

A supportive approach in psychodynamic-oriented psychotherapy. An empirically supported single case study

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Abstract

This paper evaluates process and outcome in a 2 years supportive psychotherapy psychodynamic-oriented of a young adult self-referred for concerns about University choice. The diagnosis was Panic Attack Disorder (DSM-IV) with features of obsessive-compulsive and narcissistic personality disorder (PDM). Twenty-eight verbatim transcripts of the sessions were coded with the Psychodynamic Intervention Rating Scales, the Collaborative Interactions Scale and Defense Mechanism Rating Scale. A log linear analysis model showed the trends of process variables during the treatment. A hierarchical regression analysis evaluated the importance of tailoring the clinician interventions in respect to the average level of defenses. Outcome results showed how patient's diagnosis changed and symptoms decreased.

Key words

Psychodynamic-oriented supportive psychotherapy, therapist intervention, therapeutic alliance, defense mechanisms, process-outcome.

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Theoretical background

Psychodynamic individual psychotherapies are described as a continuum that extends from supportive to expressive psychotherapies (Gabbard, 2005). Psychoanalysis, which is found at the “expressive” pole of the spectrum, includes approaches that accomplish personality change by analyzing the relationship between the therapeutic couple and insights derived from the exploration of unrecognized feelings, thoughts and conflicts (Luborsky, 1984). As Gabbard (2009) recently pointed out, the aim of supportive psychotherapy is not to change the patient’s personality but to help the patient cope with symptoms, conscious conflicts or transient problems. Several authors have suggested different definitions of supportive intervention, but all agree that this kind of treatment helps to improve patient self-esteem, maximizes patient adaptive skills, and restores ego functions, maintaining or reestablishing a consistent level of functioning, given the patient’s personality and life circumstances (Dewald, 1971; Ursano & Silberman, 1996). Although in real clinical practice, psychodynamic therapists use a mix of supportive and expressive approaches, there are substantial differences regarding the indications for use of supportive therapy. They range from the classical view that supportive therapy should be prescribed for “low functioning” patients, to the view that this intervention should be used with “high functioning patients” to scaffold ego functions (Hellerstein, Pinsker, Rosenthal, & Klee, 1994; Douglas 2008). As Douglas suggested (2008), supportive therapies help the patient see things more clearly by sustaining reality, and testing and challenging unrealistic ideas. The clinician must help the patient to regulate a wider range of affects, and to talk about his/her inner life in a more consistent way. Therapeutic actions need to be characterized by affective mirroring and interpersonal warmth (Markowitz, 2008). The supportive intervention should help the patient socialize better with others by strengthening control over socially unacceptable behavior and encouraging more consistent ways of relating to others (Misch, 2000).

The patient who cannot experience trusted and consistent relationships, or is avoided by others, can find an accepting person in the clinician. The clinician's openness and interest in the patient is communicated through validation and confirmation of what the patient has said, liked and so on (Appelbaum, 2005). To reach these objectives, a detailed assessment is crucial (Misch, 2000). Moreover, during the intervention, the clinician needs to examine the patient's real or transference relationships and past-present pattern of emotional responses and behaviors (Gabbard, 2009).

In conclusion, interventions need to be tailored according to these specific aims. As Douglas (2008, p. 447) suggested, one of the central rules of supportive interventions is "Do not say everything you know, only what will be helpful." The clinician has to do "just enough" to reduce anxiety, increase self-esteem and hope, support inconsistent psychological functions, and improve overall functioning. For example, in supportive psychotherapies, transference does occur, but the clinician does not interpret it. The clinician manages the transference only, encouraging the development of the patient's positive feelings towards the therapist himself (Misch, 2000). These positive feelings are useful for the patient to maintain a good working alliance and to have consistent identification with the clinician (Rockland, 1989; Safran & Muran, 2000; Douglas, 2008). Working alliance is a crucial aspect in both expressive and supportive interventions. In supportive psychotherapies, working alliance is recognized as a highly important element of the treatment. However, it becomes the subject of discussion only when problems within the relationship threaten to disrupt the treatment itself (Appelbaum, 2005; Colli & Lingardi, 2009). The aim of supportive therapy is to avoid alliance rupture and enhance collaborative processes in order to create and maintain a holding environment (Skean, 2005). The psychodynamic framework maintains that an important way to understand a person is in the context of the

unfolding relationship with the therapist. Through this relationship, the patient brings his or her interpersonal world into the treatment room and allows the therapist to experience aspects of the client's structuring of reality (Skean, 2005). In order to foster the therapeutic effect, one of the priorities of supportive intervention is to create a "holding environment," an atmosphere based on emotional safety and trust (Crits-Christoph & Connolly, 1999). The clinician needs to work actively from the very beginning, helping the patient to contain anxiety, shame, and anger (Winston, Rosenthal, & Pinsker, 2004). The approach to patient defense mechanisms plays a central role in differentiating expressive from supportive psychotherapies. In expressive interventions, defenses are identified and examined in depth in order to reach the underlying conflict. In supportive treatments, defenses are questioned only when they become maladaptive for the patient (Gabbard, 2009).

Many clinical papers have been devoted to distinguishing expressive from supportive therapies, and expressive versus supportive interventions. However, very few studies have studied empirically the specificity of the therapist's intervention, alliance and defensive trends in supportive psychotherapies as compared with expressive intervention or psychotherapies, as will be seen in the literature reported below. The aim of this paper is to discuss these issues in a single case supportive approach in a psychodynamic-oriented psychotherapy.

Several studies have investigated the therapist's in-session activities that could influence therapeutic alliance (for a review see Ackerman & Hillsenroth, 2001, 2003). Some studies have examined the therapist's misapplication of techniques that impede the development of the alliance. However, mixed results have been found. Eaton, Abeles, and Gutfreund (1993) identified a significant positive relationship between a weak alliance and the therapist's failure to structure the session and failure to address resistance. Marmar, Gaston, Gallagher, and

Thompson (1989) investigated the therapeutic alliance in brief dynamic grief therapy and reported a significant positive relationship between the therapist's increased focus on avoidance of important issues, the patient's hostile resistance, and patient's negative experience of the alliance. These diverging results may be due to the amount of time and emphasis placed on addressing resistance as well as the way in which the resistance was addressed.

The influence of alliance depends on how the therapist's actions are attuned to certain patient factors such as personality style, ego strength, core conflictual relationship and, finally, defense level functioning (Despland, de Roten, Despars, Stiglar, & Perry, 2001; Lingiardi, Shedler, & Gazzillo, 2006). It is therefore necessary to study the efficacy of specific therapist interventions in fostering the alliance. This must be done by considering not only the specific action of the therapist, but also the relationship and accuracy of the therapist's techniques according to several patient factors and in relation to a specific moment of the therapy and session. One of techniques the therapist uses is to deal with patient defenses and to interpret defensive maneuvers. Several studies investigating the relationship between defensive functioning and therapeutic alliance have produced mixed results. Some have found a direct positive relationship (Gaston, Marmar, Thompson, & Gallagher, 1988) while others have failed to find such a relationship (Hersough, Høglend, Monsen, & Havik, 2001). Foreman and Marmar (1985) found that when therapists actively focused on patient defenses and resistances, the alliance improved within four sessions. These results have been supported by other studies (Bond, Banon, & Grenier, 1998; Perry & Bond, 2000). In these studies, defense interpretations enhanced therapeutic work without increasing defensiveness in both high and low alliance patients. Milbrath, Bond, Cooper, Znoj, Horowitz, and Perry (1999) suggested that interpreting a patient's defense mechanism was followed by greater

emotional elaboration and insightful connections. Other studies have found that patient defensive functioning per se is less significant for alliance formation than how the therapist chooses to intervene according to the patient's defense functioning. These studies investigated the relationship between patient therapeutic alliance and defenses, and therapist interventions at a global session level. Although this could be a useful strategy for studying therapeutic alliance in general, it may be less useful for studying the process of alliance construction and, in particular, alliance rupture and resolution processes (Colli & Lingardi, 2009; Watson & McMullen, 2005).

The question of how a clinician should deal with patient defense during a psychotherapy session is crucial for psychodynamic therapies in general, and for supportive psychodynamic psychotherapies (Siefert, Hilsenroth, Weinberger, Blagys, & Ackerman, 2006). A way to assess expressive versus supportive psychotherapy is to consider the ratio between the expressive interpretative level of the therapist interventions and the patient defense level of functioning (Despland, et al., 2001; Junod, De Roten, Martinez, Drapeau, & Despland, 2005), rather than using only the therapist's expressive interventions (Gabbard, 1994).

Despland et al. (2001) examined what they termed "therapist adjustment," which refers to how a therapist adjusts his interventions to a patient's level of defensive functioning. These authors first used the Defense Mechanism Rating Scale (DMRS; Perry, 1990; see also Lingardi, Lonati, Fossati, Vanzulli, & Maffei, 1999) to calculate patients' overall defensive functioning score (ODF: from 1 = very immature defenses to 7 = highly mature defenses). They then rated therapist interventions using the Psychodynamic Interventions Rating Scale (PIRS; Cooper & Bond, 1992) and rank ordered therapist interventions according to an Expressive Supportive Intervention Level continuum (ESIL: from 1 = very supportive to 7 = very expressive) (Figure 1). The adjustment ratio of therapist intervention was then

calculated by dividing ESIL by ODF (see Figure 1). In this way, an adjustment score of 1 indicated that the therapist adjusted his/her interventions perfectly to the patient's defensive level. A lower level ($AR < 1$) indicated that the therapist intervention was adjusted toward the supportive pole, instead, a higher level ($AR > 1$) indicates that therapist intervention was adjusted toward the expressive pole. The general conclusion that can be drawn from the studies cited is that addressing a patient's defense can produce a positive effect.

Figure 1. Scales used to measure adjustment of interventions to defense mechanisms.

Intervention Scale (ESIL)			Defense Scale (ODF)	
Transference interpretation	7	↑	↓	7 Mature
Defense interpretation	6			6 Obsessional
Defense interpretation	5			5 Hysterical, other neurotic
Question, clarification, WES	4			4 Minor image - distorting
Reflection	3			3 Disavowal
Support strategy, CA	2			2 Major image - distorting
Association	1			1 Action

Note. ESIL: Expressive-Supportive Intervention Level; ODF: Overall Defensive Functioning scores; WES: Work-Enhancing Strategy; CA: Contractual Arrangement.

Empirical research in psychotherapy is only concerned with evidence-based forms of psychotherapy with “scientifically proven efficacy.” Supportive therapy has not been sufficiently manualized or tested in controlled clinical trials for it to be considered evidence-based (Douglas, 2008). However, research studies have reported clinical observations that supportive therapies are effective for a broad range of conditions. Winston and Winston (2002) pointed out the need for further clinical trials to establish the legitimacy of supportive psychotherapy as an evidence-based form of psychotherapy with scientifically proven efficacy. Empirical psychotherapy research includes outcome and process

studies (Orlinsky, Ronnestad, & Willutzki, 2004; Dazzi, Lingiardi, & Colli, 2006).

Despite the great number of process and process-outcome studies, there have been very few studies investigating the psychotherapy process in supportive therapies (Orlinsky, et al., 2004). Unfortunately, little empirical effort has been made to understand further the nature of this process. In addition, in these studies, the role of therapist intervention, alliance and defense interpretation was not investigated in supportive psychotherapies. The main topic of this paper is to demonstrate empirically how a supportive psychodynamic-oriented therapy helped a young woman referred for anxiety disorder. The following hypotheses were supported:

1. Outcome. A reduction in psychopathological symptoms and an improvement in personality functioning was expected, as assessed at the beginning and at the end of the therapy.
2. Therapist intervention. A higher level of supportive vs. interpretative intervention was expected from the therapy. However, it was expected that interpretative intervention would be introduced in the central part of the therapy.
3. Alliance development. A positive trend in therapeutic alliance level through the therapy was expected. Specific trends of rupture and collaborative processes were expected according to supportive versus interpretative therapist interventions.
4. Defense structure and change during therapy. A stable structure of variety and frequency of defenses were expected in the assessment phase in the central and final parts of the therapy. However, we expected that the relational process between therapist and patient, comprising expressive as well supportive interventions, would lead to the appearance of different kinds of defenses that could be detached from the various phases of the treatment. We also expected that the therapy would allow a more flexible defense structure.

5. Alliance ruptures, therapist interventions and patient defenses. The relationship between therapist interventions, therapeutic alliance ruptures, and patient defense mechanisms were investigated. Specifically, we wanted to test the relationship between two different indexes of the Adjustment Ratio of therapist interventions: Session Adjustment Ratio (SAR, that is the ratio between the expressive level of the therapist's intervention and the average patient's defensive functioning) and the Interaction Adjustment Ratio (IAR, obtained by comparing the expression level of intervention to the patient's defensive level of functioning immediately before the intervention). We expected IAR to be a better predictor of patient alliance ruptures than the SAR.

Method

Clinical Case

Matilde is a 20-year-old student who referred herself to a Clinical Service in order to resolve some concerns about her choice of University course. She attends the second year of Medical School, but is not sure that this is the right career for her. She wears casual clothes, does not use any kind of make up, and does not follow fashion. She left the small town where her family live to study, and now shares an apartment with other students near the Medical School. She feels confused and insecure, and this insecurity caused her quite severe crises of crying, pervasive anxiety, and some physical symptoms, such as psychomotor agitation and tachycardia. She had taken light tranquilizers in the previous three months. She is fluent, clear and precise in the cognitive evaluation of her disease.

At the beginning of the first session, she seemed quite distrustful, but aware that she needed someone to teach her new means and perspectives for understanding and handling her uneasiness. She

recognized that she needed help in facing the state of uneasiness that she feels.

Matilde is smart, reflective and trim, and has a clear and accurate way of speaking and thinking. She did not talk about any other satisfying relationships and does not have many friends. In her native small town, she lived with her parents and a younger sister. She still stays with them when she returns for vacations. She is very proud of her family, and has a good relationship with her mother. They often talk a lot and she recounts her problems. Sometimes Matilde feels guilty for worrying her mother and involving her in Matilde's anxiety and uneasiness. Matilde describes her father as rigid and very involved in practical duties. She has a 10-year-old sister, Sarah. They are very close, and Matilde describes Sarah as very different from her. The younger sister is very funny, ironic and with a lot of energy. They spend a lot of time playing together, and Matilde becomes unconcerned about her worries when Sarah is close to her. She says she is very lucky to have such a family.

Although Matilde's descriptions of her family were detailed, most of the time they were neutral and dull. She often told about things they did together, without any reference to shared emotions or feelings.

Matilde described herself as very close to her schoolmates and said she had several friends during high school years. Her schoolmates considered her as their main confiding friend, although they seemed to share school topics only. Now that she is at University, she is frequently in touch with them. They do not know anything about the difficult period she was going through. Since starting University, her life is very taken up with studying and she does not seem to have the time or desire to be engaged in social relationships.

She has never had a boyfriend. She feels very uncomfortable talking about sexual topics, saying that sex is not important at the moment.

Assessment and Treatment

Matilde underwent three assessment sessions and one feedback session. In the feedback session, a once-a-week supportive psychodynamic-oriented psychotherapy was proposed and accepted by Matilde. The supportive therapy lasted 22 months. Therapy was concluded by consent. The treatment included approximately 56 sessions. The present study is focused on 28 audiotaped and transcribed sessions, 50% of the entire treatment. The sessions considered are spread over the entire intervention period. Matilde's sessions were divided into five periods. The first period (t1–four sessions) was called the assessment/beginning period. These sessions were also used to complete the SWAP. The fifth period (t5–four sessions) was defined as the final period because the therapist and patient agreed about the conclusion of the treatment and talked about it. The central part of the treatment was divided into three phases (t2–seven sessions, t3–seven sessions, t4–six sessions) based on interruptions for holidays.

SWAP-200 and GAF pre- and post-treatment were scored on assessment and treatment conclusion, respectively.

Measures

Assessment measures

Shedler–Westen Assessment Procedure (SWAP-200; Westen & Shedler, 1999a, 1999b). The SWAP-200 is a set of 200 personality-descriptive statements, each printed on a separate index card (Shedler & Westen, 1998; Westen & Shedler, 1999a, 1999b). A clinician who knows a patient well is asked to describe him/her by arranging the statements into eight categories, from those that are not descriptive (assigned a value of “0”) to those that are highly descriptive (assigned a value of “7”). Thus, the procedure yields a numeric score from 0 to 7 for

each of the 200 personality-descriptive variables. Items are written in straightforward language, and items that require inferences about internal mental processes are written without recourse to jargon. The instrument is based on the Q-sort method that requires clinicians to arrange items into a fixed distribution (Block, 1978). The item set was developed and revised over a 7-year period and incorporates constructs drawn from a wide range of sources. These include the Axis II diagnostic criteria of the DSM-III (3rd ed.; American Psychiatric Association, 1980), the DSM-IV, selected Axis I criteria that reflect personality traits (e.g., depression and anxiety), research in personality psychology, clinical literature on PDs from the past 50 years, and the feedback of hundreds of psychologists and psychiatrists who used earlier versions of the instrument to describe their patients (Shedler & Westen, 1998; Westen & Shedler, 1999a).

The Symptom Checklist 90 Revised (SCL-90-R; Derogatis, 1983) is a self-report symptom inventory. The 90 items of the questionnaire are scored on a five-point Likert scale of distress from 0 (none) to 4 (extreme), indicating the rate of occurrence of the symptom during the time reference (Derogatis, Lipman, & Covi, 1973). The SCL-90 is intended to measure symptom intensity on ten different dimensions: Somatization (SOM), Obsessive-compulsive (O-C), Interpersonal sensitivity (I-S), Depression (DEP), Anxiety (ANX), Hostility (HOS), Phobic anxiety (PHOB), Paranoid ideation (PAR), Psychoticism (PSY), and sleep difficulties (SLEEP). A Global Severity Index (GSI) of distress is calculated. According to the Italian Manual, an intensity raw score higher than one is considered in the clinical range, and qualifies as penetrating the clinical range. The internal consistency coefficient alphas for the nine symptom dimensions ranged from .77 for Psychoticism, to .90 for Depression. Test-retest reliability coefficients ranged between .80 and .90 after one week of therapy. The few validity studies of the SCL-90-R demonstrate levels of concurrent, convergent,

discriminant, and construct validity comparable to other self-report inventories (Derogatis, 1983).

The Global Assessment of Functioning (GAF; DSM IV) is a numerical scale based on the fifth axis in the DSM system for reporting the clinician's judgment of the individual's overall level of functioning. The aim of the scale is to assess psychiatric status, ranging from 1 (lowest level of functioning) to 100 (highest level), measuring the psychological, social, and occupational functioning of adult patients. The GAF scale is divided into 10 ranges of functioning. Making a GAF rating involves choosing a single value that best reflects the individual's overall level of functioning. The description of each 10-point range in the GAF scale has two components: the first part covers symptom severity, and the second covers functioning. The GAF rating is within a particular decile if either symptom severity or level of functioning falls within the range.

Process Measures

Defense Mechanisms Rating Scale – DMRS. The DMRS (Perry, 1990; Perry, Kardos, & Pagano, 1993; Lingiardi, et al., 1999; Perry, 2001;) manual describes how to identify 28 individual defense mechanisms in videotaped or audiotaped sessions or transcripts. The introduction includes general directions for the qualitative and quantitative identification of defenses, along with suggestions about handling problems presented by different data sources. The body of the manual consists of directions for identifying 28 individual defenses. The manual includes a definition of each defense, a description of how the defense functions, a section on how to discriminate each defense from similar defenses (e.g., suppression vs. repression vs. denial), and a three-point scale. Each scale is clearly identified with specific examples of (0) no use of the defense, (1) probable use and (2) definite use of the defense. The examples provide prototypical instances of the defense, which expands

and complements the formal definitions. In the DMRS system there are seven defense levels arranged hierarchically, with each defense assigned to a particular level. The defense levels are characterized in brief as follows, in descending order of health:

7. High Adaptive Level (also called “Mature”): affiliation, altruism, anticipation, humor, self-assertion, self-observation, sublimation, suppression;
6. Obsessional: isolation, intellectualization, undoing;
5. Other Neurotic: repression, dissociation, reaction formation, displacement;
4. Minor Image-distorting (also called “Narcissistic”): omnipotence, idealization, devaluation;
3. Disavowal: negation, projection, rationalization, autistic fantasy;
2. Major-Image-distorting (also called “Borderline”): splitting of others’ image, splitting of self-image, projective identification;
1. Action: acting-out, passive aggression, hypochondriasis.

The rater identifies each use of the defense as it occurs, bracketing the part of the text in which it operates. After completion of the ratings, the number of times each defense was identified in the text is divided by the total instances of all defenses, yielding a percentage score for each defense. The total percentage of defenses at each level then forms the basis for a “defense profile” (see Figure 1, later in this paper) which represents the nature of the patient’s functioning, and may be compared with earlier or later functioning in the course of treatment.

All the defense scores are summarized by an Overall Defensive Functioning (ODF) score (Perry & Høglend, 1998). If all defenses are at the “1” level, the ODF score would be 1, and if all were at the “7” level the ODF would be 7. In clinical samples based on whole interviews,

scores usually range between 2.5 and 6.5.

Collaborative Interactions Scale-CIS. The CIS (Colli & Lingiardi, 2009) is a rating system for the assessment of alliance ruptures and repairs in psychotherapy. External raters conduct their evaluations on transcripts. The CIS comprises two main scales: one for the evaluation of patient rupture and collaborative processes, CIS-P, and one for the evaluation of therapist positive and negative contributions to the therapeutic relationship, CIS-T. The CIS-P includes three main subscales, the Direct Rupture Markers Scale (DRMs), the Indirect Rupture Markers Scale (IRMs), and the Collaborative Processes Scale (CPs). DRMs are characterized by an aggressive and accusatory statement of resentment or dissatisfaction with the therapist or some aspect of the therapy process (Safran, Muran, Stevens, & Rothman, 2008). IRMs are characterized by indirect forms of emotional disengagement from the therapist, from some aspect of the therapy process, or from his/her internal experience (Safran, et al., 2008). Patient CPs include the patient bringing salient and significant themes, sharing intimate and salient information with the therapist, self-observation of his/her reactions, or working actively with the therapist's comments. The CIS-T Positive Intervention scale evaluates collaborative and repairing therapist interventions. The CIS-T Negative Intervention scale evaluates negative contributions by the therapist. Although the CIS is rooted in the psychodynamic relational and cognitive-interpersonal approaches, the items are written in a transtheoretical language, which makes it useful for researchers from a variety of backgrounds.

The Psychodynamic Intervention Rating Scales (PIRS; Cooper & Bond, 1992) detects nine types of therapeutic intervention based on psychodynamic psychotherapy. The scale includes two main categories: the interpretative and non-interpretative. Interpretive interventions

consist of transference (TI) and defense interpretations (DI). Non-interpretive interventions include acknowledgments (A), clarifications (Cl), questions (Q), therapist associations (Ass), reflections (R), work-enhancing strategies (WES), support strategies (SS), and contractual arrangements (CA). PIRS has been developed to code all therapist utterances (TU). The raw count is expressed as a frequency of all interventions. The PIRS was scored by two experienced raters trained in the use of this scale. Inter-rater reliability was good, with Kappas for all categories greater than .79. According to the literature, the PIRS shows consistent reliability and construct validity (Milbrath, et al., 1999). Some evidence for construct validity is sustained by relationships between class of therapist intervention and the patient's initial level of distress, and between subsequent therapist elaboration and patient outcome (Despland et al., 2001).

Therapist interventions were organized following Despland et al. (2001), according to a rank-ordering scale from the most supportive (1) association, to the most exploratory, (7) transference interpretation. Acknowledgments (e.g., "Uh-hunh") by the therapist are omitted as they are considered neutral interventions.

Procedure

The first aim of this paper was to assess possible trends and changes in therapist intervention, therapeutic alliance and defenses over time. A two way log-linear model was chosen to assess associations between the different categories included in these variables during the therapy. The log-linear analysis is a non-dependent procedure for associating categorical or grouped data, looking at all levels of possible main and interaction effects, with the primary purpose of finding the most parsimonious model that can account for cell frequencies in a table. More specifically, a saturated model was preferred. A saturated log-linear model for two variables is one that incorporates all possible

effects: a 1-way effect for each variable, all 2-way interaction effects for models with two variables. Overall, there will be $(2k - 1)$ terms plus a constant in the equation of a saturated model predicting the log of an expected table frequency, where k is the number of variables. A saturated model imposes no constraints on the data and always reproduces the observed cell frequencies. As such, the saturated model forms the “baseline” for log-linear analyses. Since the number of sessions was not the same for all periods, a specific procedure was carried out to homogenize cell frequencies. For all variables, tables will be presented that report the effect parameter estimates for the variables and their interactions (Knoke and Burke, 1980) and the probability of the standardized parameters. Only significant $p < .001$ effects will be interpreted.

The therapist interventions, assessed with the PIRS, were divided in two main categories, supportive versus interpretative. To assess the relationship between therapist intervention, therapeutic alliance and defenses at a microanalytic level, we referred to a procedure described by Despland et al. (2001) to estimate the adjustment ratio of therapist interventions with respect to the level of patient defensive functioning (Figure 1). We have calculated two different indexes of Adjustment Ratio of therapist interventions: Session Adjustment Ratio (SAR) and Interaction Adjustment Ratio (IAR). As already described, SAR is the ratio between the expressive level of the therapist’s intervention and the average patient’s defensive functioning. IAR is an index created for this research and obtained by comparing the expression level of intervention and the patient’s defensive level of functioning immediately before the IAR intervention. It was designed to understand better the relationship between therapist intervention and patient functioning in a specific moment of the session.

Results

Outcome

Case formulation assessment at the beginning phase

According to SWAP-200, Matilde is conscientious and responsible. She has moral and ethical standards and strives to live up to them. She is able to use her talents, abilities, and energy effectively and productively. However, she lacks a stable image of who she is or would like to become (e.g., attitudes, values, goals, or feelings about herself may be unstable and changing). She has trouble making decisions and tends to be indecisive or vacillate when faced with choices.

Matilde is excessively devoted to work and productivity, to the detriment of leisure and relationships and tends to adhere rigidly to daily routines and become anxious or uncomfortable when they are altered. She tends to be overly concerned with rules, procedures, order, organization, schedules, etc. and is self-critical. She sets unrealistically high standards for herself and is intolerant of her own human defects. She expects to be “perfect” (e.g., in appearance, achievements, performance, etc.), and, therefore, tends to feel guilty, unhappy, depressed and despondent. She feels inadequate, inferior, thinks of herself as a failure and tends to avoid social situations because of a fear of embarrassment or humiliation.

Matilde appears to find little or no pleasure, satisfaction, or enjoyment in life’s activities. She tends to be insufficiently concerned with meeting her own needs and tends to oscillate between undercontrol and overcontrol of needs and impulses. She appears to have a limited or restricted range of emotions and, in particular, has difficulty acknowledging or expressing anger. More generally, Matilde tends to be inhibited or constricted and has difficulty allowing herself to acknowledge or express wishes and impulses. Her mood tends to cycle

over intervals of weeks or months between excited and depressed states and she tends to be anxious. Moreover, she has anxiety attacks lasting from a few minutes to a few hours, accompanied by strong physiological responses (e.g., racing heart, shortness of breath, feelings of choking, nausea, dizziness, etc.). She tends to develop somatic symptoms in response to stress or conflict (e.g., headache, backache, abdominal pain, asthma, etc.).

Matilde seems to know less about the ways of the world than might be expected, given her intelligence and background; she appears naive or innocent. She thinks in concrete terms and interprets things in overly literal ways; she has limited ability to appreciate metaphor, analogy, or nuance. Matilde thinks in abstract and intellectualized terms, even in matters of personal importance and tends to see herself as logical and rational, uninfluenced by emotion. She prefers to operate as if emotions were irrelevant or inconsequential.

Matilde's SCL-90-R symptom profile reveals a pattern and magnitude within the clinical range, and qualifies her as a positive clinical case. Overall intensity of distress is somewhat elevated and she has endorsed a marked number of symptoms. Scores in certain areas approach, or have already penetrated, the clinical range. Matilde's depression, anxiety, and obsessive-compulsive levels are above average, and clinical in nature. Matilde's level of somatization is significantly elevated suggesting a clinical picture involving enhanced distress associated with somatic complaints. Difficulties with feelings of personal inadequacy and considerations about devalued self-worth (interpersonal sensitivity) approach the clinical level. Matilde's psychoticism score is approaching the clinical range. However, it is more likely that this reflects a slight experience with social alienation, rather than a thought disorder. Matilde's record reveals levels of phobic anxiety, anger-hostility, paranoid ideation, and sleeping difficulties that are not particularly marked.

Moreover, according to the GAF, Matilde shows moderate symptoms (flat affect, occasional panic attacks) and moderate difficulty in social functioning (e.g., few friends).

Assessment at the conclusion phase

According to the SWAP-200, Matilde is conscientious and responsible and has moral and ethical standards that she strives to live up to; she is able to use her talents, abilities, and energy effectively and productively. She is also able to assert herself effectively and appropriately when necessary; she enjoys challenges and takes more pleasure than before in accomplishing things. She can now find meaning and satisfaction in the pursuit of long-term goals and ambitions. Matilde finds meaning in belonging and contributing to a larger community and finds contentment and more happiness in life's activities. She forms closer friendships characterized by mutual support and shared experiences and is more attracted to the idea of a love relationship characterized by genuine intimacy and caring.

Notwithstanding all this resources, Matilde still does not have a stable image of who she is or would like to become, and tends to see herself as logical and rational, uninfluenced by emotion. Sometimes she prefers to operate as if emotions were irrelevant or inconsequential. Matilde very often thinks in abstract and intellectualized terms, even in matters of personal import, and describes experiences in general terms, sometimes being unable to offer specific details. She also tends to think in concrete terms and interpret things in overly literal ways, and sometimes her ability to appreciate metaphor, analogy, or nuance is limited.

Matilde is still excessively devoted to work and productivity, to the detriment of leisure and relationships. She can be competitive with others and sometimes overly concerned with rules, procedures, order, organization, schedules and so on, and she tends to adhere rigidly to

daily routines (becoming anxious or uncomfortable when they are altered). Matilde is self-critical and sets unrealistically high standards for herself and is intolerant of own human defects. She expects herself to be “perfect” and has fantasies of unlimited success and power.

Matilde has difficulty allowing herself to experience strong pleasurable emotions (e.g., excitement, joy, pride) and tends to be inhibited or constricted, having difficulty allowing herself to acknowledge or express wishes and impulses. She appears to have a limited range of emotions and is often anxious. She appears to fear being alone and may go to great lengths to avoid this situation.

Matilde sometimes appears unable to describe important figures in a way that conveys a sense of who they are as people. Descriptions of others still come across as two-dimensional and lacking in richness. Sometimes, it seems she has little psychological insight into her own motives and behaviors. She is unable to consider alternate interpretations of her experiences and seems to know less about the ways of the world than might be expected, given her intelligence and background.

Matilde's SCL-90-R symptom profile reveals a pattern and magnitude considered to be within the normal range. Overall intensity of distress is not particularly remarkable. Only some symptomatic distress levels obsessive-compulsive and anxiety-still penetrated the clinical range. There is some evidence to suggest that Matilde is still experiencing difficulty with feelings of personal inadequacy and considerations about devalued self-worth. Distress, however, is only approaching clinical levels. Matilde's record reveals that levels of somatization, depression, anger-hostility, phobic anxiety, paranoid ideation, psychoticism, and sleeping difficulties are not particularly marked.

According to the GAF, Matilde presents some mild symptoms (depressed mood and anxiety) and mild difficulties in social functioning

but, generally, functions well, and has some meaningful interpersonal relationships.

As well as a qualitative comparison, the results of the SCL-90 R and SWAP-200 were also compared at a statistical level using the Wilcoxon rank-sum test. At the assessment-beginning phase and at the conclusion phase, the SCL-90 R reported a significantly different rank distribution ($z = -2.37, p < .05$) showing lower levels of symptomatology at the end of the treatment. PD SWAP-200 scores at the assessment-beginning phase and at the conclusion phase showed a significantly different rank distribution ($z = -2.29, p < .05$) confirming a lower level of clinical scores in personality dimension at the end of the treatment. Table 1 summarizes case formulation at the beginning and at the conclusion phase.

Process

Therapist interventions

Table 2 reports the results of the log-linear model. Row (periods), Column (supportive versus interpretative), and Interaction had a significant effect ($p < .001$). As expected, supportive interventions were significantly more frequent than interpretative interventions. Over time, therapist interventions were significantly more frequent in times t2 and t3 and diminished significantly in times t4 and t5. This trend could highlight how, in the first part of the therapeutic process (t2 and t3), the therapist mainly had to support the patient.

Specifically, t2 was devoted to supportive intervention such as questions, clarification, association, and reflection in order to make Matilde feel supported, understood and more engaged in her therapeutic process. Instead, t3 and t4 showed an increase in expressive intervention. The relationship between patient and therapist was already established so the therapist interventions could be addressed more at an interpretative level, such as addressing dynamic

Table 1. Case Formulation at the beginning and at the conclusion phases.

Diagnosis	Assessment	Outcome
DSM	Axis I: Panic Attack Disorder	Axis I: No diagnosis
	Axis II: No diagnosis	Axis II: No diagnosis
PDM	P axis: features of obsessive-compulsive personality disorder and of a narcissistic personality disorder	P axis: features of obsessive-compulsive personality disorder and of a narcissistic personality disorder
	M axis: Mild Constrictions and inflexibility	M axis: Mild Constrictions and inflexibility
	S axis: none	S axis: none
SCL - 90	GSI=1.14 SOM=1.17 O-C=1.40 I-S=1.00 DEP=1.85 ANX=1.70 HOS=.50 PHOB=.29 PAR=.33 PSY=1.00 SLEEP=.00	GSI=.69 SOM=1.10 O-C=1.10 I-S=1.00 DEP=.77 ANX=1.10 HOS=.33 PHOB=.29 PAR=.20 PSY=.50 SLEEP=.00
	GAF	51 - 60
SWAP - 200	PD Factor: Obsessive-compulsive (68) and schizoid (60)	PD Factor: Obsessive-compulsive (62.82)
	Q Factor: Avoidant style (60.69)	Q Factor: Obsessive style (70.50)
	High Functioning (55.40)	High Functioning

Note. For descriptive purposes, we report only meaningful values of the different instruments.

conflict, to refer to, or explain the reasons for processes that mitigate or diminish affect, or processes that reflect shifts in the content of topics or representations of persons. In the final phase (t5), the therapist interventions were very low to allow Matilde to access the end of the process. Regarding interaction, the supportive interventions are

significantly more present in time t2 and give more significant space to expressive intervention in times t3 and t4.

Table 2. PIRS log-linear model. Parameter estimates for the period and intervention and their interactions, and the probability of standardized parameters.

Periods	PIRS Therapist intervention		
	Expressive Intervention	Supportive Intervention	Overall Intervention
t1	-.11**	.11**	-.02
t2	-.37***	.37***	.28***
t3	.20***	-.21***	.25***
t4	.23***	-.23***	-.16***
t5	.04	-.04	-.35***
	-1.79***	1.79***	

*** $p < .001$, ** $p < .01$, * $p < .05$.

$\chi^2_{rc(4)} = 186.19$ $p < .001$

$Y^2_{r(4)} = 5299.50$ $p < .001$ (Periods)

$Y^2_{c(1)} = 38893.36$ $p < .001$ (Expressive intervention vs. Supportive intervention)

$Y^2_{rc(1)} = 188.09$ $p < .001$ (Interaction periods x Expressive intervention vs. supportive intervention).

Alliance development

Matilde did not use Direct Rupture Markers (DRM) in the therapy session and the therapist did not use Negative Intervention (NI). The three remaining categories, PI, IRM, CP were analyzed using the log-linear model to assess the trend of therapeutic processes (Table 3). Row (periods), Column (therapist or patient alliance processes), and Interaction had a significant effect ($p < .001$). Therapist positive intervention and patient collaboration processes were significantly more frequent than patient indirect rupture markers. The therapist Positive Interventions (PI) made it possible to focus attention on the “here and now” of the relationship. Matilde responded to this positive therapeutic attitude with a high level of Collaborative Processes (CP) instead of Indirect Rupture Markers (IRM). She was able to convey significant themes, and sometimes to share intimate and salient information with the therapist. Over time, therapeutic processes were significantly more frequent in times t1 and t2 and became significantly lower in t4. In t4, the patient and therapist seemed to have broken a sort of equilibrium.

In this period, compared with the other phases, the patient and therapist needed to reinforce therapeutic alliance less. There was a growing number of patient Indirect Rupture Markers (IRM). Clinically, the patient indirectly expressed a form of emotional disengagement from the therapist. The patient skipped from topic to topic in a manner that prevented the therapist from exploring the issues in depth. She responded in an overly intellectualized way and became less able to be collaborative. For this reason, the therapist improved her efforts to reestablish a collaborative level of alliance with his positive intervention. Interaction patterns generally revealed that more processes (collaborative or rupture processes) were significantly more present in the patient than in the therapist. However, striking results appeared in t4 when the patient became significantly less collaborative, made significantly more ruptures, while the therapist needed to make significantly more positive interventions. No rupture markers, however, were present in the last period

Table 3. CIS log-linear model. Parameter estimates for the period and intervention and their interactions, and the probability of the standardized parameters.

Period	CIS			
	Therapist Positive Intervention	Indirect Rupture Markers	Collaborative Processes	Overall processes
t1	-.32***	-.16***	.48***	.42***
t2	-.10***	-.66***	.76***	.68***
t3	-.19***	-.34***	.53***	.32***
t4	1.27***	1.15***	-2.42***	-1.67***
t5	-.66***	.01	.65***	.24***
	1.28***	-1.73***	.45***	

*** $p < .001$, ** $p < .01$, * $p < .05$.

$\chi^2_{rc(8)} = 4778.81$ $p < .001$

$Y^2_{t(4)} = 14052.34$ $p < .001$ (Periods)

$Y^2_{c(2)} = 40058.07$ $p < .001$ (PI, IRM, CP)

$Y^{2r}_{rc(8)} = 6165.52$ $p < .001$ (Interaction period x PI, IRM, CP).

Defense structure and change along therapy

Matilde's Borderline defenses were so low that a log-linear model could not be interpreted. A log-linear model was applied to the other six categories of defense (Table 4). Row (periods), Column (defense

categories), and Interaction had a significant effect ($p < .001$). Overall Matilde showed a significantly high presence of mature, obsessive and disavowal defenses and a significantly low level of narcissistic defenses.

Matilde showed good adjustment skills and ability when dealing with stressors, in preserving her ideas and thoughts as consistent and not distorted (mature defenses). Among the mature defense patterns, self-observation was the most representative. Matilde seemed to be able to think about her thoughts, feelings and actions. However, she did not seem to rely significantly on others (low Affiliation). Moreover, her defensive pattern made her unable to experience simultaneously the cognitive and affective components of life's events. Matilde's affective aspects were kept from consciousness (obsessional defenses). Among the obsessional defense patterns, intellectualization was significantly the most representative compared with undoing. Matilde seemed to neutralize the arousal of emotional content mostly through intellectualization. Finally, Matilde tended to resolve emotional conflict by avoiding perceiving or consciously acknowledging the more unpleasant aspects of external reality (disavowal). On the other hand, Matilde's defensive pattern was scarcely characterized by Minor Image Distortion (also called "Narcissistic.") Overall defenses were significantly lower in the assessment/beginning phase than in the second and third therapy periods. In t1 she showed a significantly higher presence of Mature, Obsessional and Disavowal defenses and a very scarce presence of Minor Image distortion. The assessment/beginning phase appeared to be devoted mostly to case history collection and assessing patient motivation. Regarding interaction, the range of defenses in the first period confirmed the overall pattern of defenses. However in the following periods narcissistic and acting out defenses were significantly present. Acting out defenses diminished abruptly in the fourth period. The final period was characterized by a very low (more maladaptive) level of defenses compared with the previous periods.

In t2 Matilde's use of High Adaptive Level, Obsessional and Neurotic defenses decreased significantly as Minor image distortion increased. Attempts at mental inhibition or avoiding stressful events from consciousness seemed to be scarcely present. Matilde became more and more open to the clinician's interventions. At the same time, because issues concerning herself and her self-esteem began to be addressed, Matilde tried to compensate through a more consistent use of Minor image distortion mechanisms.

In t3, Minor Distortion Image mechanisms were still present and Action mechanisms increased significantly. On the other hand, Disavowal mechanisms decreased significantly compared with the assessment\beginning phase. The clinical material confirmed that, in this very central period, Matilde experienced a critical moment of regression in which primitive aspects seemed to prevail. She used Action mechanisms very consistently, also showing great attachment to the clinical setting. In this period, Matilde left the therapy for several sessions.

In t4, Action mechanisms decreased very significantly, and the overall pattern of defenses was not as consistent when compared with the previous period. Matilde no longer experienced the need to use a consistent pattern of defenses in the therapeutic relationship. This period seemed to be devoted to the elaboration of her experiences, and a real change in Matilde's dysfunctional pattern of functioning seemed to occur.

In t5, most defensive mechanisms seemed to decrease significantly (Mature, Obsessional, and Disavowal). In this period too, Matilde no longer experienced the need to use a consistent pattern of defenses. The therapeutic couple was working on separation. Although literature about expressive interventions shows that, at the end of treatment, defensive mechanisms are usually activated; this did not happen in Matilde's intervention. Because of the supportive nature of Matilde's

treatment, the clinician did not address defenses during separation, but tried to consolidate her adjustment. According to the referral, Matilde's main conflictual aspects were related to interpersonal and social functioning. From a qualitative point of view, we paid attention to the trend of Mature defensive mechanisms related to this domain: Altruism and Affiliation. Altruism was less frequent in the treatment; therefore, Matilde did not show a vicarious and gratifying fulfillment of other needs. Affiliation showed meaningful changes during the treatment. It seemed to increase over periods, showing a more consistent ability to turn to others for help and support in facing everyday difficulties.

Table 4. DMRS log-linear model. Parameter estimates for the period and intervention and their interactions, and the probability of the standardized parameters.

Period	DMRS Defenses						Overall
	Mature	Obsessive	Neurotic	Narcissistic	Disavowal	Action	
t1	.80***	.91***	.30	-3.30***	.93***	.36*	-.75***
t2	-.60***	-.38***	-.76***	1.50***	-.05	.29***	.36***
t3	.01	-.18**	-.38***	.68**	-.90***	.77***	.41***
t4	.16*	.00	.44***	.64**	.14*	-1.38***	-.09
t5	-.38***	-.34***	.40***	.49*	-.12*	-.05	.06
	.61***	.77***	.34***	-1.76***	.86***	-.82***	

*** $p < .001$, ** $p < .01$, * $p < .05$.

$\chi^2_{rc(20)} = 938.85$ $p < .001$

$Y^2_{t(4)} = 59.46$ $p < .001$ (Periods)

$Y^2_{c(5)} = 2150.10$ $p < .001$ (Defense categories)

$Y^2_{rc(20)} = 992.85$ $p < .001$ (Interaction period x defense categories).

More detailed analyses were carried out for the three main defense categories: mature, obsessive and disavowal. Among the mature defenses, a log-linear model was applied to the most frequent categories: affiliation, self-assertion, self-observation (Table 5). Row (periods), Column (mature defense categories), and Interaction had a significant effect ($p < .001$). Overall, Matilde showed a significantly higher presence of self-observation defenses and a significantly lower level of affiliation defenses. Overall, mature defenses were significantly more present in t3 and significantly less present in the assessment/beginning phase. However, interaction effects showed a significant increase of affiliation defenses from t1 to t4.

Table 5. DMRS mature category log-linear model. Parameter estimates for the period and intervention and their interactions, and the probability of the standardized parameters.

Period	DMRS Mature defenses			Overall mature
	Affiliation	Self-Assertion	Self-Observation	
t1	-2.75***	1.15**	1.60***	-.99**
t2	.81***	-.97***	.15	-.10
t3	.66***	-.05	-.61***	1.03***
t4	1.44***	-.25*	-.90***	.01
t5	.14	.11	-.25*	.05
	-.82***	-.11	.93***	

*** $p < .001$, ** $p < .01$, * $p < .05$.

$\chi^2_{rc(8)} = 197.62$ $p < .001$

$Y^2_{r(4)} = 179.34$ $p < .001$ (Periods)

$Y^2_{c(2)} = 290.39$ $p < .001$ (Mature defenses)

$Y^2_{rc(8)} = 244.83$ $p < .001$ (Interaction periods x mature defense).

A log-linear model was applied to the most frequent categories of obsessional defenses: intellectualization and undoing (Table 6). Row (periods), Column (obsessional defense categories), and Interaction had a significant effect ($p < .001$).

Overall, Matilde showed a significantly higher presence of intellectualization defenses and a significantly lower level of undoing defenses. Overall, obsessional defenses were significantly lower in the assessment/beginning period, and greater in the central phase (t2, t3, t4). Regarding interaction, Matilde appeared to use alternatively intellectualization and undoing.

Table 6. DMRS obsessive category log-linear model. Parameter estimates for the period and intervention and their interactions, and the probability of the standardized parameters.

Period	DMRS Obsessive defenses		
	Intellectualization	Undoing	Total
t1	.55***	-.55***	-.72***
t2	-.39***	.39***	.28***
t3	.21***	-.21***	.33***
t4	-.43***	.43***	.21***
t5	.06	-.06	-.10
	.43***	-.43***	

*** $p < .001$, ** $p < .01$, * $p < .05$.

$\chi^2_{rc(8)} = 197.62$ $p < .001$

$Y^2_{r(4)} = 114.84$ $p < .001$ (Periods)

$Y^2_{c(1)} = 187.66$ $p < .001$ (Obsessive defenses)

$Y^2_{rc(4)} = 151.85$ $p < .001$ (Interaction periods x defenses).

Alliance ruptures, therapist interventions and patient defenses: therapist interventions adjustment ratio and patient collaboration

One of the aims of our research was to investigate the relationship between therapist intervention, patient defense and collaboration. We performed a hierarchical regression analysis and considered as independent variables — IV — the Interaction Adjustment Ratio, the Session Adjustment Ratio and the Expressive Intervention Level preceding each patient communication characterized by the presence of at least one rupture marker. We considered as Independent Variable the mean patient intensity of collaboration in the two subsequent interactions after therapist intervention.

The results are reported in Tables 7 and 8.

The Interaction Adjustment Ratio was significantly negatively correlated with patient alliance ruptures. The other two variables — Session Adjustment Ratio and Expressive Intervention Level — did not correlate significantly with the dependent variable.

Table 7. Characteristics of therapist intervention which could predict an alliance rupture.

Model	Correct R-Squared	Standard Error of Estimate	Adjustment Range				
			Variation of R-Squared	Variation of F	df1	df2	Sig. variation of F
IAR	.653	.66228	.664	63.22	1	32	.001
IAR-SAR	.644	.67110	.002	.164	1	31	.688
IAR-SAR-ESIL	.646	.66977	.012	1.123	1	30	.298

Note. IAR (Interaction Adjustment Ratio): the ratio between the Expressive-Supportive Intervention Level (ESIL) of the intervention and the patient's level of defensive functioning in patient communication antecedent to the intervention evaluated. SAR (Session Adjustment Ratio): the ratio between the Expressive-Supportive Intervention Level (ESIL) of the intervention and the patient's level of defensive functioning during the session summarized by the ODF assessed by the DMRS. ESIL (Interaction Expressive Supportive Intervention Level): determined by constructing an expressive Supportive Intervention Level summary score for the PIRS by rank ordering the intervention scores from the most supportive to the most expressive.

Table 8. Regression analysis. Characteristics of a therapist's intervention could predict an alliance rupture.

Model	Variables	Beta	T	p.
1	IAR _(a)	-.815	-7.951	.001
2	IAR	-.834	-7.311	.001
	SAR _(b)	.046	.405	.688
3	IAR	-.848	-7.399	.001
	SAR	-.156	-.701	.489
	ESIL _(c)	.235	1.060	.298

Note.

a. IAR (Interaction Adjustment Ratio): the ratio between the Expressive-Supportive Intervention Level of the intervention and the patient's level of defensive functioning in patient communication antecedent to the intervention evaluated.

b. SAR (Session Adjustment Ratio): the ratio between the Expressive-Supportive Intervention Level of the intervention and the patient's level of defensive functioning during the session summarized by the ODF assessed by the DMRS.

c. ESIL (Expressive Supportive Intervention Level): determined by constructing an expressive Supportive Intervention Level summary score for the PIRS, by rank ordering the intervention scores from the most supportive to the most expressive.

Discussion and Conclusion

The aim of this study was to investigate empirically a psychotherapy process and outcome in a supportive approach in a psychodynamic oriented psychotherapy. Very few studies have investigated psychotherapy process and outcome in supportive therapies (e.g., Orlinsky et al., 2004). In specific terms, the literature supports assessing specific process variables such as clinician intervention, working alliance and defensive mechanism, and their interplay, in supportive psychotherapies. As Douglas (2008) suggested, although research has reported that supportive therapies are effective for a broad range of conditions, this clinical approach has not been sufficiently manualized and consequently, very few studies have been devoted to assessing process and outcome in supportive interventions. One of the specific aims of this study, therefore, was to contribute to understanding the nature of the supportive psychotherapy process,

using validated measures of the process itself through the combined use of a clinical-qualitative and statistical-quantitative methodology. In keeping with the clinical-qualitative pole of this spectrum, this paper is also focused on a specific case formulation of the patient. As Hilliard (1993) pointed out, single-case studies highlight the importance of assessing patient idiographic and intrasubjective features (Lingiardi, Gazzillo, & Waldron, 2010). In the clinical context, this aspect is represented by the diagnosis. Moreover, the nature of the single-case perspective requires a rich diagnostic process that includes both a nosographic approach (such as DSM-IV) and a more multifaceted point of view which can assess the interplay of specific clinical variables. As McWilliams (1999) suggested, the DSM approach reflects an empirical descriptive orientation that deliberately eschews psychodynamic assumptions. Moreover, the PDM task force (2006) intended to expand the DSM efforts by cataloging the symptoms and behaviors of mental health patients, demonstrating the importance of focusing on the full range and depth of emotional and social functioning. These variables represent the specific patient's psychological functioning that "makes diagnosis meaningful" (Barron, 1998; Shelder & Westen, 2007). This paper therefore aimed to produce a complete case formulation in order to arrive at a sophisticated rationale that links assessment to treatment. First of all, as Misch (2001) suggested, a case formulation was produced. Three clinical interviews and the administration of SCL-90 allowed the clinician to understand the level of functioning: the SWAP-200 and the GAF were applied by the therapist in order to reflect on diagnostic aspects and plan the most suitable psychological treatment. The diagnosis was conducted by combining both the DSM-IV nosographic approach and the PDM psychodynamic perspective. According to the DSM-IV, Matilde suffered from Panic Attack Disorder and, according to PDM, anxiety disorder with obsessive-compulsive narcissistic personality disorder features. The SWAP-200 revealed a

high level of functioning, with aspects of obsessive-compulsive, schizoid and avoidant style. The choice to unite DSM-IV, PDM and SWAP-200 was based on the suggestions of Westen, Gabbard and Blagov (2006) that anxiety disorder may be better explained in the context of a specific personality disorder. In this particular case, supportive therapy was prescribed to a “high functioning patient” in order to scaffold ego functions in transient and specific crisis situations (Hellerstein et al., 1994; Douglas, 2008).

Regarding the psychotherapy process, therapist interventions, working alliance and defensive mechanisms trends made it possible to understand how supportive psychotherapy works.

First, the therapist used supportive interventions as well as expressive interventions. Supportive strategies were more frequent in the first part of the treatment, while in the core section of the psychotherapy the interventions became more expressive. This aspect was in line with the literature that describes how supportive therapies do not use only supportive intervention, but a specific and patient-tailored combination of supportive and interpretative strategies (Douglas, 2008; Gabbard, 2009).

The therapeutic alliance trend followed a U-shaped pattern with lower alliance levels in the core phase of the therapy (Stiles & Goldsmith, 2010). In this phase, there was also a high presence of expressive intervention. This result may be explained in several ways.

The lower level of alliance in the middle phase may be explained as the consequence of a deeper elaboration by Matilde of her problems with consequent emotional activation. In other terms, we could say that in the middle phase, there was an increased intensity in the patient’s ambivalence in relation to the process of separation-individuation (Malan, 1976).

As suggested by Luborsky, this therapeutic alliance pattern with weaker alliance in the middle phase and the co-occurrence of expressive

interventions could also be explained by a surge in transference, which may then be diminished by therapist interpretations (Luborsky, 1984). In any case, at this level of analysis we are unable to say whether therapist expressive interventions are a response to a weaker alliance of the patient, or vice versa.

Matilde's alliance rupture style was characterized by the presence of withdrawal maneuvers: emotional disengagement from the therapist, skipping from topic to topic, responding in an overly intellectualized fashion, and very short answers (Safran & Muran, 2000). Considering Matilde's personality style, in the light of SWAP 200 results, to be very close to an introjective organization (Blatt & Shichman, 1983) it could be said that her rupture style was in line with her personality structure, characterized by a more passive and introvert way of functioning. In other words, the way Matilde organized and structured the relationship with her therapist, especially in very difficult moments of the therapy, was very similar to the relational style emerging from the assessment. This result points to the importance of personality assessment also in the case of Axis I disorders, in order to help therapists tailor their intervention and prepare to manage difficult moments in therapy.

Regarding defensive mechanisms, Matilde's structure included mainly mature, obsessional and disavowal defenses, in line with her high level of functioning and the diagnostic aspects highlighted with the SWAP-200. Some of Matilde's maladaptive defensive mechanisms, such as obsessional and disavowal defenses, decreased significantly during the treatment. This result is in agreement with Gabbard's (2009) considerations that in supportive therapies, maladaptive mechanisms are treated and interpreted, and for this reason, can be reduced. This result is also in accordance with Wallerstein's (1989) findings about the possibility of supportive therapies to produce structural changes. Structural change was also supported by a comparison between the SWAP-200 evaluations at the beginning and termination phases. At the

conclusion phase, the schizoid traits disappeared, meaning that Matilde was less introverted and in contact with her feelings.

The changes in Matilde's capacity to stay connected with her feelings, suggested by the decrease in obsessional defenses and the increase in high functioning levels of the SWAP (which also evaluated the patient's capacity to reflect on his/her emotions), seem peculiar of dynamic therapy, which encourages exploration of patient emotions, as pointed out by Shelder (2010).

Another aim of our study was to evaluate at a micro level the relationship between the adjustment ratio of the therapist's interventions in relation to the patient's defensive functioning and patient alliance ruptures in order to investigate the causal link between our set of variables (defenses, therapist interventions and therapeutic alliance). To evaluate the relationship between therapist interventions and patient defensive functioning, we referred to a procedure proposed by Despland et al. (2001): the Adjustment ratio (AR). Specifically, we investigated the relationship between two different indexes of AR: the Session Adjustment Ratio and the Interaction Adjustment Ratio, which is an index devised ad hoc for this study.

The results show that the Interaction Adjustment Ratio (IAR), which evaluates the adjustment of therapist intervention in relation to patient defense levels in the immediacy of the interaction, is negatively associated to a collaborative relationship with the patient. This result suggests that if the therapist's intervention is too expressive when considering the patient's defensive functioning that precedes therapist intervention, the quality of the alliance would suffer a negative effect. The other two variables, the Session Adjustment Ratio, which, as already mentioned, indicates the adequacy of the intervention compared with patient global defensive functioning and not the current interaction, and the expressive level independent of the defensive functioning, were not able to predict an immediate change in the quality

of the alliance. This result seems to suggest that in developing collaboration with a patient, one should not only relate to the global expressive level of intervention, or to the patient's global defense level, but one should always consider the patient's defensive level in the immediacy of the interaction. Moreover, this result seems to be in agreement with several authors who suggest that the negotiation process takes place at a micro level of interaction (Boston Change Process Group, 2010; Colli & Lingiardi, 2009). In any case, it is important to note that at this level of analysis, the effect of the interventions subsequent patient responses were evaluated. In other words, we do not know if an intervention which is too expressive could have a positive effect later on the quality of the relationship. From another point of view, these results seem to suggest, in agreement with other studies (Hersough et al., 2001), that it is also necessary to redefine the optimal AR proposed originally by Despland (Despland et al., 2001). The optimal AR and ranking of supportive expressive interventions were established at a theoretical level and were not empirically derived. In the future, it will probably be necessary to derive an optimal AR level empirically, by taking into consideration other variables such as patient personality, therapeutic approach, stage of therapy, etc. Our proposal of a new AR index, the Interaction Adjustment Ratio, and the need to verify the optimal AR in relation to different therapies and patients, is in line with Hill and Knox's (2009) considerations about the "need to learn more about the timing of relational events and to develop innovative methods for studying this phenomenon, because it is a complicated process that takes place over time and varies from dyad to dyad" (Hill & Knox, 2009, p. 27).

This study has several limitations. First, this paper focused on a single case study, so the conclusions cannot be generalized to other patients with the same diagnosis. Second, the sessions analyzed for the process dimension were only 50% of Matilde's entire therapeutic

process. These sessions were those for which audio-recorded tapes were available. Third, the choice to divide the process into five periods was related to the actual divisions which occurred during the psychotherapy (i.e., holidays). This method did not take into account specific patient “life events” which could have affected the course of the therapy. The process variables including therapeutic interventions, defensive mechanisms and working alliance, were analyzed through three separate log linear models without applying a unique and more complex model. In such a model, reciprocal influences between process variables should have been assessed. Finally, the dimensions measured may have been influenced by any number of other psychological and contextual processes that were not assessed. Perhaps future studies of different individuals in diverse settings might reveal more of the hallmarks of the clinical utility of combining the use of qualitative and quantitative approaches in the study of process and outcome dimensions. As Kazdin (2008) pointed out, to reduce the gap between research and practice it is fundamental to evaluate therapeutic change mechanisms. In supportive psychotherapy, a complete case formulation is important, in order to have a clinical base line from which to study the change. Moreover, both the qualitative and quantitative approaches contributed to highlighting the nature of moderator variables in terms of clinical change. In such a way, processes which explain why psychodynamically-oriented supportive psychotherapy works, or how it produce changes, can be assessed.

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