Ugazio, Negri & Fellin, 2011) using the FSG (Ugazio et al., 2009) or other instruments, including Kelly's Repertory Grids (1955). The results that have emerged can also, at least for phobic and depressive organizations, be considered as support for the hypotheses of cognitivist authors referred to above. Guidano and Liotti (1983) were the first to suggest that fear dominates phobic organizations and that anger-despair characterize depressive organizations. Even though, according to Ugazio (1998, 2012/2013), they are not the only emotions that characterize the semantics of freedom and of belonging, nevertheless form their basis along with other emotions.

This study provides indications on the process of constructing meanings between patient and therapist. The results demonstrate that patients (irrespective of their psychopathology) all use critical semantics and "other semantics", a category which includes the broadest variety of meanings extraneous to the semantics of freedom, of goodness, of power and of belonging. This is a result that must be emphasized because it demonstrates that one semantic, even when it dominates the conversation (as happens in clinical groups with the critical semantic), never saturates it. There are always many polarities in patients' intersubjective contexts in addition to the critical one. As Ugazio has stated (2013):

> In all families, there are several salient semantics. Schismogenetic processes tend to reduce, but not eliminate, the variety of semantics around which the conversation is organized. The story of each person is therefore defined by their position inside several semantic polarities. Although a single semantic can assume considerable centrality in the family conversation, and plays a central role in defining the position of each member, it does not exhaust the conversational possibilities available to each individual. His or her position always offers access to stories different from those generated by the critical semantic (pp. 280-281).

The patients in our study, though prototypical, have shown themselves, like all human beings, to be capable of interacting within a range of meanings much wider than their own critical semantic.

The research confirms the asymmetry of the therapy relationship. In the nature of the semantic exchange, the prime responsibility is upon the patient, who introduces two-thirds of the semantic polarities. The therapist is not however a passive listener and contributes toward the same prevalence of critical semantics. This is not surprising: "It is an inevitable process, which the therapist cannot *at first* avoid" (Ugazio, 2013, p. 281). The therapist, especially in the early sessions, is involved in a continuous questioning of her own understanding of the

patient's world through questions and observations that clarify, repeat and return to the meanings expressed by the patient, expanding on them or narrowing them down. Understanding and talking the patient's language also helps the therapist to create and build up the therapeutic alliance, without which therapy is difficult if not impossible. It should be added that precisely because the patient's position inside the critical semantic is particularly conflictual, the therapist must allow patients to express their difficulties and position themselves within this semantic, helping them to clarify their own position in relation to that of other members of their family. In this way the therapist also contributes toward placing the critical semantic at the center of the conversation. The results also show a movement of the therapist that goes in the opposite direction. In these early sessions, she is already beginning to extend the repertory of the patient's semantic contents. It emerges, in fact, that the therapist makes proportionally more use of "other semantics", which include all the meanings that do not come within the four semantics connected to the four psychopathologies with which we are concerned. It is a first cautious move in the direction of change. Part of the therapy, according to Ugazio (1998; 2012/2013), is directed toward opening the worlds of patients and their families to new meanings, so as to give each member the possibility of interpreting their current situation, their selves, their individual and family history in a different way.

> If the therapeutic experience is not to be limited to prompting adjustments in the patient's position within one semantic organization that is not substantially modified, the therapeutic conversation must, at a certain point, give salience to semantics other than the critical one (Ugazio, 2013, p. 281).

The phases in which the process of change become central are not, of course, those at the very beginning, but this study nevertheless shows that during the first two sessions the

therapist—presumably intentionally—is already taking steps to provide patients with new possibilities of narrating their own story and their own positioning within it.

Despite their clinical relevance, the results relating to the patient–therapist dynamic must be treated with caution since no analysis by subjects has been carried out to confirm them. Furthermore, due to the limited number of occurrences relating to semantic polarities expressed by the therapist with each of the participants, it has not been possible to take account of the crucial distinction between meanings introduced into conversation for the first time by the therapist and meanings taken from the patient's previous comments, and re-elaborated.

The study presents one surprising result, provided by the cluster analysis. Fifty-nine out of the 60 participants taking part in the research were assigned to the correct clinical group solely on the basis of the frequency with which they had used the semantics in the therapy conversation. The only one to be placed by the analysis into the "wrong" diagnostic category was an obsessive-compulsive patient who had been included in the comparison group. Semantic analysis alone would therefore seem capable of attributing the patient to his or her corresponding diagnostic group. If this result were confirmed by other studies, the semantic would seem to be a useful diagnostic dimension for those interested in understanding the patient for the purposes of therapeutic change.

It may be enough for the psychopharmacologist to make a nosographic diagnosis because his objective is to establish the appropriate drug for a particular category of patient. The same cannot be said for the psychotherapist, who needs a diagnosis that helps him/her in understanding each patient and their relational world and some initial guidance on how to relate to them and formulate a treatment plan. Understanding the patient's semantic helps the therapist to reach these objectives. Its identification makes it possible to anticipate some restrictions and resources not only of the patient but also of the conversational contexts

within which he or she has developed. Each semantic can in fact be seen as a set of possibilities and limitations, developed during a history, which may involve several generations or be circumscribed to the last one. Knowing this makes it possible to anticipate the patient's relational patterns, especially in their interaction with the therapist, and to understand in what position the therapist may end up. The therapist, even without being aware of it, especially at the beginning of therapy, inevitably co-positions herself within the patient's semantic. Understanding the patient's–therapist's mutual positions is crucial for the therapy project.

> Certain therapy stories that are possible in one 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, p. 275).

The semantic, understood as a diagnostic dimension, offers the possibility of formulating more discriminative diagnoses, above all in relation to disorders where the traditional nosographic descriptions are particularly unsatisfactory. We refer here to depression, where the limits of the *DSM* (APA, 4th ed., text rev., 2000; 5th ed., 2013) are evident (Greenberg, 2010; Horwitz & Wakefield, 2007; Wakefield, 2012), but also to eating disorders and, to some extent, to anxiety disorders. Categorical diagnostic classifications that take only symptoms into account are too broad and generic to be of use for treatment purposes. An analysis of the "semantic profile" can, for example, make it possible to distinguish a depression within the semantic of goodness from another developed in the semantic of power or belonging. While falling within the *DSM-5* (APA, 2013) criteria for major depression, these depressions are extremely different in their course and in their prognosis and require different forms of treatment.

Semantic polarities have also a contextual and cultural diagnostic dimension. They emerge from the conversation with the therapist and express the family's micro-culture within which psychopathology develops, but also from the wider cultural context (Ugazio, 1998, 2012/2013). This semantic approach reopens the debate—which the prevailing biological orientation in psychiatry would like to close—on the social origin of the psychopathology, at least for the four psychopathologies of this study. The demand for clinically useful evaluations — in addition to or instead of categorical classifications—has been supported by many clinicians (Brown & Barlow, 2009; Cooper & Balsis, 2009; Mullins-Sweatt & Widiger, 2009; Shedler & Westen, 2004; Smith, McCarthy, & Zaposki, 2009; Smith & Oltmanns, 2009; Westen, Shedler, & Bradley, 2006; Widiger, Livesley, & Clark, 2009) during the debate that accompanied the revision of the *DSM-IV-TR* (APA, 2000). The recent publication of the *DSM-5* (APA, 2013) has unfortunately disappointed this expectation: The supplementary measures included in Section III leave little space for a genuine multi-dimensional understanding of the patient's clinical situation. Even the instrument introduced for investigating personality, which was supposed to have offered "an alternative model for diagnosis of personality disorders" (p. 731) is limited in reality to examining only a few "maladaptive variants" (p. 773) of the "Big Five": Negative affectivity (vs. emotional stability), detachment (vs. extraversion), antagonism (vs. agreeableness), disinhibition (vs. conscientiousness), and psychoticism (vs. lucidity). There has been no consideration of dimensional aspects of personality that might be an expression not only of the constraints but also of the resources of the patient.

The results discussed here are promising. First of all, they provide some empirical validation of Ugazio's model (1998; 2012/2013): The connection between psychopathology and meanings is further confirmed. We have highlighted the possible advantages obtained from using the "semantic" dimension in the diagnostic process as well. We are nevertheless

aware of the limits of our study. The first one is methodological: All the sessions were conducted by the same therapist, who is also the author of the family semantic polarities model. We cannot therefore exclude that she—at least unconsciously—might have contributed to her patients construction of meanings coherent to her theory. Nevertheless we can only stress that our findings show that it is the patient who makes the major semantic contribution. The therapist plays a marginal semantic role in the first sessions and she has not yet formulated a nosographic or hermeneutic diagnosis. As we have said before, to avoid defining the context as medical, the therapist does not delve into the symptoms at the beginning. The diagnostic information is gathered in the subsequent sessions. Moreover other scholars have found similar results in research interviews using other tools such as the Repertory Grids (Faccio, Belloni & Castelnuovo, 2012) or Self-characterization (Veronese, Romaioli, & Castiglioni, 2012).

Nevertheless, in order to reach more reliable conclusions we need to repeat this study using transcripts of sessions carried out with therapists blind to the theoretical model or adopting different therapeutic approaches. A first attempt was made by two of us (Ugazio & Fellin, in press) in a recent study in which a video-taped transcribed couples therapy, carried out by Jaakko Seikkula in a Finnish context, was analyzed.

A second limitation is the number of participants, we need to expand this and include participants from different cultures. This limitation has prevented us from carrying out analysis that would have enabled, for example, to look at the semantic exchange between patient and therapist. All the supporting data for the family semantic polarities model, including those conducted by other colleagues, have so far been gathered from European contexts. It would also be helpful to repeat this study using transcripts of sessions carried out with different psychotherapeutic approaches.

Furthermore, the polarities explored here are only those narrated, more similar to Kelly's personal constructs (1955) than to actual semantic polarities or to Procter's family constructs (1996), which have much in common with semantic polarities. An analysis of interactive polarities would provide further validation to this model. In addition, the study does not take account of the patient's position within the critical semantic, a position which for Ugazio (1998; 2012/2013) plays a central role in the development of the psychopathology. Normal functioning does not differ from pathological functioning either quantitatively or qualitatively for the semantic involved. The difference lies in the difficulty experienced by the individual who develops a psychopathology in positioning him or herself within the critical semantic. This difficulty has the appearance of a dilemma (Cronen et al., 1982; Feixas & Saùl, 2004; Feixas et al., 2009). The meanings relating to the critical semantic remain entangled in a series of irreconcilable and ever shifting perspectives that make it impossible for the individual to find an acceptable co-position with the other conversational partners.

Lastly, it should be emphasized that it could have been difficult to obtain such clear results with less prototypical participants, especially for some of the diagnostic categories considered, above all depression. The cases included in the mood disorders group had not suffered from merely depressed mood or other symptoms for a couple of weeks (the minimum period according to the criteria laid down by the *DSM-IV-TR* and *DSM-5* (APA, 2000, 2013) for a diagnosis of major depression): Almost all patients at the moment in which they had requested therapy were suffering from serious depression, with persistent insomnia, suicidal thoughts, serious concentration difficulties for at least six months. In addition, around half also suffered from depression for several years and had attempted suicide. Also the majority of the patients of the other clinical groups presented severe symptoms and had had a long history of illness.

We hope that this contribution, though partial, reawakens the interest of clinicians and researchers in an explicative psychopathology that conceives diagnosis as an instrument for planning the therapeutic process and for starting up processes of transformation and change, rather than as an instrument whose purpose is the prescription of drugs or the allocation of stigmatizing labels.

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Table 1

Significant Effects Resulting from the Log-linear General Model (Diagnosis x Semantic x Speaker) of the Polarities Intoduced by Patients and Therapist (N = 7255; Costant = 5.868)

Effects	*df*	L^2 Partial Associations
First-order		
Diagnosis [A]	4	103.81*
Semantic [B]	4	2645.37*
Speaker [C]	1	1715.85*
Second-order		
[A] x [B]	16	2746.02*
[A] x [C]	4	30.72*
[B] x [C]	4	30.12*
Third-order		
[A] x [B] x [C]	16	34.70**

* $p < .001$ ** $p < .01$.

Table 2

Percentages and Standardized Parameters of the Significant Effects Resulting from the Log-linear General Model (Diagnosis x Semantic x Speaker) of the Polarities Introduced by Patients and Therapist (N = 7255)

Effects		%					Standardized Parameter Estimates				
[A]		PD	OD	ED	MD	COM	PD	OD	ED	MD	COM
		18.18	16.29	21.30	21.70	22.54	0.028	-0.784	1.729	0.552	-1.561
[B]		Freedom	Goodness	Power	Belonging	Others	Freedom	Goodness	Power	Belonging	Others
		14.51	8.52	14.80	16.36	45.80	-3.902***	-15.346***	-5.462***	-1.334	47.969***
[C]		Patient		Therapist			Patient			Therapist	
		73.87		26.13			27.274***			-27.274***	
[A] x [B]		PD	OD	ED	MD	COM	PD	OD	ED	MD	COM
	Freedom	7.71	1.54	1.85	1.57	1.85	20.830***	-4.444***	-4.202***	-4.364***	-2.089
	Goodness	0.74	4.70	0.91	1.06	1.10	-4.117***	18.471***	-3.919***	-3.129*	-0.848
	Power	1.59	1.43	8.27	1.63	1.89	-3.783***	-4.037***	19.816***	-4.303***	-2.141
	Belonging	1.87	1.41	1.97	9.43	1.68	-2.511	-5.857***	-4.003***	20.599***	-3.538**
	Others	6.27	7.21	8.30	8.01	16.02	-5.332***	-3.637**	-2.570	-2.249	14.943***
[A] x [C]		PD	OD	ED	MD	COM	PD	OD	ED	MD	COM
	Patient	12.67	12.07	16.73	16.73	16.07	-3.228**	-1.541	1.805	2.549*	0.177
	Therapist	5.51	4.22	4.96	4.96	4.46	3.228**	1.541	-1.805	-2.549*	-0.177
		Freedom	Goodness	Power	Belonging	Others	Freedom	Goodness	Power	Belonging	Others

[B] x [C]	Patient	10.76	6.73	11.65	12.03	32.69	0.041	2.575*	2.247	-4.226***	-2.737*
	Therapist	3.75	1.79	3.16	4.33	13.11	-0.041	-2.575*	-2.246	4.226***	2.737*

			PD	OD	ED	MD	COM	PD	OD	ED	MD	COM
[A] x [B] x [C]	Patient	Freedom	7.69	1.55	1.96	1.49	1.88	1.870	0.578	0.458	-2.612	0.219
		Goodness	0.73	4.98	0.99	1.23	1.18	-0.653	0.449	-0.412	0.964	-0.256
		Power	1.62	1.38	8.92	1.75	2.09	0.775	-1.442	-0.169	-0.576	1.349
		Belonging	1.46	1.18	1.94	10.21	1.51	-1.517	-1.115	0.486	3.565**	-0.651
		Others	5.65	7.26	8.29	7.97	15.10	-0.114	2.509	-0.350	-1.112	-1.187
	Therapist	Freedom	7.75	1.53	1.53	1.79	1.74	-1.870	-0.578	-0.458	2.612	-0.219
		Goodness	0.79	3.90	0.69	0.58	0.90	0.653	-0.449	0.412	-0.964	0.256
		Power	1.48	1.58	6.43	1.27	1.32	-0.775	1.442	0.169	0.576	-1.349
		Belonging	3.06	2.06	2.06	7.23	2.16	1.517	1.115	-0.486	-3.565**	0.651
		Others	8.02	7.07	8.33	8.12	18.62	0.114	-2.509	0.350	1.112	1.187

Note. PD = phobic disorders group, OD = obsessive-compulsive disorders group, ED = eating disorders group, MD = mood disorders group, Com = comparison groups.
* $p < .05$ ** $p < .01$ *** $p < .001$ (two-tailed and corrected according to the *df*).

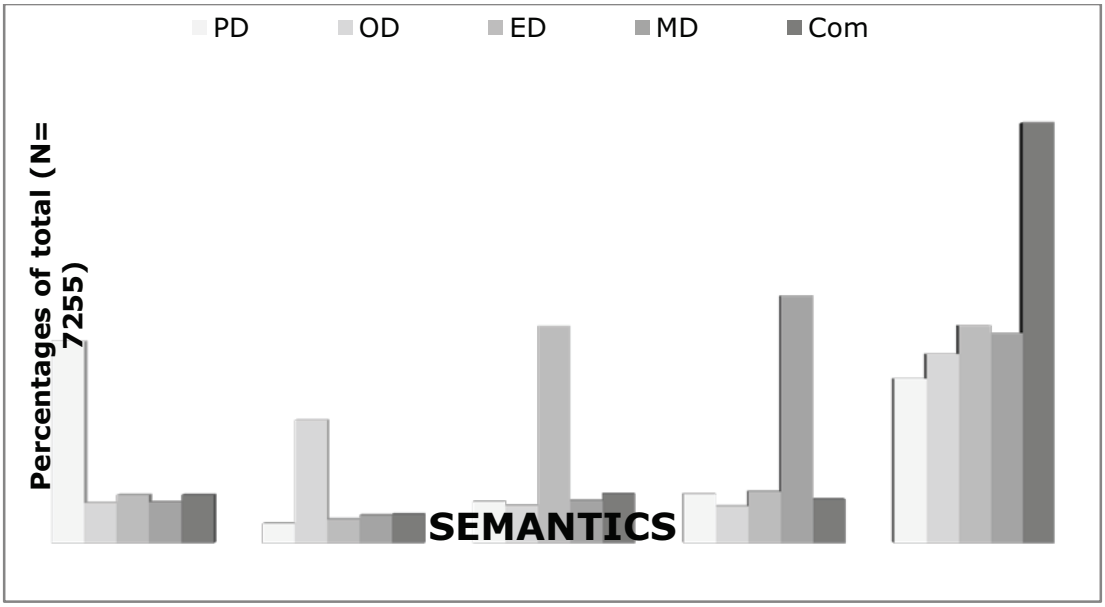

Figure 1. The polarities, grouped by semantic, emerging from the therapeutic conversations with the five groups of patients (PD = phobic disorders group, OD = obsessive-compulsive disorders group, ED = eating disorders group, MD = mood disorders group, Com = comparison groups).

Table 3

The Polarities (N = 5359), Grouped by Semantic, Introduced by the Five Patients Groups in the Therapeutic Conversation: Means of Absolute and Percentage Frequencies and Medians of the Percentage Frequencies

	Semantics				
Groups	Freedom	Goodness	Power	Belonging	Others
Phobic disorders					
Mean frequency	34.3	3.3	7.3	6.5	25.3
Mean percentage	**45.9**$_{a}$°	4.4$_{b}$<	9.7$_{c}$<	8.1$_{d}$<	31.9$_{e}$<
Median of percentages	46.3	4.5	10.4	5.2	32.9
Obsessive-compulsive disorders					
Mean frequency	6.9	22.3	6.2	5.3	32.4
Mean percentage	11.5$_{a}$<	**30.4**$_{b}$°	8.3$_{c}$<	7.5$_{d}$<	42.3$_{e}$>
Median of percentages	9.6	31.5	8.2	7.6	45.7
Eating disorders					
Mean frequency	8.8	4.4	39.8	8.7	37.0
Mean percentage	8.9$_{a}$<	4.2$_{b}$<	**40.8**$_{c}$°	8.5$_{d}$<	37.6$_{e}$
Median of percentages	8.0	3.1	41.8	9.4	38.1
Mood disorders					
Mean frequency	6.7	5.5	7.8	45.6	35.6
Mean percentage	5.6$_{a}$<	4.2$_{b}$<	7.6$_{c}$<	**48.8**$_{d}$°	33.8$_{e}$<
Median of percentages	3.9	4.3	6.1	49.3	33.2
Comparison					
Mean frequency	8.4	5.3	9.3	6.8	67.4
Mean percentage	8.4$_{a}$<	5.9$_{b}$<	9.1$_{c}$<	7.1$_{d}$<	**69.5**$_{e}$°
Median of percentages	7.5	3.8	8.4	4.6	68.9
Total					

Mean frequency	13.0	8.1	14.8	14.5	39.5
Mean percentage	16.0	9.9	15.1	16.0	43.0
Median of percentages	9.5	5.3	10.4	8.6	39.7

Note. Percentages sharing a common subscript are statistically different at α = .001 according to the Kruskal-Wallis' test. Percentages of the critical semantics are in boldface.
° percentages statistically different from those of any other group at the Mann-Whitney's test (comparison by columns; $p < .001$ with Bonferroni correction). $^{<}$ percentages statistically lower than those of the critical semantics for each group at Wilcoxon's test (comparison by rows; $p < .05$ with Bonferroni correction). $^{>}$ percentages statistically higher than those of the critical semantics for each group at Wilcoxon's test (comparison by rows; $p < .05$ with Bonferroni correction).

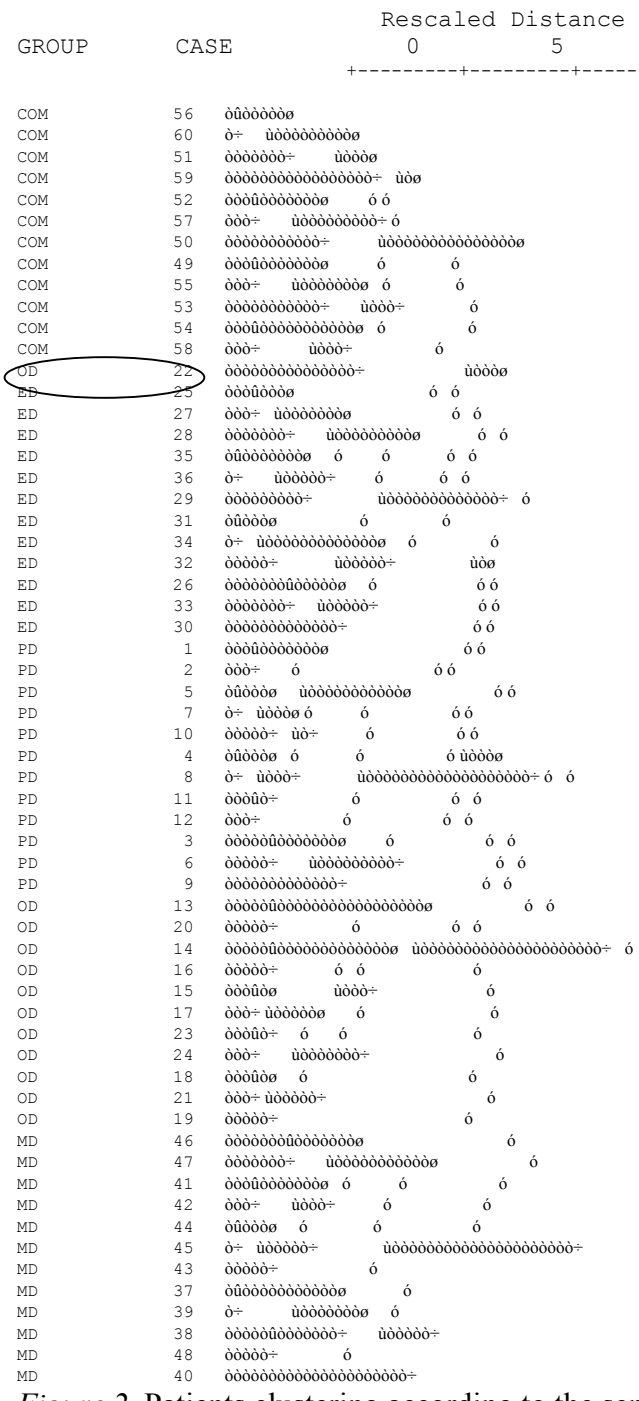

Figure 2. Patients clustering according to the semantics of the polarities introduced by patients (N = 5359; PD = phobic disorders group, OD = obsessive-compulsive disorders group, ED = eating disorders group, MD = mood disorders group, Com = comparison groups).