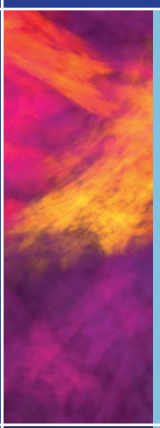
pISSN: 2499-7552
eISSN: 2239-8031

2018
Vol. 21, Suppl. 1

RESEARCH IN PSYCHOTHERAPY

PSYCHOPATHOLOGY, PROCESS AND OUTCOME



Abstract book

XII Congresso Nazionale della Società per la Ricerca in Psicoterapia SPR-Italia

OLTRE LE TECNICHE | Psicoterapia e Ricerca

Palermo, 5-6 ottobre 2018

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Palermo 5-6 ottobre 2018

XII National Conference of the Society for Psychotherapy Research - Italian Section

BEYOND THE TECHNIQUES: PSYCHOTHERAPY AND RESEARCH

October 5-6, 2018, Palermo

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SYMPOSIA

Ethics and practice of online psychological interventions

Proposer: Manzoni Gian Mauro
Faculty of Psychology, eCampus University, Novedrate (CO), Italy

Discussant: Gullo Salvatore
Università N. Cusano, Roma, Italy

In 2017, an interest group on online psychological interventions was formed within the SPR-Italian Area Group and set the following main objectives: a) to develop an Italian network of psychologists and psychotherapists using or interested in using the Internet and related technologies to provide remote psychological interventions; b) to promote scientific research on the processes and outcomes of online psychological interventions in Italy; (c) to facilitate collaboration among members in planning, discussion, and conduct of methodologically sound, large-scale multi-center studies on the mechanisms, efficacy and effectiveness of online psychological interventions; d) to plan and deliver workshops on the ethics and practice of online psychological interventions. This symposium has the aim to present the interest group to the SPR meeting participants and includes four oral presentations. The first one concerns the ethics of online psychological interventions and is focused on the new Italian guidelines that were developed and published by Italian National Council of Psychologists (CNOP) in 2017. The second presentation describes the EU-funded MASTERMIND project and focuses on the pros and cons of providing Internet interventions to patients with a depressive disorder. The third speech presents and reports the preliminary findings of the SHARED trial, a randomized and multi-center clinical study that aims to test the acceptability and effectiveness of a six-week online guided self-help intervention for outpatients with a diagnosis of anorexia nervosa. The forth contribution concerns the mental health and remote psychological treatment of expatriates, and describes an exploratory study whose aims were to investigate the difficulties that may occur during the experience of expatriation, international commuting or mobility in general, and to understand the subjective experiences of therapists providing internet interventions to expatriates in order to develop a new paradigm of psychological counseling and short online therapy for workers in conditions of international mobility.

Italian guidelines for online psychological Interventions

Manzoni Gian Mauro[1,3], Pietrabissa Giada[2,3], Castelnuovo Gianluca[2,3]

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Introduction: The number of clinical psychologists and psychotherapists using the Internet to provide remote counseling and psychotherapy to their clients and patients is rapidly growing worldwide. In Italy, a 2015 survey of online psychological services on the Internet found 389 websites and classified them according to four domains of criteria: a) service organization, b) professional profile, c) contract with clients and d) deontology. Three categories were identified by means of a grounded theory approach followed by a multiple correspondence analysis and a cluster analysis: a) unspecific services (n=162; 41,67%), b) prosocial services (n=78, 20,05%) and c) freelance services (n=149; 38,3%) Given the ethical, legal and practical peculiarities of remote psychological interventions and psychotherapy via the Internet, several psychological associations and societies in the world have developed recommendations and guidelines to help practitioners who provide online psychological interventions and psychotherapy stay within their legal and ethical limits. *Methods*: Italian guidelines, recommendations and ethical codes for online psychological interventions and psychotherapy were searched on the websites of the most representative psychological associations in Italy: the Italian National Council of Psychologists (CNOP), the Italian Association of Psychologists (AIP), the Academic Conference of Psychology (CPA) and the Unitary Association of Italian Psychologists (AUPI). *Results*: Recommendations and guidelines for online psychological services were developed and published by the Italian National Council of Psychologists (CNOP) in 2013 and 2017 respectively. The guidelines updated the previous recommendations and resulted from the systematic review of 19 international documents on the ethics of online psychological services. Inclusion and classification criteria were derived from a similar work that was done by the Australian Psychological Society in 2016. The articles of each document were grouped in seven ethical domains (appropriateness of the online intervention, practitioner competence, legal considerations, privacy, consent, professional limits and crisis management) and their prevalence rates were assessed in order to select the ones that were present in 50% of documents at least (n=11). The articles that did not satisfy the inclusion criterion were excluded from the guidelines and were classified as provisional (n=123). Selected articles were then compared to the 2013 recommendations in order to highlight commonalities and to develop an updated document including articles that were missing. The resulting and final guidelines consists in 15 articles that are organized in seven domains: 1) ethics; 2) appropriateness; 3) competence; 4) legal aspects; 5) privacy; 6) consent and 7) crisis management. *Conclusions*: Italian guidelines for online psychological services are available and up-to-date. The document consists in 15 articles classified in seven domains. The first article states that the ethical principles and norms of the Deontological Code apply also to psychological services that are provided by means of the Internet and related technologies. The second article requires psychologists to assess the appropriateness of the online psychological intervention for clients and patients. The third, fourth, fifth, sixth and seventh articles require psychologists to provide online interventions only within the limits of their competence, to possess both the appropriate technologies and the skills to use them, to make visible their competence, skills and qualifications, to assess their competence, skills and technologies repeatedly, and to inform their regional psychological association about their web address and technological tools. The eighth, ninth and tenth articles concern legal norms about the prohibition or restriction of online psychological interventions in different countries, data protection and the obligation to make explicit to clients and patients the professional license to provide online psychological interventions. The eleventh and twelfth articles require psychologists to know the risks of data violation when providing interventions via the Internet and to protect their privacy and that of their clients or patients by means of effective hardware and software data protection systems. The thirteenth and fourteenth articles concern the informed consent and specify that it has to include additional information about the online intervention and all its peculiar characteristics, including the used communication technology and its specific features, the psychologist's competence, skills and qualifications in

providing an online intervention, the communication limits, the crisis management strategies and the alternatives to the online intervention. The last article, the fifth one, states that psychologists should inform their clients or patients about the clinical institutes where they could turn to in case of emergency before starting the online intervention.

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Online psychotherapy for expat. An exploratory study

Di Girolamo Mariza[1], Pisterzi Anna[2], Bianchi Valeria[3], Druetta Vanda[4], Gullo Salvatore[5]

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Introduction: Emigration is a process that brings with it some stress factors. To date, there is a vast literature on the symptomatic etiology of immigrants from non-EU countries to Europe, whereas only few researches have studied the psychological effects of the reverse phenomenon, the increasingly frequent expatriation from EU countries to non-western countries (or to the phenomena of corporate migration or nomadism). Evidence suggests that expatriation in personal or family history is a risk factor for the development of mental illnesses and that migration can universally contain some aspects of pathogenicity , linked both to the removal from the country of origin and to adapt to the host one: on the one hand, the physical eradication, the distance from one's family and friendship structure, can make the separation from one's country of origin difficult; on the other, cultural and linguistic barriers, different eating habits or different economic standards can make the experience of adaptation to new life very difficult. Moreover, ambiguous experiences involved in the life of the highly mobile professional, in relation to the popular iconic image of the figure of the corporate expatriate as someone who leads a glamorous and problem-free lifestyle. In contrast, the fear of returning home, which depending on the more or less temporary condition, can have a different weight than the effort of adaptation of an individual. Taken together, these aspects represent a transformation of one's own identity, of roles, of codes, of life choices, and can lead to loneliness, uncertainty, anxiety, and constitute risk factors for the onset of forms of psychological distress, even serious ones, such as increase in promiscuous behavior, dependency behavior or substance abuse disorders. The use of language in psychotherapy with expatriates is a critical factor.. Several studies have highlighted the link between language and development of identity and changes in the reading of reality and personality traits through the new linguistic code. The available literature reports that clients who receive therapy in their native language are better able to express themselves and form closer relationships with their clinicians. Evidence supports that treatment is more effective when client and therapist share the same native language. Sharing the language is also sharing the historical, social and economic precipitations that shape individual identities and give meaning to the project of life and change not only in conservative terms but above all in the evolutionary perspective. In this regard, online psychotherapy specific for expatriation seems to open a new possibility to offer a path of psychotherapy in their native language, which maintains a bridge with the culture of origin, ensuring a link with the belonging, with the roots, and avoiding fragmentation but, at the same time, accepting distance and supporting the change of new life. *Methods*: The present preliminary study has the following primary aims: - to investigate aspects of difficulties that may occur during the experience of expatriation, international commuting or mobility in general, in order to prevent and/or treat more or less severe conditions of psychological distress. - to understand the subjective experiences of the therapists who work online through a D-VoIP system, in order to develop a new paradigm of psychological counseling and short online therapy for workers in conditions of international mobility. Sample 1: 35 Italian expats, recruited on a voluntary basis within the closed groups of Italians abroad on Facebook who will be given a one-hour semi-structured interview through D-Stanza - a platform created ad hoc for online psychotherapy - in order to collect the issues that those who live the experience of expatriation feel as more significant. Sample 2: 35 Italian psychotherapists who have done at least one cycle of 6 online therapy sessions, with D-VoIP systems for distant psychotherapy, and who are trained on the differences between traditional psychotherapy and D-Voip psychotherapy. The data of both samples were subjected to qualitative analysis and the results allowed to structure a first research hypothesis, aimed at outlining some guidelines for designing a type of effective intervention for the prevention and treatment of conditions of mental distress in Italians living/resident abroad. *Results*: The present study shows that expat have problematic issues linked to the initial motivation, to the expectation of the host country, the fear of returning, the identity and the presence or absence of a social network. The psychotherapists who completed the interview provided intriguing answers about the differences between online and vis-à-vis sessions regarding the nature and the quality of the relationship with their clients (expat and non-expat), changes in perception of the psychotherapist's role and in client's perception of the worth of treatment, and modifications in the transference - countertransference relationship. *Conclusions*: In recent years, increased attention has been given to the need to adapt psychotherapy to clients' cultural values and contexts. In short, our findings confirm that both therapists and clients considered internet-delivered interventions as a valuable and reliable tool mostly at the particular condition of expatriation, and provide support of the benefits of culturally adapting psychological interventions, particularly when the interventions are conducted in clients' preferred language. The data presented support increased inquiry into adaptations of mental health interventions according to clients' cultural contexts.

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Extra-setting factors affecting psychotherapy process

Proposer/Discussant: Porcelli Piero

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This symposium is focused on the influence of external factors of the therapeutic setting (conceived as variables of the psychotherapy settings as material elements and therapist-patient relationship) to the therapeutic process and outcome. Those factors can be viewed as intermediate between unspecific factors – being variables of the patients' personality organization indirectly influencing the therapeutic relationship – and Lambart's extra-specific factors (therapist's personality, socio-economic variables, life context, job status, marital status, etc.). The 3 presentations analyze these factors from different point of views. In Palmieri et al.'s intervention, a new research paradigm of the therapeutic process based on simultaneous assessment of physiological reactivity (Interpersonal Physiology) and temporal patterns hidden in session transcripts (Discourse Flow Analysis) will be shown. Carfora Lettieri *et al.* will analyze findings of the influence of past traumatic experiences on the personality organization and motivation to psychotherapy in female obese patients. Finally, Biagiarelli et al. will analyze the influence of Panksepp's brain primary emotional systems on therapeutic alliance and countransference factors in a group of adolescent outpatients.

Towards a new paradigm in the psychotherapy process research: An empirical study on text analysis and psychophysiology

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Introduction: Recent theoretical and empirical advancements in literature are leading toward a paradigm shift in the research of psychotherapy process, in terms of: a) a focus on moment-by-moment interpersonal or intersubjective exchanges, b) the study of their temporal dynamics, c) the preference for idiographic and explorative designs and d) the use of objective measurement tools such as physiological measures, and computer-assisted analysis of videos and transcripts of the clinical interactions. Specifically, in regard to the latter, the use of Interpersonal Physiology (IP; for a review see Palumbo *et al.*, 2017) as a tool to investigate the somatic perspective in the clinical setting is receiving increasing interest. IP consists in the analysis of the simultaneous physiological activity in two interacting persons and is being increasingly investigated as a biomarker of interpersonal emotional regulation. Specifically, in psychotherapy research, the technique has been successfully used to associate the synchronization of skin conductance (SC) to various interpersonal constructs, such as empathy and therapeutic alliance (Kleinbub, 2017). While IP techniques have already been employed to investigate the interaction dynamics of a therapist-patient dyad (*e.g.*: Palmieri *et al.*, 2018), to the best of our knowledge no research effort in literature has yet empirically studied the convergence between clinical micro-process and IP. Given these background, we propose a novel approach, rooted within this modern research paradigm, aimed to investigate the physiological dynamics in the patient-therapists process as assessed by the Discourse Flow Analysis methodology (DFA; Salvatore *et al.*, 2010; Gennaro *et al.*, 2010). DFA is an automated low-inferential procedure of content analysis, focusing psychotherapy process as an intersubjective meaning-making dynamic. Specifically, DFA focuses on the temporal patterns of meanings embedded in psychotherapeutic transcripts and categorized in light of a multidimensional analysis's procedure, rather than on the survey of discrete contents. *Methods*: In the present study we analyzed IP and DFA in a clinical dyad in 16 sessions of psychodynamic psychotherapy. During each session, skin conductance was acquired simultaneously in patient and therapist, and IP was assessed as the moving-window cross-correlation of the two signals. DFA was applied on the sessions transcripts, and the resulting clusters timing was extracted, to allow a direct comparison between content and physiology. *Results and Conclusions*: We identified differences in the amount of skin conductance synchronization during the main thematic clusters across sessions, and a correspondence between the discourse network dynamics and the IP modifications across sessions. In conclusion, our a single-case study highlights the potential benefits of employing this new research paradigm, in order to overcome the limitations of the classical process research designs, for instance by employing high-frequency objective assessments that provides sophisticated data that in turn enrich and empower the theoretical development. Results and theoretical implications will be discussed in detail also in the perspective of the psychotherapy outcome.

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Traumatic factors and mental functioning: Therapeutical implications in a group intervention

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Introduction: In recent years, the scientific community has given an increasing importance to the effects of traumatic experiences. Empirical and neurological evidences, indeed, have suggested that Adverse Childhood Experiences are strongly related to many difficulties and diseases in adulthood. Stressful events are aspecific factors which, combined with a condition of vulnerability, determine a more likely development of both psychopathology and physical

illnesses in individuals (Zennaro, 2011). Moreover, they also influence the progress of the diseases, worsen the prognosis and to provoke relapses in cases of chronic conditions (Felitti & Anda, 2010). Some researches have highlighted the association between traumatic life events and the risk to develop obesity and Binge Eating Disorder in adulthood (Palmisano, Innamorati e Vanderlinden, 2016). The goal of this study was to better understand this link, to deepen the understanding of obese patients' mental functioning, in order to shape a more effective treatment for this kind of patients. *Methods*: The study was carried out on the Clinical Psychology Unit of the ASST Rhodense hospital, which has dealt with individual and group treatments of obese patients for many years. We started a research on 20 obese patients, all females, about their childhood traumatic experiences, using different instruments such as the Rorschach Test (R-PAS method) and the Adverse Childhood Experiences (ACEs) interview. *Results and Conclusions*: Results showed that all obese patients had significant traumatic events in their lives, and that they tended not to talk about them with anyone. These findings helped to better understand their way to perceive themselves and others, and to shape our group treatment so to help them be in contact with those fragile parts of themselves, and work on and elaborate them.

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Relationships between Affective Neuroscience primary brain emotional systems, working alliance and countertranference in a sample of adolescent helpseekers

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Introduction: Affective Neurosciences identify seven ancestral emotion systems, categorizing them in positive (SEEKING, LUST, CARE, PLAY) and negative (FEAR, RAGE, SADNESS/PANIC). The activation of one – or more – of the seven emotional systems is related to distinct affect feeling states, promoting some specific behavioral patterns according to individual's experience. Each one of the seven systems is important to understand and define features of human personality. These domains are presented as fundamental for the development of the human personality, and can therefore be used as a potentially new model for the evaluation of the personality and for the therapeutic process. Futhermore, the consideration of these basic emotional sistems can produce longer therapeutical changes (Montag, Panksepp, 2017). In this regard, working alliance and countertranference are considered very important "common factors" of the therapeutic process (Norcross, 2011) and they are associated to a good outcome and to reduction of the drop-out (Horvath, Re, Fluckiger, Symonds, 2011). Therefore, we evaluated the relationship between Affective Neuroscience primary brain emotional systems, working alliance and countertranference in a sample of adolescent helpseekers. *Methods*: A sample of 87 patients, 48% males, (14-18 years) were included and referred to the clinic for Anxiety and Mood Disorders in Adolescence (Department of Psychiatry of Sant'Andrea Hospital in Rome). Subjects met diagnostic criteria for the following DSM-5 diagnoses: Anxiety Disorders (30%), Depressive Disorders (40%), Bipolar Disorders (15%), Obsessive-Compulsive Disorders (10%). The sample was evaluated with the Affective Neuroscience Personality Scales 2.4 (ANPS 2.4), Working Alliance Inventory-Therapist Form (WAI-T) and Therapist Response Questionnaire (TRP). *Results and Conclusions*: Higher levels of CARE correlate with a better working alliance and with a countertransference response Special/Overinvolved. Instead, high levels of RAGE and Dominance correlate with lower levels of working alliance. Low activation of SEEKING correlates with high levels of the factors Helpless/Inadequate, Parental/Protective and Disengaged. The emotive and motivational system FEAR correlates with the countertranference factors Positive/Satisfying, Parental/Protective, Overwhelmed/Disorganized, Special/Overinvolved. There is a relationship between the RAGE system and the countertransference factor Hostile/Mistreated. SADNESS/PANIC system correlates with Parental/Protective and Special/Overinvolved factors. Dominance is related to the factor Overwhelmed/Disorganized. In conclusion, the drive to care and compassion appears to be associated with a better ability to cooperate with the therapist in order to achieve common goals, contrary to the propensity to defensive, choleric and intrapsychic or interpersonal control (Gilbert, 2014), which also trigger reactions of antagonism in the therapist or a sense of confusion. The feelings of impotence, protection and detachment from the therapist can signal the hypoactivation of attitudes of exploration, problem-solving and curiosity in the patient (Panksepp, 2010). The activation of threat feelings seems to trigger a variegated countertransferential reaction. The sense of loneliness and the need for attachment activate therapeutic attitudes of care and hypercooling.

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Linguistic style, communicative patterns and content analysis. Three approaches to the exploration of subjectivity in conversational processes

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Over the last decades psychology, like many other disciplines, has witnessed a paradigm shift, moving from a reductionist to a more complexly oriented epistemology. Many authors recognize that for a proper understanding of human subjectivity there needs to be some concordance between the object of study, the epistemic principles adopted in the investigation, and the theories developed in relation to such object. When human subjectivity is the object of study, we must take into account such complexity and resist simplification (Bocchi & Ceruti, 2007). From this epistemological perspective subjectivity: (a) exists and is knowable only through a subjective point of view; (b) is not and unilaterally modifiable, and (c) is only partially explainable trough complex and recursive models of space, time and causes. It follows that the best way to reach a plausible and ecological knowledge on subjectivity is to adopt a pluralistic point of view, and employ multiple levels of analysis with a variety of research instruments and methodologies. This symposium will focus on one of the main manifestations of subjectivity: the human conversation. Three approaches that focus on different aspects of this complex and ubiquitous phenomenon will be presented, taking into account both therapeutic and non-therapeutic contexts: (1) Bucci's theory of Referential Process (1997), based on Multiple Code Theory, explains how, through language, we connect symbolic modalities of experience, such as images and words, to sub-symbolic modalities, including all sorts of bodily sensations. The referential process is at the heart of the "talking cure" and allows us to connect not only the patient and analyst's subjectivities, but also to begin to understand multiple systems in which they encode their experiences. From this perspective, the psychotherapeutic conversation is an embodied, contextual and relational process. We will be presenting two instruments that attempt to capture the referential process just described: the Italian Weighted Reflection and Reorganization List (I-WRRL); and the Referential Process Post Session Scale (RPPS). These two measures detect stylistic qualities of language and can distinguish the three main phases of the referential process: (a) Arousal – a problematic emotion schema is activated; the patient appears to be struggling with painful feelings and ideas associated with the schema; it is dominant the sub-symbolic processing system, involving bodily and sensory experience, that is at the core of the schema, (b) Symbolizing – a specific experience emerges that represents aspects of the problematic schema that the patient can tell about verbally, as a narrative of a dream, event, memory or fantasy; this represents the essential symbolizing process, connecting the sub-symbolic flow of experience to language; the speaker must be emotionally engaged in the schema to enable the symbolizing process to operate effectively in expressing emotion verbally, and (c) Reflection/Reorganization – once the schema has been experienced and represented as a narrative, or played out in the relationship, therapeutic interventions can then come into play to interpret, explore and reflect upon the issues that are being expressed. Herein lies the potential for new connections and changes in emotional organization to be made. (2) The second approach is a dynamic systems approach (Haken, 2010) to psychotherapeutic communication that assumes the continuous and recursive interaction between subsystems comprising communication. From this perspective, therapeutic communication is a dynamic system characterized by pattern formation and transformation at the multiple levels in which the system unfolds: linguistic, paralinguistic, and extralinguistic; as well as within the individual and between individuals. The theoretical foundations of a dynamic systems approach to psychotherapeutic communication will be sketched out, and the empirical literature reviewed. (3) The third approach is a content and social representation analysis perspective (Salès-Wuillemin, 2005). This perspective allows us to map and detect variation, differences and correspondences in the themes of the conversations. These themes when mapped become measures of the intersubjective processes experienced by the speakers within specific local contexts. We will present a study that highlights differences in group cohesion by comparing the conversation of educators and adolescents in different types of residential communities. The comparison of these three different perspectives will highlight the constraints and resources of each specific scope of analysis – linguistic style, communicative patterns and content analysis – and the usefulness of their integration to better understand the complexity of human conversation, both in and outside of therapeutic contexts.

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The Italian weighted reflection and reorganization list (I-WRRL): A new linguistic measure detecting the third phase of the referential process

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Introduction: In psychotherapy process research, Multiple Code Theory (MCT; Bucci, 1997, 2015) remains an inspirational and important point of reference for researchers, clinical psychologists, and psychotherapists interested in the reconceptualization – both clinically and empirically – of psychoanalytic theory. Moreover, MCT made explicit some psychotherapeutic implications of adopting an embodied, intersubjective and contextual conception of the mind. The central hypothesis of MCT is that our experience of the world is coded in at least three systems – non symbolic, nonverbal symbolic, verbal symbolic – that are not completely connected and integrated with each other. In psychotherapy the Referential Process (RP) is activated, with an attempt at connecting these systems and shaping three phases: (a) arousal in which one or more patterns of emotion are activated within the interaction, (b) symbolization in which the patient expresses in words what he is experiencing on an emotional level, and (c) reorganization/reflection in which the experience is reorganized and reframed, creating greater and more varied connections between the three systems of experience. Ac-

cording to MCT, each of the three phases are manifested in different linguistic styles: the first one, arousal, would be characterized by silences and fragmented verbalizations with high disfluency; the second one, symbolization, by vivid, concrete, specific, and clear language; and the third phase, reorganization, is manifested in speech by a reflective and at the same time vivid language. Only for the symbolization phase do we have a weighted and validated dictionary of the Italian words that captures the relative linguistic style – the Italian Weighted Referential Activity Dictionary (I-WRAD; Mariani, Maskit, Bucci, & De Coro, 2013). The two other main dictionaries are unweighted (and therefore less sensitive): the Italian disfluency and reflection dictionaries, which detect the arousal and reorganization/reflection phases respectively. Our goal has been to construct a weighted dictionary called the Italian Weighted Reflection and Reorganization List (I-WRRL) that will captures the reorganization phase of the referential process, which is considered crucial for an effective psychotherapeutic process. According to the operative definition of the reorganization and reflection function (Bucci, Maskit, Murphy, Zhou, & Fishman, 2018) that we have adopted, the linguistic style of the third phase of the referential process is characterized by (a) an active search for a subjective and emotional meaning of the experience, (b) a vividness indicating an emotional engagement with what one is talking about and (c) a sense of wonder and novelty with respect to emerging meanings. *Methods*: Six independent raters have applied the WRRL manual (Bucci, Maskit, Murphy, Zhou, & Fishman, 2018) to 1,010 text units from psychotherapy sessions, autobiographical narratives, adult attachment interviews, and autobiographical literary books. After having achieved a good reliability on a first set of units (alpha=.927; ICC=.679), the 6 raters were divided into 3 pairs, with each pair coding 1/3 of the entire text units corpus. They assessed the extent to which the reorganization/reflection function was present in each text unit by assigning a score ranging from 0 (absent) to 10 (highly present). *Results*: In order to construct the I-WRRL only the words with al least 4 occurrences from at least two different text units were considered. Through this process, a dictionary of 764 words typical of the reorganization and reflection function was composed. Each word was assigned a weight. The dictionary then applied to 32 additional text units and was found to account for 85% of the text. The correlation between the manual scores and the scores arrived at by the use of the dictionary was positive (r=.25). *Conclusions*: IWRRL is a new measure that is distinguishable from other measures of reflection in the psychotherapeutic process. First of all, it is an automatic and indirect measure of the reorganization/reflection phase and so it is less affected by any evaluator bias (patient or therapist) or rater's subjectivity; secondly, it is based mainly on language style – typically defined by function words – rather than on conversation content; thirdly, I-WRRL does not measure just the function of reflection or abstract thought but specifically the reflective and reorganization function when activated in relation to a process of emotional engagement and associated to a sense of novelty and wonder, which is typical of an effective psychotherapeutic process. The construction of this new dictionary thus makes it possible to investigate the reorganization and reflection phase with more precision and completeness, in connection with the other three phases of the RP. I-IWRRL and I-WRAD together are instruments useful both for outcome/process research and for clinical monitoring and supervision in practice.

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A dynamic systems approach to psychotherapeutic communication: Pattern formation and transformation in clinical contexts

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Introduction: Psychotherapy is a communicative process occurring within the patient-therapist interaction in the form of a dialogical conversation. Traditional information-processing approaches consider psychotherapeutic communication as an exchange of discrete meanings sent from a sender to a receiver, already existing outside the social exchange, and changing within the individual as a result of the direct influence of the other. Such approaches do not seem able to adequately take into account the complex and dynamic nature of psychotherapeutic communication; moreover, they do not explain the extent to which the quality of information-processing at an inter-individual level (client [C] and therapist [T] in interaction) relates to the quality of information-processing at an intra-individual level (C and T considered alone); finally, they tend to focus on the linguistic aspects of communication, disregarding para- and extra linguistic aspects. The present paper argues that a dynamic systems approach (Haken, 2010) to therapeutic communication may allow to overcome these limitations. Therefore, we sketch its theoretical foundations and review initial empirical evidence for it. *Methods*: The principles of a dynamic systems (DS) approach to psychotherapy (Gelo & Salvatore, 2016; Salvatore & Gennaro, 2015; Salvatore & Tschacher, 2012; Salvatore, Tschacher, Gelo, & Koch, 2015) are applied to psychotherapeutic communication in order to conceptualize this latter as a dynamic system which self-organizes. The existing empirical literature is reviewed coherently with the principles underlying this theoretical model. *Results*: According to a DS approach, psychotherapeutic communication consists in the mutual construction (*i.e.*, co-construction) of meanings emerging and changing within the social exchange. More specifically, therapeutic communication is a dynamic system comprised by two subsystems – the C and the T – which steadily change over time according to communicative self-organization. This takes place by means of what we define communicative patterning, which is the process through which the synchronous interaction (*i.e.*, coordination) of communicative signs produces a communicative frame of meaning (see the concept of meaning-making) over time. From this perspective, meaning is represented by the very communicative patterning taking place within the interaction of C and T. Communicative patterning takes place both at an intra-individual level (concerning the communicative self-regulation of C and T considered alone) and at an inter-individual level (concerning the communicative mutual regulation between C and T), with each level dynamically constraining the other. A DS approach to therapeutic communication predicts communicative patterning varies over time so that a frame of meaning will emerge (pattern formation hypothesis) and eventually transform (pattern transformation hypothesis) during the course of a treatment. Pattern formation is the process through which a communicative frame of meaning spontaneously emerges over time as a result of the increasing synchronized interaction between the communicative signs employed. Pattern transformation is the process

which, under specific circumstances, allows the transformation of an already existing frame of meaning as result of the re-organization of the way the communicative signs interact with each other. These processes are to be expected for C and T taken alone (intra-individual level) and in interaction (inter-individual level). Finally, they characterize all aspects of communication (linguistic, paralinguistic, and extralinguistic). The existing empirical literature reviewed provides an initial support to both the pattern formation and pattern transformation hypotheses, showing how these are characteristics of a good therapeutic process. This is true at a linguistic, paralinguistic, and extralinguistic level. These studies tend to focus on either the intra-individual level (C ant T considered alone) or the inter-individual level (C and T in interaction), but still scarce is the attention paid to the reciprocal influence between these two levels. *Conclusions*: We conclude that a DS approach to psychotherapeutic communication may allow to overcome the limitations of traditional information-processing approaches, thus providing an innovative perspective for conceptualizing and empirically investigating communicative processes within psychotherapy and their relationship with the change processes. From this perspective, it is suggested that psychotherapeutic communication should not be studied with regard of the meaning of individual signs, but rather considering the way these co-ordinate allowing the emergence and transformation of a global frame of meaning.

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Shared social representations and group processes as effectiveness factors in communities interventions with adolescent

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Introduction: Research on Social Representations (SR - Moscovici 1984) has the primary objective to analyze the individual and group processes involved in the "reconstruction of reality" that each group implements when trying to make sense of reality. Each representation is defined at the same time by a content (information, images, opinions, attitudes about a concrete object), and by a group (family, social class, professional group, ...) that assumes a representation according to the relations that he has with other social groups. Representations can be seen as fundamental elements in the management of relationships, within the group and between groups, because of the influence they exert on the actions and emotions within groups. Discourse is the natural environment of the SR, it is by the discourse that they exist and are diffused in the social environment (Py, 2004). The analysis of discursive materials about an object makes it possible to apprehend the mode of diffusion of knowledge and their evolution but also the sharing of these contents and their translation through a sense matrix common to different groups (Salès-Wuillemin, 2005). This contribute aims to explore the relational and group factors most related to the effectiveness of residential community intervention for adolescent through the analysis of discourse and SR of educators and adolescents in residential communities in Italy. The choice of communities as an object of study derives from the recognition of their character as a group and social place and from the consensus on the importance of relational dynamics in the creation of a protective and enriching context for the adolescent and his life trajectories (Guarnaccia, Giannone, Sales-Wuillemin, 2018). The effectiveness of community residential care is, in fact, strongly influenced by the characteristics ant the quality of the "therapeutic" environment, this environment is characterized by multiple structural and temporal dimensions both in the internal environment (between adolescents, between adolescents and educators, between educators) and in the broader social context (families of users, social services and health, neighborhood, justice system, ...). The need to have a thorough analysis of the representations of communities and their way of communicating through language appears necessary to better understand the systems that act in the complexity of these structures and in the interaction between educators and adolescents who are supported. *Methods*: To collect our data we conducted 6 Photolangage groups (3 with adolescents and 3 with educators) in 3 different residential communities in different areas of Sicily. Groups met for 5 weekly sessions of 1 ½ hours for each group, for a total of 30 group sessions. The groups were led by a clinical psychologist who was also responsible for the research, with the presence of a participant observer. Each session was conducted with all the adolescents and the educators, in two separate sessions, all sessions were recorded and transcribed. Overall 32 adolescents, between 14 and 20 years old (M=17, SD=1.85) and 23 educators (10 men and 12 women) between the ages of 24 and 57 (M=40, SD 9.44) participated in groups sessions. The texts resulting from the transcripts of the group sessions (for a total of 120511 token - that is the single occurrence words, and 7685 types - that is all the words used) were analyzed using the IRAMUTEQ software (Ratinaud & Dejean, 2009) in order to organize the discourse highlighting the "lexical classes" in which some expressions are more frequently used and, consequently, identified as "typical" of that representation. *Results*: Our results reveal a common corpus of representations of the different actors of community life, with sharing and concordance of representations between adolescents and educators. Several data point in the direction of an opposition between the communities that structure their action according to processes of "occupational-education" type and others that take care of the adolescent with the idea of giving a new meaning to its developmental process. Correspondence factor analysis (CFA) leads us to observe the presence of two factors, factor 1 is more representative of the effect of the variable "intervention model", factor 2 is more representative of the effect of the variable "Group" (adolescents *vs* educators). We also observe a greater presence of indicators related to group dynamics of greater cohesion and better group climate in the communities that have developed their inter-

vention around the concept of participation and global care of the person compared to the occupational type of community that neglect the group dimension. The theoretical and applied model of "care" chosen by different communities seems to affect the type of representation with likely consequences for lifestyle and day-today involvement. *Conclusions*: In conclusion we underlined the need to work in order to reduce the gap between the caregivers and the users for improving the relationship between the different protagonists of the interaction and, consequently, the possibilities of good success and effectiveness of therapeutic interventions in residential communities. Despite the limitations of this study due in particular to the small number of participants, the in-depth analysis allows to draw useful information and recommendations for the work of homes for teenagers who invest in structuring a good climate. group as a basis for a comprehensive care of the person and relationships. The attention to good practice cannot be made independent of the experience and knowledge that all actors bring in the process, in particular the central role of adolescents "privileged witnesses" who become essential in the process of evaluation and knowledge of representations that, if shared, are the basis of effective work practices and interventions.

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Validity and clinical utility of the Therapist version of the referential Process Post-session Scale (RPPS-T)

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Introduction: According to Bucci's multiple code theory (Bucci, 1997; Bucci, Maskit, Murphy, 2015) a significant change in the patient-therapist relationship should reflect a referential process that is shaped by alternating phases: (a) arousal: experiencing emotion schemas, (b) symbolization: translating into words the emotional experiences, and (c) reorganization/reflection: recognizing, understanding and expanding the emotional significance. So far, in order to monitor the development of these three phases therapists and researchers have relied on their own clinical sensitivity and automated measures of the referential process (Mariani, Maskit, Bucci, & De Coro, 2013), which require the use of transcribed session material. In order to develop a parallel and less time-consuming method, developed a self-report questionnaire measuring the phases of the referential process, the Referential Process Post-session Scale – Therapist version (RPPS-T). Six constructs we intended to measure through the questionnaire: the emotional arousal of the therapist at the end of the session, the clarity, specificity, concreteness and imagery of therapeutic conversation according to the therapist – the four linguistic dimensions of the symbolization phase – and the extent of reorganization/reflection work performed during the session according to the therapist. *Methods*: To test the RPPS-T factorial structure psychotherapists were asked to complete an extended version (36 items) of the questionnaire at the end of their sessions. We collected 105 evaluations form eight psychotherapists regarding 29 patients. From the extended version of the questionnaire, through an exploratory factorial analysis we developed a shortened questionnaire (12 items) completed by other nine psychotherapists on 24 patients for a total of 130 compilations. On this second administration we conducted a confirmatory factor analysis. We also tested the concurrent validity checking the correlation between the RPPS-T scores and the computerized linguistic measures of the referential process obtained onto some session transcripts (n=18) and of therapist's notes (n=18). *Results*: The exploratory factorial analysis has detected a well-defined solution, consistent with the hypothesized constructs, consisting of four factors (with three items each), one regarding the therapist emotional arousal, two referring the linguistic characteristics of the in-session conversation and one concerning the in-session symbolization work. We called these four factor a) emotion memory clarity, b) concreteness/imagery, c) specificity, and d) symbolization. The four-factor solution has demonstrated a good fit (^{2}(48)=105.395, p<.001; CFI=0.940; TLI=0.91; RMSA=0.97; SRMR=0.049) by the confirmatory factor analysis conducted on the second administration. Internal consistency of the scales was adequate (α >.82). Two among the four RPPS-T scales yielded significant correlations with the computerized linguistic measures of the sessions and therapist notes: the RPPS-T symbolization scale positively correlates with High Weighted Referential Activity Dictionary (HWRAD) index measured onto the in-session patients interventions – a measure of the intensity of Referential Activity – and the RPPR-T emotion memory clarity correlates with the Weighted Referential Activity Dictionary (WRAD) and HWRAD indexes measured on the therapist notes. The RPPRS concreteness/imagery and specificity scales instead did not correlate with the linguistic measures of sessions and notes. *Conclusions*: RPPS-T had shown a valid factor structure and internal consistency and could be considered as a valid instrument from a statistical point of view. The factorial structure found confirms that the questionnaire detects the hypothesized constructs of the referential process. Also the criterion validity is partially confirmed by the correlation with the computerized linguistic measures of the session transcriptions and therapist's notes. The more the patient has a clear, specific, concrete and vivid language during the session the more the therapist at the end of the session will have the impression of a good work of symbolization and connection jointly carried forward. Moreover, the more the therapist have a clear memory of the emotions experienced during the session, the more her/his notes on the session itself will have a high referential activity indicating a good elaboration and emotional connection with the patient. We can conclude that RPPS-T can be used as a quick and reliable measure of the referential process along the psychotherapeutic treatment. It does not replace the computerized linguistic measures of the session transcriptions, the richer and more direct indicators of the progress of the referential process in the session and in the treatment; however it is a parallel and less time-consuming measure available to therapists and researchers: the firsts can easily use it as a tool for clinical monitoring and supervision, the seconds can apply it to study the referential process in correlation with the outcome measure and with the other important clinical constructs.

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Making personality diagnosis clinically meaningful in children, adolescents, and young adults

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For decades, the international scientific debate was characterized by heated arguments around the question of whether personality pathology can really be diagnosed in childhood and adolescence, or whether personality diagnosis should be exclusively used to describe adult patients. For example, the Diagnostic and Statistical Manual of Mental Disorders (most recently DSM-IV-TR and DSM-5; American Psychiatric Association, 2000, 2013) and the International Classification of Diseases (currently ICD-10; World Health Organization, 1992) recommended caution against diagnosing adolescent personality disorders. However, this cautious approach likely arose less from research findings and more from difficulties both to differentiate characteristics normative to adolescent developmental stage of turmoil from persistent pathology (Casey, Jones, & Levita, 2010), and to protect youth from social stigma (Catthoor, Feenstra, Hutsebaut, Schrijvers, & Sabbe, 2015; Laurensenn, Hutsebaut, Feenstra, Van Busschbach, & Luyten, 2013). A ever-growing body of clinical observations and empirical evidence indicates that: (a) personality patterns form during childhood and continue to develop over the subsequent phases of life; (b) personality pathology in children and adolescents is distinct from both normal development and abnormal psychopathology; (c) emerging patterns of personality pathology in adolescence are both highly prevalent and persistent in adulthood. In line with the research in the field, the *Psychodynamic Diagnostic Manual* (PDM-2; Lingiardi, McWilliams, 2017) emphasizes the critical importance for informing the diagnostic process in specific developmental stages, and suggests to the clinicians to consider "emerging personality patterns" that may have clinical utility in helping them create formulations and develop individualized treatments (see PC, PA and P Axes in the Manual). Moreover, according to the PDM-2, it is important to recognize that personality is the meaningful diathesis for psychopathology, and if we intend to better understand symptoms, we have to know the person who hosts them (Westen *et al.*, 2006). Thus, carefully understanding of enduring patterns of thinking, feeling, defense, interpersonal functioning, experiencing self and others, and so on, in which mental health problems are rooted, can clarify the meaning and function of specific psychological difficulties, as well as provides a road map for effective therapeutic intervention and decision making. Moreover, it is important to take into account that personality plays a crucial role in how patients respond to treatment. Consistent with the PDM-2 diagnostic framework, this panel consists of four studies that try to deal with some of the critical issue in the international debate on the personality field and its disorders. The first contribution of Fortunato and Speranza focuses on the development of a Q-Sort assessment procedure designed to evaluate children personality, and provides the promising data on the psychometric properties of this new instrument. The second contribution of Boldrini, Pontillo, Erbuto, Santonastaso, Pompili, Vicari, and Lingiardi examines the personality characteristics and attachment patterns in a sample of adolescents at risk of developing a psychosis (UHR), and highlights the importance of these

individual features in guiding individualized treatments. The third contribution of Tanzilli, Gualco, Shedler, and Lingiardi investigates the therapists' emotional responses (or countertransference) related to personality patterns/syndromes in adolescent patients, and emphasizes their relevant role in understanding core dynamics of patient's pathology and helping therapists in clinical practice. The fourth contribution of Parolin, Simonelli, and Cristofalo describes specific personality subtypes in young adults with substance use disorders and suggests that treatment of this severe pathology should be integrated to interventions focused on personality patterns that moderate therapy response. The empirical results will be discussed and their clinical implications will be addressed.

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Assessment of childhood personality, traits and disorders: Validation of a Q-Sort procedure

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Introduction: The debate on childhood personality disorders still rages, despite a growing number of studies confirming that it is possible to evaluate childhood personality from a developmental perspective (Caspi *et al.* 2005, Widiger *et al.* 2009, McAdams & Olson 2010). Certain authors have inquired whether it is appropriate to evaluate personality in childhood, given the developmental features of mental functioning, but others, with the support of empirical and clinical data, confirmed the early structuring of PDs and the need for early intervention and prevention. The Psychodynamic Diagnostic Manual, Second Edition (PDM-2; Lingiardi and McWilliams 2017) states that young children do have personalities and traits that may persist over time, and it underlines the importance of assessment even in childhood. The controversy over the existence of personality disorders in childhood has continued due to the limitations of studies in this research area and to the reluctance to apply adult personality diagnoses to children. The aims of this work are: to develop a Q-Sort assessment procedure for the evaluation of children personality and to give a contribution on the debate of childhood personality (Fortunato & Speranza, *in press*). *Methods*: From a literature review we derived seven Emerging Personality Patterns and four Personality Organizations. Through the four Mental Functions defined by the PDM-2 (cognitive and affective processes, identity and relationships, defense and coping, Self-awareness and self-direction) we described the characteristics of each patterns and we derived 200 items that describe specific patterns of affect, cognition, motivation and behavior in childhood with a straightforward manner. Beyond the consideration of whether it is better not to label, avoiding stigmatization and leaving the development to have its course or rather is it higher risk to do so for traits that exist and could lead to a structured pathology without intervention, we would like to consider emerging personality patterns in childhood as developmental trajectories that can be examined. We believe that investigating the precursors and pathways of personality disorders during childhood, integrating developmental issues, biological vulnerabilities, and problematic environments, has the potential to define a longitudinal developmental approach to personality development and psychopathology. Our approach tries to address this challenge, conjugating both top-down (theoretical) and bottom-up (research) perspectives, based on research and clinical evidence (Fortunato & Speranza, *in press*). First Personality Organization is the Healthy Personality, the second one is the Neurotic Personality Organization that includes: Inhibited/Withdrawn Emerging Personality Pattern, Pathological Obsessiveness Emerging Personality Pattern and Dysphoric Emerging Personality Pattern. The third one is the Borderline Personality organization that includes: Dysregulated Emerging Personality Pattern and Pathological Narcissism Emerging Personality Pattern. The last one is the Psychotic Personality Organization that includes: Suspicious Emerging Personality Pattern and Schizoid emerging personality pattern. Items and Patterns were tested through theoretical and statistical consensus. The theoretical consensus was obtained by 30 expert clinicians that evaluated on a 5-point Likert scale each Pattern and item. The statistical consensus involved 42 clinicians assessing 42 children (M=7.92; 64% male). Afterwards, we started with the validation procedure. One hundred clinicians evaluated 100 children (M=8,7; 74% male), from 5 to 11 years old, in treatment from 2 to 12 months. Procedure includes other instruments: CPNI (Coolidge, 2002), CBCL (Achenbach, 2001) e PDC-C (Malberg, Rosenberg, Malone, 2017). *Results*: Theoretical consensus: clinicians rated 4 or 5 to all the Patterns and most of the items, only few items were rated 3. Statistical consensus: we evaluated the mean score and the standard deviation (SD) for each item. Only 16 out of 200 items reached a SD lower than 1.50 and a little mean score. Then, to evaluate the internal coherence of each Pattern, we measured the Cronbach's alpha that reached really good or excellent levels for each Emerging Patterns. According to the consensus results, we modified the problematic items to obtain the final version of the instrument. For the validation procedure we conducted the Q-Factor analysis to obtain Emerging Personality Patterns empirically derived. Then we evaluated the correlation between the Q-Factor's and the other instruments. Validation procedure highlights the Q-Sort's validity to evaluate childhood personality. *Conclusions*: Using the literature and research data, this study defined possible developmental pathways for emerging personality patterns in childhood. We consider that it is possible to define emerging patterns that may lead to personality disorders in adolescence and adulthood. The study of childhood personality can inform us about mental functioning, precursors and pathways of development. Preliminary data is promising and seems to confirm that the personality can be investigated during childhood. The Q-Sort procedure is the best way to assess childhood personality and its elements.

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Clinical assessment of personality and attachment patterns in adolescents at ultra high risk for psychosis

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Introduction: "Ultra-high risk" (UHR) diagnostic criteria (Miller *et al.*, 2003) pinpoint a combination of state (attenuated or brief intermittent positive psychotic symptoms) and trait (genetic risk with a deterioration in functioning) risk factors that identify youth and young adults at heightened and imminent risk of developing a first episode of psychosis. Identifying UHR individuals can help guide mental health practitioners in their treatment decision-making and adapt their interventions to the individual characteristics of patients in order to prevent the onset of psychosis. Nevertheless, UHR population is highly heterogeneous, displaying varying clinical conditions, including anxiety, depression and substance disorders. As this heterogeneity undermines both clinical research and the evaluation and treatment of patients, many mental health care providers express concern with the current diagnostic practice, which does not enable efficacious therapeutic planning. In particular, according to epidemiological data, has been shown that about 40% of UHR patients receive at least one diagnosis of personality disorder. Although some common genetic and environmental diatheses underlie both schizotypal personality disorders and schizophrenia, some studies have shown the rates of schizotypal UHR patients to be relatively modest. In contrast, other studies have found a considerable prevalence of schizoid, borderline and avoidant personality traits/disorders among UHR patients (Shurze-Lutter *et al.*, 2012). So far, only few studies have thus evaluated personality features in the UHR population, suggesting that the personality characteristics of such patients vary considerably. To our knowledge, these personality differences have never been systematically evaluated. Furthermore, there are evidences linking attachment adversity to psychosis, from the premorbid stages of the disorder to its clinical forms. To date, very little research has evaluated attachment patterns in UHR individuals. In each case, the researchers used exclusively self-report instruments and detected a high rate of insecure patterns (*e.g.*, 93% in Quijada *et al.*, 2015; and 95% in Russo *et al.*, 2018). We consider a systematic investigation of the UHR population critical for improving our understanding of the different symptom patterns of UHR individuals and achieving more accurate diagnoses. We aim to conduct such an investigation by: (1) examining the full spectrum of person-specific psychopathology and its manifestation in patient personality structures, under the assumption that symptoms take different meanings and roles according to the larger context of patient personality functioning. (2) investigating attachment patterns using the gold standard measure for attachment. *Methods*: 40 adolescent UHR outpatients were compared to 40 individuals who didn't meet the ultra-high risk criteria. The recruited patients' treating clinicians were also involved and asked to provide basic demographic and diagnostic data, and to complete clinician-report assessment tools. Each patient received a DSM personality diagnosis and was assessed using the Brief Psychiatric Rating Scale (BPRS). The Structured Interview for Prodromal Syndromes (SIPS/SOPS) has been administered to assess prodromal symptoms. According to the SIPS, UHR participants must meet one of three criteria: (1) increasing but attenuated positive symptoms; (2) a recent, brief psychotic episode that is too short in duration to meet diagnostic criteria for a psychosis disorder; or (3) a first-degree relative with psychosis, and recent functional decline. The Adult Attachment Interview (AAI), a semi-structured interview used to assess individuals' "state of mind" or internal working models with respect to attachment relationships, was administered to each patient. The AAI interviews have been audio recorded, transcribed verbatim, and coded by two independent certified coders who were blind to all other study conditions. Childhood trauma has been coded from the verbatim transcripts of the AAI by two independent raters, according to the clinical version of the Complex-TQ, a questionnaire aimed to assess multi-dimensional features of childhood trauma. Finally, treating clinicians were supervised by the researchers for evaluate patients' personality trait and disorders, according to the SWAP-200, a well-established and widely used psychometric procedure that provides a comprehensive assessment of personality and personality pathology. *Results*: No differences between groups have been found when personality disorders were measured according to the DSM-IV-TR categories. However, UHR patients showed more impaired personality functioning and higher scores on two Q-factors of the SWAP-200: "inhibited/self-critical" and "emotionally dysregulated". Finally, a higher degree of "cannot classify low-coherence" attachment patterns was found in UHR patients' group. *Conclusions*: These primary findings seem to suggest the importance of taking into account the emotional dysregulation, social inhibition and disorganized attachment in treatment planning of UHR patients. To date, the intervention strategies available to significantly change the clinical course of UHR conditions have proven to be poorly effective in follow-ups longer than 12 months (Davies *et al.*, 2018). Preliminary results this study seem to suggest that attachment-informed psychotherapy, tailored to the personality characteristics of patients, may be an effective preventive treatment for UHR patients.

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Patient personality and therapist emotional responses in the psychotherapy with adolescents: An empirical investigation

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Introduction: Therapist's emotional responses to the patient (or countertransference) are more and more considered as an important component of the patient-therapist relationship that are able to play a critical role in the psychotherapy process and outcome across different treatment approaches (Hayes, Gelso, & Hummel, 2011; Hayes, Nelson, & Fauth, 2015; Norcross, 2011). The classical psychoanalytic concept of countertransference—originally defined as the analyst's transference to the patient's transference, and considered a disruptive obstacle to the therapeutic process (Freud, 1910, 1912)— has evolved considerably becoming a valuable source of information about patient's intrapsychic and interpersonal dynamics (Heimann, 1950). According to this totalistic perspective (Kernberg, 1965), all the clinician's reactions to the patient can be helpful to make accurate diagnostic formulations and provide effective therapeutic interventions, especially in the treatment of personality pathology (Bateman & Fonagy, 2016; Beck, Davis, & Freeman, 2004; Dahl *et al.*, 2014; Gabbard, 2014; Lingiardi & McWilliams, 2017; Yeomans, Clarkin, & Kernberg, 2015). To date, empirical investigations have examined the relationships between patient's personality styles/syndromes and therapists' responses showing that they are not arbitrary. Countertransference patterns were related to personality disorders and dimensions in clinically coherent and systematically predictable ways (*e.g.*, Betan, Heim, Zittel Conklin, & Westen, 2005; Colli, Tanzilli, Dimaggio, & Lingiardi, 2014; Tanzilli, Lingiardi, & Hilsenroth, 2018; Tanzilli, Muzi, Ronningstam, & Lingiardi, 2017). However, these studies were mostly based on clinicians' subjective experience to adult personality-disordered patients. Only a few studies have explored the associations between countertransference and specific styles/syndromes of personality in the psychotherapy with adolescents (*e.g.*, Knaus *et al.*, 2016; Satir, Thompson-Brenner, Boisseau, & Crisafulli, 2009; Tishby & Vered, 2011). The aims of this study were to: 1) examine the stability of the factor structure and psychometric properties of the Therapist Response Questionnaire – Adolescent Version (TRQ-A; Satir *et al.*, 2009); 2) investigate the relationship between therapists' emotional responses and specific emerging personality patterns of their adolescent patients. *Methods*: A national sample of psychiatrists and clinical psychologists (*N*=140) completed the TRQ-A to identify patterns of therapist response, as well as the Shedler–Westen Assessment Procedure–II-A (SWAP-II-A; Westen *et al.*, 2014) to assess personality styles/syndromes regarding an adolescent patient currently in their care. An exploratory factor analysis (EFA) was carried out to identify the factor structure of the TRQ-A. Reliability of the TRQ-A's scales was calculated using the Cronbach's alpha coefficients. Bivariate correlations between the TRQ-A's scales and personality styles/syndromes were conducted to assess the criterion validity of the TRQ-A and examine the associations of countertransference dimensions with patients' personality pathology. *Results*: EFA revealed six distinct countertransference scales that were conceptually coherent and psychometrically robust: (a) hostile/devaluated, (b) positive, (c) bored/failing, (d) overwhelmed/scared, (e) overinvolved, and (f) sexualized. This factor solution accounted for about 51% of the variance, and the six scales were well marked by at least five items each, suggesting a stable factor structure unlikely to be substantially affected by sample size (Fabrigar, Wegener, MacCallum, & Strahan, 1999). The scales of the TRQ-A's current version showed excellent reliability and validity. Their internal consistencies were: hostile/devaluated (α=.87), positive (α=.93), bored/failing (α=.84), overwhelmed/scared (α=.90), overinvolved (α=.85), and sexualized (α=.89). They were significantly associated with distinct personality styles/syndromes. Notably, more severe level of personality functioning was related to the bored/failing and overwhelmed/scared countertransference. Narcissistic and antisocial/psychopathic personality styles/syndromes were associated with the hostile/devaluated and overwhelmed/scared therapist responses, and borderline style/syndrome was related to the overwhelmed/scared and overinvolved countertransference. Schizoid personality style/syndrome was associated with the bored/failing countertransference, while impulsive/histrionic style/syndrome was related to the sexualized therapist response. Positive countertransference was related to the obsessional personality style. *Conclusions*: The TRQ-A is a very useful instrument to evaluate countertransference reactions in clinically sensitive and psychometrically robust ways. Moreover, adolescents' emerging personality styles/syndromes were consistently associated with specific emotional responses, which suggests that clinicians can make diagnostic and therapeutic use of their responses to patients. This study supports the potential strengths of the TRQ-A's use in both clinical and empirical contexts. It could be employed by therapists or supervisors of different theoretical orientations for making accurate case formulations and planning effective therapeutic interventions at the beginning of treatment, or for monitoring possible changes in the personality and the ways of interacting of adolescent patients during the psychotherapy process. In empirical terms, its applicability is equally relevant to examine countertransference across different clinical populations, or in the field of process-outcome research.

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Personality assessment and subtypes in young adults with substance use disorders. A preliminary study with the SWAP-200

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Introduction: Emerging adulthood implies new and challenging developmental tasks and it is perceived as a time of vulnerability for

the onset of psychopathology. Youth transitioning into adulthood show some of the highest rates of alcohol and substance abuse (Wisk, *et al.*, 2016) and among patients undergoing treatment for Substance Use Disorders (SUDs) an increasing percentage of youths are 18-24 years old: the percentage of addicted patients younger than 25 years is put at 27%. Nevertheless, studies specifically targeting this developmental age and its characteristics are still scarce in the field of substance dependence and its treatment. It is well established that Substance Use Disorders show high rates of co-occurrence with Personality Disorders (PDs), but studies focusing on personality disorders in young adults with drug addiction are limited (Langas, *et al.*, 2012). Moreover, research attests a pervasiveness of Cluster B disorders among individuals with SUDs, especially Borderline and Antisocial disorders, but some investigations report considerable rates of Cluster C and Cluster A disorders as well, such as schizotypal (Grant *et al.*, 2016). Thus, to date, studies suggest a substantial variability in personality among individuals with SUDs: therefore, personality subtyping might represent a valuable approach accounting for this complexity, as reported by literature on other clinical populations. It is widely acknowledged that comorbidity increases severity and complicates recovery: personality is one of the most consistent risk factors for dropout from treatment and relapses (Brorson *et al.*, 2013). This is true also for comorbid youth, who tend to respond to treatment initially reducing their drug intake, but they are more likely to return to initial levels of substance use and to engage in problematic behaviors over 1 year after treatment (Grella *et al.*, 2001). The present study aims to: (1) provide a detailed assessment of personality pathology in young adults with SUDS; (2) empirically identify personality subtypes in young adults with SUDs; (3) investigate the ability of personality subtypes to predict treatment outcomes, in terms of relapses and dropouts from treatment. *Methods*: The study involved 73 inpatients aged 18-24 (mean age: 21 years) admitted to a residential facility for SUDs treatment; 53% of them were males. Participants fulfilled the following inclusion criteria: (a) meeting the DSM-5 criteria for SUD; (b) being admitted to the residential treatment community for less than 3 months; (c) age ranging from 18 to 24 years. At recruitment, the participants had been abstinent for 2.83 months on average. The Shedler-Westen Assesment Procedure – 200 items (SWAP-200; Shedler, *et al.*, 2014) was administered; it is a clinician-rated procedure, based on the Q-Sort method. It provides two personality profile (a) one based on the matching of the patient's description with 10 prototypical descriptions of *DSM-IV* personality disorders; (b) the other one based on the matching of the patient with 11 Q-factors of personality derived empirically. Relapses and dropouts were reported from the therapeutic community registers. Descriptive statistics were applied to investigate personality pathology; Q-factor analysis were performed to identify personality subtypes of individuals with SUDs; finally, the predictivity of personality subtypes was tested. *Results*: Preliminary results show that a high rate of subjects met criteria for at least one PD according to both classifications (62,5% and 73%). With respect to DSM classification, the primary diagnosis referred more frequently to cluster B disorders and Borderline and Histrionic were the most frequent diagnosis, followed by Dependent disorder. In relation to Q-Factors categorization, the primary diagnoses were Dependent and Histrionic disorders. Q-factor analysis yielded 3 personality subtypes, which were labeled as: 1) Histrionic-Dependent; 2) Avoidant-Schizoid; 3) Paranoid-Hostile.
Personality subtypes did not predict treatment retention and relapses at 12 months after admission to treatment. *Conclusions*: Data indicate that the sample of young adults with SUDs show a severe clinical condition, despite their young age. First, participants show high rates of personality disorders, encompassing especially but not exclusively former-known Cluster B disorders (characterized by instability and unpredictability in emotions, behaviors and relationships): in fact, also Dependent personality disorders were diagnosed for a considerable number of participants. Thus, drug addiction seems to represent just a part of a wider problem in which personality pathology poses concerns itself for recovery and future individual wellbeing and adjustment. Second, Q-factor analysis identified 3 personality subtypes: each of them showed severe characteristics and a medium or high functioning- subtypes was lacking; these results came out on the side of a severe psychological condition. Finally, the lack of association between personality subtypes and treatment outcomes can be explained by the fact that dropout and relapse might depend on different and/or multiple factors, rather than single variables. Moreover, it must be taken into account the severity of all the 3 groups. Overall, results can be informative for clinicians in addressing diagnosis and treatment, which should be informed in respect of the delicate pathology and developmental age that young adults with SUDs present.

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The effectiveness of group treatments

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The symposium focuses on the different paths of exploration of the clinical effectiveness of group treatments. In different intervention contexts, process and outcomes and their interconnections are researched. The studies are designed as single-case reports. Central is the interest in clinical reflection supported by empirical data. Gullo, Vasta, Girelli, Piperno, Billi Di Sandorno, Falsi and Misici, will present two time-limited group psychotherapies for young people. Aims of the study is to verify if time-limited group therapy is able to improve patient's mentalization skills and if these changes are associated with positive outcome measured in terms of health functioning and interpersonal style. It also wants to explore the relationship between outcome, mentalization and group process. The aim of the work of Marogna, Caccamo, Ghedin and Compagno is to observe two group interventions for staff members of critical departments, conducted with active techniques (Photolangage and Social dreaming), to reduce stress and burnout levels between the operators and amplify the emotional resonance of the group, focusing attention on the symbolization processes. Esposito, Cutolo, Parlato, Gonçalves and Freda, will propose a work with four counselling groups of underachieving university students at risk of drop-out. The objective of the study is to analyze, by an innovative moments coding system (IMCS; Gonçalves *et al.*, 2011), the emerging narrative markers of change in nine-sessions groups counselling aimed at promoting reflexive functions and their relation with the group counselling outcomes. Finally, Mancuso, Guarnaccia, Patronaggio, Lo Coco, Lo Cascio and Giannone will present a study on a group-analytic group psychotherapy for patients who are victims of IPV(?). The objective of the study is to verify if time-limited group therapy is able to improve patient's outcome, and specifically self-esteem, interpersonal relationships, psychological functioning and attachment style. The relationship between outcome and group process is also considered.

Exploring outcome, process and changes of ability to mentalize in time-limited group therapy for young people. A single-case study

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Group therapy is often considered the treatment modality of choice for adolescent and young adults struggling with anxiety, social conflict, interpersonal difficulties, family issues and addiction. As it has been well demonstrate (Fonagy *et al.*, 2006), young people are hypersensitive to the mental states of both themselves and others. While there may be normative difficulties in the capacity to mentalize in adolescence, when this integration becomes too demanding, impairments in mentalizing can become apparent leading to potential emerging presentation of symptoms consistent with those observed in adult personality disorders. Group therapy offers an opportunity to explore and work on mentalizing issues *in vivo*. Evidence support the theoretical idea (Karterud, 2015) that group modality may offer particular advantages in developing patients' mentalizing skills. However, although the literature on the psychotherapy for young adults provided evidence that support the effectiveness of different forms of group psychotherapy for this age group have (Lindgren, Werbart and Philips, 2010), only few studies have up to date examined whether group therapy plays a role in improving mentalizing abilities in young people. The present study aims to verify if time-limited group therapy is able to improve patient's mentalization skills and if these changes are associated with positive outcome measured in terms of health functioning and interpersonal style. As secondary aim, the study explores the relationship between outcome, mentalization and group process. The study was designed as single-case and involved 13 patients (range 15-23 years old) that attended two separate time-limited group psychotherapies (each lasted 1 year) conducted by experienced psychodynamic psychotherapists. Outcome was measured by OQ-45 and IIP-32, mentalization abilities were measured by PMS, MMS and MZQ, group process was monitored by repeated administrations of GQ. Promising results showed that difficulties in interpersonal relationship and ability to mentalize improved at the end of treatment. Patients who reported a change in interpersonal style and mentalizing functioning were likely to get a positive outcome in group therapy. The results also suggested that group relationship plays a considerable role in achieving better interpersonal modalities, mentalizing abilities and positive outcome. Clinical implications will be discussed.

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Processes of meaning reconstruction in group counselling: An analysis of markers of change with the Innovative Moments Coding System

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Introduction: In the field of process research, many studies have analyzed the emergence of narrative markers of change along the sessions of individual psychotherapy with good or bad outcomes (*e.g.* Angus, Levitt, & Hardtke, 1999). Nevertheless, not enough is known on which types of narrative markers of change appeared in group psychotherapy and counselling (Burlingame & Jensen, 2017; Greene, 2016). The objective of this study is to analyze which narrative markers of change emerge in nine-sessions groups counselling aimed at promoting reflexive functions with underachieving university students lagging behind in their studies. *Methods*: Four groups counselling (N Group A=7; N Group B=7; N Group C=7; N Group D=5) of underachieving university students at risk of drop-out were considered for this study. Stu-

dents were enrolled in the bachelor and master degree courses of the University of Naples Federico II. Groups counselling adopted a multimodal narrative method (Narrative Mediation Path) which combined in a unique methodology both five narrative modes (metaphorical, iconography, writing, bodily, and agency) and the group narrative device. Groups counselling were conducted by two clinical psychologists in 2017 and 2018 and they took place in different locations of the SInAPSi center (Center for Active Participation and Inclusion of University Students; University of Naples Federico II). In order to assess the effectiveness of the counselling paths, the academic performance inventory (API; Esposito *et al.*, 2016) was administered in the pre and post-test phase. Socio-demographic information and markers of academic performance (ECTS, number of examination passed, etc.) were detected. Transcripts of 36 audio-recorded sessions were analyzed through the innovative moments coding system (IMCS; Gonçalves *et al.*, 2011), which is a reliable method for studying change by tracking innovative moments (IMs), namely narrative innovations (Action 1 and 2, Reflection 1 and 2, Protest 1 and 2, Reconceptualization) in the therapeutic process. IMs were assessed by two reliable coders who showed a strong inter-rater agreement on IMs (from 83.5% to 95.6%) and high Cohen's Kappa for IM categories (from .94 to 1). *Results*: Outcome results showed that two groups improved in terms of academic performance. Specifically, students reported a significant improvement of ECTS (Group A: Z=-2.36; p=.01; Group B: Z =-2.21; p =.02) and of examinations passed (Group A: Z=-2.38; p=.01; Group B: Z=-2.2; p =.02) from pre to post-test. Process analysis with IMCS showed that, in the good outcome groups, members produced a higher proportion of IMs (about 15% *vs* 10%). Moreover, despite reflexive IMs (Reflection 1 and 2) appeared both in good and bad outcomes groups, the most complex form of IM, namely Reconceptualization, emerged only in the good outcome groups counselling and from the middle of the counselling. *Conclusions*: The results seem to confirm the previous findings obtained in studies conducted in the field of individual psychotherapy (Gonçalves *et al.*, 2011) which showed the key role of Reconceptualization for the effectiveness of psychotherapy. Moreover, these findings put on the spotlight the relevance of this complex form of meaning construction also in group counselling. Specifically, the discussion will regard the relation between group counselling outcomes and the emergence of Reconceptualization, which implies a process of meaning reconstruction along the therapeutic process and which seems to play a key role for the effectiveness of group counseling.

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Use of the mediator object in the care team

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Introduction: In the literature, it has been found that group experiences directed at staff members of critical departments conducted with active techniques meet lower participant's resistance than would happen in an unstructured verbal psychotherapy group and reduce stress and burnout levels between the operators (Caccamo *et al.*, 2017; Calditoni *et al.*, 2015; Özba, & Tel, 2016; Ozturkcu, *et al.*, 2018). The awareness of the difficulties encountered when dealing with "strong" issues such as the emotions arising from contact with critically ill patients, led to favoring the group setting and choosing, as an aid to group exchanges, the technique of Photolangage and Social dreaming, which it allowed to facilitate narratives by amplifying the emotional resonance of the group. Through the active techniques the synergy between the characteristics of the group and those of the mediator object allows to improve the group work and, with an audience not accustomed to contact and reflection on emotions, can allow access to non-thought forms always "thinkable" to individuals. The mediating object (the photo, the dream) thanks to its quality of "malleability" is manipulated and recreated in different ways by the group, thus assuming a function of "intermediary" between the individual and the group. This mediation makes it possible to start a process of symbolization that helps the operator to become aware of internal images to explore and question them in a path that goes from image to word. The aim of this work is to observe two group interventions conducted with active techniques, focusing attention on the symbolization processes that the use of techniques allows throughout the group process. *Methods*: Two qualitative research works are presented at two institutions of care. The first is a group of psychological support aimed at operators working in palliative care conducted with Social Dreaming technique, the second is a supervision group aimed at operators working in the psychiatric field conducted with Photolangage technique. *Results*: The Social Dreaming and Photolangage sessions were recorded and then transcribed. The transcripts were qualitatively analyzed using the Iramuteq software, which made it possible to identify the central themes of the transcripts. By comparing the associative nuclei of the two groups it was possible to identify some clinically relevant topics in the care professions. *Conclusions*: The use of textual analysis techniques is considered as one of the bridge strategies between quantitative and qualitative methods, thanks to the possibility of combining the need to produce controlled empirical studies, with the richness of interpretation. This study has revealed semantic and sometimes unexpected dimensions, subject to the same textual data, highlighting the point of view of the producers of the texts analyzed.

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Group psychoterapy for women victim of intimate partner violence

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Intimate Partner Violence (IPV) against women is a major global public health problem (World Health Organization [WHO], 2013). Most common studied interventions for women victim of IPV are Group-Cognitive Beahavioural Therapy, EMDR or counselling (Kirk, Terry, Lokuge & Watterson, 2017), but there are very few empirically tested psychodinamic psychotherapy groups for women with IPV histories. We will propose here a study on a group analytic psychotherapy for female patients who are victims of IPV. The objective of the study is to verify if time-limited group therapy is able to improve patient's outcome of self-esteem, interpersonal relationship, psychological functioning and attachment style. The relationship between outcome and group process is also considered. The group was led by a young female psychotherapist, with a psychodinamic group-analytic orientation. It was a closed and time-limited- group (10 months), with 7 female patients (*M*=43.29; *SD*=6.32; range 34-50 years). The treatment took place at the "Harmony Center for the Treatment of Traumas of Sexual Abuse, Maltreatment and Stalking", in the Operative Unit of Psychology for the "Care of Parental Fragility and Trauma from Abuse and Maltreatment" of a Public Health Service of Palermo. The sessions were weekly and lasted two hours. The study used a longitudinal single-case design (Kadzin, 2003). The tools used to evaluate the process and the outcome of the therapy were: the Group Questionnaire (GQ, Burlingame, McClendon, Alonso, 2011); the Inventory of Interpersonal Problems (IIP-32) (Horowitz *et al.*, 2000); the Rosenberg Self Esteem Scale (R-SES; Rosenberg, 1979); the Outcome Questionnaire-45 (OQ-45.2; Lambert *et al.*, 2004; Lo Coco *et al.*, 2006); the Attachment Style Questionnaire (ASQ; Feeney, 1994; Fossati *et al.*, 2003). Descriptive statistics and the Reliable Change Index (RCI) to measure if the changes obtained by the patients were statistically reliable were implemented. Results showed some patients significant positive changes in ASQ – Need of acceptance and ASQ - Worry for relationships. In two patients significant negative changes have been detected at the R-SES, related to specific contextual situations. In the other outcome measures patients had no significative change but it is possible to observe a positive evolution during the therapeutic process. In order to the process variables, positive changes resulted in Positive Bonding and Positive Working. In the Negative Relationship, the values showed a decreasing trend. Qualitative clinical considerations will complement the proposed data. In conclusion, the work proposed the experience of a time-limited group with women victims of IPV, "accompanied" by the detection of empirical indices both of changes in patients over time, and of the trend of the therapeutic process. For each of them the therapeutic path was monitored, which recorded, despite fluctuations, a positive trend of change. The time-limited group-analytical group has shown to "work", even if, coherently with the model used, the group time has been configured as an important part of a path, which however needs further investigation (Giannone, Lo Verso, Sperandeo, 2009).Despite all the limitations that stem from the analysis of a single case, the monitored sessions and the variety of instruments used, allow for the formulation of multiple reflections on the development of the therapeutic process and on how it works.

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The efficacy and effectiveness of psychological treatment for eating disorders

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The panel aims at exploring the efficacy and effectiveness of psychological treatments for eating disorders. Despite the growing evidence regarding the benefit of psychotherapy for patients with eating problems, they are still considered as difficult-to treat clients, given their modest rate of recovery and their difficulties in maintaining positive changes (Linardon, 2018; Nazar *et al.*, 2016; Swift & Greenberg, 2014). In this panel, two presentations will report efficacy data from a RCT and meta-analysis, which were conducted in Italy and UK. The study by Pietrabissa *et al.* investigated the effectiveness of brief strategic therapy (BST) compared to cognitive behavioral therapy (CBT) one year after a two-phase inpatient and outpatient telemedicine treatment for Binge Eating Disorder. The results showed that BST was more effective than CBT in reducing binge eating and weight, and in improving global well-being of patients. The study by Albano *et al.* reports the preliminary results of a systematic review and meta-analysis of the self-management approaches to anorexia nervosa. Six RCTs which compared patients who received guided self-help (materials and guidance) with a comparison group were eligible for the meta-analysis. Preliminary results showed a small treatment effect for BMI and a positive effect for drop-out, anxiety and depression. The study by Muzi *et al.* examined the effectiveness of a multidimensional intervention for inpatients with eating disorders and found that the majority of patients reported both reliable and clinically significant symptomatic improvement at discharge. Finally, the study by Brugnera *et al.* focuses on the analysis of interpersonal profile of patients with BED and identified the main areas of interpersonal distress which may trigger binge eating symptoms. Interestingly, a cross-cultural comparison between Italians and Canadians patients was conducted and results supported the invariance across cultures. Overall, the results of these studies highlight some important therapeutic strategies which can lead to patient's symptomatic change.

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Brief strategic therapy and cognitive behavioral therapy for obese women with binge eating disorder: A randomized clinical trial one-year follow-up

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Background: Obesity is increasingly a worldwide problem of epidemic proportions (Roberto *et al.*, 2015) and it often shows comorbidity with binge eating disorder (BED), a mental health disorder characterized by uncontrolled consumption of abnormally large amounts of food in a discrete period of time in absence of compensatory weight control methods, such as purging, fasting, or excessive exercise (APA, 2013). Compared with obese individuals without BED, those with BED report greater functional impairment and lower quality of life, as well as significantly greater levels of psychiatric comorbidity (Wilson, 2011). Moreover, obese individuals with BED are more likely to dropout of weight loss treatment and demonstrate lower behavior change self-efficacy than those without BED (Rieger, Wilfley, Stein, Marino, & Crow, 2005). Cognitive behavioral therapy (CBT) is the most established and researched psychotherapy treatment for BED and obesity (Grilo, 2017). However, research has revealed that CBT has only shown modest success in long-term reduction of BED symptomatology and limited efficacy in promoting weight loss (Vocks *et al.*, 2010). Therefore, it is important to examine alternative treatments to CBT for increased effectiveness in improving BED symptomology, weight loss, and weight loss maintenance (Castelnuovo *et al.*, 2015). Empirical studies have shown brief strategic therapy (BST) to be clinically effective in treating several psychological disorders, including BED (Nardone & Brook Barbieri, 2010). Also, telemedicine offers advantages in terms of cost and accessibility and has proven effective in promoting weight loss, treatment adherence, and treatment retention among people who are overweight or obese (Sorgente *et al.*, 2017). *Objectives*: The present randomized control trial (RCT) is amed to evaluate the statistical and clinical effectiveness of BST compared to CBT, one year after a two-phase inpatient and outpatient telemedicine treatment for BED. *Methods*: Obese Italian women with BED were recruited from a self-referred inpatient treatment program for weight loss (n=60) and randomly assigned to either the BST treatment condition (n=30) or CBT treatment condition (n=30). Inpatient psychotherapy sessions were conducted in person and outpatient telemedicine psychotherapy sessions were conducted over the telephone. Participants were blinded regarding treatment allocation. Treatment duration for both conditions was 7 months. As part of the 1-month inpatient phase, participants in both conditions attended an inpatient weight loss treatment program including eight face-to-face 45-min psychotherapy sessions (2 per week). As part of the 6-month outpatient telemedicine phase, participants received eight telephone psychotherapy sessions (2 sessions per month the first two months after discharge and one session per month for the subsequent four months). Outcomes were assessed at pretreatment (T1), inpatient discharge (T2 - approximately 1 month after the pretreatment measure), posttreatment (T3 - approximately 7 months after the pretreatment measure), 6-month follow-up (T4), and 1-year follow-up (T5). Multilevel growth curve modeling was used to estimate the average pretreatment levels and growth trajectories from baseline to one year after treatment for the following outcomes: average weekly binge episode frequency, weight, and global functioning. Clinical significance was calculated for each outcome by identifying the proportion of participants who demonstrated meaningful change from pretreatment to 12-month posttreatment (Kendall, 1999). *Results*: Preliminary analyses for between-condition differences indicated there were no significant baseline differences on outcome variables or demographic characteristics between BST participants and CBT participants. BST average weekly binge episode frequency, weight and participant global functioning (as measure by the assessed by the Outcome Questionnaire - OQ-45) were lower than that of CBT at posttreatment, 6-month follow-up, and 1-year fol-

low-up. BST was statistically and clinically superior to CBT in improving binge eating frequency, weight, and global functioning. *Conclusions*: Examining BED given the current obesity epidemic is an important area of study. Findings suggest that stepped-care telemedicine BST approach is statistically and clinically more effective than CBT in treating BED, promoting weight loss, and improving global functioning among obese women one year after treatment. The most likely reason for the results may be the differing BED symptom conceptualization and mechanisms of change behind the BST and CBT interventions: CBT provides problem-focused treatment aimed at helping clients control binge eating by restructuring associated cognitive distortions and replacing maladaptive behavioral patterns with more adaptive eating behavioral patterns, while BST provides solution-focused treatment aimed at helping clients shift the dysfunctional perceptive-reactive system around restricting by replacing dysfunctional attempted solutions with more functional solutions often through paradoxical intervention. Additional research are needed to determine if BST is an empirically supported treatment for BED and obesity, and to confirm the effectiveness of the stepped-care model by comparing BST treatment across various treatment delivery modes.

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Guided and non-guided self-care in anorexia nervosa: A systematic review and meta-analysis of specific and general symptom outcomes and adherence and process measures

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Introduction: There is a large treatment gap with a delay or failure to seek treatment for people with eating disorders[1]. This gap is particularly relevant in anorexia nervosa for which early detection and intervention are extremely important in preventing the illness from becoming chronic[2]. To our knowledge there has not been a systematic review and meta-analysis of self-management approaches to anorexia nervosa. Like Loring et al, reported in their article on the definition of self-management (2003), it aims at helping patients to maintain a wellness in their foreground perspective; indeed the term self-management provides an active role to the participants involved into treatment[3]. The aim of this systematic review was to include studies that have used guided self-help and self-help in the treatment of anorexia nervosa for either the patients themselves or their families or close others, with the goal of improving patient treatment outcomes. *Methods*: A systematic review and meta-analysis were conducted following the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidelines[4] and using the consecutive electronic database: PubMed, Web of Knowledge and AGRIS, Embase, Medline, PsychINFO, Psych articles through Ovid database. We decided to conduct two parallel searches: the first literature search identified 589 papers and the second one 1540. For both searches, studies were included in the systematic review if: a) the study participants had a diagnosis of Anorexia Nervosa according to the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM V) or the International Classification of Diseases 10th edition (ICD-10); b) the content of the intervention was clearly described; c) the intervention met at least two of the four proposed criteria to define the use of a (guided) self-help approach (please see the Checklist C1): 1) use of self-directed educational and practise materials, 2) focus on skills training (*i.e.* through behaviour change techniques), 3) the level of training of therapist/professional skills, 4) the level of support for the intervention was=<20 sessions. Studies were considered elegible for the meta-analyses if they were RCTs and reported quantitative data on some or all of the following outcome measures: drop-out, body mass index and psychological functioning (*i.e.* depression, anxiety, quality of life). *Results*: Six studies were eligible for the meta-analysis and they were suitable for the purposes of this review. All the included studies compared groups of participants (adults or adolescents) with a diagnosis of anorexia nervosa (inpatients or outpatients or day care), who received guided self-help (materials and guidance) for those in the intervention arm and "other treatment" (treatment as usual (TAU) or Specialist Supportive clinical management (SSCM) for those in the control group. The outcomes extracted were: adherence to the treatment and drop-out, body Mass Index (primary outcome), anxiety, depression (secondary outcome) and quality of life. Regarding the primary outcome, we found a not significant, greater increase in the BMI for guided self-help comparing other treatment and also a greater increase not significant in the quality of life (secondary outcome) for GSH comparing OT. Regarding the secondary outcome (anxiety and depression) we reported a greater reduction for the control group comparing GSH. Finally, we found a significant finding related to the adherence and drop-out rates in guided self-help. It shows greater, significant drop-out percentage in other treatment comparing guided self-help intervention. *Conclusions*: Preliminary findings evidenced the efficacy of self-help interventions for AN, with positive outcomes comparable to those reported in other treatments.

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Evaluating empirically valid and clinically meaningful change in specialized inpatient treatment for severe eating disorders

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Introduction: Eating disorders (EDs) often exhibit poor treatment outcomes, high rates of relapse or treatment dropout, and elevated rates of comorbid medical complexities (Friedman *et al.*, 2016), posing significant challenges for both the researchers and treating clinicians. Despite guidelines for the treatment of this clinical population recommend that individuals with the most severe eating disorder symptoms and co-occurring emotional disorders receive treatment in intensive care settings such as residential, multimodal, and multidisciplinary programs (Thompson-Brenner *et al.*, 2018), empirical evidence are still scarce. One reason is that widely used criteria for treatment response in severe EDs are typically focused primarily on the statistically-significant reduction of psychopathological symptomatology, thus not considering whether or not the observed post-test level of functioning falls outside the range of the dysfunctional population (Schlegl *et al.*, 2016). The aim of the present study was to evaluate the clinical relevance of change in an intensive inpatient treatment for EDs using a combination of clinical significance (CS) and the Reliable Change Index (RCI) (Wise, 2004). Thereby, we aimed to classify patients into four specific treatment outcome groups: patients who have deteriorated, remained unchanged, made a reliable improvement and made a clinically significant improvement. *Methods*: A national sample of eating disorder (ED) patients (N=112) were assessed at intake, at 1-month and at treatment termination on measures of ED symptoms, such as the Eating Attitudes Test-40 (EAT-40), the Eating Disorder Inventory-3 (EDI-3), and Body Uneasiness Test (BUT), as well as psychiatric symptoms, such as Beck Depression Inventory-II (BDI-II), and the Symptom Checklist-90-Revised (SCL-90-R). The inclusion criteria were: (a) aged at least 18 years; (b) a pre-treatment diagnoses of either DSM-IV-TR/DSM-5 anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), or otherwise specified feeding and eating disorders (OSFED) posed by a licensed staff psychologist or psychiatrist and based on the Structured Clinical Interview for DSM disorders (SCID); (c) presenting no organic syndromes, psychotic disorder, or syndrome with psychotic symptoms that could complicate the assessment of any variable in the study. No limits were applied to the body mass index (BMI) at the admission. Treatment was provided in a multidisciplinary clinical inpatient setting and consisted in individual weekly psychotherapy sessions, encounters with specialized social workers, and sessions with a nutritional physician. *Results*: Findings showed a statistically significant symptom reduction, with moderate to large effect sizes, especially on overall eating disorder and depressive symptoms severity, even when controlling for treatment length. Moreover, the majority of patients showed both reliable and clinically significant symptomatic improvement at discharge. Regarding differences between treatment outcome groups, we found that patients with clinically significant improvement were suffering from less overall and depressive symptomatology at intake. *Conclusions*: These findings suggest the beneficial effects of intensive and multidisciplinary residential treatment setting for patients with severe EDs (Thompson-Brenner, 2015). This kind of treatment intervention might be highly recommended for individuals with EDs who are medically stable but have severe symptoms or comorbidities that interfere with treatment at less intensive levels of care. Furthermore, considering multiple indices of symptomatic change enables a more clinically useful perspective of treatment outcomes in this clinical population (Björk *et al.*, 2011). In an effort to increase treatment responsiveness and effectiveness, future studies should continue to evaluate the clinical significance of therapeutic change obtained by these types of treatment programs in wide samples of individuals with severe EDs.

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Friendly and submissive interpersonal styles among patients with binge-eating disorder: A cross-cultural comparison between italian and canadian patients

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Introduction: Interpersonal problems, or difficulties in relating to others, are a common cause of subjective distress and can contribute to the development and maintenance of a variety of mental disorders (Arcelus *et al.*, 2013). For example, patients with Binge Eating Disorder (BED) experience distressing relationships, which could trigger negative affect and over-eating (Ivanova *et al.*, 2015), and are associated with treatment outcomes (Blomquist *et al.*, 2012). Previous findings showed that Italian patients with BED experience clinically significant levels of friendly-submissive interpersonal styles, characterized by a mixture of over-nurturance and exploitability, while those with obesity have non-clinical levels of friendly-dominant themes (Brugnera *et al.*, 2018). However, these results may be culturally-related and specific to the European population. Therefore, the purpose of this study was to perform a cross-cultural comparison of the interpersonal styles of BED and obese participants across similar samples of European and North American patients. *Methods*: A total of

177 Italian patients with BED (mean age: 41.0±12.5 years; 11.3% males), 321 obese non-BED adults (mean age: 44.5±13.4 years; 28% males), and 108 normal weight adults (mean age: 37.3±9.6 years; 53% males) was compared with a Canadian sample composed by 101 overweight women with BED (mean age: 44.42±11.81 years), 46 overweight (mean age: 46.35±12.13) and 49 normal weight women without a diagnosis of BED (mean age: 43.39±11.65 years). All participants completed the Inventory of Interpersonal Problems (IIP; Lo Coco *et al.*, 2018). Scale scores were *z*-transformed using gender-corrected norms provided in the IIP manual and compared using MANOVAs followed by Tuckey's post-hoc tests. In addition, circular statistics and structural summary methods were applied to the circular profile of the IIP. *Results*: In both Italian and Canadian samples, we found that those with BED had significantly higher scores in all *z*-transformed IIP dimensions, compared to overweight and normal weight participants, with medium to large effects. As regards cross-cultural comparisons, post-hocs showed that Italian patients with BED had higher levels of Domineering and lower levels of Cold, Socially-Inhibited and Non-assertive subscale scores, compared to Canadian patients, but effects were rather small. Similarly, Italian patients with obesity had higher levels in Vindictive, Overly-Accomodating and Intrusive scale scores, compared to the Canadian ones, with small effects. Interestingly, Italian and Canadian patients with BED or obesity reported the same main interpersonal theme: those with BED were characterized by pathological levels of friendly-submissive interpersonal styles, while those with obesity reported non-clinical levels of friendly-dominant interpersonal themes. *Conclusions*: Findings lend support to an interpersonal model of binge eating and confirm that BED is associated with high levels of interpersonal distress. Cross-cultural comparisons evidenced that friendly and submissive interpersonal themes are a highly prototypical characteristic of BED, both in the European and in North-American samples (*i.e.*, regardless of culture). In addition, patients with BED and non-BED obese adults seem to have significantly different interpersonal profiles: in both cases, these differences are cross-culturally invariant. Given the importance of over-nurturance and exploitability among patients with BED, the clinical management of this disorder should focus on non-assertion and on problems with experiences and expression of anger. Such treatments would allow patients to deal in a better way with those negative affects exacerbated by interpersonal difficulties which lead to binge eating symptoms.

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The legacy of Jeremy Safran: technique and relationship in psychotherapy research

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The panel proposes to dedicate a tribute to Jeremy Safran, in order to encourage the theoretical and clinical reflection and research debate. His work had significant implications for the clinical practice, specifically for the management of the therapeutic empasses and rupture episodes in psychotherapy process. Jeremy Safran was able to integrate not only different roles and souls (researcher, theorist, and clinician) but also different approaches (cognitivism, interpersonal theories, and relational psychoanalysis). In his conceptualization, we find an emphasis on patients' and therapists' emotional experience, the interpersonal dimension of clinical work, and his attention to the here and now in the therapeutic relationship. The therapeutic alliance is not a given, nor an *a priori* requirement. It is a process of ongoing negotiation that in some cases, for example in the treatment of patients with severe personality disorders, can constitute the purpose of the treatment itself. The conceptualization of the therapeutic alliance proposed by Safran (together with Chris Muran) is empirically-based and grounded on task-analytic investigations, a method that allowed the construction of clinical models that describe the different ways in which the alliance breaks down (*i.e.*, withdrawal or confrontation) and the stages that can be usually identified when those are resolved. The meaning of any technical element can therefore be only understood in the relational context in which it emerges, and the technical indications provided by the authors are not standardized manual-type prescriptions, but almost "experiences" lived in the relational frame. From this perspective, the "interpretation *vs* relationship" dialectic seems to be outdated, and more attention has to be dedicated to the mutual interdependence of both elements. As emphasized since the beginning by the authors of the "relational turn", the significance of each technical intervention has to be considered in the relational context. The same technical intervention can produce a positive or negative impact on the therapeutic alliance. The therapist's contribution to therapeutic alliance includes both relational (*i.e.*, empathy or tact) and technical factors (reframing or interpretation). If from the one hand, the therapeutic alliance is a "curative" factor in itself, on the other it can be considered a necessary but not sufficient condition: it can be influenced by technical factors, and its influence can be different depending on the treatment approaches. The panel includes four contributions characterized by different methodologies (process-outcome studies, single case), treatment orientation (psychodynamic, cognitive), settings (individual psychotherapy, short-term therapy), and patient populations (personality disorders, clinical syndromes, such as eating, somatizing, depressive or anxious symptoms). Del Giacco *et al.* examine the relation between the unfolding of therapeutic alliance construction and verbal content, quality of voice and interruption behaviours along 15 sessions of a brief psychodynamic therapy of a young adult. Brasini *et al.* explore the role of the motivational system in the ruptures' and resolutions' process in a sample of 60 sessions of cognitive approach. Colli *et al.* investigate the association between patient's collaboration and reflective functioning in 50 sessions of 10 patients in psychodynamic and cog-

nitive treatment. Gentile *et al.* analyze the differential effect of therapist's interventions on the alliance ruptures and resolutions in a sample of 130 psychodynamic and cognitive sessions of 65 anaclitic and introjective patients.

Collaboration and beyond: The micro-processual analysis of the therapeutic relationship

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If we look at the therapeutic relationship as a process of reciprocal attunement, and if we define the therapeutic alliance as a sequence of ruptures and repairs in that interpersonal attunement (Safran & Muran 2000), it follows that in order to evaluate the quality this relationship it necessary to observe the so-called "local level" of the interaction (BCPSG, 2010), adopting a single communicative exchange (*i.e.* turn of speech) as a unit of measurement. The Collaborative Interactions Scales Revised (Colli, Gentile, Condino, & Lingiardi, 2014, 2017) and the Analysis of Interpersonal Motivations in Transcripts (Liotti & Monticelli, 2008) are two tools to be applied in clinical session transcripts, that have been developed within different theoretical frameworks, but that share a common interest in the study of the therapeutic relationship at the micro-process level. Nowadays, few theories claiming that our cognitive processes are oriented by a finite number of psychobiological systems whose goal are innate and set by the evolution of the species, whereas their functioning is shaped by interpersonal experience. Apart from attachment and sexuality, almost all authors also agree on the existence of at least a caregiving system and a ranking-competitive system. According to the evolutionary anthropology, a more recent motivational system appeared in some primates, and it is also visible in infants from the age of nine months, together with a sense of fairness and equity which anticipates the appearing of the morality: that of the peer cooperation. Thank to this motivational system, we are able to share our intentions and goals with other people. It is Giovanni Liotti in particular who placed the peer cooperation system at the centre of his conceptualisation of the therapeutic interaction (Liotti & Monticelli, 2014). Our work is part of a series of studies (Gentile et al, 2009; Colli *et al.*, 2010, 2011; Lingiardi *et al.*, 2014) that have found: (i) a correspondence between the collaborative interventions and the activation of the peer cooperation interpersonal motivational system; and (ii) a correspondence between the rupture markers and the activation of the rank interpersonal motivational system. The present study proposed to deepen the knowledge of the motivational attunement processes underlying the phases of "collaboration" and of "rupture". Specifically, our aims are to investigate if: (1) the coordinations of the interpersonal motivational systems are predictive of collaborative processes; (2) the caregiving/careseeking interpersonal motivational systems are predictive both of collaborative processes and the ruptures processes. *Methods*: Sample is composed of sixty (n=60) transcript sessions from 30 Caucasians patients (14 men, 16 women; mean age=33.23 years, SD=6.76) in cognitive psychotherapy. All patients received a DSM–5 diagnosis (APA, 2013). A total of 11 patients had at least one PD diagnosis (cluster A=2; cluster B=4; cluster C= 4; not otherwise specified=1). Twelve patients have a clinical syndrome without PD diagnosis (mood disorders=2; anxiety disorders=3; eating disorders=2; adjustment disorder=4; substance use disorder=1). Seven patients have a PD diagnosis and a clinical syndrome in comorbidity. Psychotherapies were administered by 11 psychologists and 4 psychiatrists (mean age=45 years, SD=9), with a mean clinical experience of twelve years (SD=7). Therapists practiced in a private setting and in a mental health institutions. The transcript sessions were analyzed in a double-blind design with the CIS-R and AIMIT. Two group of independent raters evaluated the sessions. The raters were trained psychologists with a good IRR (ICC=.80 for the CIS-R and ICC=.78 for the AIMIT). Measures: (1) the Collaborative Interactions Scale-Revised (CIS-R) to evaluate therapeutic alliance ruptures and collaborative/resolution processes from an observer' s perspective. The scale is inspired to the Safran and Muran's model. The CIS-R is divided into two scales, one for the patient (CIS-P) and one for the therapist (CIS-T). The CIS-P is further divided into four subscales: Direct Rupture Markers (DRMs; three items), Indirect Rupture Markers (IRMs; four items), Direct Collaborative Processes (DCPs; three items), and Indirect Collaborative Processes (ICPs; three items). The CIS-T is composed of four subscales: Direct Collaborative Interventions (DCIs; four items), Indirect Collaborative Interventions (ICIs; three items), Rupture Interventions (RIs; five items), and Therapist Interventions (four items): supportive, explicative, explorative, and expressive). (2) the Assessing Interpersonal Motivations in Transcripts (AIMIT) is a validated coding system to assess the activation of interpersonal motivational systems in the transcripts of psychotherapy sessions as well as in any kind of human verbal interaction. According to a multi-motivational approach developed on the basis of attachment theory, the AIMIT include five basic motivational systems: care seeking and care giving systems for attachment relationships, rank system for the definition of dominance or submission, sexual mating and the cooperative system. AIMIT method allows the evaluation of the interpersonal styles of both the patient and the therapist as well as their interactions in sessions. It is considered a useful instrument for exploring the relational context, especially in the ruptures and repairs of the therapeutic alliance, where AIMIT are typically either improper or not synchronized. The results evidenced that the coordination of the interpersonal motivational systems is predictive of a better quality of the therapeutic alliance. The collaborative interactions (DCP, ICP, DCI, ICI) are mainly predicted by the cooperative interpersonal motivational system (b=.829, p=.000), whereas ruptures (DRM, IRM, RI) are characterized by competitive exchanges (b=.746, p=.05). However, results suggest that the processes of interpersonal attunement may be more rich and variated than that; as an example, the social rank interpersonal motivational system may be involved in the direct negotiation of goals and tasks of the therapy (b=.658, p=.000), and the caregiving/careseeking interpersonal motivational systems may appear in both the indirect collaborative processes (b=.547, p=.003) and the indirect ruptures markers (b=.732, p=.025). These results will be discussed in the light of the convergence aspects and of the main theoretical differences between the two instruments and their theoretical perspectives.

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Therapeutic alliance and patients' reflective functioning: Preliminary results of a micro-analytic investigation of session transcripts

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This study aims at investigating the relationship between therapeutic alliance ruptures and resolutions and patient's reflective functioning (RF). The relationship between these two variables is yet unclear and complex: several authors have noted that mentalization to some extent may be a prerequisite for effective use of psychotherapy but from another point of view intersubjective negotiation and the resolution of alliance ruptures could promote the creation of an in session secure base effect and improvements in patient's reflective functioning. Although empirical literature on this topic, especially at in session level, rarely examined together these constructs, investigating fluctuations in reflective functioning and in the alliance within sessions may be an interesting level of research for clinicians because it may inform psychotherapeutic technique and practice. Our objectives are to: (1) evaluate whether low levels of RF will be related to rupture processes; (2) verify whether high levels of RF will be related to collaborative processes; (3) verify if a direct/confrontation ruptures are associated with lower RF scores with respect to indirect/withdrawal ruptures. In doing so we hypothesize that: (1) patient's ruptures would be associated with lower scores of RF, while patient's collaborative processes would be associated with higher RF scores; (2) different ruptures would be associated with different RF scores, specifically direct/ confrontation ruptures would be characterized by lower RF scores than indirect/withdrawal ruptures. *Methods*: We evaluated 50 session transcripts (1,032 narrative units) from 10 Caucasians patients (2 men, 8 women; mean age=29.91 years, SD=10.12) in psychotherapy. Before entering psychotherapy, all patients received a DSM–5 diagnosis (APA, 2013). A total of 4 patients had at least one PD diagnosis. Psychotherapies were administered by 8 psychologists and 2 psychiatrists (mean age=44 years, SD=8.5). Therapists practiced in a private setting and in a mental health institutions. Eight therapists reported a psychodynamic theoretical and clinical approach while 2 reported a cognitive-behavioral approach. Measures. (a) Collaborative Interactions Scale Revised (Colli, Gentile, Condino, & Lingiardi, 2017), for the assessment of alliance's ruptures and resolution processes on the basis of Safran and Muran's (2000) model. The CIS-R is divided into two sub-sales: CIS-R Patient and CIS-R Therapist, each focused on the specific contribution of each member of the therapeutic dyad at the communication process. The CIS-R Patient is composed of four scales: Direct Rupture Markers (DRS; 3 items); Indirect Rupture Makers (IRM; 4 items); Direct Collaborative Processes (DCP; 3 items); Indirect Collaborative Processes (ICP; 3 items). The CIS-R Therapist is composed of four scales: Direct Collaborative Interventions (DCI; 4 items); Indirect Collaborative Interventions (ICI; 3 items); Rupture Interventions (RI; 5 items); Therapist Interventions (TI; 4 items); (b) Reflective Functioning Scale (Fonagy *et al.*, 1998) for the assessment of patient's RF on a Likert scale from -1 (negative RF) to +9 (marked RF). The RFS has been developed for the assessment of the verbatim transcripts of the Adult Attachment Interview, but can also be applied to psychotherapy session transcript. The RFS assesses the presence of mentalization on the basis of four different subscales: Awareness of the nature of mental states (4.1); Explicit effort to tease out mental states underlying behavior (4.2); Recognizing developmental aspects of mental states (4.3); Mental states in relation to the interviewer (4.4). In the present study, raters assessed the presence or absence of each marker of the CIS-R and the RFS in each verbal unit. Each transcript was rated by two independent and trained raters for each measure (CIS–R and RFS). In the present study the mean overall inter-rater reliability for CIS–R ranged from .67 to .81 (Cohen's Kappa) while for the RFS ranged from .60 to .85 (ICC; single measure, absolute agreement). *Results*: Our results enlighten the presence of lower scores of RF in psychotherapy session fragments characterized by therapeutic alliance ruptures. More specifically, partial correlations indicated that patient's direct rupture markers (DRM) were significantly negatively correlated with RF [r=-.086, p=.002]. Moreover, we found a significant negative correlation between indirect rupture processes (IRM) and RF [r=-.155, p=.000]. We didn't find a significant correlation between direct collaborative processes (DCP) and RF, but our results showed a strong positive correlation between indirect collaborative processes (ICP) and RF [r=.127, p=.000]. Our results didn't enlighten the presence of a correlation between therapists collaborative interventions and patients's RF. We did find a strong negative correlation between therapists rupture interventions and patients' RF [r=-.106, p=.000]. *Conclusions*: Results confirm our hypothesis about the relationship between alliance ruptures and resolutions and patient's reflective functioning and show how patients alliance ruptures are characterized by lower FR level than patient collaborative processes. Contrary to our hypothesis patent's indirect ruptures are characterized by lower RF scores than direct ruptures. We may hypothesize that direct rupture markers, even though with a non-collaborative modality, are characterized by an expression by the patient of the affect mental state, which does not happen in other rupture processes. In future will be important to investigate if different rupture markers are associated with different kind of prementalizing modes such as psychic equivalence and pretend mode. We did not find a correlation between therapists' collaborative interventions and RF. This may be due to the specific analysis adopted in this study, which does not allow for us to see the effect of therapists interventions on the subsequents verbal units. For the future, further analyses will be necessary in order to address this issue. This study represents an attempt to micro-analytically investigate the fluctuations in patient's RF in response to therapeutic alliance's ruptures and collaborative processes. Clinical implications will be discussed.

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Therapeutic alliance development: The contribution of therapist's verbal content, voice quality and interruption behaviors during interactions with patient

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The therapeutic alliance, as a predictor of psychotherapy outcome (Ardito & Rabellino, 2011), is a collaborative relationship which varies through different phases of the therapy (Lingiardi, Holmqvist, & Safran, 2016) and is influenced in its quality by patient and therapist's contributions (Koole & Tschacher, 2016). It is not exempt from ruptures, as strains in the patient-therapist collaborative relationship or deteriorations of the communicative processes, which could lead up to positive therapeutic change or negative outcome, respectively when they are adequately managed or not by the therapist (Lingiardi *et al.*, 2016). Therefore, positive verbal and nonverbal communicative exchanges between therapist and patient represent the necessary conditions to the construction of a collaborative relationship (Gabbard, 2006). Specifically, therapist's verbal and nonverbal communications interact together, conveying meanings and building such a collaborative interaction, and channel into a therapeutic discourse which present an asymmetric structure oriented towards the reciprocal influence of participants (Leahy, 2004). Very recently the Communicative Modes Analysis System in Psychotherapy (CMASP; Del Giacco, Salcuni, Anguera, 2018) was developed on a performative function of language derived from the Speech Act Theory (SAT; Searle, 2017) according to which *by saying something we do something*. Language as an action would enclose the essence of the therapeutic relationship: co-construction of meanings through language is what determines the change (Dagnino, Krause, Pérez, Valdés, & Tomicic, 2012). Therefore, therapist's communicative and interactive action contributes to co-construct the meanings within psychotherapy through specific verbal (content) and extra-linguistic (voice quality and interruptions) communicative modes. Each verbal behavior, considered as a linguistic act performed by a participant with a specific structural form, transmits information (contents) connected to the speaker's communicative intention within a coding and decoding process, leading to a mutual regulation (Valdés, Tomicic, Pérez, & Krause, 2010). On the other side, during communicative exchanges therapist's voice quality transmits psychological meanings and emotional messages apart from the content of speech within a process of mutual affection with patient, influencing the emotional state of each other reciprocally (Tomicic *et al.*, 2015). Finally, interruption behaviors, as every human linguistic act with intentionality (Wallis & Edmonds, 2017), affect each speaker in supporting or hindering the co-construction of meanings during communicative exchanges (Murata, 1994). The aim of this paper is to examine the relation between the unfolding of therapeutic alliance construction and therapist's verbal content, quality of voice and interruption behaviors along a brief psychodynamic psychotherapy. Specifically, we assume that: 1) during alliance rupture and resolution episodes, heterogenous patterns of therapist's communicative intents and structural forms emerge, evolve, as well as they could differentiate such episodes in the course of the therapy; 2) during alliance rupture and resolution episodes, therapist mostly uses different vocal modes which remain stable along the therapy steps; 3) therapist's cooperative interruption behaviors most likely precede alliance resolution episodes, while intrusive interruption behaviors most likely precede the alliance rupture ones. Methods. They were analyzed 15 sessions (corresponding to 4440 speaking turns) of a once-a-week psychodynamic therapy of a young adult University student (aged 25 years old), self-referred to the Dynamic Psychotherapy Service of the University of Padua; he presented depressive symptomatology detected by the Beck Depression Inventory-II (BDI-II; Italian version: Ghisi, Flebus, Montano, Sanavio, & Sica, 2006) with scores greater than the 85° percentile (Total score, Somatic-Affective Area and Cognitive Area equal to the 99° percentile). The Collaborative Interaction Scale-Revised (CIS-R; Colli, Gentile, Condino, & Lingiardi, 2014, 2017) was applied on transcripts to assess alliance, as well as ruptures and repairs (inter-rater reliability: Cohen's =.75 - .81; Cohen, 1960). It consists of the CIS-P, evaluating patient's rupture and collaborative processes, and the CIS-T, evaluating therapist's positive and negative contributions to the therapeutic relationship. The CMASP (Del Giacco *et al.*, 2018) was applied on transcripts and audio recordings of psychotherapy sessions for the indirect observation of therapist's verbal and extra-linguistic behaviors (inter-rater reliability: Krippendorff canonical agreement coefficient's Cc=92% - 94%; Krippendorff, 1980). It is a classification system consisting of 33 exhaustive and mutually exclusive categories (E/ME; Anguera, Portell, Chacón-Moscoso, & Sanduvete-Chaves, 2018) enable to detect verbal, vocal, and interruption modes implemented by patient and therapist during psychotherapy communicative exchanges turn-by-turn. Intra and intersession analyses (descriptive statistics and sequential analysis) were performed. Specifically, a multievent sequential analysis was used and performed through the Generalized Sequential Querier program (GSEQ 5.1; Bakeman & Quera, 2011) to determine -with no causality effect- the probability of occurrence of a given and a target behavior together. Since the CIS-R coding instruction, considering therapeutic interventions as an antecedent of patient's conversational turn, discourse unit as well as lag 1 of sequential analysis are made by a therapist's intervention connected to subsequent patient's speech. Results. The integration of nonverbal interaction dimensions with standardized evaluation, as well as the presence of repeated communicative patterns, provide evidence about how alliance develops. The two instruments are connected and specific associations of therapist's communicative characteristics emerged differentiating patient and therapist's contributions on the therapeutic alliance. The first hypothesis has been partly confirmed, since the structural form Question and the communicative intentions Exploring and Deepening implemented by therapist's communications co-occur only with the patient's collaborative processes, while the structural form Assertion and the communicative intent Resignifying of therapist's communications co-occur with ruptures marker. The second hypothesis confirmed since therapist's Declarative and Pure emotional positive vocal modalities co-occur only with patient rupture markers, while a Connected modality co-occurs with a collaborative process of the patient. With regard to the Interruption Mode dimension, results showed the therapist's cooperative interruption tends to achieve a patient's collaborative interaction. Conclusions. Verbal and non-verbal communicative modalities are an important process indicator in psychotherapy that can provide important indications for the theoretical and clinical development of the relational processes underlying the therapy success or failure. Specifically, the results underlined, trough the association between CMASP and CIS-R, that the therapeutic alliance is a complex intertwined of acts and reactions that occur in an exchange timeline (Roth & Fonagy, 2013).

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Therapist interventions and ruptures and resolutions of therapeutic alliance in anaclitic and introjective patients

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This study explores the relationship between therapist's interventions and ruptures and resolutions processes of therapeutic alliance in anaclitic and introjective patients. We also present the revised version of the *Collaborative Interactions Scale Revised* (CIS-R; Colli, Gentile, Condino, & Lingiardi, 2017), an observer-rated measure for the assessment of therapeutic-alliance ruptures and resolutions. Our aim is to investigate the impact of the therapist's techniques on the (a) ruptures markers and (b) collaborative processes in two groups of patients. Specifically, we hypothesize the effects of these therapist's interventions: (a) The focus on the relationship and/or affects are predictive of the collaborative processes in anaclitic patients and of the indirect rupture markers in the introjective patients; (b) the intervention on insight and/or defenses and/or recurrent patterns are predictive of the collaborations in the introjective patients and on the direct rupture markers in the anaclitic patients. Method: three raters conducted a blind evaluation of a sample of 130 sessions (390 segments; 7,214 narrative units) with 65 patients (33 had an anaclitic orientation and 32 had a introjective orientation). Measures: Collaborative Interactions Scale Revised (CIS-R; Colli, *et al.*, 2014, 2017) to evaluate the ruptures and collaborative processes in the session; Comparative Psychotherapy Process Scale (CPPS; Hilsenroth *et al.*, 2005; Gentile & Tanzilli, 2015) to assess therapist's interventions; Prototype Matching of Anaclitic–Introjective Personality Configuration (PMAI; Werbart & Levander, 2014, 2016) for the assessment of the anaclitic and introjective; Psychodynamic Functioning Scale (PFS; Høglend *et al.*, 2000, 2006, 2008) for the evaluation of the patient's level of functioning. Results: The linear regression evidenced that the focus on affects interventions are predictive of collaborative process in anaclitic patients only in presence of high level of functioning (b=.683, sig.=.001). The focus on the relationship are predictive of collaborative processes both in anaclitic (b=.472, sig.=.000) and introjective patients (b=.389, sig.=.05) in presence of low level of functioning. The interventions focused on insight (b=.541, sig.=.000) and defenses (b=.767, sig.=.005) are predictive of collaborative process in introjective patients with a high level of functioning. Conclusions: The application of the scale seems to confirm that¾as evidenced by the former version (Colli & Lingiardi, 2009)¾ also the CIS-R is a reliable rating system that is useful for both empirical research and clinical assessments. The data seem suggesting the differential impact of therapist techniques according patient's characteristic and focusing the importance of the tailoring in order to promote patient's collaboration in session. Clinical implications of these results will be discussed.

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The process of evaluation in residential treatments for adult and adolescent patients

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Introduction: The late beginning of empirical research on the effectiveness of community treatment, already consolidated in the 1950s, can be referred to the idealizing and self-referential tendency that characterized the pioneering movement of the origins, in the British and Italian context, but also in the presence of variables more complex than other methods of care and the difficulty of measuring them with appropriate tools. In England in the 1990s, the dominant opinion that communities were expensive and there was no evidence of effectiveness, stimulated the awareness that a solid empirical basis was fundamental to their economic and real survival. The breakthrough of the studies was encouraged by a review of the efficacy of the therapeutic community commissioned by the High Security Psychiatric Services Commissioning Board to the researchers Lees, Manning and Rawlings who realized in 1997-98 a systematic review on an international scale of the salient literature and the subsequent meta-analysis of 29 researches with strong tests, starting from the selection of 8160 studies of which 10 with randomized control; it comes to confirm the effectiveness of the treatment of the therapeutic community, especially with CT samples in prisons and drug addicts: "There is proof of demonstrated clinical evidence that CTs produce changes in people's mental health; although this needs to be supported by qualitative quantitative and qualitative research studies "(Lees, Manning, Rowiling, 1999, p. 43). In the reflection on which type of research is suitable for CT, it is known that the TRC considered a "gold standard" from the medical model, is actually unworkable as a research methodology on community treatment, due to the complexity of factors, the difficulty in selecting the sample, abandonment in the course of the research, modification of the objectives along the path, change both intrapsychic and behavioral, etc., but also for dissatisfaction with studies that are not based on the real world of clinical practice. In this respect, the indications of Seligman that considers not suitable for TRC may be valid: long-term therapies, self-correction therapies, those with patients who have multiple diagnostic problems, when the improvement affects the overall functioning of the personality; these conditions, fully observed in the community treatment (Seligman, 1995). From the international literature emerges therefore the utility of integrating two types of research, starting from the different questions and problems posed by the complexity of the CT: the quantitative approach in which the data are subjected to statistical analysis, when there are sufficiently numerous samples, can be useful for measuring the outcome and the clinical and psychosocial follow-up of the treatments, for a comparison with other types of intervention or for testing the validity of innovative tools etc., integrated with the qualitative approach that can explain the reason for certain results , can explore specific and a-specific therapeutic factors, trying to understand the reasons for success or failure, analyzing the process of change and the emotionally past of those who have experienced it. In Italy after the closure of psychiatric hospitals in 2000, the reality of high, medium and low protection residential therapeutic communities has increased exponentially in Italy (Progress 2001) while there are still few therapeutic structures that admit children and adolescents. In CT patients are mainly with severe mental psychopathologies, psychotic and borderline, who cannot benefit from outpatient care. Although there are significant trials and networks of high quality therapeutic communities that document the effectiveness of this treatment, but quantitative growth has not yet been accompanied by systematic methodological reflection and a widespread evaluation process. On the other hand, residential treatment presents a complexity of factors and interventions realized in everyday life (psychotropic, individual and group psychotherapies, psychosocial rehabilitation interventions, family interventions, social inclusion, etc.) and a multiplicity of relationships that make assessment difficult. according to traditional criteria. However, we note that the lack of constant monitoring of residential treatment can generate a chronicity that tends to reproduce new forms of institutionalization. The risks are those of iatrogenic consequences for adult and minor patients. The purpose of this symposium is to start with researchers and clinicians a discussion on the importance of the evaluation process of residential community functioning, which actively involves all the protagonists of this method of care: operators, patients, family members and possibly sending services. The introductory paper by Francesca Giannone *et al.* presents a longitudinal study carried out with the Visiting, a path of peer accreditation between adult CT and GA and the identification of functioning standards that may be indicators of treatment's effectiveness in the therapeutic communities for mental health. The Visiting is an innovative form of evaluation, which incorporates the English experience of Community of Communities according to the characteristics of the Italian system. The second contribution by Stefano Benzoni, Alessandro Chinello *et al.*, "Child and adolescent needs and strengths (CANS) for therapeutic residential care in Italy" proposes a research project in which 30 Therapeutic Communities for adolescents are participating, using as a CANS-NY tool conceived by J. S.Lyons in the USA (1999, 2011) and validated recently in Italy, which involves all the actors of the care path in the evolutionary assessment of users' needs and resources. The third paper by Sergiu Grajdean and Marino De Crescente analyze the social anxiety in residents of the community, how it is perceived by the residents of CT Passaggi (Aquila Italy) and how their subjective perception of social anxiety changes in time, living in a comfort environment, a therapeutic community. The latest Federica Canonico, Filippo Piraino, Giampietro Savuto and paper is dedicated to the Light Residential (RL) service in the Lighea ONLUS in Milan (Italy), for psychotic patients who have concluded the treatment and investigates the factors of team cohesion and recovery, the climate of the meeting and, in parallel, the evolution of symptoms and the residents achievement of autonomy skills with a multi-instrumental evaluation.

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The measure of change in a longitudinal perspective. Towards a research procedure on effectiveness in the therapeutic communities

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Introduction: Therapeutic Communities represent the most important service structures since the asylum closed. They are the new mental health care centers and, above all, a place for mentally ill people to live in a reparative and developmental dimension. What makes a community a therapeutic environment, when residential care is effective, and the identification of functioning standards that may be indicators of treatment's effectiveness in the therapeutic communities for mental health, are topics of particular importance in the research on the evaluation of the intervention with patients with severe mental disorders (Lees, Manning, Rawling, 2004; Bruschetta, Giannone, *et al.* 2012; Pearce & Haigh, 2017). But empirical research on community contexts is very limited: researchers experience methodological difficulties connected to the range of the examined variables, their operationalization, the intersection of many reciprocal influences; clinicians distruste research, considering it useless and invasive to their work settings. However, a number of ongoing developments are promising. We are witnessing a mutual, growing interest among researchers and clinicians and a growing effort for the introduction of research experiences, even in complex contexts of care. This paper proposes the advances of an empirical study conducted in community settings (Therapeutic Communities and Group-Apartments), which investigates both contextual aspects and more exquisitely clinical aspects of the care, proposed in a group of communities participating in a training, evaluation and research project and quality accreditation: the Visiting Project. This is a project which has the aim of encouraging communities to get to know each other through a process of assessing therapeutic and structural factors for the purpose of better identifying TCs' weaknesses and strengths and encouraging the definition of annual improvement goals and collaboration with the other participating TCs. The ultimate goal is to establish a set of common quality standards and benchmarks and to generate a circular exchange of good practices, procedures and materials, making more evolved experiences accessible to communities that have been unable to produce them (Angelini, Bruschetta, De Crescente, Gaburri, Giannone, Mingarelli, Pismataro, Vigorelli, 2017). *Methods*: Participants: Operators, users and family members of 45 CT and 7 GA. Tools: the VIVACOM Questionnaire (Visiting and Valuation of Communities) (Vigorelli *et al.*, 2017), that proposes 10 areas of functioning of the community environments (general organisation, personalisation and rights, therapeutic climate and setting comfort, general treatment features: individual and group, family-focused activities, resident and caregiver safety, staff management and training, organisational supplements and collaboration, clinical documentation and reporting system, quality assessment and research); the VIVAGRAP Questionnaire (Bruschetta, 2014), that is an adaptation of VIVACOM for apartment groups; the DTCRO Questionnaire (Democratic Therapeutic Community Recovery Oriented) (Bruschetta, Monasteri, Barone, 2014) that proposes 9 areas of investigation, related to the experience of care (renewing hope and commitment, being supported by others, finding their place in the local community, redefining themselves, assimilating the disease, managing symptoms, taking control, fighting stigma, maturing empowerment); the GAS-SET (Grid for the Analysis of Set(ting) - SET) (Bruschetta, Pezzoli, 2014; Bruschetta, Giannone, Parroco, 2018), that notes the organizational and structural variables of the community structure (structure data, collaborations, equipment data, staff data, data of the care, management of psychofarmacies, regulation of the community). Descriptive statistical analyzes and testing of changes over time (Wilcoxon Signed Rank-test for dependent samples) were implemented, in communities with two and more cycles of participation. *Results*: The first results show that the evaluations of community operators and users tend to improve over time. Users evaluate the functioning of the communities at VIVACOM more positively than the operators. Otherwise, the DTCRO evaluations of users are less positive, but significant changes are recorded in the areas Redefining oneself, Assimilating the disease, Maturing empowerment and Fighting the stigma. *Conclusions*: The identification of empirical indicators of the therapeutic communities functioning is the central interest of the work. Although there are still many difficulties, both methodological and in the creation of a research culture in complex contexts, it is now possible to identify, in a shared and ostensible way, variables, areas of functioning, quality standards on which to make comparisons. The ability to use empirical data to which anchor the clinical reflection is a challenge started, which begins to show the first results. This may have an important clinical and social impact, for the chance to base clinical practice on clear and shared scientific data, with less risk of improvised or emotionally and ideologically oriented evaluations. A conscious clinical practice, founded on values of democracy and sharing and empirically supported, can be an important contribution towards a broader acceptance, even social, of the problems of mental health and, ultimately, of a more general social improvement.

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Child and adolescent needs and strengths (CANS) for therapeutic residential care in Italy

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Introduction: Few researches tried to identify and classify the main features of clinical populations of adolescents in residential communities at the national level. This lack of information represents a relevant problem, both at the management level of mental health system on a national and regional scale, and at the level of resi-

dential communities management. Collecting more detailed epidemiological data would provide extremely useful clues as to more appropriately define needs in the population, plan, implement and monitor clinical programs, place resources. Furthermore, data collection would have extended potential benefits if the tools used to collect information could simultaneously monitor clinical outcomes for the examined population. TCOM (Transformational Collaborative Outcome Management) is a theoretical framework dedicated to a multidimensional and multiaxial system for adolescents, already used in different mental health services across US, Canada and in different Regions of South America. TCOM uses a set of tools known as CANS (Child and Adolescent Needs and Strengths) that are specifically conceived to collect and communicate information, support shared decisions and evaluate outcomes about children and youth in Mental health systems. Information in CANS are i) focused on needs and strengths as independent variables ii) collected in items with high face validity iii) items directly translate into action levels iii) conceived to be shared amongst users, families and mental health and community professional. A CANS "protocol" is meant to be scored, for each patient, in a collaborative way, with the network of professionals, with family and youth. The overall scores for each CANS at a given clinical time represent thus an systematic picture of actionable needs and strengths. For this reason not only they "describe" a certain clinical condition (at that given clinical time), but they do so already embedding in this picture a grid of priorities for clinical action (both on the strengths and needs domains) that have been previously negotiated amongst professionals, with youth and family. When implemented systematically through time, CANS becomes a powerful tool to connect a certain set of shared information to inform clinical decisions e to evaluate outcomes. The present study aims to identify the specific needs and strengths of a clinical population of residential communities at the national level by using a communimetric approach (TCOM), classifying the main factors involved in clinical decision making and outcome evaluation in the mild term (6 months). *Methods*: 30 Italian residential communities are involved in this study. By using a mixed approach (both observational and longitudinal), needs and strengths of adolescents were measured every 6 months (T0,T1,T2,T3,T4) with the tool CANS (Child and Adolescent Needs and Strengths), a communimetric assessment tool, from January 2018 to January 2020. The sample is composed of Italian speakers adolescents hosted in residential communities with an age range of 10-18 (y.o.). Data were analyzed considering levels of action and specific scoring procedures coherently with the TCOM/CANS approach. The preliminary results of the first six months of experimentation are considered in this study (Jan. 2018-Jun2018). *Results*: Data of 50 minors (24 F, 26 M), placed in 10 different residential communities were collected and analyzed. 35 minors were born in Italy, 28 were Italian citizen, 2 were non accompanied foreign minors. Average age was 16.1. 13 youth were reported to be diagnosed with ICD9 F30-39 (Mood disorders) as main diagnosis, 12 youth with ICD9 F60-69 (personality disorders) and 15 with ICD9 F90-98 (Behavioral disorders). 20 youth were placed under civil Justice orders. Qualitatively, minors are characterized by the presence of past parental separation, relocations, traumatic experiences, emotional abuses and negligence. Problems are reported regarding the role of father during the child development, emotional stability of caregiver, disorganized attachment, with frequent difficulties even at school (*i.e.* failure, abandonment). At the entry level in a residential community, minors exhibit specific needs regarding their life context, social functioning and recreational activities with symptoms mainly associated to impulsivity, anger, depression, anxiety and risk behaviors (*i.e.* self harm). Parental caregiver shows educational lacks and stress. Moreover, our findings suggest the role of some needs on the level of clinical activation (TAI, total actionable items) in a community. In particular, within the life context domain, sleeping and communication disorders, cultural stress and legal aspects improve the TAI level. Alternatively, optimism and talents/aptitudes represent the most relevant strengths to improve in minors, with higher TAIs in case of low self-expression skills and treatment engagement. *Conclusions*: Even if current data are only preliminary, and can provide hints on factors to be considered more in detail throughout the course of the study in the next months, they nevertheless outline a quite significant picture of the given population characteristics. Data show that youth placed in residential communities tend to express a set of very complex needs. 88% of inmates population is reported to be diagnosed (main and secondary diagnosis) with a set clinical conditions that are per se characterized by a heavy burden of functional impairment, and high risk for either self harm (28%) and/or impulsive behaviors (60%). A more detailed analysis conducted with CANS show how life and social functioning, specific symptoms, cultural stress and legal aspects are relevant areas of frequent needs improving the TAI level in this population. CANS analysis suggest also that optimism, talents/aptitudes, self-expression skills and treatment engagement are particularly frequent and may represent a specific set of domains on which to improve clinical recovery programs, in view of discharge. The project findings improve the comprehension and knowledge of residential clinical teams regarding adolescent population for new possible strategies about service quality, management and clinical outcome evaluation in medium and long terms.

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Subjective perception of social anxiety and its changes in a safe environment, a therapeutic comunity. Case study: Social anxiety and psychosis

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Introduction: The therapeutic community Passaggi is focused on the treatment of the patients who are suffering from different psychotic related disorders. One of the main objectives of the therapeutic community is to empower the person and help the patients gain their ability to be part of a familiar and social group, to help them re-gain the abilities in order to succeed in everyday life. This objective was the starting point of our survey. To be able to help the patients, we need to comprehend well the whole situation. Most of the times, one of the impediments that rises at the end of a therapeutic treatment in a community is social anxiety. Returning to the quotidian life, often a banality for most of us, can be a serious hinder in the process of re-gaining the power on one's life. People suffering from psychosis often have difficulties distinguishing what is real and what is not; that's why it's extremely important to understand how they perceive and cope with social anxiety before finishing the treatment. Psychosis include a variety of symptoms that affect a person's

behaviour, emotions and cognitive system, the combination of which making each patient be different from the other. Often, the negative symptoms such as apathy, blunted emotional responses or social withdrawal aggravate the social anxiety and the process of re-integration in society. On the other hand, the social anxiety is a significant cause of stress that can aggravate the positive symptoms. The project was intended to analyze the social anxiety in residents of the community, how it is perceived by the residents of Passaggi and how their subjective perception of social anxiety changes in time, living in a comfort environment, a therapeutic community. In order to assess the changes over time, we tested the subjects three times, each at an interval of four months; therefore, the project lasted twelve months. Knowing how a patient's perception changes over a year can give important hints on the therapeutic directions that are put into practice and can also offer us important insight on which points there's still lots of work to be done in order to achieve our goal, the well being of the patient. *Methods*: Twelve subjects participated at this research. All the participants, diagnosed with at least one episode of psychosis, were/are residents of the therapeutic community, Passaggi. The participants were divided in two groups according to how long they have stayed in the community. The tests used were: IAS (Interaction Anxiousness Scale) of Leary and LSPS (Liebowitz Social Phobia Scale). Besides, these tests, during the first assessment, the participants were asked a series of questions of how they remember their perception of social anxiety when they joined the community for the first time. The results to the tests were recorded according to the official scoring of these, IAS and respectively LSPS. *Results*: According to the results given by the participants at the first assessment, 4 out of 12 subjects reported an interesting fact; they reported an increase of social anxiety since they joined the therapeutic community. The results of the second assessment point out a decrease of the social anxiety in most of the participants. Moreover, at the third assessment (after 12months of therapy in the community), 11 out of 12 participants reported no social anxiety at all. *Conclusions*: We advanced two possible explanations to interpret the data. Before joining the community, most of our participants had lived in a relatively social seclusion in which they weren't adequately stimulated. Beginning the therapy in the community, they were inevitably socially stimulated both with the workers and with other participants. These new social stimuli made them aware of a difficulty that was invisible to them prior the treatment. Therefore, the social anxiety was invisible to the patients prior the treatment. Secondly, the accentuated perception of social anxiety at the beginning of the treatment in the community could be caused by the treatment itself. Once the treatment begins, the psychotic symptoms should lessen and eventually fade out. However, some symptoms, especially negative ones, such as depression, decreased self esteem, social problems and difficulties with work or school, may linger as they are less responsive to medication and need longer and deeper treatments, such as psychotherapy, for a full recovery. Often, the beginning of the treatment is making the person more aware of the difficulties he's having. Being more aware of the difficulties, the patients can find himself in front of high levels of anxiety. High levels of anxiety can cause the patients a low sense of self-efficacy. All this is just a vicious circle that could reinforce high levels of social anxiety and a feeling of total incapacity to cope with the situation. In a therapeutic community, patients are undergoing a lot of social activity that can simply put them in a new situation, unknown to them prior the treatment; psychotherapy, different practical laboratories, therapy groups, family group therapy, new social interactions and other intrinsic elements of the treatment made the participants be more aware of their difficulties, including social anxiety. The work presented could be a good starting point for larger research on this topic, that can offer important and useful insight to the professionals how to sustain the patients to re-integrate in the society again.

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The light residential (RL) service in the Lighea onlus foundation: An observational study

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Introduction: Initially conceived as a form of completion of the rehabilitation program for patients with severe psychiatric pathology in the Therapeutic Community, today the Light Residential interventions in Italy are also proposed as the beginning of a specific individualized therapeutic-rehabilitative program, approved after a careful evaluation of the patient. In the RL service the work of the équipe focuses on four instances promoting the therapeutic course of patients: the house, understood as "living" (the équipe works so that patients are able to perceive themselves as a family group), the treatment (the operators work together for the common goals of relieving pain of the guests and reducing their existential and social disease), social interactions and work activities (the équipe supports social involvement of the guests in community's life and encourages personal realization). A specific feature of the RL is the "transitory" character of the service, in which guests are supported and fostered to autonomy. The experience of the small group in RL guides the person not only in the rehabilitation of domestic and social life, it includes him in the context of the territory too, in a network which creates a sense of belonging that makes the citizen feels the rights and the participation. It is an opportunity for the relations with neighborhood and with voluntary institutions and associations, which offer support and job opportunities. This phase of the journey is extremely important because it can gradually prepare the resignation, with the reassignment of personal responsibility in a life-project. The success of this experience, however, is connected to the relation and the collaboration with other rehabilitative projects, thus overcoming the sense of isolation and self-referentiality. *Methods*: First of all, the observational study describes the birth and functioning of RL service in the Lighea Onlus Foundation, located in Milan (Italy). Subsequently, the main goal of the research consisted in the analysis of some characteristics of the équipe (composed by 15 operators) and the 9 residents of the apartments, with the purpose of catching strengths and weakness of the service in the last four years (2014-2018). Tools: the équipe filled out two types of questionnaires, the CFQ-28image (Cerbino *et al.*, 2014) and the DTCRO (Bruschetta, Monasteri *et al.*, 2014) in its version for Operators. Regarding the CFQ-28image, it has been calculated and analysed the average score obtained by the operators to the 28 items of the questionnaire, gathered according the three constructs the questionnaire is focused on (Team work and leadership, Processes of

Accountability and Emotional climate); then it has been analysed the graphic area, which scans more deeply the emotional climate during the équipe meeting, and it has been compared the graphic evaluation with the scores attributed by the compilers to the different items. As for the CFQ-28image, in the DTCRO it has been calculated the average score achieved by the operators in the 45 items of the questionnaire, grouped in 9 macro-areas (Renovate hope and commitment; Being supported by others; Find place in the local community; Redefine thyself; Assimilate the disease; Manage symptoms; Take control; Fight against stigma; Get empowerment). The tools for the valuation of the guests affected by chronic psychological disorders were: the analysis of the medical records and the HoNOS and BPRS scales, compiled every year. Regarding the HoNOS, it has been analysed the average score gained to the 12 items of the scale, gathered in 4 areas (Behavioural problems, Deficits and disabilities, Psychopathological symptoms, Environmental problems), then it has been observed the trend, in each area, during the surveys. Even for the BPRS scale it has been calculated the average score attributed to the 24 items, grouped into 3 areas (the same of the HoNOS scale without the Deficit and disabilities area), and then it has been evaluated the trend, in each area, during these last 4 years. It also has been evaluated, within the therapeutic course of each guest, the presence or absence of some meaningful variables like: suicide attempts, resignation/drop-out, psychiatric hospitalization, starting/keeping some work activities, significant life events. *Results*: The set of collected data returned an image of a cohesive équipe, well-organized and strongly oriented to the assistance of their guests, these latter characterized by a good autonomy despite the unavoidable symptomatic oscillations (particularly noticed in the last semester) caused by the disorders they are afflicted of. The evidences that the guests of the RL service in Lighea cohabit peacefully in the apartments and engage themselves in different work activities suggest that their good level of autonomy is favourably oriented to satisfy those evolutionary needs that are typical of the individual, as well as to maintain a coherent identity representation, despite the complexity of social interactions and the chronic nature of their severe psychiatric disorders. *Conclusions*: The scores obtained by the operators to the questionnaires, which have outlined a cohesive group and well-oriented to Recovery, especially in those areas focused on fighting stigma, renewing hope and commitment and redefining the identity of the guests, can be interpreted as a strong and challenging response from the équipe to the symptomatic decline of the residents expressed in the last period.

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The study of therapist's characteristics. Some new contributions from the italian area

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The research on the therapist effect can shed a light on why patients change in psychotherapy. Accumulating evidence from both clinical trials and routine data has shown that therapists have a significant effect on patient outcome. Results indicate that therapists account for around 5–10 % of unexplained variance in patient outcomes, with 8–9 % being most commonly reported (Baldwin & Imel, 2013; Kim *et al.*, 2006). However, there has been little research into why some therapists are more effective than others, even when delivering the same therapy model (Norcross, 2011). Traditionally, the dominance of RCTs has left little room for attending the therapist qualities such as personality, beliefs, culture, and demographics (Beutler *et al.*, 2004). In recent years, good research on the influence of therapist's characteristics on patient's outcome improved at a rapid pace (Baldwin and Imel, 2013) and these studies quantified how much a number of therapists differ from each other (Heinonen *et al.*, 2012). Moreover, examining differences between therapists could be useful for training psychotherapists and could be used to enhance their outcomes. This panel will focus on some recent studies on therapist's characteristics and, specifically, how these characteristics can play a role in the clinical management of patients in therapy. The study by Muzi *et al.* investigated the link between therapists' personality characteristics and empirically-derived transference and countertransference dimensions. They found that patient secure/engaged transference factor was positively associated with therapists' healthy personality functioning, and negatively related to SWAP-200 scales characterized by emotional dysregulation and interpersonal problems. The study by Brugnera *et al.* provided a contribution to the Italian validation of the Cooper-Norcross Inventory of Patient Preferences (C-NIP) and the Personal Style of the Therapist Questionnaire (PST-Q). The preliminary findings showed that these two scales have good psychometric properties, with a good factorial structure and a moderate internal consistency. The study by Di Carlo *et al.* provided initial evidence that the therapist response is specifically linked to the patient's symptoms and personality functioning. In particular, borderline features with severe symptoms seems to be linked with therapist's over-involvement. Finally, the study by Messina *et al.* reported preliminary results from the international collaborative study on psychotherapy trainees' development, planned by the Society for Psychotherapy Research Interest Section on Therapist Training and Development (SPRISTAD), with a specific focus on the influence of therapists' current life on the perception of their development. Overall, these studies suggest that there is a growing importance to the characteristics of therapists and their training development in Italy, and these studies can create the basis for a cooperation between research, clinical practice and training experiences.

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Therapists' subjective variables and transference-countertransference configuration: An empirical investigation

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Introduction: Despite a prevalent culture that presumed therapists to be uniform across different patients' group and treatment modalities, a growing body of evidence highlights that certain therapists' personal characteristics could positively or negatively influence the quality of the therapeutic relationship (*e.g.*, Ackerman & Hilsenroth, 2003). Some theoretical contributions suggest that therapists' variables are able to influence the patients' emotional, cognitive and behavioral reactions toward them (*i.e.*, a broader definition of transference; Gelso, 2014). Furthermore, countertransference is increasingly been viewed as a joint creation involving contributions from both clinician and patient (Gabbard, 2001). In particular, preliminary evidences suggest that therapist attachment might affect therapeutic relationship through interaction effects with other patient or therapist variables, but methodological weaknesses of these studies highlight the need for more rigorously designed research (Degnan *et al.*, 2016). Furthermore, studies on therapist personality seem to conceptualize this variable more as general attributes rather than measure a broad spectrum of personality traits and styles in a systematic and complex way. Thus, it remains an underresearched area despite its clinical relevance (for a review, see Lingiardi *et al.*, 2018). This study aimed to investigate the relationship between therapists' personality characteristics and attachment representations with empirically-derived transference and countertransference dimensions. *Methods*: Fifty-five psychodynamic therapists were interviewed with the Adult Attachment Interview (AAI) followed by the Clinical Diagnostic Interview (CDI) to assess their personality with the Shedler-Westen Assessment Procedure-200 (SWAP-200). They were also asked to complete the Psychotherapy Relationship Questionnaire (PRQ) and the Therapist Response Questionnaire (TRQ) on a patient currently in treatment who fulfilled the following inclusion criteria: (1) aged at least 18 years; (2) presenting no organic syndrome, psychotic disorder, or syndrome with psychotic symptoms that could complicate the assessment of any variable in the study; and (3) in treatment for a minimum of four sessions and a maximum of 6 months (in an individual setting with at least one session per week). In order to compensate the underrepresentation of specific AAI classifications, a well-established dimensional approach (Waters *et al.*, 2007) has been employed. *Results*: Findings showed that the therapist personality characteristics that were more strongly represented in this sample were obsessive-compulsive and narcissistic with respect to SWAP-200 PD scores, and obsessive-compulsive and dysphoric-high functioning/depressive with respect to SWAP-200 Q-factor scores. Moreover, more than half of the therapists were classified as having secure attachment, but a moderate percentage fell into the dismissing and unresolved attachment categories. Only a few therapists were classified as insecure/preoccupied. Results also showed that patient secure/engaged transference factor was positively associated with therapists' healthy personality functioning, and negatively related to SWAP-200 scales characterized by emotional dysregulation and interpersonal problems. These scales were also associated with patients' relational patterns characterized by hostility or dismissive attitudes. Furthermore, the relationship between therapists' personality functioning and patients' secure/engaged relational pattern was moderated by higher level of therapists' attachment security. Regarding therapists' emotional responses, no differences were found between therapists with secure *vs* insecure attachment styles, but healthier therapist personality functioning was negatively related to helpless/inadequate countertransference pattern. Interestingly, narcissistic Q-factor was found to be related to positive countertransference pattern. *Conclusions*: These findings seems particularly relevant when applied to psychodynamic therapies, which share a careful appreciation of the contribution of therapist's subjectivity. Therapists' improved knowledge of the role of their own subjective characteristics in the therapeutic relationship could be particularly useful to better understand their actions in therapy, guide therapeutic interventions, track in-session processes with their patients, and deal with ruptures in the therapeutic alliance, in order to provide better treatments. Moreover, this information would be particularly relevant in the supervisory relationship, which is one of the most important components in psychodynamic therapists' professional development. Overall, this study aimed to promote a better understanding of the underlying factors of "therapist effects", one of the most important emerging topics in psychotherapy research (Castonguay & Hill, 2017).

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Italian validation of the Cooper - Norcross Inventory of Patient Preferences (C-NIP) and Personal Style of the Therapist Questionnaire (PST-Q): Preliminary data and considerations on training to become psychotherapists

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Introduction: Several common and specific therapeutic factors can affect treatment outcomes: for example, therapeutic alliance and clients' expectations are two well-known therapeutic dimensions that could reduce over time the psychological distress experienced by patients (Straus *et al.*, 2005). In recent years,

researchers started focusing on two understudied factors, such as traits of the therapist and client preferences when determining a psychological treatment. Preliminary findings suggested a positive relationship between these dimensions and therapy outcomes (Castañeiras *et al.*, 2006; Straus *et al.*, 2005; Cooper & Norcross, 2016), leading to the development of two questionnaires to investigate both patient preferences (Cooper-Norcross Inventory of Patient Preferences; C-NIP, 18 items. Cooper & Norcross, 2016) and the traits of the therapist (Personal Style of the Therapist Questionnaire; PST-Q, 36 items. Fernández Álvarez *et al.*, 2003). We sought to investigate the psychometric properties of the Italian version of both instruments, administering a battery of questionnaires to a large number of participants. *Methods*: First, both self-report measures were cross-culturally adapted into Italian using a multistage procedure. As regards C-NIP, a total of 736 university students (mean age: 21.71±1.34 years; 71.4% women) and 368 adults (mean age: 31.38±11.35 years; 69.5% women) completed the questionnaire, together with commonly used scales of interpersonal problems (Inventory of Interpersonal Problems, IIP-32), psychological distress (Outcome Questionnaire 45, OQ45) and well-being (Psychological General Well-Being Index, PGWBI). Participants were recruited from undergraduate courses at University of Bergamo or through a snowball procedure, starting from students' friends and relatives; one third of the sample attended a psychological treatment in the past, or was currently in treatment. As regards PST-Q, a total of 228 mental health professionals (psychotherapists or psychiatrists; mean age: 42.47±9.96 years; 77.2% women) completed a psychological battery which included PST-Q, sociodemographic information and scales on attachment (Experience in Close Relationship Scale; ECRS) and reflective functioning (Reflective Functioning-8, RF8). Participants self-referred by responding to media advertisements or to email alerts sent by their former schools of psychotherapy, or scientific societies. In both validation studies, we performed several preliminary analyses using common statistical techniques (*e.g.*, Pearson's *r* correlations, and multiple linear regression analyses). *Results*: As regards C-NIP, Pearson's *r* correlation indexes showed that patients with a strong preference for emotional intensity (*e.g.*, they preferred that the therapist encourage them to express strong feelings) had lower levels of interpersonal problems (r=-.071, p=0.02). Finally, patients with a strong preference for therapist directiveness, emotional intensity, and warm support from their therapists, had higher levels of attachment anxiety (r=.11, p <0.01; r=.08, p=0.01; r=.07, p=0.02, respectively). As regards PST-Q, multiple linear regression analyses showed that among Italian psychotherapists, higher levels of attachment anxiety (measured through ECRS) predicted a lower number of patients under treatment (β=-0.185, t=-2.491, p=0.01), and that higher levels of reflective functioning (measured through RF8) predicted working more hours per week (β=0.159, t=2.399, p=0.02) and having more patients under treatment (β=0.148, t=2.214, p=0.03). These findings were partly in accordance with previous literature (Cologon *et al.*, 2017). In addition, Pearson's *r* correlation indexes showed that those with higher levels of RF gave more importance to the therapeutic relationship (evaluated through a 10-points Likert scale; "in a scale from 0 to 10, how important is for you the therapeutic relationship?". r=0.145; p=0.30), and were more willing to adapt their techniques to the specific characteristics of the patients (evaluated through a 10-points Likert scale; r=0.133; p=0.047). On the contrary, higher levels of attachment avoidance were negatively associated with the self-reported importance given to the therapeutic relationship (r=-.177; p <0.01). Finally, hypomentalization, attachment anxiety and attachment avoidance were all negatively associated with the psychotherapist's tendency to adapt his/her techniques to the specific characteristics of the patients (r=-.180, p <0.01; r=-.138, p=0.04 and r=-.151, p=0.02, respectively). *Conclusions*: Our findings provide further evidence that specific therapists' traits (*i.e.*, reflective functioning and attachment) predict both therapist's own effectiveness and the quality of his work. In addition, findings suggest that patient's preferences could be influenced by specific traits (*i.e.*, interpersonal problems and attachment dimensions). As such, clinicians should routinely assess patient preferences in clinical practice, and focus in strengthening those personal traits that seem associated with better treatment outcomes.

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Therapist response as a function of patients' symptoms and personality functioning: A preliminary study

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Introduction: Therapists' emotional responses to their patients constitute a critical variable that significantly affect the development and maintenance of therapeutic alliance and even the success of psychotherapy (Colli *et al.*, 2014). The current study explore how patients' personality functioning and psychiatric symptoms might influence the emotional responses and countertransference reactions of their therapists. *Methods*: Twenty-three individuals (74% females) aged between 21 and 58 years old (M=30.48, SD=10.05) who were seeking for psychotherapy were enrolled in this study. Mean years of education in the participants' group was 15 (SD=2.34). Participants were consecutively recruited at the Clinical Centre "Lo Spazio" in Palermo (Italy), which provides outpatient psychodynamic treatment for adults. The four therapists who accepted to treat these clients (all with 5 or more years of clinical experience) illustrated the objectives of the study to the participants, and all of them accepted to participate and signed the informed consent. During the assessment interviews, all the patients completed the Symptom-Checklist-90-Revised (SCL-90-R; Derogatis, 1994). After completion of the assessment interviews, the therapists completed the Shedler-Westen Assessment Procedure-200 (SWAP-200; Shedler & Westen, 2007) to evaluate the personality styles and disorders of the patients. Between the 12th and 16th clinical interview following the assessment phase, the therapists also completed the Therapist Response Questionnaire (TRQ; Betan *et al.*, 2005). Statistical analysis included descriptive statistics, zero-order correlations between the investigated variables, and stepwise linear regressions to identify the combination of symptom domains and personality functioning variables that best predicted the therapist response. *Re-*

sults: Symptom reporting at the SCL-90-R was high in this group (M=54.39, SD=20.47); however, intensity of symptom domains was mild to moderate, with highest peaks mainly observed in obsessive-compulsive (M=1.73, SD=.88) and depressive symptoms (M=1.66, SD=.96). The patients mainly displayed personality traits, styles and disorders related to the Cluster C of personality disorders (avoidant, dependent, and obsessive-compulsive), even though all the personality disorders but histrionic were represented in this group. Prevalent emotional responses by therapists were positive (M=2.57, SD=.72) and parental (M=2.30, SD=.76), but also disengaged responses were frequently observed (M=1.91, SD=.63). Correlational analysis showed that the global severity index of the SCL-90-R correlated with patients' borderline features (r=.53, p=.01) and clinician's overinvolved responses (r=.44, p=.03). Clinician's positive emotional responses were linked to high levels of patients' personality functioning (r=.49, p=.02), whereas overwhelmed, helpless and criticized therapists' responses were linked to patients' paranoid traits (r ranging from .50 to .58 , all p <.02) and higher age (r ranging from -.43 to -53 , all p <.05). Patients' low levels of education were strongly linked with therapists' disengaged responses. Regression analyses showed that therapist response was linked with both symptoms and personality features of patients: (1) overwhelmed responses were predicted by patients' hostility, psychoticism, and paranoid symptoms and personality ($R^{2=}$.78); (2) helpless responses were predicted by patients' paranoid personality and higher age ($R^{2=}$.44); (3) positive responses were predicted by patients' high levels of personality functioning and phobic symptoms ($R^{2=}$.41); (4) overinvolved responses were predicted by patients' depression ($R^{2=}$.24);(5) disengaged responses were predicted by patients' low education ($R^{2=}$.45); (6) parental responses were predicted by patients' interpersonal sensitivity ($R^{2=}$.19); (7) mistreated responses were predicted by patients' hostility, psychoticism, and paranoid personality ($R^{2=}$.69). No variables were entered as predictors for therapists' sexualized responses. *Conclusions*: Taken together, these findings support the view that the therapist response is specifically linked to the patient's symptoms and personality functioning. In particular, borderline features with severe symptoms seems to be linked with therapist's over-involvement. More positive responses were evoked in the therapist instead, when the patient came with circumscribed symptoms and high levels of personality functioning. Furthermore, it was observed that paranoid states in the patients may generate problematic responses in the therapist, especially when the patient is older, and thus the maladaptive personality features might appear as highly embedded in his or her personality. Some effects of education on therapist's disengaged responses were also observed, suggesting that low patient's education might not facilitate psychodynamic treatment. This preliminary study has a number of limitations that strongly limits its reproducibility, and thus its generalizability. However, the study might elucidate how some emotional responses in the therapist might be evoked by the patient's problems and personality, also indicating the usefulness of examining the therapist's emotional response to deepen the understanding of patient's functioning and to improve the efficacy of treatment.

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The person of the psychotherapy trainee: Influences of personal background and current life on perceived development as psychotherapist

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Introduction: The person of the therapist does make the difference for psychotherapy effectiveness (Wampold & Brown, 2005). In line with this evidence, data collection concerning the persons of psychotherapy trainees has been included within the aims of an international collaborative study on psychotherapy trainees' development, planned by the Society for Psychotherapy Research Interest Section on Therapist Training and Development (SPRISTAD) (Orlinsky & Rønnestad, 2005). Previous data collected in the Italian context have shown that personal experiences of trainees were frequently reported as a motivation in undertaking psychotherapy training and were associated with negative aspects of trainees' personal background (Messina *et al.*, 2018). However, the influence of personal background on trainees' development during psychotherapy training remains an outstanding issue in psychotherapy research. Additional to personal background, also the current life of psychotherapy trainees may influence trainees' development. Indeed, it has been shown that therapists' sense of currently experienced professional growth is influenced by their current life, with alternate moments of enthusiasm and disillusion about therapy (Rønnestad & Skovholt, 2003). Similar influences of current life may be detected in psychotherapy trainees, as observed in previous cross-sectional comparison (Messina *et al.*, 2017). Here, we present early longitudinal results coming from the Italian data collection as part of SPRISTAD study, with a focus on the persons of the trainee. We considered: 1) personal motivation in starting a psychotherapy training; 2) the impact of personal background on trainees' development during their training; 2) the influence of trainees' current life on current perception of their development. *Methods*: We used the Trainees Current Progress Report (TCPR) to collect information about dependent variables (perceived development, perceived skills, perceived difficulties, enthusiasm about therapy and disillusion about therapy) and independent variables concerning trainees' current life (satisfaction with life, emotional functioning and quality of life). We used the Trainees Background Information Form (TBIF) to evaluate independent variables concerning trainees background (motivation, care in childhood, familiar functioning in childhood and traumatic experiences). From the SPRISTAD database, the following data coming from Italian trainings institutes were extracted: a) to evaluate personal motivation, data from 178 trainees that have completed the TBIF; b) for the evaluation of current life, data from 68 trainees that have completed the TCPR, with at least two different longitudinal evaluations during a period of two years; c) for the evaluation of the influence of personal background on perceived development, data from 50 trainees that have completed both the TBIF and the TCPR . Repeated measures o simple regression analyses (with trainees as random factor) were carried out to investigate the association between dependent and independent variables, adding the time since

the beginning of the training (in months) as covariates in each analysis. *Results*: We confirmed that negative experiences in personal background are most frequent reported motivation to start a psychotherapy training (47.6% of participants reported this category of motivation), and that this category of motivation was associated to less care in childhood (t=-2.62, p =.009), less familiar functioning in childhood (t=-3.54, p <.001) and more traumatic experiences (t=-2.35, p =.020). However, in the subgroup of longitudinally evaluated trainees, background variables were not predictive of trainees' perceived development, with few exceptions such as less difficulties in having a real empathy for patients in more traumatized trainees (t=-2.54, p =.015). Several aspects of trainees' current life were predictive of their current psychotherapy practice: reported enthusiasms in doing psychotherapy was associated with satisfaction for actual life (t=2.07, p =.041), emotional functioning (t=3.16, p =.002), whereas quality of current life was predictive of more disillusion about therapy (t=-2.05, p =.043) and more difficulties in psychotherapy sessions (t=-2.92, p =.004). *Conclusions*: The data of the present study confirmed that the personal background of trainees is source of motivation to start a psychotherapy training, however we did not provide enough evidence that elements of personal background influence therapists' development during their training. Regarding the influence of therapists' current life on the perception of their development, the present study accounts for an important influence of current life on enthusiasm about therapy and perception of difficulties in psychotherapy practice. These conclusions are tempered by several limitations including the limited sample size and the variability in the number of evaluation and time interval regularity in the longitudinal evaluation of each trainee. A more extended data collection obtained through the SPRISTAD online survey system will provide stronger conclusions for the suggestions emerged in the present preliminary study.

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Therapeutic process: from relational and technical factors to an interactive process between therapist and patient

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Classically, literature on therapeutic process underlined the importance of the interdependency of technical and relational factors (Bordin, 1979; Safran & Muran, 2000). In the last years, on the theoretical side, the therapeutic process has been reformulated under an intersubjective perspective, and it is now conceived as a "specific psychological field" created by the interplay between the patient's and therapist's subjectivities (Stolorow, Brandchaft & Atwood, 2014). In this way, the therapeutic process is re-interpreted with an intersubjective perspective, in which two subjectivities, with their own histories and specificities, may continuously influence each other (Benjamin, 1990). Similarly, Mitchell (1993), within the relational movement, underlined that the negotiation between patient's and therapist's desire is a fundamental therapeutic mechanism of change. Consequently, relational dimensions and technical factors are conceived as inextricably interconnected. At both theoretical and empirical levels, therapist-patient interaction is characterized by a complex association between interactive variables. This perspective, however, opened a window onto a new, wide and complex perspective of the therapy process. The investigation on the therapeutic dyad, in fact, has showed that psychotherapeutic change is probably not a linear process, but rather a process characterized by sudden gains and regressions. These findings indicate the huge complexity in understanding the therapy outcome and therapy changing point and they underline the necessity of a more comprehensive perspective in understanding the psychotherapy process. On these grounds, the solely study of the correlation between technical and relational factors seems to represent a restricted exploration of the psychotherapy process. The complexity of process-outcome research, as well as the complex interaction of many therapeutic variables, underlines the necessity to better understand the interrelation between psychotherapy factors. This symposium aims to collect therapy process studies that explore original domains and dynamics of the therapeutic process between therapist and patient in order to offer a contribution on this complex issue. Interestingly, all the studies involve both technical factor and relational factor that may explicit different way in exploring the intersubjective area: therapeutic alliance, countertransference, family affects and mentalization function. The first study "In-session interactive dynamics of the psychotherapy process" (Locati, Rossi, Parolin) is focus on the therapeutic alliance recent conceptualization as an "intersubjective negotiation process" (Safran & Muran, 2000) that interacts with the other variables of the therapeutic process (Roth & Fonagy, 2013), although little is still known about the precise dynamic involving these key dimensions. The first study involves PD and neurotic patients in psychodynamic weekly treatments and investigates the in-session interaction of therapeutic process variables, focusing on the patient metacognition, the therapeutic alliance, the technical intervention, the therapist expertise and the patient functioning. The second study "Therapist's interventions and patient's reflective functioning" (Colli, Gagliardini) is focus on the investigate the relationship between therapist's interventions in Mentalization Based Treatment principles and patient's fluctuations (positive and negative) in Reflective Functioning at in

session level, to unmask the mechanism of change of reflective functioning across psychotherapy process. The third study, "Systemic Family Psychotherapy Process: A Pilot Study Using The Family Affects Behaviours & Interactions Scales (FABIS)" (Bassi, Viviani, Salcuni) explore the process-outcome of systemic family therapy. The study aim to measure and compare the trends of some specific psychotherapy techniques characteristics of SFT (such as corporeal and sculptural session, *vs* standard verbal psychotherapy sessions), applying the Family Affects Behaviours & Interactions Scales (FABIS), a new observational measure that permits to score both verbal and non-verbal process dimensions of SFT psychotherapy video-recorded sessions. Finally, the last study "Therapist response to the patient: techniques and countertransference" (Ferrero, Simonelli, Rutto, Lerda, Fassina, Gagliardini, Colli) evaluate processes and outcome of Adlerian Psychodynamic Psychotherapy (APP), a treatment technique with preliminary evidences of effectiveness in patients with Generalized Anxiety Disorder, Eating Disorders, Borderline Personality Disorder and Oncologic Pain. More specifically, in the third study, clinical and psychopathological features of the patient are intended as possibly related to both therapist's technical strategies and emotional response during the sessions, including countertransference.

In-session interactive dynamics of the psychotherapy process

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Introduction: Recent literature on the therapy process has emphasized the necessity of a more comprehensive perspective in understanding the dynamics underlying the therapy process and outcome (Ackerman & Hilsenroth, 2003; Levy, Ablon, & Kächele, 2012) in which, all the therapeutic process factors are seen as interconnected, often interacting in a nonlinear way and mutually reinforcing or declining the role of each other (Luyten, Blatt, Van Houdenhove, & Corveleyn, 2006). In the recent years, several authors explore different dimensions of psychotherapy process, such as patient metacognition, therapeutic alliance, technical intervention, therapist expertise and patient functioning. Between all these variables, literatures found some bidirectional link: for examples, metacognition may be favoured by a positive alliance with the clinician; on the other hand, metacognitive deficits may obstacle the alliance (Popolo *et al.*, 2010; Semerari, 1999). Interestingly, the therapist technical intervention may in turn influence both therapeutic alliance and metacognition functioning (Bateman & Fonagy, 2004; Liotti, 2011). Although, little is still known about the global interaction between different dimensions during the psychotherapy process. Accordingly with the recent literature, the study aims to explore the five key dimensions of the therapy process (*i.e.*, therapeutic alliance, technical interventions, therapist expertise, patient metacognition and patient functioning level) and their relative impact on each other. *Methods*: Participants included 45 patients involved in a psychodynamic weekly treatment in two Clinical Centre. The clinical sample includes heterogeneous patients in terms of diagnosis, measured with SWAP-200 (Westen & Shedler, 1999): 33 patients with neuroticism and 12 patients with personality disorders. Clinicians were 14 therapists (10 females and 4 males) aged between 28 and 65 years old (M=46.5 ys, SD=14.75). The clinicians are psychodynamic oriented therapists, 12 therapist-in-training and 2 expert psychotherapists. Four instruments were applied on the first three sessions of the psychotherapy (178 transcripts verbatim): MAS-R (Carcione *et al.*, 2010), CIS (Colli & Lingiardi, 2009), PIRS (Cooper & Bond, 1992) and the SWAP-200 (Westen & Shedler, 1999). The research procedure consists of two different steps. The first step investigates the interaction between technical intervention and therapeutic alliance at a microanalytic level; the second step explore the interaction between technical intervention, therapeutic alliance, metacognition function, therapist expertise and the patient's high functioning level at a macroanalytic level (Locati, Rossi & Parolin, 2017). *Results*: Sequential analysis revealed that different therapist interventions co-occurred with three different levels of therapeutic alliance: a first one characterized by a positive collaboration, the second one by a neutral collaboration and the third one by ruptures. In particular, the Positive alliance showed significant positive co-occurrences with Acknowledgments and Reflections. The Neutral alliance was positively associated with Contractual Arrangements, Associations, Clarification and Questions. Finally, the Negative Alliance was positively associated with Transference Interpretations, Work-enhancing strategies and Support Strategies. Regarding the second procedure step, first a confirmatory factor analysis (CFA) was performed to confirm the relationship between therapist intervention and the patient's alliance, and, successively, a structural equation model (SEM) was performed to explore the relationship between the alliance and the others key variables (*i.e.*, metacognition, therapist expertise and high-level functioning). Resulting from SEM, the Positive Alliance a significant effect of the "therapist expertise" was found. Similarly, in the Neutral Alliance a significant effect of the metacognition variable and patient's high functioning were found. Moreover, results also showed a significant negative effect of therapist expertise variable. Finally, in the Negative Alliance, a significant effect of the therapist expertise was found. A significant effect of the therapist expertise to metacognition variable was found. *Conclusions*: The present findings suggest the existence of a specific interdependence between the variables involved in the research and the therapist expertise is a key element that can completely modify the in-session interactive dynamic. Results unveiled a positive effect of therapist expertise on both the Positive Alliance and the Negative Alliance. On the contrary, therapist expertise exerted a negative effect on the Neutral Alliance, whereas the metacognitive function and patient's high-functioning exerted a positive influence. The expert therapist seems to be able to move the dialogue on ruptures or positive alliance, disinvesting from a neutral alliance. This finding seems to be linked to a better identifying deterioration or poor alliances of experienced therapists (Mallinckrodt & Nelson, 1991). The ability to better detect the patients' relational problems in therapy enables these therapists to build and repair their alliances with these difficult patients more efficiently. Expert therapists manage the therapeutic process in a dialectical way moving from negative to positive alliance: the resolution of ruptures in the alliance allows them to explore the relational and emotional meaning of negative feelings about the therapy (Safran & Muran, 2000a). It is likely that patients in treatment with therapists who frequently use this kind of interventions have a more passive representation of the therapeutic process, as it seems to be strongly led by therapist's questions. Contrary to expert therapists, who are able to identify and face the negativity of ruptures provoking and stimulate patient's change, inexpert therapists seem to establish and maintain a more passive and neutral collaborative relationship.

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Therapist's interventions and patient's reflective functioning

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Mentalization-based treatment (MBT) is an evidence-based treatment for borderline personality disorder (BPD). MBT is based on the theories of mentalization, personality disorders and principles of psychodynamic treatment. The key element is the focus on mentalizing within the therapy and in the external environment. Mentalizing capacities are considered an aspecific factor related to outcome in all forms of psychotherapy: patients' ability to reflect on mental states, although not specifically addressed, has a role in many therapeutic approaches as well as in psychological health. Therefore, such an ability is likely to facilitate the therapeutic work and to make change easier to achieve. Despite the growing literature on MBT efficacy and on mentalization, the mechanism of change of reflective functioning across psychotherapy process is still not completely understood. The only research that tried to address this issue found that MBT adherence and competence predicted higher session RF, even while controlling for pre-treatment RF and in addition, therapist interventions directed toward exploring mental states predicted higher RF of subsequent patient responses (Moller *et al.*, 2016). In light of these considerations is important to promote researches that try to understand the specifc mechanisms that help therapist in promoting patients reflective functioning at an in-session level. The aim of this study is to investigate the relationship between therapist's interventions and adherence to MBT principles and patient's fluctuations (positive and negative) in RF at in session level. In doing so we made some a-priori predictions: 1) we hypothesized that therapists' explorative interventions (as rated with the CIS–R) would be related to higher RF scores for patients; 2) we hypothesized that adherence to MBT would positively correlate to in-session RF. *Methods*: We evaluated 50 sessions transcripts (1,032 narrative units) related to10 differentpatients (5 sessions for each patient). The sample was composed by ten Caucasian patients (2 men, 8 women; mean age=29.91 years, SD=10.12), four patients had at least one PD diagnosis. Psychotherapies were administered by 8 psychologist and 2 psychiatrists mean age=44, SD=8.5). Therapists practiced in a private setting and in a mental health institutions. 8 therapists reported a psychodynamic theoretical and clinical approach while 2 reported a cognitive-behavioral approach. Each session was rated with the therapist's intervention subscale of Collaborative Interactions Scale - Revised (Colli, Gentile, Condino & Lingiardi, 2017), the MBT Adherence Scale (Karterud *et al.*, 2012), and the Reflective Functioning Scale (Fonagy *et al.*, 1998). The mean overall inter-rater reliability was on average good: CIS (.67 to .81; Cohen's Kappa); RFS (.60 to .85; ICC; singlemeasure, absolute agreement); MBT Adherence Scale (.65 to .70 ICC; single measure, absolute agreement). *Measures*: CIS – T is composed of four different scales: Direct (DCI; 4 items) and Indirect Collaborative Interventions (ICI; 3 items); Rupture Interventions (RI; 5 items) and differentiate therapist's contributions in relation to 4 different forms of the interventions (Supportive; Explicative; Explorative and Expressive). The reflective-functioning scale (RFS; Fonagy *et al.*, 1998) assesses reflective functioning on a level from -1 (rejection of RF) to 9 (marked or exceptional RF). In our work, we used the RFS by adopting a micro-analytical approach and assessed each patient and therapist verbal exchange by rating the presence or absence of each RF marker and providing an RF score for each utterance in which RF markers were present. The MBT Adherence and Competence scale is a 17- item scale (Karterud *et al.*, 2012) designed to measure the quality and timing as well as frequency of interventions that are central to MBT. Every item is given a score of adherence on a Likert-scale (varying from 1, meaning "absence of the intervention", to 7 "extensive frequency of the intervention") and a score of competence (varying from 1, "poor", to 7, "excellent"). Adherence is defined as the frequency of interventions connoted by the item in question. Competence is defined as the quality level of the interventions delivered, that is, the skillfulness, sensitivity, and timing that characterizes the therapist's use of the interventions. *Results*: We applied a multiple stepwise regression analysis: therapists' rupture interventions resulted associated and in a negative way with patient RF in the following verbal unit (t=-3,231; $p \leq 0{,}0019$). Conversely Explorative interventions predicted RF increase at in session level. MBT adherence resulted associated with significant increases in patient RF during sessions. *Discussion*: These results suggest the importance of a therapist explorative stance (the so-called "not knowing stance") to promote patient's reflective functioning at an in-session level and confirms clinical and theoretical literature on this topic. Clinical implications will be discussed.

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Systemic family psychotherapy process: A pilot study using the family affects behaviours and interactions scales (FABIS)

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Systemic Psychotherapy theorized that individuals cannot be un-

derstood in isolation but rather within various systems, this includes the family system, as well as work and social life. The most common type of systemic therapy is family therapy (SFT) that views difficulties and issues arising in the relationships, interactions, language and maladaptive behavior patterns as developed between individuals within a family system, rather than in the individuals themselves (AA VV, 2012). It involves gathering the system together and discussing how current behaviors are being perpetuated and how change may come about, with the aim to support the individual to change within the context of a supportive environment. Rather than providing answers and solutions, the therapist is more of a facilitator, aiding members of the system to provide, discuss and carry out solutions of their own. Therapy can vary in length, even if one-years-once-a-month is the more used format. SFT is flexible and uses of a variety of tools, named analogic, which include family sculpture, corporal aspects, collages, simulate, clinic cartoons, besides gestures, visual expressions, voice volume and the space use. In this perspective, SFT takes into account both verbal and non-verbal aspects, using video-recording of therapy and a unidirectional mirror in order to comprehend the relationship between family members in a deep way. For instance, during SFT the therapist can learn much information using the family sculpture tool such as the posture, the gazes' direction, the proximity and the distance between members. These patients' non-verbal factors are fundamental because they can transmit the tonic-emotional aspects to the therapist. In the SFT approach, the "hic et nunc" and the patients' perceived experience of change (effectiveness) seem to be more relevant than the therapy outcomes (Wampold, 2001). Although the research reviews and meta-analysis demonstrated that SFT is effective, acceptable to clients, and cost-effective for a sufficient range of conditions (*e.g.* Shadish & Baldwin, 2003; Sydow *et al.*, 2010), many reviewers have commented on the limited information in published studies about the precise nature of the therapy being examined (Wampold, 2001). In fact, due to the complexity and the number of variables of family interaction, the systematic and empirical study of SFT process variables is complex and less evaluated (Stratton, 2016). *Methods*: The main aims of this explorative study on SFT process were a) to measure and b) to compare the trends of some specific psychotherapy techniques characteristics of SFT (such as corporeal and sculptural session, *vs* standard verbal psychotherapy sessions), applying the Family Affects Behaviours & Interactions Scales (FABIS), a new observational measure that permits to score both verbal and non-verbal process dimensions of SFT psychotherapy video-recorded sessions. Eleven sessions, from November 2015 to June 2016, and 1-year follow-up session, were scored on an adoptive family's psychotherapy (mother, father, 16ys old adopted daughter and her 10 yr old sister). The parents self-referred for their "high anger and complete inability" in managing their older daughter's conduct problems and aggressive communication. The psychotherapy was aimed to decrease aggressive communications and refusal behaviors, and increasing alliance and affective support in respect to her and in general in the family climate. *Measure*: The Family Affects Behaviours & Interactions Scales (FABIS) has been constructed within a grounded theory framework, using a qualitative research procedure to analyze and score both verbal and observational data (mixed method). Seven mutually excludes dimensions were detected and operationalized by a team of 4 researchers (3+1 supervisor): trust/trust in, affection, alliance, aggression, refusal/ nonacceptance, control, grief. Each dimension was measured on a seven-point Likert scale from 0 (absent behavior) to 6 (strongly present behavior). After a training period, interscorer reliability reached Kappa=.82-.91 range on the seven dimensions. Two total subscales are also provided: positive dimensions (sum of trust/trust in, affective, alliance) and negative ones (sum of aggression, refusal/ nonacceptance, control, grief). The FABIS was applied on the four family members of the SFT, along with the 11 sessions (5 verbal psychotherapy *vs* 6 corporal and sculpture sessions) and at 1 year follow up. Descriptives and not-parametrical regression analysis with respect to the session order (time) for each dimension and the total subscales were performed, for the family system trends as well as for each participants *vs* the others, showing during the therapy both the time-trend of the dimensions at the family level, and the specific change of each member in respect with each other. Moreover, differences between verbal *vs* corporal and sculpture sessions were evaluated, at the family system level. *Results*: The psychotherapy process showed the dimension of alliance and affection between the family members presented increasing values; on the other hand, the refusal dimension tended to decrease during the unfolding therapy. Comparing data with respect to kind of technique, the seven dimensions time trend emerged more clearly with non-verbal communications (corporal and sculptural sessions) compared to traditional verbal therapy. Moreover, the positive trend persisted after the end of treatment, showing the family has not reported any relapse or worsening. *Discussion*: SFT is a wide known valid therapy in terms of outcome (Stratton, 2016), and also this SFR had beneficial effects on the whole family system and not only on the designated patient (Hazelrigg, Cooper & Borduin, 1987); the expression of the seven FABIS dimensions resulted higher in the non verbal than in the verbal psychotherapy sessions and also their change during the unfolding therapy. As Statton suggested (2016, pg. 45), "the potential for an integration of process research with outcome measurement is enhanced by recent substantial developments in qualitative methodologies that are specifically designed within a systemic framework". This pilot study tried to fill the gap in existing literature through the use of FABIS, a flexible and tool devoted to psychotherapy process evaluation; however, many limitations remained.

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Therapist response to the patient: Techniques and countertransference

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Introduction: Current research suggests that psychotherapy efficacy evaluation should not be separated from highlighting the common and specific process factors that are involved in treatments outcome. In this way, specific psychotherapies could be tailored

according to specific patient's needs, functioning and disorders. A research network, including Department of Mental Health – Health Local Agency Turin 4 (ASL TO4) - Chivasso (TO) - Italy, Department of Psychology and Department of Cultures, Politics, and Society – University of Turin - Italy, and Department of Humanistic Studies – University "Carlo Bo" of Urbino – Italy has been established in 2017, in order to evaluate processes and outcome of Adlerian Psychodynamic Psychotherapy (APP), a treatment technique with preliminary evidences of effectiveness in patients with Generalized Anxiety Disorder, Eating Disorders, Borderline Personality Disorder and Oncologic Pain. APP is conceived as a psychopathology-based treatment, that is the therapist's technical strategies have to be addressed to the specific patient's dysfunctions that underlie symptoms. To this aim, attention is paid by the therapist in order to detect how the patient's personality organization (as a latent construct) and its manifest derivatives may contribute to pathology that should be treated. Furthermore, clinical and psychopathological features of the patient are also considered as possibly related to emotional response during the sessions, including countertransference. Objective of this study is to evaluate the relationship between patient's and therapist's personality, therapeutic technique and outcome in APP treatments. *Methods*: The clinical sample includes patients of the Piedmont Expert Regional Center for Personality Disorders - Department of Mental Health – ASL TO4, Chivasso (TO). Inclusion criteria are these following: diagnosis of Personality Disorder according to DSM 5 criteria; age over 18 years; absence of mental retardation; absence of another comorbid acute mental disorder; absence of drug abuse, valid inform consent. Recruitment started on September 1st, 2017. A 40 sessions module of Sequential-Brief Adlerian Psychodynamic Psychotherapy is delivered to all patients. Psychotherapists are all licensed and graduate psychologists or psychiatrists. A group of them are fully trained APP psychotherapists, while a control group includes psychotherapists with only a preliminary technical training. Patients symptoms and personality dimensions are evaluated at intake (T0) and at treatment's end (T40) by means of self-administered questionnaires: Symtom Checklist – 90 – R (SCL -90 – R); Beck Depression Inventory II (BDI – II); State-Trait Anxiety Inventory – Y (STAI – Y), State -Trait Anger Expression Inventory – 2 (STAXI – 2); Toronto Alexithymia Scale – 20 (TAS – 20); Barratt Impulsiveness Scale – 11 (BIS – 11), Temperament and Character Inventory (TCI). Patients personality dynamic organization and the corresponding dysfunctions in five core areas (identity, comprehension, negative emotions, action-regulation and social skills) are evaluated by means of Psychopathological Functioning Levels - Rating Scale (PFL-RS), at T0, after 20 sessions (T20) and at T40. Furthermore, patients mentalization modes and polarities are further investigated by means of two self-administered questionnaires: Modes of Mentalization Scale (MMS) and Polarities of Mentalization Scale (PMS). Evenly, their scores are collected at T0, T20 and T40. Concerning therapeutic process, the quality of working alliance, the use of specific technical instruments and strategies as well as therapist's countertransference are evaluated every 5 sessions and at psychotherapy's end, by means of Working Alliance Inventory (WAI-T, WAI-P), Comparative Psychotherapy Process Scale (CPPS-T, CPPS-P) and Therapist Response Questionnaire (TRQ), even comparing patients and therapists perspectives. *Preliminary Results*: Preliminary findings from the evaluations of 150 sessions of 30 patients will be shown, concerning correlations between the dimensions above mentioned. In particular, correlations between three patients psychopathological dimensions (MMS, PMS and PFL-RS) and both quality of technical strategies (CPPS-T, CPPS-P) and countertransference (TRQ) will be pointed out. The data will be analysed with SPSS software. *Conclusions*: The study is in the initial phase. In general, it is aimed at verifying if the flexibility of therapeutic choices according to psychopathological dysfunctions of the patients is a relevant effective factor of treatment. More in detail, the study also tries to understand how the variations of the technique may influence the working alliance with the patient, which is a proven common factor of effectiveness. Contextually, the implications of the emotional condition of the therapist can be evaluated, at least as far as he or she can be aware of it. Finally, the study could provide information on the importance of therapist training, both concerning technical and emotional aspects.

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Training and development in psychotherapy: findings from the SPRISTAD studies of the trainees' progress from their own and their supervisor's perspective

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In recent years, a growing interest has been dedicated to the study of therapist's personal characteristics and professional abilities. Evidence supports the importance of these aspects in predicting the outcome of psychotherapy. Consequently, understanding how the personal characteristics influence the training and understand how these professional skills develop during the training has become a very important topic for the future of psychotherapy. In line with this, the first study conducted by Salcuni & coll. aims to explore key aspects of development among psychotherapy trainees attending different years of their training program. The study deals with the effect of quality of supervision and personal therapy on trainee development involving young therapists who had at least one experience in doing psychotherapy. The other three studies focused on the process of development of trainee's skills by adopting longitudinal designs. In particular, the study conducted by Messina et coll., provides evidence of changes in psychotherapy trainees' perception of their development over time. In particular, the study presents findings regarding changes in perception of improvement, overcoming limitations and realization of potential. The study was conducted on a convenient sample of trainees recruited in four Italian institutes for the training of psychotherapists that have different theoretical orientations. In a similar way the study presented by Gelo and coll. focus on the development of clinical relational abilities during training in a convenient sample of Austrian trainees. The study was specifically designed to verify whether personal relational abilities increased during the training and personal therapy was associated with higher values of relational abilities. The last study conducted by Giordano and coll. explores similar topics from a different perspective. The study aims to investigate how professional skills and personal representation of oneself as psychotherapist changes during the experience in doing psychotherapy. To pursue these objectives the study was designed as single-case and adopted a mixed method that integrates quantitative and qualitative data. The study focused on the effectiveness of empirically-supported supervision on trainee's management of therapy, exploring how supervisees refine their clinical skills, manage their difficulties in clinical practice, and changes their professional self-representation as an effect of the supervision activity empirically guided. Comparison of results provided by the four studies was facilitated by the sharing of common measures extract from the SPRISTAD project. On the basis of findings arose from the studies clinical implications will be discussed.

Trainees' self evaluation of their development as psychotherapists: An update of spristad data collection in Italy

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Introduction: In psychotherapy research, therapist variable is emerging as an important predictor of psychotherapy outcome, suggesting that psychotherapy training effectiveness deserve more attention (Messina, 2018). Due to this increasing interest for psychotherapy training effectiveness, the Society for Psychotherapy Research Interest Section on Therapist Training and Development (SPRISTAD) has launched a large scale collaborative, multisite, and multinational study of therapist development in psychotherapy training programs (Orlinsky *et al.*, 2015). Previous studies in the Italian context have documented the existence of cross sectional differences between trainees in different years of training and have explored the influence of core training experiences - supervision and personal therapy - on their perceived development as therapists (Messina *et al.*, 2017). Here, we present an update of this Italian data collection, focused on trainees' perception of their development evaluated with the Trainee Current Progress Report questionnaire (TCPR). Despite the TCPR was developed with the purpose of longitudinal evaluation of psychotherapy trainees' development (Orlinsky & Rønnestad, 2005), in the present study we realized a preliminary cross-sectional application. The primary goals of this study were (a) to provide a preliminary assessment of the TCPR as an instrument measuring key aspects of development among psychotherapy trainees at different years of their training (b) to explore how much supervision and personal therapy do contribute to trainee development. *Methods*: A convenient sample of trainees was recruited in four different psychotherapy institutes (dynamic, systemic, cognitive and constructivist). Initially, a total of 180 Italian trainees were involved in the present study. However, only 123 trainees (age 34.73±10.11, females=105 and males=18) reported having had at least one experience in doing psychotherapy and were able to complete the TCPR. We focused on the following independent variables: years of training, personal therapy (yes *versus* not) and quality of supervision (perceived support in supervision and perceived critics in supervision). And, we considered the following dependent variables: several dimensions of perceived development (perceived change, perceived improvement, perceived decline, overcoming limitations, satisfaction with development, and realization of potential al therapist), perceived skills and perceived difficulties in doing psychotherapy. With regard to data analyses, we used simple regression analysis to test the effect of variable year of training on dependent variables. Then, controlling for variable time, we used multiple regression to test the effect of personal therapy and quality of supervision on dependent variables. *Results*: Years of training predicted several aspects of perceived development: perceived change (t=3.32, p=.001), satisfaction with development (t=3.17, p =.002), and realization of potential (t=4.15, p=<.001). Moreover, years of training predicted less difficulties in psychotherapy practice (t=-2.23, p=.027). Personal therapy was highly predictive of perceived change (t=2.74, p=.007), perceived improvement (t=3.13, p=.002), and perceived skills in doing therapy (t=2.20, p=.030). In regards to quality of supervision, perceived support in supervision was associated to perceived change (t=2.65, p=.009), less perceived decline (t=- 2.57, p=.012), and satisfaction with development (t=2.29, p=.024), whereas perceived critics was strongly associated to perceived difficulties in doing psychotherapy (t=3.69, p=<.001). *Conclusions*: This study confirms that trainees with more years of training reported significantly higher levels of perceived development, confirming our previous study in an extended sample. These results account for a sufficient sensitivity of the TCPR to measure change in trainees at different steps of their training, and probably it may be also a sensitive

measure of their chance over the course of time, as required for longitudinal evaluations. Beyond time in training, we confirm also that the quality of training experiences is important for therapists' perception of their development. The quality of trainees' experiences with supervisors was associated with several aspects of their perceived development, suggesting that the issue of supervisory relationship should deserve more attention in psychotherapy research. These results are in line with the literature on the importance of supervisory alliance for the development of trainees (for a review see Watkins, 2014). Finally, we confirmed also the importance of personal therapy, which appears as an undeniable experience in therapist training. Moreover, the association of personal therapy and satisfaction for the development suggests that trainees agree on the importance of personal therapy as part of their training. Despite such interesting suggestions, stronger conclusions about therapists' development in psychotherapy training would require future studies with longitudinal designs.

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Trainees' self evaluation of their development as psychotherapists: Early results of a longitudinal study

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Introduction: Therapist development in psychotherapy training and training effectiveness are receiving a growing interest in psychotherapy research. Previous studies have shown that the perception of development vary between beginner and experienced clinicians, without considering the role of psychotherapy trainings in such development (Orlinsky & Rønnestad, 2005). With a more specific focus on trainings, a recent review has concluded that early evidence suggests changes across time in psychotherapy trainees, but more studies are required to confirm these conclusions due to the lack of replications and the evaluation of the effects of training in very small groups (Hill & Knox, 2013). In the Italian context, psychotherapy training studies have shown differences between trainees at different years of training in cross sectional comparison (Messina *et al.*, 2017). Moreover, this study has reported effects of personal therapy and quality of supervision on trainees' perception of their development (controlling for time in training). However, stronger conclusion about training effectiveness require longitudinal designs. In the present preliminary study, we present early longitudinal data collected in Italy as part of the large scale collaborative, multisite, and multinational study of therapist development in psychotherapy training programs of the Society for Psychotherapy Research Interest Section on Therapist Training and Development (SPRISTAD) (Orlinsky *et al.*, 2015). We used the Trainee Current Progress Report questionnaire (TCPR) created by SPRISTAD for longitudinal evaluation of psychotherapy trainees' development (Orlinsky & Rønnestad, 2005). The primary goal of this study was to provide evidence of changes in psychotherapy trainees' perception of their development over time. Moreover, we also evaluated the effect of supervision and personal therapy. *Methods*: A convenient sample of 76 Italian trainees, recruited in four different psychotherapy institutes (dynamic, systemic, cognitive and constructivist), were involved in the present study. The data provided by each trainees varied in the total duration of the longitudinal evaluation (from 1 to 2 years of training) and in the number of longitudinal evaluation (all trainees completed the questionnaires 4 times, however they have had at least one experience in doing psychotherapy to complete all items of TCPR), reaching around 190 observations. Due to this variability, we chose to evaluate the effect of time considering the number of months since the beginning of psychotherapy training. We tested the effect of variables time, quality of supervision (perceived support in supervision and perceived critics in supervision), and personal therapy (yes *versus* not), on the following dependent variables: perceived development (perceived change, perceived improvement, perceived decline, overcoming limitations, satisfaction with development, and realization of potential as therapist), perceived skills and perceived difficulties in doing psychotherapy. We used repeated-measures regressions analysis, with trainees and training institutes as random factors, to test the effect of variable time, quality of supervision, and personal therapy, on our dependent variables. *Results*: Most of dependent variables were significantly predicted by the time: perceived change ($t=4.57$, $p<.001$), perceived improvement ($t=2.73$, $p=.007$), overcoming part limitations ($t=4.84$, $p<.001$) satisfaction with development ($t=4.19$, $p<.001$), realization of potential ($t=3.31$, $p=.001$), and therapeutic skills ($t=2.07$, $p=.041$). The quality of supervision, and in particular the perception of support in supervision was predictive of most of dependent variables: perceived change ($t=3.36$, $p<.001$), perceived improvement ($t=3.04$, $p=.003$), perceived decline ($t=-3.63$, $p<.001$), overcoming part limitations ($t=2.88$, $p=.005$) satisfaction with development ($t=2.17$, $p=.033$), and therapeutic skills ($t=3.23$, $p=.002$). Having had a personal therapy influences only trainees' perception of their overall change ($t=2.12$, $p=.037$) *Conclusions*: This preliminary study provided very encouraging results with statistically significant changes in trainees' perception of their development over time in training. Thus, we are able to confirm that the sensitivity of TCPR as an instrument to measure longitudinal change and we suggest that psychotherapy training involved in the study are likely to be effective in train future therapists (but we cannot generalize such conclusions for Italian trainings in general). Moreover, the quality of supervision emerged as an important factor for training effectiveness. Our conclusions should be tempered by considering few limitation of the present study, including the limited number of trainees and the limited number of training institute recruited until now. Future effort should be addressed to a more extended data collection through the SPRISTAD online survey system, which would provide also information concerning training programs in widely different cultural contexts and would give opportunities for

the influence of trainees' background on their development (Messina *et al.*, 2018).

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Development of personal relational abilities in the process of becoming a psychotherapist: Preliminary results from the Austrian context

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Introduction: In recent years there has been an increasing interest in the empirical investigation of psychotherapy training, in line with a renewed attention to the person of the psychotherapist and his/her professional development (Orlinsky & Rønnestad, 2005). This is testified, among others, by the foundation of the Society for Psychotherapy Research Interest Section on Therapist Training and Development (SPRISTAD). The current study reports some preliminary results from a large-scale, multisite, and multinational longitudinal study launched by SPRISTAD on the development of psychotherapy trainees' relational abilities. According to a humanistic-interpersonal perspective, who we are is strictly interconnected to how we relate to others, and this deeply impacts the quality of our therapeutic work. This is true for both clinical relational abilities (how we relate with clients within the clinical setting) and personal relational abilities (how we relate with significant others in everyday life). From this perspective, psychotherapy training can be considered a developmental process aimed at fostering as well clinical as personal relational abilities of trainees. Existing empirical research on psychotherapy training has begun to focus on the development of professional relational abilities during training. Studies have shown an increase of basic relational skills over the training (Dennhag & Yrandt, 2013), that years of training predict warm relational agency (but not relational manner) (Messina *et al.*, 2017), and that trainees with personal training show higher warm relational agency and relational manner (Messina *et al.*, 2017). On the contrary, only a few studies have focused on trainees' personal relational abilities. For example, Tilkidzhieva *et al.* (submitted) found that advanced trainees – compared to beginners – believe that an ideal therapist should be more invested and affirming, while beginners – compared to advanced – consider themselves more invested (*i.e.*, over-involvement) with regard of an ideal therapist. The present study aims at further exploring the role of personal relational abilities in psychotherapy training. We test the following hypotheses: (1) personal relational abilities increase during the training; (2) personal therapy is associated with higher values of relational abilities. *Methods*: The sample was comprised by a total of N=221 psychotherapy trainees (female=73%; age: M=26.4; SD=7.7) at the Sigmund Freud University, Vienna. They belonged to three different cohorts, and were tracked over the first two years of their training. According to the Austrian psychotherapy law, the first two years of a psychotherapy training (Propedäutikum) provide trainees with extensive basic theoretical knowledge on psychotherapy, self-awareness experience, and psychosocial practice and supervision; this aims at allowing the trainees to become acquainted with the different psychotherapy approaches and to then choose the approach they prefer during the following three years of the program (Fachspezifikum). Data was collected using a combined and slightly modified version of the Trainee Background Information Form and Trainee Current Practice Report (Tilkidzhieva *et al.*, submitted) to assess the ability to form, influence, and withhold a personal relationship (relational agency: 'invested', 'efficacious'), the typical way to come into a personal relationship (relational manner: 'affirming', 'reserved'), and the skills for managing and sustaining a personal relationship (relational competence: 'expertise', 'basic skills', and 'advanced skills'). The instrument was administered before the beginning of the training, and then every six months for the following 4 semesters. Hierarchical Linear Modelling was used to investigate changes in the relational abilities over time and to identify the moderator role of personal therapy. *Results*: Contrary to our first hypothesis, all the considered subscales showed a small but significant decrease over the considered timespan. This result, though surprising, suggests that trainees might experience a disruption of existing relational abilities in order to allow the reorganization required by a process of personal development during training. This result is coherent with the findings of Tilkidzhieva *et al.* (submitted) showing a distance between trainees' *self-perception* and the *ideal image* at the beginning of the training; it is moreover coherent with the description given by Rønnestad and Skovholt (2013) regarding *novice* trainees compared to *advanced* ones. Finally, this result is coherent with a dynamic systems approach (Gelo & Salvatore, 2016), according to which the development of a system necessarily requires a disorganization of its way of functioning in order for new ways of functioning to emerge. Our second hypothesis concerning the positive association between personal therapy and higher values of relational abilities could be confirmed only for the subscale relational agency (item 'invested'). This finding suggests that, with one exception, personal therapy might take longer to influence relational manner and relational competence during the course of training. *Conclusions*: Personal relational abilities of psychotherapy trainees, as well as their relationship with personal therapy, should be taken into consideration in the implementation of psychotherapy training programs. Moreover, they should be further explored in future studies.

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Empirically grounded supervision. A preliminary mixed-method investigation

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The importance of the therapist feedback in monitoring the outcome of the psychotherapy, have already been addressed in literature (Lambert, 2015). Recently, attention has also been given to the impact of feedback monitoring in group therapy (Slone *et al.*, 2015). Specifically, identify at-risk group members and preventing treatment failure while monitoring the progress of group therapy can facilitate the therapist's understanding of the quality of the therapeutic alliance, and the motivation and readiness for change of patients. Several studies demonstrated the benefits of continuous feedback on treatment progress and alliance in group therapy to patients and therapists compared with both a no process or outcome feedback condition and a condition providing only outcome feedback (Janis, Burlingame, Olsen, 2018). The monitoring of psychotherapy outcome and process is particularly important during psychotherapy training programs to verify and refine clinical skills, to overcome difficulties in clinical practice, and to work more consciously on building good therapeutic relationships. However, to date discussions between supervisors and trainee clinicians in supervision are still largely based on subjective report made by the trainees, whereas, intriguingly, one could suggested integrating client and therapist data and feedback (of outcome and process) into the supervisory process. In the present study, we focused on the effect of the empirically-grounded supervision on trainee's management of therapy. In particular, the study aims to explore how supervisees refine their clinical skills, manage their difficulties in clinical practice, and changes their professional self-representation as an effect of the supervision activity empirically guided. To pursuit these objectives the study was designed as single-case and adopted a mixed method that integrates quantitative and qualitative data. The method adopted in the present study consisted in: monitoring outcome and process during psychotherapy (client feedback), using client feedback to inform discussions on clients during supervision meeting, identifying patterns of outcomes across clients to refine therapeutic strategies implemented by trainees, using therapist self-monitoring (process and outcome) to facilitate trainees growth and development. The therapeutic group conducted by two therapists in training, followed through an empirically grounded supervision over 6 months. The group leaders received monthly session feedback reports on patients' responses to the Partners for Change Outcome Management System (PCOMS; Ducan, 2012;) a combined measure designed to evaluate the outcomes (ORS) and the group relationships (GSRS). Moreover, patients filled out measures of alliance by the Working Alliance Inventory (WAI) and the Group Questionnaire (GQ) at 3nd and 6th months of therapy. Concurrently, group leaders completed measures of alliance (WAI-T), the Trainee Background Information Form (TBIF), and Trainee Current Practice Report (TCPR) at 6th months of therapy. These last two measures are part of core instruments of the SPRISTAD project (Orlinsky *et al.*, 2015). Results showed that professional skills and personal representation of oneself as psychotherapist drastically changes during the experience in doing psychotherapy providing initial support to efficacy of the empirically-grounded supervision. Qualitative data confirmed that the activity of supervision empirically guided played a crucial role in trainees' abilities development.

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ORAL COMMUNICATIONS

Combined individual/group psychodynamic psychotherapy: Human developmental process and therapeutic process

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Introduction: The author presents a model of combined individual/group psychodynamic psychotherapy in which the therapeutic process follows the steps of the developmental process of the human being. The methodology has been fixed as a consequence and not as a premise of the clinical work with patient and their representations of the process of growth inside dreams and the relation. Since birth, as neuropsychology shows, the new-born is active with the environment that is mostly represented by a dual relationship, usually the mother. In the first years of life the right hemisphere works more than the left one and this period is widely mediated by sensorial perceptions. Therefore the kind of relation of first years of life drives significantly the development of the child for the constitution of his/her identity. The affective moments perceived by the baby remain as traces in the mind and emerge from dreams of the patient as images. Dreams are the most effective skill to regain that period and the emotions related. The dysfunctional feelings and dynamics experienced in first years of life are explored, interpreted and transformed during the individual therapy as a dual relation mother-child, with a strong intervention of the role of dreams. When the patient starts to elaborate a separation process from those dynamics and restores his/her separation process that emerges as located between 1 and 3-4 years, the therapeutic work is both individual and group therapy. In this way there is the possibility to experience the progressive separation between the dual relation (mother-therapist) and the social one (others-group) where both relations are still walking together. Inside the group the relations and dreams are considered and interpreted. When the patient goes out from the dual system that is unconsciously represented by "me and myself" and can extend his/her dynamics to social ones, the individual therapy/the mother is not necessary anymore so the therapy proceed only within the group until it ends. The group only represents the work on the autonomy of the self, free from the need of the dual relation. The group progressively works on actual dynamics and relations and less on the past-ones and dreams show this change of the unconscious images that are coherent with the here and now of the person. The unconscious split is substituted by the return to the one's integrity, the whole identity. *Methods*: 2 groups of psychodynamic psychotherapy, open for age, sex, psychopathology, length of therapy; weekly sessions, 2 hours for one group and 1h 30m for the other, maximum 8 participants, 1 conductor, the same therapist as individual therapy. Every member has started with individual psychotherapy and the entrance into the group was strictly personal in terms of time to start the group. One group is older than the other so there is the choice to put inside a new patient following the personal characteristic and dynamics of the person, his/her way of elaboration, mentalization and working process. *Results*: Every patient works entirely on his/her personal world. The person follows a process that is explained step by step, its significance in the past (the personal history) and in the present (the psychotherapeutic work). The main advantage of this methodology is that where psychodynamic psychotherapies exploring mainly the unconscious dynamics emerging from dreams could lack in the exploration of the present behaviors, relations and the way in which the elaborated dynamics are daily activated, the psychotherapies focused on the interpersonal and intersubjective aspects don't give enough spaces to dreams and their meanings in the building of the identity of firs years of life, while in this way both the processes are included and specifically explored. It is perceivable the moment in which patients don't need the interpretation of the past dynamics because they are unconsciously resolved in terms of dreams but they need the time and space to feel that they are really acting the important changes they've hardly and deeply made. The patient really feels to be accompanied by hand for a certain time of the psychotherapy and then progressively goes with his/her own legs and it is a chance to experience the progresses reached during the work with dreams. *Conclusions*: The relevance of the methodology presented is that was built during the clinical process, with the understanding of the unconscious developmental process of the baby/adult patient, evaluating the inner specie-specific capacity of Humans to activate since birth a strong potential to invest affectively with the environment. These traces emerge from dreams together with the dysfunctional and suffering experiences. What emerges is completely similar to recent neuropshycological findings concerning the first three years of life and the effects on the brain of valid attachment. The emerging Human Potential is the main skill that the therapist has to transform the psychopathological aspects of the Self and restore the physiology as the unicuum body/mind. This primal therapeutic activity is based mostly on dreams and their interpretation, later it is possible to realize a more effective integrity of the interpersonal and relational aspects of patients that are played inside the group.

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Do systematic replication, single-case meta-analysis and benchmarking represent a low cost and robust methodology for recognition of marginalized and emerging models of psychotherapy? The case of transactional analysis for depression

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Introduction: To address the demands of Evidence-Based Practice, proponents of all approaches are pressed to conduct more and better Randomized Clinical Trials (RCTs). Approaches without evidence from RCTs are marginalized and disenfranchised, whereas approaches with a great deal of evidence are given prominence. To help Marginalized or Emerging Psychotherapies (MEPs) make their journey toward credibility, Stiles, Hills and Elliott (2015) sug-

gested a four steps pathway: the first two are based on systematic single case studies, specifically on direct and systematic replication of single-case researches, development of practitioner research networks and online data collection facilities, allowing accumulation of low-cost uncontrolled practice-based evidence, that can be analysed and compared to benchmarks for tentative inferences about MEP's effect on client change; the last two steps are based on RCTs and political networking. . The aim of this study is to present the journey of a MEP (*i.e.*, Transactional Analysis, TA) toward recognition, based on the first two steps of Stiles and colleagues' pathway. We present: a) a systematic review of all published systematic single-case studies on efficacy or effectiveness of a manualized TA treatment for depression (Widdowson, 2017); b) a meta-analysis of single-cases with a standardized mean difference statistic; c) a comparison of the single-case meta-analysis effect size (ES) against ES drawn from studies on efficacy (RCTs) and effectiveness (open trials) of treatments for depression, and from studies on natural history (control or no treatment) of depression. *Methods*: *Systematic review*. We conducted a comprehensive search for single-case TA treatment for depression using the following electronic databases: PubMed, EBSCO, PsychINFO, Scopus, Web of Science and in Google Scholar to find published open access research articles, peer- reviewed, non-indexed journals. These searches were conducted in October 2017 using as primary key terms: "Transactional Analysis", "Depression", "Single-Case", "Case-Study" anywhere in the article. 575 articles were retrieved. We assessed for eligibility only research articles which: A) clearly defined population, B) manualized or *bona-fide* intervention, C) continuous assessment of outcome measures, D) outcome measures with: (a) research evidence of robust validity and reliability; (b) availability in several languages and formats to maximize accessibility; (c) extent of published normative data for more feasible comparative research. We assessed also reactivity and specificity of outcome measures for comparison with benchmarks drawn from outcome measures with similar characteristics. We obtained raw data from tables or graphs in published articles and from authors when necessary. *Meta-analysis*. We followed the procedure reported in Shadish, Hedges, and Pustejovsky (2014), estimating the effect of TA treatment for depression with Hedges standardized mean difference, corrected for small sample bias, Hedges' *g*, commonly reported for between-group designs. This method uses between-case and within-case variance to calculate an ES for a study of at least three cases. We obtained ES estimator of the phase contrast (*i.e.*, baseline-treatment), using a random-effect model. Heterogeneity was calculated using restricted maximum likelihood estimation, and standard errors according Shadish and colleagues (2014) recommendations. *Benchmarking*. We followed Minami, Wampold, Serlin, Kircher and Brown (2007) standard procedures to compare the ES of our meta-analysis to published benchmarks for depression. Efficacy benchmarks were drawn from Minami *et al.* (2007) that calculated outcome benchmarks for the outpatient treatment of adults with major depression, by meta-analytically aggregating outcomes from a review of clinical trials. They reasoned that if the ES observed in routine practice is within 0.2 standard deviations of the efficacy benchmark, it will be determined clinically equivalent. They estimated an efficacy benchmark of 1.7 ($d_{.025}$ 1.6 – $d_{.975}$ 1.82) and a natural history benchmarks of 0.37 ($d_{.025}$ 0.2 – $d_{.975}$ 0.54) for studies that used low reactivity and high specificity outcome measures, (*i.e.*, PHQ-9 and BDI-II). Effectiveness benchmarks were drawn from data published by Delgadillo and colleagues (2014) on the effectiveness of the Improved Access To Psychotherapy (IAPT) program in routine practice during the first year of implementation in 30 routine services in England. They estimated high (0.91), average (0.73) and poor (0.46) performance ES for routine IAPT services using PHQ-9 as outcome measure. They proposed a null hypothesis: whether estimated benchmarks are contained within confidence intervals of meta-analysis' ES, there won't be significant differences between benchmark and ES. *Results*: The systematic review retrieved 11 systematic case studies fulfilling inclusion criteria. All studies used low reactivity and high specificity outcome measures, (*i.e.* BDI-II and PHQ-9). We calculated Hedges' *g* for each study and an overall weighted average for baseline-treatment comparison. TA had a large effect (0.98 [95% CI 0.44 to 1.53]) on depressive disorders. Namely, TA resulted in about 1-standard-deviation change in the outcome variable, on average. The comparison with efficacy benchmark shows that TA ES for depression (0.98) was larger than the natural history benchmark (0.37), low (0.46), average (0.73) and high (0.91) benchmarks drawn from IAPT effectiveness studies, and smaller than benchmark drawn from efficacy studies (1.7). The confidence interval of our ES encompasses low, average and high benchmarks drawn from effectiveness studies. *Conclusions*: We proposed to support systematic replication of single-case, meta-analysis and benchmarking to support recognition of MEPs. This meta-analysis synthesized the effect of TA treatment for depressive disorders from 11 single-case research studies. TA shows a large effect, that equates best results obtained from previous study on effectiveness of Cognitive-Behavioural Treatments for depression. The wide confidence interval, probably due to few retrieved studies, allows only tentative conclusions on effectiveness of TA for depressive disorder. The result of this meta-analysis should be examined considering several limitations. First, we only considered studies with a primary outcome on depressive symptomatology, not considering any comorbidity. Second, we used a random effect model, which might be biased with small numbers of studies. Third, our findings may be biased by allegiance and publication bias, being the retrieved literature published only by two research groups that collaborated with the principal investigator of this meta-analysis. Despite these limitations, findings from the present study may corroborate the diffusion of single-case systematic replication and meta-analysis for benchmarking ES of MEPs and support their recognition as Empirically Supported Treatment.

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Cost-benefit, cost-effectiveness and cost-utility analysis in clinical health psychology and psychotherapy

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Introduction: Evidence-based psychological interventions and psychotherapies are very relevant for different national healthcare systems in order to face with a critical challenge for the modern society: to treat mental disorders. Even if these treatments are strongly recommended according to many guidelines and the recent scientific literature, the real provision of psychological consultations has not achieved a key impact in many countries. Clinical studies providing not only medical and psychological data, but also reliable cost estimations about treatments provided are lacking and further investigation is needed in order to demonstrate that psychological treatments could be effective at clinical and economic level. Considering CBT, one the traditional gold-standard treatment for many psychopathological disorders, many controlled randomized trials have established the clinical efficacy of this approach, but research in cost-benefit analysis is lacking for this kind of psychotherapy too. *Methods*: A possible factor that could reduce the impact of psychology in the health care systems is not the clinical efficacy, but the lack of evidences in providing cost-effective solutions. An overview of the situation about cost-benefit analysis, cost-effectiveness analysis and cost-utility analysis in clinical psychology and psychotherapy, considering Italy and other countries as example, has been performed. Particularly cost-benefit analysis could be considered as the study of the socially desirable outcome achieved by a particular treatment, whereas the cost-effectiveness analysis considers the relationship between monetary costs and measures of treatment outcome, taking into account possible outputs such as symptoms reduction or work productivity. Cost-utility analysis has overlapping characteristics of the cost-effectiveness analysis, but it uses a specific methodology that includes a valuing metric for measuring the treatment impact standardized in terms of quality-adjusted life years-QALY. *Results*: The legitimization of clinical psychology and psychotherapy in different health care systems is not always present, with some examples of best practices (such as in UK and in US) and some situations where the psychological part of the care is neglected even if the framework considered is the biopsychosocial one (such as in Italy and partially in France). At least 3 steps are requested in each country in order to legitimize clinical psychology in health care systems. 1) Clinical psychology and psychotherapy should select evidence-based psychological treatments or research-supported ones as traditionally reported by APA (Division 12-Clinical Psychology of the American Psychological Association at the website https://www.div12.org/psychological-treatments. 2) psychology and psychotherapy should measure clinical efficacy using well-known and scientifically recognized questionnaires-scales such as Behavior and Symptom Identification Scale-24; Clinical Outcomes in Routine Evaluation Outcome Measure; Depression Anxiety Stress Scales; Health Survey Short Form-36; Outcome Questionnaire-45; Patient Reported Outcome Measurement Information, System; Symptom Checklist-90-Revised and Brief Symptom Inventory (3) Clinical psychology and psychotherapy should include cost-benefit analysis, cost-effectiveness analysis and cost-utility analysis in their studies and trials, using well-validated tools, such as QALY, to measure the standardized treatment impact expressed in quality-adjusted life years, or the Trimbos/iMTA questionnaire, to measure the costs in psychopathology. *Conclusions*: Suggestions to the community of clinical psychologists and psychotherapists are provided in order to enhance the legitimization procedures of psychological practices in health care systems. New evidences about the economic impact of psychotherapy is necessary in order to avoid the Emmelkamp's warning (2014), "even if a psychological treatment could show strong efficacy and/or effectiveness, due to high costs it might never be assimilated in real clinical practice" (p. 67). We have to take into account that psychological interventions are also successful in reducing the use of healthcare services by the patients. For example considering the chronic pain management, comprehensive and multidisciplinary pain programs, including the clinical and health psychology component, could reduce both the direct and indirect costs of the treatment saving untill 8,500-13,000$ per patient per year. Further research is also necessary to better select which psychological interventions, among the different evidence-based ones, are most cost-effective for a particular pathology and for whom. Moreover a societal perspective has to be stressed, measuring productivity losses and informal-indirect care costs. Another possible trend that could help clinical health psychology in reducing costs is the use and implementation of new technologies, such as Internet-based or mhealth-based interventions with different level of intensity about the psychotherapist presence and feedback provision in the treatment. Digital solutions can enhance the accessibility and availability of mental health services for many potential patients, reducing direct and indirect costs.

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The relationship between guilt, transference and personality in a sample of italian patients in therapy

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Guilt is a complex and distressing emotion with multiple determinants that can be experienced in a variety of different situations (Gazzillo *et al.*, 2017). It may be chronic or transitory, as well as conscious or unconscious, and it occurs when a person has done or feels to have done something wrong or when a person feels wrong and dangerous for being how s/he is (Albertsen, O'Connor, & Berry, 2006; Bush, 2005). If according to the psychoanalytical point of view guilt derives primarily from unconscious wishes to hurt others and stems from motives such as revenge, envy, jealousy and hatred (Freud, 1923), recent developments in biological, psychological and social sciences led to a redefinition of conscious guilt as an interpersonal emotion based on the need to maintain attachment and/or care relationships and group bonds (Baumeister, Stillwell, & Heatherton, 1994; Haidt, 2012; O'Connor *et al.*, 2000). The first Freudian hypothesis about unconscious mental functioning fall within a model that may be described as an automatic functioning hypothesis (Weiss *et al.*, 1986), because they conceive the unconscious psychic system (Unc) as a dynamic system characterized by drives seeking immediate relief and defenses that automatically oppose them. Within this model, psychic life is mostly driven by search for pleasure and avoidance of pain (Freud, 1911), where considerations concerning reality play a secondary

role (Gazzillo *et al.*, 2018). This higher mental functioning hypothesis, which Freud developed in some of his later works, perfectly matches recent findings of neurosciences and cognitive and evolutionary sciences, according to which the human mind is characterized by a series of conscious and unconscious processes, selected by natural evolution, that allow the individual to adapt to her/his environment (Huang & Bargh, 2014; Kenrick, 2011, Kenrick & Griskevicius 2013; Lewicki *et al.*, 1992; Panksepp & Biven 2012; Wilson, 2012). According to the Control-Mastery Theory (CMT; Weiss, 1993; Weiss *et al.*, 1986; Gazzillo, 2016), the human mind is "wired", from the beginning of life, to adapt to reality, and in particular to interpersonal reality. To accomplish this, it needs to develop reliable knowledges, or beliefs, on how the surrounding environment works. Moreover, in order to survive a child needs to feel that the people caring for him or her are loving and protective, strong and happy. If this is not the case, the child will feel responsible for the parents' lack of love and unhappiness, and guilty about having caused it or not having been able to ameliorate it. So, the child may develop a series of pathogenic beliefs that associate the achievement of personal well-being and the pursuit of healthy, realistic goals, with a fear of losing vital relationships or hurting people s/he loves and cares about (in other words, with anxiety and guilt). So, while classic psychoanalytic authors (Freud, 1923, 1924, 1939; Klein 1935, 1946) focused mainly on the intrapsychic origin of guilt and the demand for self-punishment due to perverse and destructive impulses, according to CMT the origin of guilt is interpersonal and adaptive, and stems from Fear, Attachment and Care affect systems (Gazzillo *et al.*, 2018). Furthermore, interpersonal guilt may be the source of defenses, transference and self-sabotaging behaviors. Following this theory, guilt, thought as interpersonal and prosocial, may become dysfunctional when fed by pathogenic beliefs (erroneous assumptions that bring the person to associate the pursuing of a healthy and pleasurable goal with a danger) and it may be one of the organizers of transference. The patient may idealize, sexualize or devaluate his therapist; he may be worried about being a source of pain for his analyst, in the same way he was worried, once, about causing pain to his relatives (Bush, 2005). It is on these theorical bases that this research project is founded. The aim of this study is to empirically investigate the relationship between interpersonal guilt, transference and personality. The tools used in this study are: the Clinical Data Form (CDF; Westen, 1999), an anamnestic chart to collect information about patients and therapists; the Interpersonal Guilt Rating Scale-15 (Gazzillo *et al.*, 2017), and the Interpersonal Guilt Questionnaire 67 (IGQ-67; O'Connor et al, 1997) to assess interpersonal guilt of patient respectively from the therapist and the patient perspective; the Personality Relationship Questionnaire (PRQ; Bradley *et al.*, 2005; Tanzilli *et al.*, 2018) to assess transference; the Psychodynamic Diagnostic Prototype (PDP; Gazzillo *et al.*, 2010), and the Personality Inventory for DSM 5 brief form (PID-5-BF; APA, 2013), to assess personality disorders/styles from both the therapist and the patient perspective. Preliminary analyses showed significant relationships between different kinds of interpersonal guilt, transference dimensions and personalities styles. First of all, we investigated the relationship between transference and interpersonal guilt with the Generalized Estimated Equations and we found positive and significative relationship between these constructs. Then, we repeated the model to see the relationship between these two variables and personality. For example, dependent personality disorder seems to be correlated with positive/working alliance, anxious/preoccupied and sexualized transference dimensions. This personality disorder is also related to separation guilt, that is in turn related to anxious/preoccupied and sexualized transference dimensions. These results confirm the hypothesis that guilt and transference are connected and may be both considered expressions of personality. Future research will investigate the mediational role of guilt in the transference-personality relationship.

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A naturalistic ten years follow-up about outcomes in the treatment of anxiety and depressive disorders with the brief- adlerian psychodynamic psychotherapy (B-APP)

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Introduction: Some studies seem to highlight not only the effectiveness of the brief psychodynamic psychotherapy in the treatment of anxiety and depressive disorders (Fonagy P. 2015) but also its potential rule to activate psychological processes that leads to a change that continues even after the conclusion of the therapy (Abass, Hancock, Henderson *et al.* 2006). In a previous study (Ferrero *et al.*, 2007) the effectiveness of the Brief Adlerian Psychodynamic Psychotherapy (B-APP) in the treatment of generalized anxiety disorder has been evaluated, with clinical results that remain stable at 6 and 12 months, also including subjects with personality disorder (cluster C). B-APP furthermore showed an improvement of depressive symptoms' control in oncological patients (Bovero et Al. 2017). The Brief-Adlerian Psychodynamic Psychotherapy is a time-limited psychotherapy based on an adlerian psychodynamic model (Ferrero A., 2009). The treatment includes the possibility of using more intensive or supportive technical instruments, in consideration of individual aims. The aims of treatment can be mutative and/or conservative with respect to the structure of defenses and to the personality organization; the first ones are oriented to change the more dysfunctional psychological defenses; the second ones are aimed to reinforce the most adaptive mechanisms. Aims of treatment are also specifically identified for the patient from time to time; psychotherapist can promote a mainly dialogic relational strategy (that is characterized by the possibility for the patient to re-elaborate experiences and meanings) or a mainly supportive relational strategy (that is characterized by the therapist's integration of contributions). The indication for the

psychotherapy requires a psychodynamic comprehension that can identify the peculiarities of the patient's personality organization, including the symbolic aspects of the pathology. The use of the B-APP in the treatment of anxiety, depressive and eating disorders involves a time-limited setting, structured in modules of 10/15/24 sessions. The therapeutic work is organized around a focus (agreed with the patient) that corresponds to a current problem that significantly correlates with an intrapsychic (dysfunctional) aspect and therefore with the symptomatology. The aim of this study is to detect the outcomes' effectiveness and stability of the B-APP treatment in patients suffering from anxious and depressive disorders, that accessed to the Psychotherapy Service of a Public Mental Health System (CSM B, ASL TO4). *Methods*: This is a naturalistic cohort study. Data were collected from a cohort of 146 patients, with an anxious or depressive spectrum disorder, treated with B-APP during 2006-2008, with 10 sessions setting, and following clinicians' indication; 15 patients who drop-out treatment after the first sessions are excluded; 131 patients (29% Males, 71% Females; 39 years old average) were evaluated, for purposes of idiographic outcome's assessment, pre-post B-APP (T0-T1) and at the follow-up provided in accordance with the clinical praxis (at 3 and 6 months to the end of psychotherapy), by clinician reports scales: CGI (Clinical Global Impression), Hamilton Scales for Depression and Anxiety symptoms (HAM-A, HAM-D), Social and Occupational Functioning Assessment Scale (SOFAS). Diagnoses: 63,4% of patients were diagnosed with an anxiety disorder, 36,6% with a depressive disorder. A personality disorder also was diagnosed for 25 patient, (15 cluster C, 9 histrionic, 1 narcissistic). For all subjects, according to clinician's assessment, has been identified a neurotic personality organization. Treatments: 40,5% only benefit of B-APP; 59,5% benefit of B-APP in association with a pharmacological therapy (COM). A follow-up was performed 3 months after the end of psychotherapy for 76 patients (T3); a 6 months follow-up is also available for 52 subjects (T6). Subjects are now contacted (in 2018) for a 10 years follow-up interview; the same clinician reports instruments are applied (CGI, HAM-A, HAM-D, SOFAS); patients furthermore complete a scale which detects the impact (positif or negative) of significant life events that occurred in the last ten years (Life Event Questionnaire - LEQ); the informations regarding any further psychotherapeutic and/or pharmacological treatments that subjects have used in this period are detected. *Preliminary results*: Paired samples t-test was conducted. Results show a significant difference between T0 and T1 for all variables examined, indicating a symptom remission and an increase in social and working functioning (CGI: t=10,7; p=<.001; HAM-A: t=12,7; p=<.001; HAM-D: t=9,6; p=<.001; SOFAS: t=-8,5; p=<.001), also for anxiety that for depressive disorders, including patients with personality disorders. Same data trend persists at the T3 evaluation, indicating further remission of symptoms and increase of social and working functioning for all patients of the cohort (CGI: t=4,03; p=<.001; HAM-D: t=4,20; p=<.001; HAM-A: t=4,80; p=<.001; SOFAS: t=-4,49; p=<.001). There is no significant difference between the means measured at T3 and those measured at T6. The improvement for B-APP and COM patients has the same trend; COM patients presented at T0 a more serious symptomatology (which justified the indication to a combined treatment). 10 years follow-up interviews are currently ongoing. We will present the available data and the possible evaluations concerning the following questions: did subjects of this cohort requested further psychotherapeutic and / or pharmacological treatments, after the B-APP? are B-APP outcomes stable both in the presence of positive than negative life events? was B-APP, in this patient's cohort, a possible protective factor that has improved resources to deal with negative life events? *Conclusions*: Outcomes at the end of B-APP show a significant anxious and depressive symptoms remission and a significant increase of social and working functioning in the considered cohort. These results are further increased at 3 month after the end of B-APP and remain stable at 6 months. Association between B-APP and pharmacological therapy seems convenient for patients with a more serious symptoms. Certainly the results of the study are not generalizable for its naturalistic nature, for the limited number of the sample, for the use of exclusively clinician reports assessment instruments, for the impossibility of comparing the results with a control group. They furthermore can contribute to confirm the outcomes' effectiveness and the stability of B-APP in the treatment of anxiety and depressive disorders, in a Public Mental Health Service.

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Use of the mediator object in the care team

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Introduction: In the literature, it has been found that group experiences directed at staff members of critical departments conducted with active techniques meet lower participant's resistance than would happen in an unstructured verbal psychotherapy group, and reduce stress and burnout levels between the workers (Caccamo, *et al.*, 2017; Calditoni, *et al.*, 2015; Özba, & Tel, 2016; Ozturkcu, *et al.*, 2018). The awareness of the difficulties encountered when dealing with "strong" issues such as the emotions arising from contact with death and critically ill patients, led to favoring the group setting and choosing, as an aid to group exchanges, the technique of Photolangage and Social dreaming, which it allowed to facilitate narratives and verbal exchanges amplifying the emotional resonance of the group. Through these active techniques, the synergy between the characteristics of the group and those of the mediator object allows to improve the group work and, with an audience not accustomed to contact and reflection on emotions, can allow access to non-thought forms always "thinkable" to individuals. The mediating object (the photo or the dream) thanks to its quality of "malleability" is manipulated and recreated in different ways by the group, thus assuming a function of "intermediary" between the individual and the entire group. This mediation makes it possible to start a process of symbolization that helps the workers to become aware of internal images to explore and question them in a path that goes from image to word. The aim of this work is to analyze qualitatively the two group inter-

ventions conducted with active techniques, focusing attention on the symbolization processes that the use of techniques allows throughout the group process. *Methods*: Two group interventions carried out in institutions of care were assessed qualitatively. The first is a group of psychological support aimed at operators (n=13) working in palliative care conducted with Social Dreaming technique, the second is a supervision group aimed at operators (n=9) working in the psychiatric field conducted with Photolangage technique. The Social Dreaming and Photolangage sessions were recorded and then transcribed. For the present work was considered the central session of both groups, which is more representative of the issues that emerged in the group. The transcripts were qualitatively analyzed using the Iramuteq software, which made it possible to identify the central themes of the transcripts. By comparing the associative nuclei of the two groups it was possible to identify some clinically relevant topics in the care professions. *Results*: At a first level of analysis it is possible to identify some specific clusters connected to the problems of the patients to whom the care of the operators is directed. Specifically, feeling and seeing the anguish of death for the hospice operators and the continuous oscillation between shared reality and personal interpretation of reality for the operators of the mental health center. From the associative point of view two types of disposition are highlighted: radial for the Hospice group, in which there are patients at the center connected to symbolic and concrete associations of death; and a linear sequence arrangement for the operators of the mental health center, with symbolic and concrete association nuclei of perceived reality. The two associative provisions correspond to the different procedural dynamics in the two groups, where in the hospice group the contact with the affective dimension of the field is more easily reachable even if at times it is characterized by a high level of conflict. The group of the mental health center has a more avoiding process dynamics than the affective dimension of the group in which the defense of rationalization is coherent and necessary in patient care to avoid collusion, but risks inhibiting the expression of group affectivity. *Conclusions*: The use of textual analysis techniques is considered as one of the bridge strategies between quantitative and qualitative methods, thanks to the possibility of combining the need to produce controlled empirical studies, with the richness of interpretation (Del Corno & Lo Coco, 2018). This study has revealed semantic and sometimes unexpected dimensions, subject to the same textual data, highlighting the point of view of the producers of the texts analyzed. Finally, this qualitative analysis has highlighted the need for a psychoanalytic work that allows the emergence of the emotional and suffering nuclei of the operators, thanks to the work of group reverie which allows the processing of preverbal or verbal communications.

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Study on the effectiveness of treatment in anxiety disorder of adult patients through autogenic training in a public service

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Introduction: During these years of reduced resources destined to the NHS, to identify "what works for whom" becomes a priority also in relation to psychological and psychotherapies interventions. In addition to evaluating the effectiveness of the intervention, this study focuses on the subjective change of perception by users. Many people affected by anxiety disorders visit the Psychology Department asking for help. In the cases of anxious symptomatology with physical correlates and somatizations, the Autogenic Training course is indicated to adolescent or adult patients as a response to discomfort. Through the Autogenic Training of Schultz (lower level exercises), which consists in a session made of 8 meetings, patients report relief and remission of invasive symptoms. This study evaluates the effectiveness of the treatment, especially focusing on the short time spent on it and the reduced cost of the services. Treatment is performed in groups of 5-10 patients, both men and women, in some cases differentiated based on age groups (16-24 years). The meetings are held in the form of one-hour week meeting for 8 consecutive weeks. A verification meeting is proposed after one month. After the verification meeting, patients are free to access the monthly meeting of "maintenance", which is offered to all those who have attended an Autogenic Training course. Patients are invited by psychologists and psychiatrists employed by ASL. The cost of the ticket is € 66.15 for the entire course. *Methods*: As a first step, preliminary literature has been examined. Then, two different focus groups have been carried out: one with operators conducting Autogenic Training courses and another one with patients using this method. At a later stage, qualitative (focus group) and quantitative analysis methods were identified. Before the course a baseline (T0) has been proposed with: 1. Anamnesis; 2. Personality Inventory for DSM-5 Brief Form (PID-5-BF); 3. DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure - Adult (© 2013 American Psychiatric Association; 4. Sympton Questionnaire by Kellner. At the end of the course (T1) the tests at 3 and 4 were re-administered. After a month (T2) a focus group was proposed with another host. After 6 months (T3) the tests at 3 and 4 were re-administered. *Results*: The available results are based on two years of courses and 53 patients. The qualitative level of data analysis highlights clear symptomatic improvement; the results remain even after some time. The quantitative level shows a clear improvement compared to the management of anxiety, which remains even after some time. The result from the focus groups consists in the following thematic areas related to the contents described by the patients: general experience of the treatment; specific changes induced by treatment in behaviors and experiences; unsatisfactory aspects and hindering situations. The analysis made on the examination of 3 large groups of patients (1-those with clear improvement, 2-those with average improvement and 3- those without improvement or worsening) became interesting when the quantitative data would be compared with the qualitative ones: in addition, the patients being in the third group were showing a greater awareness, a greater sense of mastery and in any case a high level of satisfaction with respect to to their emotional management skills. *Conclusions*: The possibility of giving a response to patients affected by anxiety disorders through a cycle of 8 group meetings in public service, would be effective and positively perceived by patients. In general there is a symptomatic improvement; moreover, beyond the improvement in symptoms, the patients declared themselves satisfied with the acquired awareness and the competence

in recognizing and managing the symptoms of anxiety and in attributing them a clear and acceptable meaning. Improvement is perceived both at a cognitive level and at a physical level. In some cases a reduction in the use of drugs (anxiolytics, antihypertensives) is described. For some patients, it is clear that the approach to a psychological technique has allowed them to reformulate their own convictions regarding psychological care, to request a psychotherapy in an appropriate way and, finally, to propose the diffusion of a culture in which prejudices related to the field of psychology in general are reduced and transformed: *e.g.* so that Giuseppe, who returns to Sicily for the Christmas holidays, promises to tell his experience to his 30-year-old peers.

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Sense and forms of payment with the teenager. The experience of the facilitated therapy group for adolescents in the Milan center of psychoanalysis (CMP)

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Introduction: The current economic and social crisis that we are experiencing has made it necessary to make changes in the setting so that patients with serious difficulties in these areas could be taken care of. For ten years, a group of psychoanalysts of the CMP has become available to offer facilitated therapies to teenagers in serious difficulties. The present study has as its objective the reflection on the effects of gratuity or facilitated payment on therapy, on transference and countertransference. *Methods*: Psychoanalytic psychotherapies are offered to patients. The case is supervised by experienced analysts (AFT) and then periodically discussed in the enlarged group. The presentation of the case with the explanation of the state of need and the available resources, group discussion, supervision and work with analysts coming from a long training are the strengths of a very complex but equally rich and stimulating work. Thirty colleagues in the group were asked to provide a patient data collection and transfer and countertransference experiences related to payment, to the communication of the agreed payment type and to the effects of payment on therapies and the therapeutic relationship. The questionnaire was resumed on a temporal basis to evaluate changes in the setting and the status of the therapies. In ten years, 83 cases were accepted, with 70 taken in charge. The average age of patients is 16.8 years (49% males and 51% females). Treatments have an average duration of 23.2 months, which is a significantly good time, considering the difficulty of teenagers. Most cases are followed by one session per week. Diagnostic pictures are often characterized by multiple traits or problematic aspects, in 24% of cases there are situations of deprivation. 46% of patients are followed for free, 24% pay 5-10 euros per session, 14% pay between 15 and 20 euros per session and the remaining 14% more than 25% per session. In most cases (54%) the payment contract is defined on the basis of agreements with the CMP. In 17% of the cases the payment agreements were the result of personal decisions by the therapist. In 12% of cases the payment is defined on the basis of agreements of different kinds. *Results*: The questionnaire asked to express any contraindications to a free treatment and how the communication of no-payment/facilitated payment to the patient had an influence on the therapeutic relationship. Regarding the first question there is unanimous agreement that there must be a "cost" of therapy that must be defined according to the specific situation. There is agreement that if there are economic possibilities there is a payment commensurate with the sustainability of it by the boy or family or service. A facilitated therapy can represent a narcissistic wound on the social level. Regarding the reflections on the relationship there is a thought still in progress. The fantasies, the experiences, the perception that activates this contract have to do with devaluing aspects (parasitic attitudes or "not giving the right value to therapeutic work both by the patient, but above all by the parents"), idealizing (ex. "Social redemption", feeling an important "object" of interest and / or research), omnipotent (ex. "defending deeper feelings of helplessness and deprivation) confusing, ambivalent (little or no separation between therapist and Sending, "probably confused me with the community", "took it for granted"), persecutors ("I am used, inquisitive," abused,"may have made the adoptive fantasy concrete and distressing") or, on the contrary, enhancement as the only possible way to build a relationship and a therapeutic path as well as recognition of the patient ("he only made it possible"). *Conclusions*: The cases followed by the group are significantly affected by the trauma and require a lot of care and attention. The work done in these years has allowed us to acquire a fundamental experience in the field. With these children, difficult to analyze in a classical context, for economic-contextual reasons and modes of psychic functioning, the therapist confronts the opportunity to know distant, alienated, marginalized, offended, abused, traumatize worlds. Offering free or facilitated therapy is essential for these therapies to take place, but always has a cost to both the analyst and the patient. Latent reflections or manifestations of payment on the therapeutic relationship are undeniable. The experiences that activate, the fantasies that produce and the verbalizations that are made need to be accepted and elaborated, so that we can create a sufficiently good basis for the path we will undertake.

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When training finds its application in clinical activity. Convergences between specificity of theoretical models, institutional mission and training evaluation

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Introduction: The aim of this work is to contribute to the evaluation of the psychotherapist's training with the fieldwork experience gath-

ered by a group of interns from different psychotherapy schools within the Mental Health Center (MHC) of the Psychiatric 1 Service in Padua. This report highlights in particular the training contribution given to the development of the specific professional skill of responsibility, which was also studied during the SPRISTAD research. It is essential to take this competence into account and that it should be recognized as a fundamental element of training, because the perception of the therapist's own effectiveness and the ability to deal with complications within the therapeutic relationship are based on this ability. In most cases, internships are carried out in public structures. These places do not just offer the possibility of putting into practice what was learnt on a theoretical level, but they also keep precise constraints for patient protection and to ensure specialized treatments that could hardly be offered without the contribution of the trainees. The model of "co-constructed coordination" favours a virtuous convergence between institutional mission, specialized theoretical models and development of the competence to take the responsibility of the therapeutic project. This area of professional competence seems to find - through supervision - partial opportunities of development within the educational path, while in public services it is often mistaken for a generic attribution of trust. *Methods*: A specific area of psychological counselling was created and developed within the Mental Health Center. The team consists of 7 trainees, students from different psychotherapy schools, 3 post-graduate trainees and the head of the psychology department as tutor. The psychological area examines the requests for psychological and psychotherapeutic intervention that come from the Psychiatric Service through counselling sessions. Each trainee, supervised by institutional tutor, manages counselling and psychotherapeutic paths that become the object of confrontation within the team of the psychological area. The psychological area can be defined on at least three levels: 1. The physical space - the intervision room - which is regularly occupied on a specific day of the week, at a specific time. 2. The virtual place, where the patient is treated from a global point of view, which goes beyond the symptoms. 3. The specific sector within the psychiatric institution devoted to the practice of psychotherapy. There are lots of contributions on the importance of the consultation and the first contacts, which help to define a more precise psychotherapeutic work. This phase lasts for 3 sessions plus a 4th – and last – one (the "final review session") in which the intern: a) suggests to the patient a new understanding of his discomfort; b) provides different intervention assumptions, which may take place within the same institution or in other public services, as well as in private facilities. In order to carry out this work assuming full responsibility for the patient's care, teamwork is necessary also to clarify the characteristics of each request for treatment the MHC received. Above the possibility to define a precise psychiatric diagnosis, for the psychological area of the MHC it is important to establish a few reference points: 1. making some hypothesis regarding the meaning of the treatment request; 2. wondering if the problem that made the patient decide to contact the Center may arise because of triggering events or because of the patient's inner world; 3. the existence of contextual factors in addition to the possible structural vulnerabilities of each patient. Depending on the precocity of the event or its recurrence over time it is possible to formulate hypothesis on the prognosis and, consequently, to suggest the patient suitable interventions; 4. taking into account the resources of each patient, both personal and environmental. *Results*: The establishment of a specific psychological area allowed giving more space and importance to the psychological component of the patients the Psychiatric Service cares for. The creation of this working group offered a great support to the trainee, who is engaged both in the fieldwork and in the "one to one" relationship with the patient. The teamwork allowed a more objective observation, and helped in keeping it free from prejudices in the same way a psychotherapist is required to do. The collaboration among the team allows the separation between observation and intervention and enriches the diagnosis. Exchanging ideas with the team offers the possibility of a prevalent thought, which is an important element often lacking in public services. The dialogue between different approaches makes it possible to address the patients' problems in a diversified way and thus enriches the clinical analysis by emphasizing aspects of the patient that were once not taken into consideration. From the trainee's point of view, the internship thus carried out has become a growth experience, which ensured a mutual and equal exchange of ideas, respect for the sensitivity and the opinion of others, openness of mind, as well as it favoured awareness and respect for everyone's personal limits, raising curiosity and the desire to grow as professionals. *Conclusions*: The training requirements for an intern pass through the clinical experience "in the field". The relationship of mutual exchange - unfortunately not yet monetized - between the student's desire to test himself and take full responsibility, and that of the public service to ensure high quality and effective interventions, must find adequate ways to receive feedback and approval. The contribution of the training and the contribution to training basic skills, both converge in a virtuous circle of research and action, provided that adherence to institutional missions is preserved. As Gaetano De Leo wrote: «The concepts of intention and its ability of anticipation, self-reflection and self-regulation of one's behaviour are considered relevant criteria and find scientific demonstration for an adequate study of responsibility».

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A systematic review of biopsychosocial mediators and moderators of the association between childhood adversity and psychosis

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Introduction: Childhood adversity is a major public health problem that has long lasting adverse consequences for mental health, including the development of depression, post-traumatic stress disorder, suicide, and substance misuse. In addition, childhood maltreatment and neglect are associated with an increased risk for subclinical psychosis and diagnosable psychotic disorders (OR 2.78, 95% CI 2.34-3.31) and account for up to 33% of the population affected with psychosis (Varese *et al.*, 2012). Given the complex aetiology of psychosis, it is important to understand how childhood abuse and neglect increase the risk for psychosis in some individuals, but not in others. In view of that, this paper aims to systematically review potential mediating and moderating fac-

tors of the relationship between childhood adversity and psychosis. Specifically, we have systematically reviewed the literature on the effect of genes, substance use, adult life events and prolonged social stress, cognitive schema and reasoning biases, attachment styles, and non-psychotic psychopathology (depression, anxiety, post-traumatic stress disorder, and dissociation) in the association between childhood adversity and psychosis. *Methods*: A systematic review of the literature on biological, psychological and social risk factors mediating or moderating the effect of childhood adversity on psychosis was carried out following the PRISMA statement guidelines. PsychINFO, Embase classic and Embase, Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) databases were screened with keywords related to psychosis, childhood adversities, genes, cannabis and other substances, life events and daily life stressors, broader social risk factors, attachment and parental bonding, psychotic and non-psychotic psychopathology, self-image and self-esteem, cognitive biases and social cognition. Studies were included if (a) they were original articles, (b) they were published in English, (c) they had a case-control, cross-sectional or cohort design, (d) they had psychotic disorders, psychotic symptoms or psychotic-like experiences as outcome, (e) one of the exposures was childhood adversity (defined as occurring prior to 18 years of age), and (f) the mediating or moderating effect of at least one other factor was investigated. Studies were excluded if (a) they had a case report or review design, (b) the timing of social adversities was not specified, or (c) the effect of childhood adversity could not be disentangled from the effect of other environmental risk factors. Studies were critically appraised using a modified version of the quality assessment tool employed in the Trotta *et al.* (2015) study, which comprised criteria such as selection bias, assessment of exposure and outcome variables, measure of the effect, and inclusion of confounders. *Results*: From the 20,051 initial records identified by the search, 16,671 articles were selected for title and abstract screening, and subsequently 592 articles for full-text screening. Following full text screening, a total of 103 studies were included; in this paper we will focus on the role of substance use and depression and anxiety symptoms. The review found inconsistent evidence regarding the moderating effect of cannabis use and a lack of research regarding the role of alcohol use. Evidence of additive or multiplicative interaction was found only in four large epidemiological surveys (NCS-R, APMS, GNPP and NEMESIS-1), while in another six population and clinical studies the interaction was not significant. According to some studies, the effect of childhood adversity was neither mediated nor confounded by cannabis use. Of 19 studies assessing the role cannabis use, only 6 were methodologically robust, and evidence of interaction was found only in studies with a large sample size. Furthermore, cannabis use was mostly defined in terms of using it at least once over the life-course, a definition that may include different patterns of consumption. Therefore, it might be speculated that, depending on the severity and timing of the adversity exposure, these may both act as an independent risk factors on psychosis, and potentially in a synergistic manner with cannabis use. Regarding the role of non-psychotic symptoms, some population (NCS, APMS, ALSPAC) and clinical studies reported a mediating or moderating effect of anxiety and, particularly, depressive symptoms, although negative findings were also present. When both depression and anxiety were included in the same model, in two studies the proportion of the association between childhood adversity and psychosis explained by depression was greater than that explained by anxiety, but in another study anxiety showed a stronger mediating effect on paranoia. According to a few studies (APMS, NEMESIS-2), mood instability mediated the effect of childhood abuse on psychosis. Overall, only three out of 15 studies were methodologically robust, whereas most of them showed limitations in the assessment of childhood adversity and depression/anxiety symptoms and inadequate control for confounders. This suggests that the effect of childhood adversity is probably mediated by common psychiatric symptoms, but the strength of the mediation effect may have been over-estimated. *Conclusions*: To date, studies suggest that the association between childhood adversity and psychosis may be mediated by depression, anxiety, and mood lability. According to the literature, the adversity-psychosis association is not confounded by cannabis use, while evidence regarding cannabis x childhood adversity interaction is inconsistent. Further research using large samples and methodologically robust designs is required on the biopsychosocial pathways between childhood adversity and later development of psychotic phenomena. This would be helpful to identify target populations for very early intervention programs and to inform the development of psychological or other interventions to prevent the onset of psychosis.

The effect of the group process on the communicative modalities of the individual: An unusual case

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Introduction: The communicational behaviour of the individual in the small interactive group is strongly influenced by the functioning of the latter, in particular by the implicit dynamics underlying the explicit interaction detectable through direct naturalistic observation (Vanni F., 1984). All this becomes evident if the participants in the group are allowed to interact with each other freely, without proposing or imposing specific arguments (Vanni F. and Sacchi M., 1990). Similarly to what occurs in the psychoanalytic setting, this non-directive approach favours the production of the patient's free associations. When applied to the group setting it produces the development of associative chains, in which a patient's expression is related to what has been already produced by others and is a stimulus for further productions. This associative process was called 'spontaneous thematic development' by F. Vanni (19849) and attributed, by various authors of a gestaltic and psychoanalytic matrix, to a level of implicit/unconscious functioning present in the group. In this perspective 'the individual is a function of the group' (Vanni F., 1984). The purpose of this work is: · To describe an unusual case that occurred during the group therapy of some psoriasis patients treated to affect both the psychological components of the disease and to alleviate the grave repercussions it has on their quality of life. The case in question presents the concomitant frequency, for institutional reasons, of the same subject in two separate groups. In this situation, it was possible to observe how the ways of communicating of the same subject varied in the two different groups. It, therefore, seems to lend itself well to the study of the influence of the functioning of the group as a whole (Spontaneous Thematic Development) on the individual (Vanni F. and Sacchi M., 1990); · To discuss the method adopted in the attempt to highlight and document the effect of the group process on how the individual participates in the same and to evaluate the possibility of experimentally replicating the observations made to gather evidence to support the theoretical hypothesis from which it draws this work. *Methods*: · Group Description: - two 'homogeneous' groups for pathology, with a fixed term with the possibility of re-

editions, both with the same conductor, psychoanalytically trained; - group-analytic orientation with an observer and weekly supervision; - twelve fifteen-monthly frequency sessions for each group; - somatic patients with specific dermatological problems (Psoriasis). · Institutional framework. The 'Group Meetings for People with Psoriasis' Project started in 2008 under the patronage of the Association for the defense of psoriatic patients (ADIPSO) and the collaboration of the Dermatology Operating Units of Venice and Padua. · The methods of observation and registration of the session are similar to those commonly applied in standard clinical work with the groups (Gelo O., Molinaro F., 2009). In fact, a participant observer is expected to be present in each group, in charge of transcribing the interactions between all the participants, also recording his/her emotional response in parallel. At a later time, also the conductor record his emotional movements. Once a week, conductor and observer, during supervision with an expert conductor, proceed to examine in detail each passage of each session. · An ad hoc grid was developed to synthetically record the Spontaneous Thematic Development of each session, highlighting above all the balance between the defensive and the explorative aspects. During the re-reading of the transcripts, the supervisor, the conductor and the observer proceeded to identify the various themes developed during the session, according to the consensual observation approach. · An ad hoc grid was also developed to synthetically record the modalities and the tone of the interactions of the subject under examination for each session, with particular attention to the balance between constructive and destructive contributions for the process. The grid was then compiled as described above for the previous one. · The data of the two groups, collected through the grids, are compared employing the test T. · Self-administered self-assessment tools of the outcome (OQ 45.2 Italian version (Lo Coco *et al.*, 2006) and of the GQ-30 group process (Krogel J. 2013) were also used to evaluate the comparability of the two situations studied. The participants compiled two other instruments more closely related to the medical situation: IPQR (Illness perception questionnaire) and DLQI (Dermatologic life quality inventory). *Results*: Although the study is still ongoing, the work presents the preliminary elaboration of the results obtained from the comparative analysis of two series of 12 sessions. We reflect on the significance of the results obtained for the starting hypothesis and the presence of institutional aspects. *Conclusions*: The work, even in the limited scope of the observational data collected so far, deals with a subject that has not been connected to empirical evidence in the literature and aims to be a contribution to the study of group processes in the interrelation between individuals and groups. The work evaluates the hypothesis of replicating the observation also in the experiential, formative or experimental field.

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POSTERS

The relationships between health-related quality of life, illness severity, personality and psychiatric symptoms in patients with psoriasis

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Introduction: Psoriasis is a chronic inflammatory skin disorder with a complex immune-mediated pathophysiology affecting between 0.91% and 8.5% of the general worldwide population and 2,1% of the Italian population (Parisi *et al.*, 2013). The etiology of the disease is not clear, but it seems to be multifactorial, indeed both genetic factors and environmental features can contribute to begin or exacerbate the disorder (Stewart *et al.*, 2018). Moreover, psychosomatic component may have a key role in inflammatory mechanism exacerbating by stress, indeed more than 60% of cases report stressful life events as causal or maintenance factors for the disorder. Nevertheless, stress responses are mediated by multiple influences that can compromise health when exceed personal capability and become overwhelming. Personality features can be considered as mediators in the relationship between stressors and individual response. For example, strong negative affect and social inhibition traits, put together in "Type D" personality (distressed personality), are frequently present in patients with psoriasis. Furthermore, has been found that high scores in some scales of MMPI-2 (depression, hypochondria and hysteria) were associated to "type II" psoriasis – that is characterized by late onset and low familiarity (whereas "type I" psoriasis has an early onset and high familiarity). Various psychopathological conditions are associated with psoriasis, and they either result from or contribute to the disorder; among these we can include depression, anxiety, sleep and eating disorders, sexual dysfunctions (Verhoeven *et al.*, 2009; Warren *et al.*, 2011). The complex manifestation of the disorder, its psychological consequences and the frequent presence of distress can reduce patients' wellbeing, extending its negative effects in other aspects of patients' life. Several studies have investigated the impact of the disorder on quality of life, reporting significative lower scores in patients with more severe lesions, psychiatric presentation and/or in patients treated with conventional systemic drugs compared to biological therapy (*e.g.* Feldman *et al.*, 2017). Since psoriasis is a common disorder, affecting a large part of the population, it is important to better understand the mechanism underlying the disorder, in an effort to reduce its impact on patients' life. For this purpose, the study aimed at evaluating the quality of life related to the illness severity, psychiatric symptoms and personality patterns in patients with psoriasis treated with biologic or topical therapy. Notably, to date, no research has examined the relationship between quality of life and personality patterns using a clinician assessment. We consider such investigation critical for improving our understanding of the specific features of each patient and guiding them to the most suitable treatment. *Methods*: The study is based on a multi-method and multi-informant design. 50 patients, 25 assigned to a biologic therapy and 25 to a topical therapy, were evaluated with self-report measures: the Symptom Checklist-90-R (SCL-90R), that considers a wide range of psychological problems and psychopathological symptoms, both externalizing (aggression, hostility, impulsiveness) and internalizing (depression, anxiety, somatization), of psychiatric patients and non-clinical subjects; the Psoriasis Index of Quality of Life (PSORIQoL), with 25 dichotomic items evaluating the impact of psoriasis on quality of life. The items focus on fear of negative reactions from others, self-consciousness and poor self-confidence, problems with socialization, physical contact and intimacy, limitations on personal freedom and impaired relaxation, sleep and emotional stability. Patients' personality and psychological functioning were also evaluated by external raters using the Shedler-Westen Assessment Procedure (SWAP-200), a clinician-report instrument, based on Q-sort methodology, with 200 items describing normal and pathological personality features. The assessment is based on the Clinical Diagnostic Interview (CDI), a semi-structured interview which explores patients' mental and personality functioning. Finally, the severity and area of their psoriatic lesions were evaluated by dermatologists with the Psoriasis Area Severity Index (PASI) – scores (from 0 to 72) indicate body surface covered by erythema in four different body areas (head, trunk, inferior and superior limbs). *Results*: Significant differences between groups (biologic *vs* topical therapy) were found in PASI scores: patients assigned to biological therapy have shown lower levels of illness severity. Nevertheless, no differences between groups were found in PSORIQoL scores. The quality of life was negatively associated with various dimensions of SCL-90R, as well as with borderline and dependent personality styles/disorders; on the contrary, it did not relate to PASI. *Conclusions*: Results seem to suggest that the quality of life in psoriatic patients is more influenced by personality characteristic and psychiatric symptoms rather than by the severity of psoriatic lesions.

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Attachment, mentalization and personality in intimate partner violence

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Violence against women and girls is both a human rights and a public health issue. It is a global phenomenon, which adversely affects individuals who experience it and carries social and financial costs for the societies in which it occurs. Recent global prevalence

figures indicate that about 1 in 3 (35%) of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime. Worldwide, almost one third (30%) of women who have been in a relationship report that they have experienced some form of physical and/or sexual violence by their intimate partner. The report also details that globally as many as 38% of murders of women are committed by an intimate partner (WHO, 2013). The term "violence against women" indicates many forms of violence, including violence by an intimate partner and rape/sexual assault and other forms of sexual violence perpetrated by someone other than a partner (non-partner sexual violence), as well as female genital mutilation, trafficking of women, etc. Intimate partner violence (IPV) is one of the most common forms of violence against women and includes physical, sexual, and emotional abuse and controlling behaviours by an intimate partner (WHO, 2012). It has been examined from a range of theoretical perspectives, one of those being attachment theory, identified as a way to assess several psychosocial risk factors for violence (Mahalik *et al.*, 2005). In the previous literature, the child's exposure to violence in the family resulted as a major predictor of subsequent exposure to IPV victimization (Widom, *et al.*, 2008). Furthemore child's exposure to violence in the family resulted as a major predictor of subsequent exposure to IPV victimization. Research on abused and traumatized samples has shown high frequencies of unresolved/disorganized attachment in adults. Attachment disorganization is associated with major problems of affect regulation and mentalizing deficits. An extensive body of research highlighted that mentalization was elaborated in terms of polarities (Fonagy *et al.*, 2012). Moreover research findings strengthen existing evidence that partner violence contributes to women's poor mental health. Women assaulted by an intimate partner experience significant health consequences including injury, chronic pain, gastrointestinal problems, sexually transmitted infections, depression, suicidality, post-traumatic stress disorder, and death. Despite the increasingly well-documented literature on this association there has been relatively less empirical focus on the interactions between IPV and personality disorders (PDs). The assumption of the interaction between inherited susceptibility and environmental factors, such as traumatic experiences (Paris 1996), could lead us to the hypothesis that these victims are at high risk of developing PD symptoms. Back *et al.* (1982) examined the personality features of battered women in a psychiatric facility and found that 83% of them were given a diagnosis of borderline, passive-dependent, or passive-aggressive PDs. Other researchers have observed a high prevalence of antisocial PD and obsessive–compulsive disorder accompanied by more frequent paranoid ideation in female victims (2008). Moreover, Shields *et al.* (1990) found a positive correlation between the severity and extent of current IPV and the severity of borderline personality disorder. Although there is a lack of homogeneity in the results available due to the variability of the sample (size, context from which women were recruited, such as shelters or clinics), the personality assessment instruments, and the criteria for intimate partner violence, the general conclusion is that IPV and PDs are frequently and positively associated (Cogan and Porcerelli 1996). This study has three aims: to analyze the relationship between childhood trauma and victimization in adulthood; to investigate attachment and mentalization ability in order to identify specific mentalizing and attachment profiles of women IPV victims; to investigate the associations between personality features and IPV. Despite the increasingly well-documented literature on this association there has been relatively less empirical focus on the interactions between IPV and personality disorders. A sample of forty women, recruited through anti-violence centers, were administered the Adult Attachment Interview (AAI, George *et al.*, 1984) and completed the Reflective Functioning Questionnaire (RFQ, Fonagy *et al.*, 2016). The hostile/helpless coding system (Lyons-Ruth & Melnick, 2004), the Complex Trauma Questionnaire (ComplexTQ, Vergano *et al.*, 2015), and the Reflective Functioning Scale (RFS, Fonagy *et al.*, 1998) were applied to AAI transcripts. The interviews were audiotaped and transcribed verbatim. Coding was conducted by two trained coders, and certified as reliable in the use of the AAI. The protocols were double coded for RFQ, ComplexTQ and RFS. The clinicians completed Shedler-Westen Assessment Procedure–200 (Shedler *et al.*, 2014), Modes of Mentalization Scale (MMS; Gagliardini *et al.*, 2017) and Polarities of Mentalization Scale (PMS; Gagliardini e Colli, 2017). Data have shown a higher percentage of women with disorganized attachment and an over-activation of automatic and affective mentalization aspects. Results will be discussed in terms of clinical and theoretical implications. Efforts to understand the etiology of intimate partner violence are critical to reduce this public health threat.

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Development and validation of a clinician report measure for the assessment of mentalizing: The modes of mentalization scale

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Introduction: Despite the growing literature on mentalization (*i.e.*, "the mental process by which an individual implicitly and explicitly interprets the actions of himself and others as meaningful on the basis of intentional mental states such as personal desires, needs, feelings, beliefs, and reasons"; Bateman & Fonagy, 2004, p. xxi), our knowledge of this construct is at its early stages, which is particularly evident in relation to some problematic issues related to the assessment of the construct. At the present time, in fact, there is no specific measure for the assessment of the quality of mentalization, in terms of the pre-mentalizing modalities of thought identified by Fonagy and Bateman (2004): concrete thought, pseudomentalization, teleological stance, and good mentalization. This work aims at providing data on three different studies for the validation of a newly developed clinician-report assessment measure of the quality of mentalization, the Modes of Mentalization Scale (MMS; Colli & Gagliardini, 2015), which is composed by 32 items rated on a Likert scale from 0 to 5 on the base of how much the item is descriptive of the selected patient: Study 1, focused on the factor structure and reliability of MIS; Study 2, focused on its convergent and the criterion validity; Study 3, focused on its reliability. *Study 1. Aim:* The objective of this study is to provide data on the factor structure and criterion validity of the MMS. In doing so we hypothesized to find four different factors: concrete thought,

pseudomentalization, teleological stance, and good mentalization. Method. We contacted by e-mail a sample of 200 clinicians and asked them to rate a patient who was at least 18 years old, who had no psychotic disorder and a personality disorder (PD). Clinicians rated the selected patient with the MMS, the Personality Disorder Checklist; the Adult Attachment Questionnaire (AAQ; Westen & Nakash, 2005) and Clinical Data Form. We used the principal axis factoring method (promax rotation) to investigate the factor structure of the scale and a multiple regression analysis to test criterion validity in relation to PDs and Attachment. *Results*: Measures of sampling adequacy had good results: Kaiser–Meyer–Olkin=.842. The intercorrelations among the five factors ranged from -.439 to .467. The explorative factor analysis suggested the presence of five factors that accounted for 62% of the variance: Factor 1, excessive certainty (coefficient alpha=.91);Factor 2, concrete thinking (coefficient alpha=.79); Factor 3, good mentalization (coefficient alpha=.83); Factor 4, teleological thought (3 items; coefficient alpha=.77); Factor 5, intrusive pseudomentalization (coefficient alpha=.67). Moreover the multiple regression analysis showed clinically coherent results: for example, secure attachment style was positively predicted by "good mentalization" and negatively predicted by "intrusive pseudomentalitation" and "excessive certainty", while disorganized attachment style was positively predicted by "intrusive pseudomentalization" and negatively predicted by "good mentalization". *Study 2. Aim:* The objective of this study was to assess the convergent validity of the MMS with other self-report measures of mentalization and other related variables such as emotional dysregulation and interpersonal sensitivity. *Methods*: We collected a fresh sample of 150 clinicians and patients and asked clinicians to rate their patients with the same measures of Study 1 (MMS; AAQ; Personality Disorder Checklist; Clinical Data Form). Patients used a series of self-report measures, including: Reflective Functioning Questionnaire (RFQ; Fonagy & Ghinai, 2008); Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004); Interpersonal Reactivity Index (IRI; Davis, 1983). *Results*: MMS factors were significantly and coherently related to RFQ, DERS and IRI's scales. *Study 3. Aim:* The objective of this study was to test MMS reliability on two groups of expert and junior raters (before and after attending a training on the use of the MMS by the authors of the scale) using the scale to assess 15 verbatim transcripts of psychotherapy session of different patients. In doing so we hypothesized that: 1. Junior assessors' (students with no clinical experience) IRR would be lower than senior assessors' (trained psychotherapists) IRR; 2. Junior assessors' IRR would be higher after a specific training than pre-training. *Methods*: From a database of 500 session transcripts of psychotherapy sessions we selected a sample of 5 patients and for each patient selected 3 sessions from different phases of the psychotherapy (beginning, central phase, conclusion). A group (N=5) of undergraduate students assessed each session without having been previously trained. The same sessions were assessed by a group (N=5) of expert raters (psychologists and psychotherapists expert in psychotherapy research and with at least 5 years of clinical practice). Undergraduate students assessed the same 5 sessions three months later, after having a specific training on the use of the measure by the authors of the scale. *Results*: ICC ranged from sufficient (.40≤ICC≤.59) to good (.60≤ICC≤.74) in all groups. Our results showed that Junior untrained assessors had the lowest ICC, which increased after they had a specific training. *Conclusions*: This study represents the attempt to develop and validate a clinician friendly measure for the assessment of the quality of mentalization. MMS has shown a good internal consistency and clinically and empirically coherent relationships with other related variables (personality disorder and attachment style) and with other assessment measures rated by the patient (for example, reflective functioning rated with the RFQ). MMS represents a clinician friendly reliable measure of mentalization dimensions, which could help clinicians in their assessment of the patients and in tailoring their interventions.

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Patient personality dimensions and transference patterns: An empirical investigation

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Introduction: Since Freud (1912, 1917) first recognized that patients displace intense feelings and conflicts associated with a significant figure of childhood onto the analyst, actualizing in therapy their dysfunctional patterns of relatedness, the concept of transference has revised radically. Beyond the theoretical divergences, as well as the technical controversies related to the use of transference interventions across various treatment (Bateman, Fonagy, & Gabbard, 2007; Gelso & Bhatia, 2012; Gilbert & Leahy, 2007; Høglend, 2014; Yeomans, Clarkin, & Kernberg, 2015), in the contemporary terms, it refers to a patient's patterns of feeling, thought, perception, motivation, and behavior that emerge within the therapeutic relationship, and reflects enduring aspects of the patient's personality functioning (Westen & Gabbard, 2002). Clinicians of all theoretical orientations should pay particular attention to these ubiquitous phenomena that provide valuable information on patients' core psychological dynamics (Gabbard, 2014; Høglend, 2014; Kernberg, 1984; Lingiardi & McWilliams, 2017; McWilliams, 2011). To date, only a few empirical investigations have examined the relationship between transference patterns and patients' personality pathology. Overall, research findings indicated that patients with Cluster A and B personality disorders, compared to Cluster C patients, tend to enact more dysfunctional and difficult to manage relational patterns in therapy; moreover, among Cluster B, borderline patients showed mixed and intense transference responses in therapy (*e.g.*, Bradley, Heim, & Westen, 2005; Bourke & Grenyer, 2010; Colli, Tanzilli, Gualco, & Lingiardi, 2016; Drapeau & Perry, 2009; Drapeau, Perry, & Koerner, 2010; Ruiz, Pincus, & Bedics, 1999; Stern, Herron, Primavera, & Kakuma, 1997). However, no research has considered the associations with personality dimensions or traits. The present study attempted to bridge this gap using a dimensional diagnostic approach based on a multifaceted model

of personality syndromes: the SWAP Personality Dimension Scales (Shedler & Westen, 2004). These personality dimensions showed psychometrically robust characteristics and clinical sensitivity to capture the complexity of personality pathology (see Westen & Muderrisoglu, 2006). *Method*: A national sample of clinicians of different theoretical orientations (N=90) completed the Psychotherapy Relationship Questionnaire (PRQ; Bradley *et al.*, 2005; Westen, 2000) to identify transference patterns, and the Shedler-Westen Assessment Procedure-200 (SWAP-200; Shedler & Westen, 2004; Shedler, Westen, & Lingiardi, 2014) to assess personality dimensions regarding a patient currently in their care. Notably, in this study we used (a) the empirically supported PRQ version (Tanzilli, Colli, Gualco, & Lingiardi, 2018), that consists of six transference dimensions characterized by excellent internal consistency (Streiner, 2003): hostile (α=.93), positive/working alliance (α=.88), special/entitled (α=.84), anxious/preoccupied (α=.82), avoidant/dismissing attachment (α=.81), and sexualized (α=.88); and (b) the twelve SWAP Personality Dimension Scales identified by Shedler and Westen (2004) performing a factor analysis to all the SWAP-200 items: psychological health; psychopathy; hostility; narcissism; emotional dysregulation; dysphoria; schizoid orientation; obsessionality; thought disorder (or schizotipy); oedipal conflict (or histrionic sexualization); dissociation; and sexual conflict. *Results*: Bivariate correlations showed that distinct SWAP personality dimension scales were significantly associated with specific transference patterns. Notably, the SWAP hostility and psychopathy were positively related to hostile transference, while the SWAP narcissism correlated with special/entitled pattern. Positive/working alliance pattern was negatively related to the SWAP schizoid orientation, while the SWAP dysphoria correlated positively with anxious/preoccupied transference. Avoidant/dismissing attachment pattern was negatively and strongly related to the SWAP emotional dysregulation, and positively associated with both SWAP schizoid orientation and narcissism. Finally, sexualized transference was related to the SWAP sexual conflict. *Conclusions*: These results showed that transference patterns are coherently and meaningfully related to patients' personality features, confirming the diagnostic value of these clinical phenomena as an essential tool in understanding personality traits/dimensions that underlie the patients' pathology. The implications for clinical practice are apparent given that these findings inform clinicians of all theoretical approaches about the interpersonal patterns that can be activated by their patients during psychotherapy, providing a roadmap for effective therapeutic intervention and decision making.. Moreover, this study supports the potential strengths of the PRQ's use in both empirical and clinical contexts.

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Psychotherapy research topics in Europe: A literature review for young researchers and PhD students

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Introduction: Psychotherapy research aims is to improve and increase scientific knowledge about psychotherapy through theoretical and empirical contributions. The domain of psychotherapy research appears to be very broad and articulated, especially – but not limited – to the topics characterizing it. For this reason, systematic reviews assessing this aspect may be very useful in order to assess the scope and evolution of the discipline, both for theoretical (what is the object of psychotherapy research?) and practical (where should scholars submit their papers?) reasons. This is true especially for young researchers which, if not adequately supported, may encounter several difficulties in identifying relevant research topics and journals suitable for submitting own papers. Several limitations may be identified in the existing literature due to the methodology used. First, in all existing literature reviews (LRs) on the topics of psychotherapy and counselling research, the content analysis of the identified literature is carried out by human raters, with the consequence of being tremendously energy- and time-consuming. A possible implication is that this might limit the amount of papers to be included in a review, and consequently the external validity of the results. Second, the content analysis carried out in the existing LRs follows a top-down approach, that is, make use of coding scheme a-priori defined by the author(s), with consequent limitations on the explorative character of LR. The present study aims to systematically review the psychotherapy research literature produce by European researchers using an automated and bottom-up procedure in order to identify (a) the research topics characterizing it and (b) the journal(s) more suitable for identified topics. *Methods*: A sample of articles was selected as representative of the field of psychotherapy research in accordance with the following procedure. Firstly, past SPR presidents (from 1970 to 2013) were contacted by mail and asked to indicate the most representative journals in the field of psychotherapy research. A ranking was identified seven journals commonly highlighted as relevant for psychotherapy research advancing. Journals and, for each of them, articles containing original contributions (theoretical and empirical studies) published in the period 2006-2016 were selected. At this point, according to our aim, we considered only the publications of authors or groups of authors belonging to European departments. At the end of this selection procedure, we obtained a final sample of 4860 articles from which the abstracts were extracted. In order to identify the main thematic categories within the analyzed scientific production, it has been used in the Automated Co-occurrence Analysis for Semantic Mapping (ACASM) procedure, an automated text analysis technique that identifies semantic categories following a bottom-up and context-sensitive methodology. This is a multidimensional analysis procedure that allows to categorize the information contained in the texts by identifying thematic clusters. Specifically, the abstracts of the selected articles were, as foreseen by the ACASM methodology, fragmented into units of elementary context (ECU) consisting of portions of text that are at the end of each punctuation mark that occurs after the first 2000 characters. Therefore, a dictionary for text analysis was constructed; in this phase every lexical form has been associated with the lemma to which it belongs in order to verify the presence of the various lemmas within each single ECU. This made it possible to group the ECUs in cluster on the basis of the co-occurrence of the

terms within them (similarity criterion). The number of clusters describing the cultural field of the analyzed corpus has been defined by an iterative algorithm that allows to identify those whose content does not require further information increase. Clusters were interpreted as the topics that characterize the current interests of European researchers in the field of psychotherapy. *Results*: Analysis allowed to retrieve the interests of European researchers in the field of psychotherapy research and define the suitability of journal in terms of publications. *Conclusions*: Results highlight a snapshot of the state of the art of psychotherapy research interest in Europe and offer a valid orientation criterion for young researchers who, for a strategic scientific production, need a map of the general interests and trends of the single journals. Furthermore, the present work highlighted the usefulness to adopt reliable quali-quantitative method of content analysis, where multidimensional techniques of data analysis ground and support the researcher's interpretative job aimed to mapping the Journals' scientific-cultural politics.

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The mediating role of attitudes toward psychological help-seeking in the path predicting psychological interventions

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Introduction: Psychological help-seeking can be defined as the behavior of actively seeking for professional help (SPH) in order to understand and treat mental disorders. Epidemiological data has shown however that only a small percentage of people suffering from psychiatric disorders actively seek for a professional treatment and even a smaller percentage receives a diagnosis. The many and complex reasons for this phenomenon, that seriously affects public health, deserve to be further investigated in order to encourage people who need it to seek for a professional psychological help. Recent population studies has shown that the stigmatization of mental illness, along with the resulting shame, negatively affect the individuals' attitude towards help-seeking (D. L. Vogel *et al.*, 2017). Along with the negative opinions and expectations towards the psychological profession, the self-stigma, that is the self-esteem reduction derived from self-labeling as socially unacceptable, reduce indeed the possibilities of searching and receiving an effective psychological help (D. L. Vogel *et al.*, 2017; Wilson & Deane, 2012). The aim of the study was to test a logistic mediation model in which attitudes toward SPH have a central role in the process that lead to psychological intervention(s). *Methods*: *Participants and Procedure.* Participants were recruited in Padua: 250 subjects [120 males (48%), 130 females (52%)] aged from 22 to 39 years (*mean*=23.41, *SD*=1.76). 55.4% of the participants lived in a family with – at least – four members and the SES ranged from "low" (9.5%) to "high" (14.5%); 43.2% of the participants asked help to psychologist(s) during his/her lifetime. An observational research design was used. Participants completed: (A) the informed consent; (B) a demographic measure form and (C) a battery with: the Italian version of the Attitudes toward Seeking Professional Psychological Help Scale – Short Form (ATSPPHS-SF); the Italian version of the Self-Stigma of Seeking Help scale (SSOSH) and the Characteristics and Attitudes toward Psychological Profession Scale (CAPPS) and a question assessing the presence or absence of undertaking psychological interventions. *Measure.* The Italian version of the ATSPPHS-SF (Rossi & Mannarini, 2018) that represents attitudes toward SPH – as the "openness to seeking treatment for emotional problems" and the "value and need in seeking treatment" – assuming an overall dimension. Higher scores represent more positive attitudes. Overall Cronbach's alpha was=0.827. The Italian version of the SSOSH (D. Vogel, Wade, & Haake, 2006) consists of a single dimension that measures concerns and worries about the loss of self-esteem (self-stigma) that a person might feel if he/she decided to seek help from a psychologist or another mental health professional. Higher scores represent more negative self-stigma toward SPH. Cronbach's alpha was=0.832. The CAPPS (Mannarini, 2018) measures the characteristics and attitudes toward the psychological profession by three different domains: a) Intrinsic Characteristics of the Psychologist (ICP), b) Negative Characteristics of the Psychologist (NCP) and c) Attitudes toward Psychological Profession (APP). In the first two dimensions (ICP and NCP), higher scores represent more negative characteristics toward the psychologist(s); opposite higher scores in APP represents more positive attitudes. Cronbach's alpha was: ICP=0.674; NCP=0.727. APW=0.720. *Results*: A logistic mediation analysis was performed. First, results revealed that the relationships between undertaking psychological intervention and its predictors (SSOSH, ICP, NCP, APP) were fully mediated by attitudes toward SPH (ATSPPHS-SF) [SSOSH (path a1: β=-0.296; SE=0.038; p <0.001); ICP (path a2: β=-0.628; SE=0.173; p <0.001); NCP (path a3: β=-0.401; SE=0.107; p <0.001), APP (path a4: β=0.698; SE=0.116; p <0.001)] in the prediction of psychological interventions (path b: β=0.135; SE=0.038; p <0.001; OR=1.148; R^2=0.210). *Conclusions*: The purpose of the study was to highlight the role of mediators of the attitudes towards SPH in the process that leads to psychological interventions. These results revealed that the attitudes towards SPH were strongly predicted by self-stigma as well as the levels of certain characteristics that people attribute to the profession of the psychologist (ICP, NCP and APP). Moreover, an increase in the attitudes results in one is being 1.148 times more likely to indicate an individual that undertake psychological interventions. These findings have important clinical implications: indeed, they points out a possible way in which psychologists should structure psychological intervention aimed to improve SPH may be made more efficacious if such factors are taken into account in the design of the project. Moreover, these findings could be used to improve mental health services seeking.

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Impulse emersion in intensive transactional analysis psychotherapy (ITAP): A preliminary study of non-verbal aspect of therapy process

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Introduction: The Intensive Transactional Analysis Psychotherapy (ITAP; Sambin & Scottà, 2018) is a short-term psychodynamic psychotherapy based on the integration between Transactional Analysis (Berne, 1961) and Short-Term Psychodynamic Psychotherapy (Davanloo, 1990, Malan, 2976). The main aim of ITAP therapy consist in increasing the intensity of therapeutic interventions and their effectiveness based on the use of intra-psychic triangle (Anxiety, Impulse and Defence) and the use of interpersonal triangle (Current Relationships, Past Relationships and Therapeutic Relationship). The previous are consider together with the maintenance of therapeutic alliance following the technique called "relational holding" (Sambin & Scottà, 2018). The Impulse emersion during the therapeutic interaction is hypothesized to be a central element for ITAP action. According to ITAP model, the Impulse is defined as "any spontaneous manifestation of the functioning of the person. In terms of psychoanalysis it corresponds to the manifestations of the Id, whereas in Transactional Analysis it would be described as a Child ego state." (Sambin & Scottà, 2018). Due to the importance of Impulse emersion, it would be very useful an operationalization of this phenomenon for research purposes. In the present naturalistic study, we explored the possibility to find descriptors of Impulse emersion in non-verbal aspects of the therapeutic interaction during a single-case series of ITAP therapy. *Methods*: Naturalistic single-case designs (N=3) were used for this study. Patients affected by common mental disorders were involved in 16 ITAP weekly sessions, for a total period of 6 months. Patients were assessed at 3 baseline points, at the end of each session, and at the follow-up (1, 3 and 6 months after therapy), using the following psychotherapy outcome measures: Clinical Outcome in Routine Evaluation – Outcome Measure (CORE-OM), Personal Questionnaire (PQ), State-Trait Anxiety Inventory (STAI) and Hamilton Depression Scale (HDS). Moments of Impulse emersion were isolated in video-recorded psychotherapy sessions and compared to Pre-Impulse emersion moments (30 seconds intervals). For each psychotherapy process segment, we evaluated the presence of the following non-verbal variables second by second: gaze contact, gaze direction (right, left, up, down), torso orientation (left, right, center), muscles tension, hands tension, hands movement and foots movement. Moreover, we evaluated voice parameters using the Vocal Quality Patterns coding system (Tomicic *et al.*, 2015). Finally, we statistically compared the presence of non-verbal indicators in Impulse *versus* Pre-Impulse moments (permutation t test analysis for not normally distributed data). *Results*: Process analysis is still work in process, we are able to provide early results obtained in one single-case. With regard to gaze, the following significant results emerged in impulse moments compared pre-impulse moments: decreased gaze contact (t=-2.36, p=.018), decreased gaze in right/down (t=-2.94, p=.003) and left/down directions (t=- 2.52, p=.012), and increased gaze in left/up direction (t=4.12, p=<.001). With regards to the body, significant results emerged in impulse moments compared pre-impulse moments: increased torso in central position (t=3.76, p <.001), with a reduction of torso is right position (t=-3.62, p <.001), and reduction in muscle tension (as expected as anxiety release) (t=-2.628 p=.023). *Conclusions*: In line with our aim explore the possibility to realize an operalization of Impulse emersion in psychotherapy sessions, our preliminary results suggest that non-verbal aspects of the interaction between therapist and patient may be valid indicators of Impulse emersion during the therapeutic interaction. Namely, left-up gaze seems to characterize the patient during the emersion of the Impulse, whereas in pre-impulse moments patient's gaze was directed down (left or right) and there was more contact with the therapist. With regards to body posture, the torso position on the center was associated to Impulse emersion, whereas muscles tension was negatively associated with the Impulse emersion. Beyond research purposes, our results have also interesting clinical implications. Indeed, the description of typical pattern of non-verbal behaviour may be an interesting indicator for the analysis of the therapeutic process carried out by the therapist during psychotherapy sessions. In order to draw stronger conclusion about non-verbal correlates of Impulse emersion in psychotherapy, more studies are required due to the limitations of the present study. First, our results cannot be generalized because of the single-case design. Second, Impulse may have different non-verbal correlates depending on its emotional quality (anger, sadness, fear or joy).

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PRESENTATION OF A PSYCHOLOGICAL SCREENING TOOL FOR UNDERGOING COSMETIC SURGERY PATIENTS

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Introduction: In recent years, in Italy as well, there has been an exponential growth in requests for plastic surgery and aesthetic interventions (AICPE, 2016). According to American Association of Plastic Surgeons (ASPS) data in United States in 2016 there has been a 4% increase (1.7 million) of plastic / aesthetic surgery compared to the same category of surgical interventions of the previous year and a 3% growth (15.4 million) of minimally invasive treatments. The Italian Society of Plastic Reconstructive and Aesthetic Surgery (SICPRE) has issued a press release in 2016, stating that although

there are no official statistics, also in Italy could be highlighted a trend that overlapped with US one. Be dissatisfied for a part of our body seem to be clear in many population sample (Paraskeva, 2014), university students as well (Marogna, 2016). The creation of a psychological assessment tool aims to identify the subjects who, due to some psychological factors, are in favour of a poor outcome, despite the body modification intervention was technically successful. The tool is to be understood as part of a routine of preoperative assessment. *Methods*: Scientific literature indicates several psychological factors associated with the risk of a postoperative poor outcome (Rumsey, 2012). These variables are: unrealistic expectations, external (or inappropriate) motivations, underlying psychological disorders and psychiatric disorders such as BDD (Harcourt, 2018). Currently the psychological screening tools developed for cosmetic surgery are few (Wilgoose, 2013) and they present different criticalities because they are too long and difficult to administer. In addition, most of the screening tools is currently focus mainly on BDD, neglecting more extensive risk factors, which proved to be equally dangerous in the post-operative setting (Brunton, 2014). Soit seemed necessary to build an instrument that would measure these factors in undergoing plastic and aesthetic surgery patients, taking into account the challenge of tight time that the world of private clinics is called to face. *Results*: In collaboration with Free Hospital of London and Bristol Center for Appearance Research, the RoFCAR was created. This is a psychological assesment tool, able to measure the variables involved in the risk of post-operative dissatisfaction, maintaining the characteristics of practicality compilation. The RoFCAR has been specifically designed to identify psychological factors that may increase the risk of psychological dissatisfaction following the body modification intervention. The pre-surgical screening tool consists of nine questions, eight on a likert scale and an open one. Items investigate a number of psychological factors associated with the "unacceptable" part of the body that prompted the patient to request the intervention. These items include questions about the perception that the patient has of the visibility of the particular, the worry, the self-awareness, the self-confidence and the eventual avoidance of certain activities due to this particular that they cannot absolutely show to the Other. The instrument that has been object of a pilot study that confirmed the psychometric properties is now undervalidation for the Italian population. *Conclusions*: Given the increasing number of body modification requests it is important to understand which patients may not benefit psycho-socially from this type of intervention. Pre-operative screening aims to improve care, treatment and support in the post-intervention period. Therefore it is important that aesthetic doctors develop and implement clear and structured guidelines for all potential patients who can benefit from an assessment, in order to improve treatment and post-operative support. At a first level RoFCAR can be a sufficient measure, if we then find high scores in the answers, or important concerns of the patient, we can proceed with a further, more exhaustive consultation, in order to verify if there are risks of mental decompensation or if it is not the optimal time for the patient to undergo a cosmetic procedure. The purpose of a psychological evaluation is not to limit or avoid an aesthetic intervention but to increase the likelihood that the patient and the aesthetic doctor will obtain a positive result. The RoFCAR is an easy-to-use tool designed to help aesthetic doctors and plastic surgeons to identify patients who may be at risk of poor outcome a postoperative dissatisfaction (despite the successful technical intervention) and to indicate situations in which requires a thorough psychological consultation. Vulnerable patient can be insert in a group therapy in order to improve social skills and resiliency (Marogna, 2014). The assessment tool created, allows, if inserted within a broader and multi-disciplinary routine, to measure the psychological factors that could lead to a poor outcome and therefore to a psycho-social discomfort for the patient and a possible psychopathological slatentization.

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Cognitive vulnerability hypothesis being tested: The effect of stressors and negative cognitive style

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Introduction: For a long time, researchers wondered why some individuals are more prone to develop depression. Similarly, in clinical practice it is relevant to identify depression's predicting factors in order to prevent its full onset. Also, detailed information on the client's cognitive beliefs are crucial for the treatment. This study aims at deepening the role of stress and negative cognitive style in predicting depression, according to the cognitive vulnerability hypothesis [1,2]. In the cognitive theories framework, in particular in the hopelessness theory, a negative life event can activate a dysfunctional and negative cognitive style which triggers the onset of depression. The hopelessness theory [1] states that one or more of the following negative inferences for negative events define a negative cognitive style: (a) belief that the causes of negative events are stable and global; (b) inference of other negative consequences deriving from a negative event; (c) inference of negative characteristics of the self, given the negative event. Such beliefs imply negative consequences on a subject's thinking and behavior, indeed cognitive psychotherapies focus on modifying dysfunctional and irrational beliefs [3]. Negative cognitive style leads individuals to generate negative inferences exposing them at higher risk of hopelessness, that is considered a proximal and sufficient cause for depression [4]. The present cross-sectional study was aimed to test the cognitive vulnerability hypothesis by investigating the role of the two factors supposed to predispose individuals to depression: perceived stress in response to negative life events and the negative cognitive style. *Methods*: The study included 300 participants (females=182, mean age=23.5, SD= 3.8) from introductory undergraduate students at the University of Padua. Participants evaluated their level of actual perceived stress due to stressing life events, then they completed the Cognitive Style Questionnaire – Short Form (CSQ-SF)[5]. The CSQ-SF is composed by 72 items arranged in eight negative scenarios that measure five dimensions derived from the hopelessness theory – internality, globality, stability, negative consequences and self-worth implications. The subject expresses its level of agreement on a 5-points Likert scale ranging from 1 ("strongly disagree") to 5 ("strongly agree"), consequently, higher total scores reflect a more negative cognitive style.

Finally, Beck Depression Inventory-II (BDI-II) was administered to evaluate depression symptoms. The BDI-II is a 21-items measure on a 4-point Likert scale (0=least, 3=most) with higher scores associated with symptoms of higher severity. After the data collection, on the basis of CSQ-SF scores, two groups were defined: a) individuals whose CSQ-SF score was under the 10th percentile (N=33) formed the low cognitive vulnerability group; b) individuals whose score was over the 90th percentile (N=31) formed the high cognitive vulnerability group. Those extreme groups were then compared to test the cognitive vulnerability hypothesis. Statistical analyses were performed using R software - version 3.5.0. *Results*: A linear model was used to predict BDI-II scores on the basis of two distinct predictor variables which are perceived stress and cognitive style. Results indicated that there was a significant proportion of variance explained by the model ($F_{(2,48)} = 25.32$, $p < 0.001$, $R^2 = 0.51$). Given the absence of a significant interaction between the predictors, the main effects were analysed. Results indicated that stress ($\beta = 1.47$, $t = 4.1$, $p < .001$) and cognitive style ($\beta = -9.88$, $t = -4.22$, $p < .001$) were both significant predictors of depressive symptoms. *Conclusions*: According to our previsions, the results showed that both the factors, the stress level and the cognitive style, play a key role in predicting depression scores. Furthermore, the results show that individuals with high cognitive depression vulnerability report higher stress levels than individuals with low depression vulnerability. Even if the perceived level of stress is the same, the high vulnerability group shows higher depression scores than the low vulnerability group. This result is in line with the cognitive vulnerability hypothesis which states that the occurrence of negative stressing life events and the presence of a negative cognitive style can make an individual more vulnerable to depression developing more depression symptoms as measured by BDI-II. These findings provide further evidence of the power and practical relevance of the cognitive vulnerability hypothesis. It might be once more stressed the importance of considering, and thus assessing, the negative cognitive style due to its the critical role as a vulnerability factor for depression. Luckily, cognitive style, and thus depression vulnerability, are both identifiable and measurable before depression onset. Assessing cognitive style can further provide valuable information about the patient's beliefs in order to plan the best psychotherapy treatment.

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The the tricks of empathy: Pilot study of psychotherapy analysis for a patient with narcissistic personality disorder

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Objectives: In attempt to identify the basic type of interventions that may favor therapeutic change the study was set out to explore the relationship between the relational episodes reported by a young adult patient (age 25 years) with a mild narcissistic personality disorder (according to the P-Axis criteria of the PDM, 2006) and the psychotherapist's interventions in the course of psychodynamically oriented psychotherapy. *Sample*: The target treatment of the study was administered face-to-face on a weekly basis, over 75 sessions in the period between October 2015 and April 2017. The average duration of each session was around 60 minutes, all were audio-recorded. *Data*: Data was categorized using method of the Core Conflictual Relational Theme (Luborsky, 1984) with the type of interventions used by the therapist in the course of treatment, codified through the expressive-supportive taxonomy (Gabbard, 2017). The study was carried out sampling 15 therapy sequences, selected at regular intervals of 5 sessions (session 1, 6, 11, 16 ...) with central sequence of each session included between the minute 30 'and 40'. These sequences were first transcribed verbatim; subsequently relational episodes present in the narration were identified and categorized making use of the analysis of two evaluators, through the categories that constitute the third clustered edition of the CCRT method (Luborsky, Luborsky, 2008); analogous procedure which was then used to codify the therapist's interventions, this time through the classification of Gabbard (2017). Subsequently, the data were organized in a matrix: unlike the traditional CCRT method the components constituting the individual relational episodes (W, RO, RS) were recorded in units distinct from each other, counting the occurrence in each sequence of the different types (8 for each type in the third clustered version) of Wishes (W), Responses from the object (RO) and Responses from the Self (RS). The same was done for the types of intervention of the therapist, counting the frequencies. *Data analysis*: With regard to the analysis of the therapeutic process, a transformation of the variables that codify the relational episodes and the therapist's interventions in time series was made, to perform a correlation test of the trends. This was followed by analysis of the possible response patterns of the therapist through a simple bivariate correlation analysis. Finally, a rudimentary analysis of the time series was carried out, investigating the impact of the therapist's interventions on the patient's relational narratives after five sessions, using the linear regression method. *Results*: The emerged preliminary results show a strong correlation between: observation interventions and wishes of contrast of the other (W2) (β =, 7; p =, 02), wishes of success (W8) (β =, 6; p =, 017), with rejection object responses (RO5) (β=7; p =, 003) and responses of the reception of the Self (RS8) (β =, 6; p =, 021); interventions of confrontation and wishes to contrast the other (W2) (β=-, 5; p =, 036); intervention of clarification and response of self-control responses (RS5) (β =, 6; p =, 005), of anger and depression responses (RS7) (β =, 6; p =, 019) and of shame and guilt responses (RS8) (β=-, 5; p =, 009); interventions of encouragement to elaborate and willingness to help responses (RS1) (β=-, 6; p =, 009). As far as the therapeutic style is concerned, a high correlation was found between interventions of interpretation and empathic validation (β =, 6, p =, 019). We then proceeded to make a rudimentary analysis of the time series, studying the impact of the therapist's interventions on the narration of relational episodes at a distance of 5 sessions using the linear regression method. The interventions of empathic validation evoked contradictory answers, in part in line with the therapeutic proposals of Kohut (1977), favoring the answers of the other codified as comprehensive and welcoming (RO8; β =, 7; p =, 012), but partly contrary even increasing responses of the other perceived as rejecting (RO5; β =, 7; p =, 011); they seem to promote responses of the other perceived as loving (RO7) in-

terpretations (β =, 4; p =, 001), observations (β =, 4; p =, 001) and encouragement to elaborate (β =, 4; p =, 000). The relation between interpretation and emphatic validation interventions needs better investigations. *Conclusions*: The results elucidate possible critical aspects of empathic validation interventions during the therapeutic process. Thus, the emergence of feelings of understanding seem to follow experiences of rejection, while interventions of an interpretive, observational and encouraging way for processing, although less effective, seem to promote the representation of the other's response as loving.

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Couple's plan formulation method: A method for the assessment and intervention in working with couples from the perspective of control-mastery theory

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Control-Mastery Theory (CMT) is a cognitive-psychodynamic theory of psychological functioning and psychopathology (Weiss, 1993; Gazzillo, 2016), empirically validated by the San Francisco Psychotherapy Research Group (1986). A central tenet of CMT is that human beings are guided by unconscious plans to disprove their pathogenic beliefs originating in traumatic childhood experiences and achieve normal and adaptive goals obstructed by them. In psychotherapy, patients want to disconfirm their pathogenic beliefs and for this reason they unconsciously test them in the therapeutic relationship. The way in which an individual will work in psychotherapy to disconfirm pathogenic beliefs, overcome problems and achieve goals is called the patient's plan (Curtis *et al.*, 1994). The plan is not to be understood as a rigid and pre-established itinerary that the patient must follow; rather, it describes general areas on which the patient will consciously or unconsciously want to work on and how the patient is likely to carry out this work. The Plan Formulation Method (PFM; Curtis *et al.*, 1994) is a standard procedure useful for clinicians and researchers to formulate the patient's plan and has proven to be reliable, simple to learn and applicable in different types of psychotherapies. Just as with individual psychotherapy, CMT can be applied also to couple's therapy. Thanks to the stability and the emotional involvement that they imply, couple relationships represent an ideal context where the partners can test their respective pathogenic beliefs (Zeitlin, 1991). Couples utilize these tests both in their everyday lives and in therapy, and if a partner doesn't pass the test, the risk is that a relational vicious cycle will come up with the partners feeling bad, afflicted or angry. The aim of this work is to present a method for the assessment of the couples plan according to CMT and its implementation to couple therapy. We hypothesize that also the couples that seeks psychotherapy have a plan which comprises goals, pathogenic beliefs, traumas, tests, dysfunctional relationship patterns -that we called "vicious relational circle"-, resources -that we called "virtuous relational circle"- and insights. We propose also a procedure by which is possible elaborate couple's plan: Couple's Plan Formulation Method (PFMc). In order to formulate the couple's plan, the clinician/rater should have access to the transcriptions of: (1) one or two couple sessions; (2) one or two individual sessions; (3) another couple session aimed at talking about what emerged during the assessment and about the specific treatment that can be proposed to them. The clinician/rater, on the basis of the formulation of the individual plan of each partner, elaborates the couple's plan as a derivative of the specific matching between the two partners. Some empirical tools may be useful for this task: the Interpersonal Guilt Rating Scale-15 (IGRS-15, Gazzillo *et al.*, 2017) and the Pathogenic/Problematic Beliefs Scale (PBS; Silberschatz, 2016), both in their clinician and self-report forms. We will present a clinical case of a couple therapy and the formulation of its plan. The couple required joint therapy in a public centre due to a general dissatisfaction about their relationship fuelled by episodes of betrayal. They have been married for 12 years and have two children. In the therapeutic work with this couple, the couple's plan allowed to better understand the dysfunctional dynamics underlying the individual and dyadic suffering and gave to the partners the opportunity to understand the meaning of their behaviors, emotions, reactions.
A therapeutic work oriented by PFMc allows the clinician to approach each couple in a case-specific way, considering the couple's specific goals, needs and difficulties. For this reason, it is possible for the clinician to use this map both in therapies with marital couples and in working with parental couples; this method, in fact, is not calibrated on categories of patients or on their diagnoses, but on the individuation of the specific vicious and virtuous relational circles that characterize the relationship. Furthermore, the couple's plan is useful both in the assessment phase, where in few sessions it is possible to understand some of the core couple's dysfunctional dynamics, and during the therapeutic process, where it allows the clinician to adapt his work to the couple's goals and needs. Future studies are needed to to evaluate the reliability and validity of this method, correlating the procedure with the assessment of the process and outcome of the treatment.

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Individual differences in hedonic capacity and subjective value representations: A functional imaging study

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Introduction: Anhedonia is considered a core feature of depression and its presence is a predictor of poor treatment response (Vrieze *et al.*, 2014). In several studies on appetitive processing, the subcortical dopaminergic areas, such as the ventral striatum, have been clearly associated to the amount of effort the individuals were

willing to do to obtain the reward (motivational components) (Treadway & Zald, 2011). Instead, functional studies of preference-based decision-making have implicated the ventromedial prefrontal cortex (vmPFC) in representing the subjective value of appetitive options, in contrast to the amount of effort to obtain them (Levy & Glimcher, 2012). Importantly, widely used anhedonia scales (SHAPS) appeared to assess the subjective value of potentially hedonic experiences. However, the relationship between the SHAPS as a scale of hedonic capacity and the construct of subjective value in the neuroscience of decision-making has not been assessed. To fill this gap, in the present functional imaging study we used a decision-making paradigm to evaluate the neural correlates of subjective value of rewarding stimuli and their modulations due to individual difference in consummatory anhedonia in a nonclinical sample. *Methods*: For this study we collected both neuroimaging and behavioural data from 315 healthy subjects. They underwent an fMRI session during which they were presented with pairs of snacks, from which they chose their preferred option. The subjective preference value of each stimulus was estimated on the basis of the number of times that stimulus had been chosen. The fMRI data were regressed on the subjective value of the chosen option to identify the neural substrates of preferences. Anhedonia scores were obtained with an established clinical scale ("Snaith-Hamilton Pleasure Scale", SHAPS; Snaith *et al.*, 1995) and used as regressors to predict modulation of brain activity associated with the subjective preference value during the snack paradigm. *Results*: The subjective value of chosen snacks was associated with increased activation of the left middle temporal gyrus (t=4.97, p <0.001), left inferior occipital gyrus (t=4.17, p=0.007) and the vmPFC (t=3.91, p=0.047, all corrected for the all brain). Confirming our hypothesis, the activation in the vmPFC was modulated by individual differences in anhedonia (t=3.92, p=0.006, ROI corrected). *Conclusions*: The present neuroimaging study has highlighted the importance of subjective value of appetitive options as a key element of anhedonia. Moreover, the involvement of the vmPFC in such processes, together with the role of such area as neurobiological marker of response to depression treatments (Salustri & Messina, 2017), account for the relevance of such aspect of hedonic capacity for tailoring treatments to patients' factors.

References

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