Patient personality and therapist responses in the psychotherapy of adolescents with depressive disorders: toward the *Psychodynamic Diagnostic Manual* - third edition

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ABSTRACT

Depressive disorders in adolescence pose unique challenges for assessment and treatment, particularly due to their high comorbidity with various personality disorders. Moreover, young depressed patients may elicit very intense and difficult-to-manage emotional responses in therapists (in this context, countertransference). This study aimed at empirically identifying specific personality disorders (or subtypes) among adolescents with depressive pathology and exploring distinct countertransference patterns emerging in their psychotherapy. 100 adolescents (58 with depressive disorders; 42 with other clinical conditions) were assessed by their respective clinicians (n=100) using the psychodiagnostic chart-adolescent of the *Psychodynamic Diagnostic Manual* (PDM)-*Second Edition*, and the therapist response questionnaire for adolescents. Results showed that depressed adolescent patients exhibited marked traits of four personality subtypes (*i.e.*, depressive, anxious-avoidant, narcissistic, and borderline) characterized by different levels of mental functioning and personality organization. These subtypes were predictably related to specific clinicians' emotional responses, even when controlling for the intensity of depressive symptomatology. Patients with depressive or anxious-avoidant personality subtypes evoked more positive countertransference responses, whereas patients with narcissistic or borderline subtypes elicited strong and hard-to-face emotional responses in therapists. Consistent with the next edition of the PDM, the study emphasizes the importance of comprehensive psychodynamic assessment in the developmental age, which frames depressive disorders in the context of accurate emerging personality and mental functioning profiles. This approach, which also relies heavily on the clinician's subjective experience in therapy, provides crucial information on how to specifically tailor interventions that more effectively meet the needs of adolescents with these heterogeneous and complex clinical conditions.

Key words: depressive disorders, personality disorders, countertransference, adolescence, PDM.

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Introduction

Depressive disorders (DD) are a leading cause of illness and disability in adolescence (World Health Organization, 2022). The burden of these syndromes is a primary reason for concern (National Institute for Health Care Excellence, 2019) with substantial costs for societies and mental health services (Bodden *et al*., 2018). In recent years, a relevant increase in the prevalence of depressive pathologies and symptoms, also as a result of the COVID-19 pandemic (Hawes *et al*., 2021), has been registered in youths. These conditions are associated with poor psychosocial outcomes (Clayborne *et al*., 2019), high comorbidity rates with other mental disorders (Alaie *et al*., 2021), and increased suicidal risk (Moselli *et al*., 2023; Sekowski *et al*., 2022).

Despite this alarming evidence, depressive syndromes in adolescence often go under-detected and under-treated, primarily due to diagnostic shortcomings (Midgley *et al*., 2015; Mullen, 2018). Indeed, both the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (American Psychiatric Association, 2022) and the *International Classification of Diseases* (ICD-11) (World Health Organization, 2019) lack specific diagnostic criteria for DD in youths, with the exception of irritable mood as an alternative or additional symptom. Indeed, current diagnostic systems can do better at capturing the nuanced psychopathological variants and manifestations of depression in this developmental phase, posing significant challenges for therapists.

The *Psychodynamic Diagnostic Manual, Second Edition* (PDM-2) (Lingiardi & McWilliams, 2017) is the only nosography system that includes a section fully dedicated to adolescence. Integrating idiographic and nomothetic approaches, the PDM-2 provides a comprehensive description of all clinical conditions across different life phases, using the patient's subjective experience as the main focus of the assessment. Each psychopathological syndrome is illustrated not only by referring to the presence of specific diagnostic criteria but also by including the individual's affective, cognitive, somatic, and relational patterns, as well as taking into account how these characteristics may vary depending on developmental stages. The diagnostic relevance of the subjective experience (or countertransference) of therapists treating clinical syndromes is also emphasized. As such, the PDM system confronts the more descriptive nature of the DSM and ICD systems.

In PDM-2, DD in adolescence are distinguished into two variants based on different developmental characteristics and trajectories. Anaclitic depression involves excessive worries in interpersonal relationships, including feelings of helplessness, loneliness, emptiness, and chronic fears of being abandoned and rejected, while introjective depression is characterized by intense concerns about self-esteem and self-criticism, as well as feelings of guilt or failure (Blatt, 2004; Van & Kool, 2018). Notably, young patients with these distinct clinical presentations have unique responses to treatment, depending, at different levels of development, on problems correlated with dependency or self-definition, or both (Blatt, 2004; Rost *et al*., 2018).

Overall, the Manual stresses the relevance of understanding the directly observable signs and symptoms of depressive pathologies in adolescents by exploring the broader context of mental functioning and emerging personality. Despite the stability of personality pathology in young populations remains a contentious issue, the PDM grounds its diagnostic approach on the basis of a large body of scientific studies suggesting that specific maladaptive features of personality may be clearly identified in this developmental stage (Chanen, 2022; Lingiardi & McWilliams, 2017; Westen *et al*., 2014). Evidence has indicated that DD are strongly associated with personality disorders (mostly, clusters B and C) in adolescence (Feenstra *et al*., 2011; Gander *et al*., 2023; Ha *et al*., 2014; Rost *et al*., 2018; Westen *et al*., 2014), and this comorbidity exerts a significant influence on prognosis and treatment outcomes (Strandholm *et al*., 2014). Notably, young depressed patients often receive a diagnosis of borderline, dependent, avoidant, obsessive-compulsive, and depressive personality disorders (Feenstra *et al*., 2011; Zanarini *et al*., 2004). In addition, some studies showed that these patients may typically deal with narcissistic issues exhibiting perfectionistic traits, reflecting a faltering self-esteem and strong tendencies toward self-criticism and devaluation (Freudenstein *et al*., 2012). These studies point to the importance of personality functioning in depressive conditions during adolescence; however, a more systematic assessment of the personality pathology associated with such syndromes at this developmental stage has not been thoroughly carried out, underscoring the need for further investigation in this field.

A great number of empirical contributions has highlighted that the therapeutic relationship provides meaningful information for psychological assessment as well as predicts psychotherapy outcomes (Norcross & Lambert, 2019). Notably, therapist's emotional responses to patients (in this context, countertransference) serve as a valuable tool for better understanding their complex intrapsychic and interpersonal dynamics, especially in adolescent treatment. Young people tend to elicit countertransference reactions that are unique in terms of affective quality, intensity, and difficulty to manage (Normandin *et al.*, 2021). Very few studies in the literature have focused on therapists' responses to adolescent patients with personality disorders or other clinical conditions (Satir *et al.*, 2009; Tanzilli & Gualco, 2020; Tanzilli *et al*., 2020). Therapists dealing with DD in adolescence may be at a loss because of the difficulty in properly identifying such conditions (Midgley *et al.*, 2015). Furthermore, the frequent co-occurrence of emerging patterns in pathological personality may elicit intense and not easily understandable emotional demands from therapists, also due to the relational impact of suicidal ideation and behaviors (Moselli *et al.*, 2023). Overall, evidence has shown that the therapists' difficulty in correctly processing and managing their own emotional responses to patients' relational patterns may undermine the creation of a positive therapeutic alliance and a clear orientation in the treatment of patients with personality disorders both in adulthood and adolescence (Norcross & Lambert, 2019). To our knowledge, only one study (Brøsholen *et al*., 2022) has investigated the relationship between therapists' reactions and therapeutic alliance in the treatment of adolescents with DD. Findings showed systematic associations between inadequate and disengaged therapist responses and poor alliance, as well as between confident and maternal responses and good quality of alliance; however, no specific knowledge was found about how patients' functioning impacts the interdependency between these dimensions of the therapeutic relationship. As of yet, the effect of depressive conditions and personality disorders on therapists' reactions remains unclear.

Based on these premises, this study employs the multiaxial assessment process of the PDM-2 to evaluate not only the depressed young patients' clinical syndromes but also their strict interplay with their personality and mental functioning. This approach seeks to provide a holistic understanding of the subjective experience of patients, beyond the sole focus on the disorder itself and takes into great consideration the subjectivity of therapists in their treatment (Lingiardi & McWilliams, 2017). Notably,

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the present research aimed at exploring: i) specific emerging personality disorders (or, in other terms, subtypes) among young patients with DD compared to those with other psychopathological diagnoses. In line with the few empirical investigations in the field (Feenstra *et al.*, 2011; Gander *et al.*, 2023), it was expected that these adolescents would show more pervasive and rigid characteristics of depressive, borderline, dependent, and avoidant personality pathology; ii) the associations between patients' personality subtypes and their overall mental functioning and personality organization. Consistent with some clinical and empirical contributions (Kernberg, 1984; Westen *et al.*, 2014), it was expected that more severe personality disorders would exhibit worse levels of impairments in several psychological domains; iii) the relationship between patients' personality subtypes and therapists' emotional responses, regardless of the effect of depressive symptoms. Overall, in line with the limited clinical and empirical literature (Normandin *et al.*, 2021; Satir *et al.*, 2009; Tanzilli *et al.*, 2020), it was expected that more severe personality disorders would relate to intense, negative, and challenging-to-manage countertransference patterns; furthermore, the intensity of depressive pathology would influence this relationship.

Methods

Participant sampling

Clinicians were recruited *via* email from Italian psychotherapy associations and institutions of the National Health System in Rome, Milan, and Genoa. A first group of therapists was asked to randomly select one of their adolescent patients according to the following inclusion and exclusion criteria: i) age between 14 and 18 years; ii) diagnosis of persistent DD or major DD according to the diagnostic criteria of DSM-5 (American Psychiatric Association, 2013), without any comorbidity with other psychopathological syndromes; iii) absence of psychotic disorders, bipolar disorders, or cognitive impairment; iv) not being on pharmacological treatment; v) being on treatment for at least 2 months to one year. A second group of therapists were asked to randomly choose an adolescent patient who had not been diagnosed with DD and was being treated for other clinical conditions in the DSM-5. In order to avoid the therapist's effects (*i.e.*, confounded issues of countertransference in the event that several patients were nested within a single therapist), each clinician provided data concerning only one patient. All therapists provided written informed consent and were instructed to withhold any identifying information about their patients. Therapists received no remuneration for participating. Adolescent patients were not involved in the research project. The study was approved by the Research Ethics Committee of the Dynamic, Clinical Psychology, and Health Studies, Faculty of Medicine and Psychology, Sapienza University of Rome (Prot. n. 0000111 of 31/01/2022).

Therapists

The sample consisted of 100 clinicians, including 68 females and 32 males. Their mean age was about 44 years [standard deviation (SD)=7.35, range 30-63). All therapists were white. The most prevalent therapeutic orientations were psychodynamic (n=73) and cognitive-behavioral (n=27). The average clinical experience was 11.76 years (SD=5.97, range 3-35). Most of the clinicians (85%) worked in private practices while the remaining 15% worked in public mental health institutions.

Patients

The sample consisted of 100 adolescent patients, including 57 females and 43 males. The mean age was about 16 years (SD=1.66, range 13–18). All patients were white. The average length of their treatment was seven months (SD=2.88, range 2–12). A group of 58 adolescents were diagnosed with DD diagnoses. The second group (n=42) presented different clinical conditions (without DD). In particular, 11 had a panic disorder, 8 had a generalized anxiety disorder, 8 had a feeding and eating disorder, 4 had a substance-related and addictive disorder, 4 had an oppositional defiant disorder, 3 had a conduct disorder, 2 had a post-traumatic stress disorder, and 2 had a separation anxiety disorder. All patients were selected by their therapists through a standard clinical assessment based on DSM-5 diagnostic categories. The two groups of adolescent patients (DD *versus*. no-DD) did not differ significantly in age: mean $(M)_{DD\ group}$=16.02, SD=1.73; $M_{No\text{-}DD\ group}$=15.93, SD=1.57; $t[98]=-.26$, p=.793, Cohen's d=.05. No significant gender differences were also found between the two groups: $\chi^2(1, 100)=.63$, p=.43.

Measures

Clinical questionnaire

A clinician-report questionnaire was constructed to obtain general information about the therapists, their adolescent patients, and their psychotherapies. Clinicians provided their demographic and professional data (such as their theoretical orientation and years of experience). They also furnished demographic data and diagnoses on their patients and other information about therapies, including length of treatment.

Psychodiagnostic chart-adolescent

The psychodiagnostic chart-adolescent (PDC-A) (Malberg *et al.*, 2017) is a clinician-report instrument developed to guide therapists in the PDM-2 assessment process of adolescents patients. PDC-A is composed of 5 sections. Section I: mental functioning (MA axis), which assesses on a scale from 1 (severe deficits or impairments) to 5 (healthy) 12 mental capacities grouped into four super-ordinated domains: i) cognitive and affective processes (capacity for regulation, attention, and learning; capacity for affective range, communication, and understanding; and capacity for mentalization and reflective functioning); ii) identity and relationships (capacity for differentiation and integration [identity], capacity for relationships and intimacy, and capacity for self-esteem regulation and quality of internal experience); iii) defense and coping (capacity for impulse control and regulation; capacity for defensive functioning; and capacity for adaptation, resiliency, and strength); iv) self-awareness and self-direction [self-observing capacities (psychological mindedness); capacity to construct and use internal standards and ideals; and capacity for meaning and purpose]. The sum of these scores provides a global index that differentiates between healthy, neurotic, borderline, and psychotic levels of functioning. Section II: level of personality organization (PA axis), which evaluates the level of patients' impairment in the following domains: identity, object relations, level of defenses, and reality testing. It provides an overall score of personality organization: "normal" (healthy), mildly dysfunctional (neurotic), dysfunctional (borderline), or severely dysfunctional (psychotic). Section III: emerging adolescent personality styles and syndromes (PA axis), which evaluates on a rating scale ranging from 1 (severe) to 5 (high functioning) the personality styles/syndromes shown by the

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patient. Section IV: symptom patterns (SA axis), which assesses the symptomatologic patterns experienced by the patients. DSM and ICD codes can also be indicated where applicable. Lastly, Section V: cultural, contextual, and other relevant considerations, which allows clinicians to indicate further information that may be relevant to the clinical assessment.

Therapist response questionnaire for adolescents

The therapist response questionnaire for adolescents (TRQ-A) (Satir *et al*., 2009; Tanzilli *et al*., 2020) is a clinician-report instrument that measures a wide spectrum of thoughts, feelings, and behaviors experienced by therapists toward their adolescent patients. It consists of 86 items that are written in jargon-free language and are easily understandable by clinicians of different theoretical orientations. They are assessed on a 7-point Likert scale ranging from 1 (not true) to 7 (very true). The present study used the well-validated Italian version of the instrument (Tanzilli *et al*., 2020) which consists of six countertransference patterns: i) warm/attuned, which refers to an experience of close connection, trust, and collaboration with the young patient (*e.g*., "I have warm, almost parental feelings toward him/her"; "I feel like I understand him/her"); ii) angry/criticized, which describes feelings of anger, hostility, and irritation, as well as a sense of being dismissed and devaluated by the patient (*e.g*., "I get enraged at him/her"; "I feel criticized by him/her"); iii) disorganized/frightened, which indicates feelings of being overwhelmed by the patient's emotions and needs, and an intense sense of anxiety and dread toward the patient (*e.g*., "I feel I am 'walking on eggshells' around him/her, afraid that if I say the wrong thing s/he will explode, fall apart, or walk out"; "I feel anxious working with him/her"); iv) overinvolved/worried, which describes excessive engagement in the therapeutic relationship, including difficulties maintaining setting, and feelings of being critical of the patient's parents (*e.g*., "I worry about him/her after sessions more than other patients"; "I talk about him/her with my spouse or significant other more than my other patients"); v) disengaged/hopeless, which describes a strong sense of frustration, inadequacy, and impotence, as well as feelings of boredom and withdrawal (*e.g*., "I feel hopeless working with him/her"; "I don't feel fully engaged in sessions with him/her"); vi) sexualized, which indicates sexual tensions in the therapeutic relationship with the patient (*e.g*., "I feel sexual tension in the room"; "His/her sexual feelings toward me make me anxious or uncomfortable"). Good/excellent internal consistency (Streiner, 2003) was demonstrated by all the TRQ-A scales: warm/attuned (α=.86); angry/criticized (α=.88), disorganized/frightened (α = .87), overinvolved/worried (α=.74), disengaged/hopeless (α=.74), and sexualized (α=.70).

Procedure

After providing their informed consent, therapists were asked to select only one adolescent patient in their care according to the inclusion/exclusion criteria described above and to evaluate their emotional responses to this patient using the TRQ-A. The length of the therapy at the time of TRQ-A completion was on average seven months (SD=2.88, range 2-12). Between 1 and 3 weeks later, they provided a comprehensive psychodynamic assessment of the adolescent patient designed using the PDC-A of the PDM-2. This interval was necessary because the TRQ-A and the PDC-A require different completion times. While the TRQ-A is more clinician-friendly and can be filled out immediately after the session with the patient, the PDC-A involves more commitment on the part of the clinician. Moreover, this temporal separation allows to mitigate potential timing or halo biases (*i.e.*, whereby clinicians' ratings of their own emotional responses could affect their concurrent evaluations of adolescent patients' functioning). In particular, this procedure reduces the respondent's (*i.e.*, the therapist) ability and/or motivation to remember and use the information provided in the previous assessment to fill in any gaps, infer missing details, and/or provide the same information in the next assessment (Podsakoff *et al*., 2012).

Statistical analyses

Statistical analyses were performed using SPSS 27 for Windows (IBM, Armonk, NY). A multivariate analysis of variance was conducted to identify differences in emerging personality styles and syndromes (in this context, subtypes) between adolescent patients with a DD diagnosis (DD group) and those with other psychiatric diagnoses (No-DD group) assessed with the PDC-A of PDM-2. To examine the relationship between specific personality subtypes identified in the DD patient group, overall mental functioning (assessed with the MA axis of the PDC-A), and level of personality organization (assessed with the PA axis of the PDC-A), point biserial correlations were performed, taking into account all the personality subtypes, the global index of mental functioning (considered as a dichotomous variable, as the patient sample included only the neurotic and borderline levels) and overall level of personality organization (considered as a dichotomous variable, since again the patient sample included only the neurotic and borderline levels). Finally, partial correlations were performed to investigate the associations between the personality subtypes of the DD patient group and their therapists' emotional responses (assessed with the TRQ-A), controlling for the intensity of depressive symptomatology (assessed with the SA axis of the PDC-A).

Results

Personality subtypes in adolescent patients with depressive disorders

The first aim of the present study was to identify specific personality disorders (or subtypes) in a group of depressed adolescent patients with respect to adolescents diagnosed with other clinical conditions. The results depicted in Table 1 revealed significant differences between groups in 4 emerging personality styles and syndromes included in the PA Axis of the PDC-A, Wilks's Λ=.45, F(10, 89)=10.98, p<.001, η^2=.55, Cohen's d=1.98.

In particular, compared with those with different conditions, young, depressed patients showed significantly more severe traits of the depressive, anxious-avoidant, borderline and narcissistic personality subtypes.

Personality subtypes in adolescent patients with depressive disorders, their mental functioning, and personality organization

The second aim of the study was to explore the relationship between personality subtypes, mental functioning, and personality organization in the group of depressed adolescent patients. Table 2 depicts the picture of point biserial correlations. Depressive and anxious-avoidant personality subtypes were significantly related

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to neurotic levels of both mental functioning and personality organization. Conversely, narcissistic and borderline personality subtypes were significantly associated with borderline levels of mental functioning and overall personality organization.

Personality subtypes in adolescent patients with depressive disorders and therapists' emotional responses

The third aim of the study was to investigate the relationship between personality subtypes in the group of depressed adolescent patients and emotional responses evoked in their clinicians during the treatment, controlling for the intensity of depressive symptomatology.

As illustrated in Table 3, the depressive and anxious-avoidant personality subtypes showed significant positive correlations with the warm/attuned countertransference patterns, and negative correlations with the angry/criticized, disorganized/frightening, and sexualized therapist responses. Conversely, the narcissistic personality subtype was positively associated with the disengaged/hopeless therapist responses and negatively with the warm/attuned and overinvolved/worried countertransference patterns. The borderline personality subtype showed significant positive correlations with the disorganized/frightening, angry/criticized, overinvolved/worried, and sexualized countertransference patterns, and negative correlations with the warm/attuned therapist response.

Discussion

The present study aimed to investigate the presence of personality subtypes in adolescent patients with DD according to the PDM-2 theoretical-clinical framework. Consistent with previous research (Feenstra *et al.*, 2011; Gander *et al.*, 2023), this investigation seems to confirm our first hypothesis, empirically supporting the great complexity in personality functioning of patients within this specific diagnostic grouping. Notably, in line with some investigations conducted on both adult and youth populations (Friborg *et al.*, 2014; Huprich *et al.*, 2014, Rost *et*

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Table 1. Differences between adolescent patients with and without depressive disorders on emerging personality styles and syndromes of the axis of emerging adolescent personality styles/syndromes in adolescence of the Psychodiagnotic Chart-Adolescent (n=100).

Emerging personality styles and syndromes (PA axis of PDC-A)#	DD group (n=58)		No-DD group (n=42)		F(1, 98)	η^2
	M	SD	M	SD		
Internalizing spectrum						
Depressive	2.82	1.76	1.26	.80	28.64***	.23
Anxious-avoidant	2.47	1.65	1.31	.78	17.78***	.15
Schizoid	1.19	.55	1.45	1.04	2.69	.03
Externalizing spectrum						
Antisocial-psychopathic	1.74	1.22	2.05	1.31	1.44	.02
Narcissistic	2.02	1.42	1.31	.75	8.67**	.08
Paranoid	1.55	.96	1.88	1.33	2.07	.02
Borderline-dysregulated spectrum						
Impulsive-histrionic	1.41	.84	1.76	1.46	2.27	.02
Borderline	1.98	1.52	1.31	.81	6.85**	.07
Dependent-victimized	1.45	.90	1.70	1.26	1.36	.01
Character style						
Obsessive	1.38	.67	1.50	.97	.54	.01

#To facilitate the interpretation of the results, the Likert scale scores of the PA axis of the PDC-A were reversed; thus, the higher the mean scores, the more severe the disorder; **p≤.01; ***p≤.001.
M, mean; SD, standard deviation; DD group, group of adolescent patients with depressive disorders; no-DD group, group of adolescent patients with other clinical conditions (except depressive disorders); PDC-A, psychodiagnostic chart-adolescent. PA axis, axis of emerging adolescent personality styles/syndromes in adolescence.

Table 2. Point-biserial correlations between personality subtypes of adolescent patients with depressive disorders and other dimensions of psychological functioning of the axis of mental functioning in adolescence and the axis of emerging adolescent personality styles/syndromes in adolescence of the Psychodiagnotic Chart-Adolescent (n=58).

Emerging personality subtypes of DD group (PA Axis of PDC-A)#	Global index of mental functioning§ (MA axis of PDC-A)	Overall level of personality organization§ (PA axis of PDC-A)
Internalizing spectrum		
Depressive	.50***	.57***
Anxious-avoidant	.29*	.47***
Externalizing spectrum		
Narcissistic	-.40**	-.44***
Borderline-dysregulated spectrum		
Borderline	-.59***	-.69***

DD group, group of adolescent patients with depressive disorders; PDC-A, psychodiagnostic chart-adolescent; MA axis, axis of mental functioning in adolescence; PA axis, axis of emerging adolescent personality styles/syndromes in adolescence. #To facilitate the interpretation of the results, the Likert scale scores of the PA axis of the PDC-A were reversed; thus, the higher the scores, the more severe the emerging personality disorder; §the global index of mental functioning and the overall level of personality organization were coded as dichotomous variables: neurotic=1, borderline=0; *p≤.05; **p≤.01; ***p≤.001.The table lists point-biserial r_{pb} values, 2-tailed.

Table 3. Partial correlations between personality subtypes of adolescent patients with depressive disorders and the therapist response questionnaire for adolescents scales, controlling for symptoms intensity of the axis of symptom patterns in adolescence of the Psychodiagnotic Chart-Adolescent (n=58).

Emerging personality subtypes of DD group (PA Axis of PDC-A)#	Warm/ attuned	Angry/ criticized	Disorganized/ frightened	Overinvolved/ worried	Disengaged/ hopeless	Sexualized
M (SD)	3.21 (.78)	2.93 (.91)	2.19 (.86)	2.85 (.84)	2.68 (.80)	1.61 (.63)
Internalizing spectrum						
Depressive	.49***	-.51***	-.47***	.26	-.19	-.28*
Anxious-avoidant	.33*	-.49***	-.46***	.08	.18	-.30*
Externalizing spectrum						
Narcissistic	-.45***	.26	-.02	-.30*	.36*	.10
Borderline-dysregulated spectrum						
Borderline	-.38**	.59***	.67***	.32*	.01	.38**

DD group, group of adolescent patients with depressive disorders; PDC-A, psychodiagnostic chart-adolescent; PA axis, axis of emerging adolescent personality styles/syndromes in adolescence; SA axis, symptom patterns in adolescence; M, mean; SD, standard deviation. #To facilitate the interpretation of the results, the Likert scale scores of the PA and SA axes of the PDC-A were reversed. Thus, in the PA axis, the higher the scores, the more severe the emerging personality disorder, while in the SA axis, the higher the scores, the more intense the depressive symptom experience; *p≤.05; **p≤.01; ***p≤.001. The table lists Pearson's r values, 2-tailed.

al., 2018; Westen *et al*., 2014), young depressed patients (compared with those with other clinical conditions) exhibited more maladaptive and clinically relevant traits of the emerging disorders of depressive, anxious-avoidant, narcissistic and borderline personality (Table 1).

According to the PDM-2 diagnostic approach, personality is viewed as the context of psychopathology, especially in adolescence (Lingiardi & McWilliams, 2017). In this perspective, young depressed patients with a depressive personality subtype might experience depressive symptoms primarily driven by underlying feelings of guilt and self-criticism, often associated with excessively high or unrealistic standards (Blatt, 2004). On the other hand, depressive pathology in adolescent patients with an anxious-avoidant subtype might be associated with their low sense of agency and high inadequacy, "free-floating" anxiety, and interpersonal sensitivity, often leading to relevant difficulties in establishing healthy relationships and participating in social contexts (Huprich *et al*., 2014; Westen *et al.*, 2014). In such vein, withdrawal problems typically connected to depressive themes in young people could also be viewed as a consequence of feelings of anguish, embarrassment, and distress in social situations, stemming from an intense fear of judgment and rejection of avoidant personalities (Lampe & Mahli, 2018).

The emerging narcissistic personality syndrome of PDM-2 describes adolescents characterized by grandiosity, need for admiration, hypersensitivity to criticism, along with a "shaky" self-esteem related to an underlying sense of inner emptiness and meaninglessness (Ogrodniczuk & Kealy, 2013; Westen *et al*., 2014). In adolescent patients with this personality subtype, depressive symptoms might reflect their inner experience characterized by a strong sense of failure and a deep vulnerability to shame and humiliation (Cheek *et al*., 2018). These young people constantly strive for perfection and accomplishments and are plagued by oscillations between feelings of superiority and triumph over the other and a sense of worthlessness and inferiority, suicidal ideation, and even conducts which characterize the "introjective" depression of Blatt (2004) (Lingiardi & McWilliams, 2017; Williams *et al*., 2021). Lastly, adolescents with an emerging borderline personality syndrome are mainly characterized by a pervasive sense of identity diffusion, primitive defense mechanisms, affective instability and impulsivity, often leading them to act self-harming behaviors or suicide attempts, as well as chaotic interpersonal relationships, which originate from the conflict between an intense desire for dependence and an equally deep fear of abandonment (Kernberg, 1967). In this patients' subtype, depressive symptoms might be strongly intertwined with marked dysphoric and labile affective tone, often connected to devalued, unworthy, or worthless representations of the self and of the object (Kernberg, 1967, 1984; Rost *et al*., 2018), and/or represent the outcome of horrific anxieties related to real or perceived separations, bereavements, and neglect (Gunderson *et al.*, 2014). Notably, these dynamics appear to be in line with the concept of "borderline depression" (Westen *et al*., 1992), and are partially overlap with the "anaclitic" depression (Blatt, 2004; Lingiardi & McWilliams, 2017).

The second objective of this study was to examine the relationship between personality subtypes of depressed adolescent patients and their levels of mental functioning and personality organization. Looking more in detail at the correlation picture in Table 2, it is possible to highlight that adolescents exhibiting depressive and anxious-avoidant subtypes showed some difficulties in limited domains of mental functioning and a more typical neurotic personality organization (Kernberg, 1984). Overall, they exhibited relatively stable experiences of self and others, a fairly adequate capacity for close relationships, tendentially neurotic defense mechanisms, and a preserved reality testing; however, some problems with self-esteem and/or self-criticism, difficulty in mentalized affectivity, and sexual and aggressive inhibitions related to depressive symptoms bring the attention of mental health professionals and begin the focus of their interventions (Di Giuseppe *et al*., 2019; Liotti *et al*., 2023; Rost *et al*., 2018). Conversely, in line with clinical literature (Kernberg, 1967; Kernberg *et al*., 2000), adolescent patients with narcissistic and borderline personality subtypes presented with a borderline level of mental functioning and personality organization, with greater difficulties in several intrapsychic and interpersonal areas.

The severe deficits in mentalization and emotional regulation, the capacity to explore one's inner world, more primitive defensive processes, and the difficulty in establishing healthy intimate relationships (*i.e.*, some of the mental capacities assessed in the MA Axis of the PDC-A) that characterize these personality subtypes contribute to shaping a more severe subjective experience of depressive pathology in these adolescents. To our knowledge, this is the first empirical validation of Kernberg's (1967) system for identifying personality pathology in adolescents – that is, that a borderline level of mental functioning associates with borderline

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and/or narcissistic personality types and that a neurotic level of mental functioning associates with depressive and anxious avoidant subtypes. This organization of psychopathology was recently adapted in a developmental framework to explain how personality pathology in adolescence indicates a higher level of general psychopathology between neurotic and psychotic disorders (Sharp *et al*., 2022; Sharp & Wall, 2018, 2021), thereby privileging intrapsychic and interpersonal areas of functioning for the diagnosis of personality disorder. These ideas are consistent with new dimensional models of psychopathology as represented in the alternative model of personality disorder (American Psychiatric Association, 2013) and the ICD-11 (World Health Organization, 2019). In addition, evidence has supported the fact that both mental functioning and personality organization significantly impact treatment outcomes (Koelen *et al*., 2012); therefore, these results confirm that making an accurate assessment that takes into account these domains is critical to obtaining insightful information regarding treatment planning of depressed adolescents.

The third aim of this study was to evaluate the specific associations between personality subtypes of patients with DD and their therapists' emotional responses, considering the impact of the intensity of depressive symptoms. Despite the paucity of clinical and empirical contributions in adolescence (Normandin *et al.*, 2021; Tanzilli *et al*., 2020), results seem to partially confirm our hypotheses, showing that each personality subtype in depressed adolescents is significantly related to distinct countertransference patterns in a clinically meaningful way, regardless of the symptom effect (Table 3). In particular, adolescent patients who presented with depressive and anxious-avoidant personality subtypes evoked less negative emotional reactions of anger, irritation, confusion, fear, or sexual tension in therapists; in general, they tended to elicit warm feelings and better emotional attunement in clinicians, which are crucial to developing an effective collaboration in psychotherapy (Tanzilli *et al.*, 2020). Evidence showed that positive countertransference plays an important role in strengthening a powerful alliance that is able to contribute to the success of treatment (Brøsholen *et al*., 2022). Moreover, fostering a collaborative and trustful relationship with these patients is associated with a reduction in depressive symptomatology (Cirasola *et al.*, 2021). Notably, clinicians treating adolescents with depressive subtype may feel particularly attuned to them and assume a parental-protective attitude towards their patients. Overall, these countertransference reactions could reflect the therapists' desire to repair some deficiency or failure in these adolescents' relationships with parents or significant others, and/or to reassure and protect their patients from their pervasive fear of disapproval or non-appreciation (Hennissen *et al*., 2019; Rost *et al*., 2018; Tanzilli *et al.*, 2018).

This research found that depressed adolescent patients with a narcissistic personality subtype tended to evoke reactions of criticism, annoyance, and disengagement in their therapists (Table 3). Consistent with the clinical and research literature (Gabbard, 2009; Tanzilli & Gualco, 2020), clinicians reported feeling unappreciated, devalued, frustrated, and ineffective with these patients. Clinicians also felt a great lack of connection and trust, which fueled their defensive withdrawal from the therapeutic relationship. These countertransference reactions seem to shed light on the severe difficulties of these patients in building intimate and reciprocal relationships with other people, which are re-actualized within the therapeutic relationship (Gabbard, 2009). These interpersonal problems are strongly related to these adolescents' grandiose fantasies and a pervasive need to be admired, which lead them to deny feelings of vulnerability and inadequacy (*e.g.*, insecurity, hypersensitivity to criticism) connected to low self-esteem (Ogrodniczuk & Kealy, 2013; Tanzilli *et al*., 2021), as well as of the need for relatedness and dependence on others (Rost *et al*., 2018). In the treatment, they feel exposed to the clinician's scrutiny, which can make them feel small, dependent, and humiliated (Kernberg *et al*., 2000), and may tend to use suicidal ideation and behaviors to exert their power over the therapeutic relationship (Tanzilli *et al*., 2021; Williams *et al*., 2021). Overall, depressed patients with marked narcissistic characteristics have more trouble fully engaging in the therapeutic process; therefore, they tend to have more difficulties in benefiting from therapeutic interventions (Gabbard, 2009), frequently cause impasses or alliance breakdowns (Ronningstam, 2019), and, more generally, show high levels of abandonment (Lamkin, 2018).

Finally, consistent with clinical and empirical literature (Hennissen *et al.*, 2019; Normandin *et al*., 2021; Tanzilli *et al.*, 2020), patients presenting with borderline personality disorder and comorbid depression elicited heterogeneous emotional therapist responses characterized by rage, disorganization, dread, anxiety, concern, and sexual tension. These adolescents show peculiar features if compared to those who do not exhibit these personality traits, primarily with respect to the phenomenology of their inner experiences (Moselli *et al.*, 2021). They seem to struggle significantly with the integration of highly polarized aspects of themselves and others (including the clinician), with whom they establish relationships characterized by marked ambivalence and instability. In these patients, depressive symptoms were found to be significantly associated with "anaclitic neediness" *i.e*., fear of abandonment and rejection, feelings of helplessness, hypertrophic desire for affection and protection, and difficulty tolerating frustration. Furthermore, borderline personality characteristics are known to heighten the frequency and lethality of suicidality among individuals with depression (Hatkevich *et al*., 2019; Sekowski *et al*., 2022). These distinctive dynamics are challenging to manage and treat in therapy, "pulling" clinicians to experience painful feelings of helplessness, worry, or confusion, and hindering the building of a good alliance (Brøsholen *et al*., 2022).

Evidence has suggested a reciprocal influence between the therapeutic alliance and therapists' emotional reactions to both adult and adolescent patients (Norcross & Lambert, 2019). Overall, building a positive therapeutic alliance is particularly challenging when working with adolescents (Cirasola & Midgley, 2023), especially those with greater impairments in personality functioning and symptom severity. At the same time, therapists working with severe adolescent patients tend to experience particularly intense and negative countertransference reactions (Satir *et al.*, 2009; Tanzilli *et al.*, 2020). These two relational dimensions (alliance and countertransference) are separated but strongly interconnected to affective, cognitive, motivational, interpersonal and behavioral processes that are functionally interrelated in patients' emerging personality styles/syndromes and symptom patterns (Brøsholen *et al*., 2022; Satir *et al*., 2009; Tanzilli & Gualco, 2020). Therefore, the present study, which is strongly based on the theoretical-clinical framework of PDM, may be useful in shedding light on potential challenges in the process of developing the therapeutic alliance, as well as on the management of emotional reactions in adolescent patients, which may, in turn, be markers of alliance ruptures (Safran & Kraus, 2014). Indeed, our findings seem to support research that highlights the need for the therapist to be more attuned to the young patient's subjective experience (a crucial element in the PDM perspective) in order to facilitate the processes of alliance development, maintenance, and repair (Binder *et al*., 2008). Failure to acknowledge the adolescent pa-

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tient's experience is one of the elements that cause serious moments of alliance breakdown in therapy (Morán *et al*., 2019).

This research presents some limitations that should be addressed. Firstly, our study considered only the therapist's perspective. Despite the relevance of the clinician's perspective in the research design examining the relationship between patients' diagnostic characteristics and relational components in adolescent psychotherapy, the exclusive use of the therapist's clinical judgment may raise potential biases. To overcome this limitation, future research should include measures assessed by the patient or an outside perspective (*e.g.*, a supervisor or external observer). Secondly, the research design did not include an assessment of process or outcome variables of psychotherapies. Therefore, there is no data on the impact of specific interventions on patient functioning during treatment, nor information on efficacy/effectiveness. Further studies (especially longitudinal) will be able to monitor these aspects associated with treatment progress and assess changes in countertransference patterns over the psychotherapy process. In acknowledgment of the dynamic nature of countertransference, it would be crucial to assess variations in clinicians' emotional responses to their youth patients over time. These could be precipitated by a multitude of factors, including the progression of therapy, specific occurrences within the therapeutic dyad, alterations in the patient's psychopathological manifestations, and transitions through specific developmental substages (*e.g.*, middle to late adolescence). Indeed, as highlighted by the PDM, each substage of adolescence is characterized by specific processes and achievements [*e.g.*, regarding attachment representations, the capacity for (epistemic) trust and intimacy, the ability to handle conflicts or internal and external sources of stress through more adaptive defensive functioning, or the need to test boundaries or violate norms as a means to assert autonomy (Lingiardi & McWilliams, in press)], which may significantly influence therapists' reactions, each posing unique challenges. Understanding these dynamics in a more sophisticated way, particularly through a longitudinal lens, will enable clinicians to adopt more flexible and responsive strategies during their therapeutic work with adolescents.

The present study explored the association between patients' personality subtypes and therapists' emotional responses, net of the effect of depressive symptoms; however, it is essential to recognize that other variables could further influence this relationship. Therefore, future empirical investigations should consider the role of specific dimensions of young patients' functioning, such as those mentioned above (in particular, attachment, epistemic trust, but also defense mechanisms, *etc*.), of their therapists (*e.g.*, personality, attachment, defensive functioning, *etc*.), and of the patient-therapist relationship (especially, as already pointed out, the quality of the alliance, with its ruptures and repairs), to obtain a more complete view of all the elements useful for the diagnostic and therapeutic process.

In addition, in the present research, all therapists and patients were white. This (random) sample composition limited the possibility of exploring the effect of cultural differences on countertransference dynamics. It is crucial to recognize that these differences can influence the therapeutic relationship, underscoring the importance for clinicians to show greater sensitivity to sociocultural issues (Tummala-Narra, 2014; Ryan *et al.*, 2023), which are pivotal in the identity formation process of adolescents (Lingiardi & McWilliams, in press).

Finally, the sample size was not very large; thus, the generalizability of our findings is limited, warranting the need for further investigations. Despite these limitations, to our knowledge, this is the first study that aims to explore personality subtypes in adolescents with DD and their associations with other clinically relevant dimensions, contributing new insights to the existing literature in this field.

Overall, the present study seems to suggest that it is not clinically useful to think of the diagnosis of depression as a unique clinical entity, especially in adolescence. In order to promote a better understanding of the adolescent experience of these disorders and formulate a good diagnosis in the service of treatment, it seems crucial to integrate the more objective (descriptive) side of the adolescent's psychopathological assessment with a fine-tuned understanding of his or her core dynamic personality and relational characteristics, which are evident in the therapeutic relationship and have a major impact on the effectiveness of psychotherapies. It cannot be underestimated that therapists' emotional responses to adolescents diagnosed with DD seem to be fundamentally determined by the patients' specific emerging personality patterns. Given the relevance of the therapist's emotional response to the patient for the creation of a solid therapeutic alliance and positive development of the clinical process, this research points out how relevant it is for the therapist to monitor his or her own emotional responses to the patient in order to aptly devise a strategy of psychotherapeutic treatment, independent of the diagnosis of depression. Future research may corroborate these findings on a larger adolescent population with the application of mediation or moderation models.

Conclusions

The present study identified 4 distinct personality subtypes among adolescents with DD, underscoring the importance of acknowledging the complexity and heterogeneity in personality functioning within this diagnostic category (Herman *et al.*, 2007; Loades *et al*., 2022). According to the next edition of PDM-3 (Lingiardi & McWilliams, in press), this research supports the clinical utility of accurate diagnostic evaluation that provides valuable information about how depressive symptomatology is "nested" in distinct emerging personality syndromes related to specific levels of mental functioning and personality organization in adolescence. It also emphasizes the importance of adequate treatment strategies of constant examination and monitoring of countertransference reactions toward young patients as a meaningful source of knowledge about their essential psychological and interpersonal characteristics (Tanzilli *et al.*, 2020).

PDM-3 emphasizes the relevance of a more comprehensive and global assessment of depressed adolescents to gain insights into the different ways in which adolescents with different personality pathologies and mental capacities perceive and navigate their subjective experiences of depression. A better understanding of the unique and specific dynamics of the young patient is essential for formulating "sensible" diagnoses and planning more effective and individualized treatment in this developmental stage.

References

Alaie, I., Ssegonja, R., Philipson, A., von Knorring, A. L., Möller, M., von Knorring, L., Ramklint, M., Bohman, H., Feldman, I., Hagberg, L., & Jonsson, U. (2021). Adolescent depression, early psychiatric comorbidities, and adulthood welfare burden: a 25-year longitudinal cohort study. *Social Psychiatry*

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and Psychiatric Epidemiology, *56*(11), 1993-2004. doi: 10.1007/s00127-021-02056-2.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing.

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text revision). American Psychiatric Publishing.

Binder, P. E., Holgersen, H., & Høstmark Nielsen, G. (2008). Reestablishing contact: a qualitative exploration of how therapists work with alliance ruptures in adolescent psychotherapy. *Counselling & Psychotherapy Research, 8*(4), 239-245. doi: 10.1080/14733140802363167.

Blatt, S. J. (2004). *Experiences of depression: theoretical, clinical, and research perspectives*. American Psychological Association Publishing. doi: 10.1037/10749-001.

Bodden, D. H. M., Stikkelbroek, Y., & Dirksen, C. D. (2018). Societal burden of adolescent depression, an overview and cost-of-illness study. *Journal of Affective Disorders*, *241*, 256-262. doi: 10.1016/j.jad.2018.06.015.

Brøsholen, P., Ulberg, R., Dahl, H. J., & Thorén, A. (2022). Therapists' emotional responses in individual therapy with depressed adolescents: an evaluation of the data structure of the feeling-word checklist-28. *International Journal of Environmental Research and Public Health*, *19*(15), 9496. doi: 10.3390/ijerph19159496.

Chanen, A. M. (2022). Debate: it is time to stop turning a blind eye to personality disorder in young people. *Child and Adolescent Mental Health*, *27*(2), 194-195. doi: 10.1111/camh.12554.

Cheek, J., Kealy, D., Joyce, A. S., & Ogrodniczuk, J. S. (2018). Interpersonal problems associated with narcissism among psychiatric outpatients: a replication study. *Archives of Psychiatry and Psychotherapy*, *20*(2), 837-842. doi: 10.12740/APP/90328.

Cirasola, A., & Midgley, N. (2023). The alliance with young people: where have we been, where are we going?. *Psychotherapy, 60*(1), 110-118. doi: 10.1037/pst0000461.

Cirasola, A., Midgley, N., Fonagy, P., IMPACT Consortium, & Martin, P. (2021). The alliance-outcome association in the treatment of adolescent depression. *Psychotherapy*, *58*(1), 95-108. doi: 10.1037/pst0000366.

Clayborne, Z. M., Varin, M., & Colman, I. (2019). Systematic review and meta-analysis: adolescent depression and long-term psychosocial outcomes. *Journal of the American Academy of Child and Adolescent Psychiatry*, *58*(1), 72-79. doi: 10.1016/j.jaac.2018.07.896.

Di Giuseppe, M., Gennaro, A., Lingiardi, V., & Perry, J. C. (2019). The role of defense mechanisms in emerging personality disorders in clinical adolescents. *Psychiatry*, *82*(2), 128-142. doi: 10.1080/00332747.2019.1579595.

Feenstra, D. J., Busschbach, J. J. V., Verheul, R., & Hutsebaut, J. (2011). Prevalence and comorbidity of axis I and axis II disorders among treatment refractory adolescents admitted for specialized psychotherapy. *Journal of Personality Disorders*, *25*(6), 842-850. doi: 10.1521/pedi.2011.25.6.842.

Freudenstein, O., Valevski, A., Apter, A., Zohar, A., Shoval, G., Nahshoni, E., Weizman, A., & Zalsman, G. (2012). Perfectionism, narcissism, and depression in suicidal and nonsuicidal adolescent inpatients. *Comprehensive Psychiatry*, *53*(6), 746-752. doi: 10.1016/j.comppsych.2011.08.011.

Friborg, O., Martinsen, E. W., Martinussen, M., Kaiser, S., Overgård, K. T., & Rosenvinge, J. H. (2014). Comorbidity of personality disorders in mood disorders: a meta-analytic review of 122 studies from 1988 to 2010. *Journal of Affective Disorders*, *152-154*, 1-11. doi: 10.1016/j.jad.2013.08.023.

Gabbard, G. O. (2009). Transference and countertransference: developments in the treatment of narcissistic personality disorder. *Psychiatric Annals*, *39*(3), 129-136. doi: 10.3928/00485713-20090301-03.

Gander, M., Buchheim, A., & Sevecke, K. (2023). Personality disorders and attachment trauma in adolescent patients with psychiatric disorders. *Research on Child and Adolescent Psychopathology*, *52*(3), 457-471. doi: 10.1007/s10802-023-01141-1.

Gunderson, J. G., Stout, R. L., Shea, M. T., Grilo, C. M., Markowitz, J. C., Morey, L. C., Sanislow, C., Yen, S., Zanarini, M. C., Keuroghlian, A. S., McGlashan, T. H., & Skodol, A. E. (2014). Interactions of borderline personality disorder and mood disorders over 10 years. *Journal of Clinical Psychiatry*, *75*(8), 829-834. doi: 10.4088/JCP.13m08972.

Ha, C., Balderas, J. C., Zanarini, M. C., Oldham, J., & Sharp, C. (2014). Psychiatric comorbidity in hospitalized adolescents with borderline personality disorder. *Journal of Clinical Psychiatry*, *75*(5), e457-e464. doi: 10.4088/JCP.13m08696.

Hatkevich, C., Penner, F., & Sharp, C. (2019). Difficulties in emotion regulation and suicide ideation and attempt in adolescent inpatients. *Psychiatry Research, 271,* 230-238. doi: 10.1016/j.psychres.2018.11.038.

Hawes, M. T., Szenczy, A. K., Klein, D. N., Hajcak, G., & Nelson, B. D. (2021). Increases in depression and anxiety symptoms in adolescents and young adults during the COVID-19 pandemic. *Psychological Medicine*, *52*(14), 3222-3230. doi: 10.1017/S0033291720005358.

Hennissen, V. C., Meganck, R., Van Nieuwenhove, K., Norman, U. A., Loeys, T., & Desmet, M. (2019). Therapists' responses toward dependent (Anaclitic) and self-critical (Introjective) depressed outpatients: a multilevel approach. *Psychotherapy*, *56*(2), 193-204. doi: 10.1037/pst0000213.

Herman, K. C., Ostrander, R., Walkup, J. T., Silva, S. G., & March, J. S. (2007). Empirically derived subtypes of adolescent depression: latent profile analysis of co-occurring symptoms in the treatment for adolescents with depression study (TADS). *Journal of Consulting and Clinical Psychology*, *75*(5), 716-728. doi: 10.1037/0022-006X.75.5.716.

Huprich, S. K., Defife, J., & Westen, D. (2014). Refining a complex diagnostic construct: subtyping dysthymia with the Shedler-Westen assessment procedure-II. *Journal of Affective Disorders*, *152-154*(1), 186-192. doi: 10.1016/j.jad.2013.09.008.

Kernberg, O. F. (1967). Borderline personality organization. *Journal of the American Psychoanalytic Association*, *15*(3), 641-685. doi: 10.1177/000306516701500309.

Kernberg, O. F. (1984). *Severe personality disorders: psychotherapeutic strategies*. Yale University Press.

Kernberg, P. F., Weiner, A. S., & Bardenstein, K. K. (2000). *Personality disorders in children and adolescents.* Basic Books.

Koelen, J. A., Luyten, P., Eurelings-Bontekoe, L. H., Diguer, L., Vermote, R., Lowyck, B., & Bühring, M. E. (2012). The impact of level of personality organization on treatment response: a systematic review. *Psychiatry*, *75*(4), 355-374. doi: 10.1521/psyc.2012.75.4.355.

Lamkin, J. (2018). Interpersonal functioning of narcissistic individuals and implications for treatment engagement. In A. D. Hermann, A. B. Brunell, J. D. Foster (Eds), *Handbook of trait*

Non-commercial use only

narcissism: key advances, research methods, and controversies (pp. 463-470). Springer International Publishing.

Lampe, L., & Malhi, G. S. (2018). Avoidant personality disorder: current insights. *Psychology Research and Behavior Management*, *11*, 55-66. doi: 10.2147/PRBM.S121073.

Lingiardi, V., & McWilliams, N. (2017). *Psychodynamic diagnostic manual: PDM-2 (*2nd ed.). Guilford Press.

Lingiardi, V., & McWilliams, N. (in press). *Psychodynamic diagnostic manual,* PDM-3 (3rd ed). Guilford Press.

Liotti, M., Milesi, A., Spitoni, G. F., Tanzilli, A., Speranza, A. M., Parolin, L., Campbell, C., Fonagy, P., Lingiardi, V., & Giovanardi, G. (2023). Unpacking trust: the Italian validation of the epistemic trust, mistrust, and credulity questionnaire (ETMCQ). *PloS One*, *18*(1), e0280328. doi: 10.1371/journal.pone.0280328.

Loades, M. E., St Clair, M. C., Orchard, F., Goodyer, I., & Reynolds, S. (2022). Depression symptom clusters in adolescents: a latent class analysis in a clinical sample. *Psychotherapy Research*, *32*(7), 860-873. doi: 10.1080/10503307.2022.2030498.

Malberg, N., Malone, J., Midgley, N., & Speranza, M. (2017). Psychodiagnostic chart–adolescent (PDC-A). In V. Lingiardi & N. McWilliams (Eds.), *Psychodynamic Diagnostic Manual,* 2nd ed. (PDM-2) (pp. 1024-1027). Guilford Press.

Midgley, N., Parkinson, S., Holmes, J., Stapley, E., Eatough, V., & Target, M. (2015). Beyond a diagnosis: the experience of depression among clinically-referred adolescents. *Journal of Adolescence*, *44*, 269-279. doi: 10.1016/j.adolescence.2015.08.007.

Moselli, M., Frattini, C., Williams, R., & Ronningstam, E. (2021). The study of motivation in the suicidal process: the motivational interview for suicidality. *Frontiers in Psychiatry, 11,* 598866. doi: 10.3389/fpsyt.2020.598866.

Moselli, M., Casini, M. P., Frattini, C., & Williams, R. (2023). Suicidality and personality pathology in adolescence: a systematic review. *Child Psychiatry and Human Development*, *54*(2), 290-311. doi: 10.1007/s10578-021-01239-x.

Morán, J., Díaz, M. F., Martínez, C., Varas, C., & Sepúlveda, R. P. (2019). The subjective experience of psychotherapists during moments of rupture in psychotherapy with adolescents. *Research in Psychotherapy: Psychopathology, Process and Outcome, 22*(1), 346. doi: 10.4081/ripppo.2019.346.

Mullen, S. (2018). Major depressive disorder in children and adolescents. *Mental Health Clinician*, *8*(6), 275-283. doi: 10.9740/mhc.2018.11.275.

National Institute for Health Care Excellence. (2019). *Depression in Children and Young People: Identification and Management*. Available from: https://www.nice.org.uk/guidance/ng134. Accessed in: May 2023.

Norcross, J. C., & Lambert, M. J. (2019). *Psychotherapy relationships that work: evidence-based therapist contributions* (3rd ed.). Oxford University Press. doi: 10.1093/med-psych/9780190843953.001.0001.

Normandin, L., Ensink, K., Weiner, A., & Kernberg, O. F. (2021). *Transference-Focused Psychotherapy for adolescents with severe personality disorders.* American Psychiatric Association Publishing.

Ogrodniczuk, J. S., & Kealy, D. (2013). Interpersonal problems of narcissistic patients. In J. S. Ogrodniczuk (Ed.), *Understanding and Treating Pathological Narcissism* (pp. 113-127). American Psychological Association.

Podsakoff, P. M., MacKenzie, S. B., & Podsakoff, N. P. (2012). Sources of method bias in social science research and recommendations on how to control it. *Annual Review of Psychology, 63,* 539-569. doi: 10.1146/annurev-psych-120710-100452.

Ronningstam, E. (2019). Narcissism and its discontents: diagnostic dilemmas and treatment strategies with narcissistic patients. *Journal of Psychiatric Practice*, *25*(3), 239-240. doi: 10.1097/PRA.0000000000000379.

Rost, F., Luyten, P., & Fonagy, P. (2018). The anaclitic-introjective depression assessment: Development and preliminary validity of an observer-rated measure. *Clinical Psychology & Psychotherapy*, *25*(2), 195-209. doi: 10.1002/cpp.2153.

Ryan, R., Berry, K., & Hartley, S. (2023). Review: therapist factors and their impact on therapeutic alliance and outcomes in child and adolescent mental health - a systematic review. *Child and Adolescent Mental Health, 28*(2), 195-211. doi: 10.1111/camh.12518.

Safran, J. D., & Kraus, J. (2014). Alliance ruptures, impasses, and enactments: a relational perspective. Psychotherapy, 51(3), 381-387. doi: 10.1037/a0036815.

Satir, D. A., Thompson-Brenner, H., Boisseau, C. L., & Crisafulli, M. A. (2009). Countertransference reactions to adolescents with eating disorders: relationships to clinician and patient factors. *International Journal of Eating Disorders*, *42*(6), 511-521. doi: 10.1002/eat.20650.

Sekowski, M., Gambin, M., Sumlin, E., & Sharp, C. (2022). Associations between symptoms of borderline personality disorder and suicidality in inpatient adolescents: the significance of identity disturbance. *Psychiatry Research, 312,* 114558. doi: 10.1016/j.psychres.2022.114558.

Sharp, C., Cano, K., Bo, S., & Hutsebaut, J. (2022). The assessment of personality function in adolescents. In S. K. Huprich (Ed.), *Personality disorders and pathology: integrating clinical assessment and practice in the DSM-5 and ICD-11 era* (pp. 109-134). American Psychological Association. doi: 10.1037/0000310-006.

Sharp, C., & Wall, K. (2018). Personality pathology grows up: adolescence as a sensitive period. *Current Opinion in Psychology, 21*, 111-116. doi: 10.1016/j.copsyc.2017.11.010.

Sharp, C., & Wall, K. (2021). DSM-5 Level of personality functioning: refocusing personality disorder on what it means to be human. *Annual Review of Clinical Psychology*, *17*, 313-337. doi: 10.1146/annurev-clinpsy-081219-105402.

Strandholm, T., Karlsson, L., Kiviruusu, O., Pelkonen, M., & Marttunen, M. (2014). Treatment characteristics and outcome of depression among depressed adolescent outpatients with and without comorbid axis II disorders. *Journal of Personality Disorders*, *28*(6), 853-863. doi: 10.1521/pedi_2012_26_073.

Streiner, D. L. (2003). Being inconsistent about consistency: when coefficient alpha does and doesn't matter. *Journal of Personality Assessment*, *80*(3), 217-222. doi: 10.1207/S15327752JPA8003_01.

Tanzilli, A., Colli, A., Gualco, I., & Lingiardi, V. (2018). Patient personality and relational patterns in psychotherapy: factor structure, reliability, and validity of the psychotherapy relationship questionnaire. *Journal of Personality Assessment, 100*(1), 96-106. doi: 10.1080/00223891.2016.1272050.

Tanzilli, A., Giovanardi, G., Patriarca, E., Lingiardi, V., & Williams, R. (2021). From a symptom-based to a person-centered approach in treating depressive disorders in adolescence: a clinical case formulation using the Psychodynamic Diagnostic Manual (PDM-2)'s framework. *International Journal of Environmental Research and Public Health*, *18*(19), 10127. doi: 10.3390/ijerph181910127.

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Tanzilli, A., & Gualco, I. (2020). Clinician emotional responses and therapeutic alliance when treating adolescent patients with narcissistic personality disorder subtypes: a clinically meaningful empirical investigation. *Journal of Personality Disorders*, *34*, 42-62. doi: 10.1521/pedi.2020.34.supp.42.

Tanzilli, A., Gualco, I., Baiocco, R., & Lingiardi, V. (2020). Clinician reactions when working with adolescent patients: the therapist response questionnaire for adolescents. *Journal of Personality Assessment*, *102*(5), 616-627. doi: 10.1080/00223891.2019.1674318.

Tummala-Narra, P. (2014). Cultural identity in the context of trauma and immigration from a psychoanalytic perspective. *Psychoanalytic Psychology, 31*(3), 396-409. doi: 10.1037/a0036539.

Van, H. L., & Kool, M. (2018). What we do, do not, and need to know about comorbid depression and personality disorders. *Lancet Psychiatry,* 5(10), 776-778. doi: 10.1016/S2215-0366(18)30260-8.

Westen, D., DeFife, J. A., Malone, J. C., & Dilallo, J. (2014). An empirically derived classification of adolescent personality disorders. *Journal of the American Academy of Child and Adolescent Psychiatry*, *53*(5), 528-549. doi: 10.1016/j.jaac.2013.12.030.

Westen, D., Moses, M. J., Silk, K. R., Lohr, N. E., Cohen, R., & Segal, H. (1992). Quality of depressive experience in borderline personality disorder and major depression: when depression is not just depression. *Journal of Personality Disorders*, *6*(4), 382-393. doi: 10.1521/pedi.1992.6.4.382.

Williams, R., Casini, M. P., Moselli, M., Frattini, C., & Ronningstam, E. (2021). The road from pathological narcissism to suicidality in adolescence: an empirical study. *International Journal of Environmental Research and Public Health*, *18*(18), 9761. doi: 10.3390/ijerph18189761.

World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th revision). Available from: https://icd.who.int/.

World Health Organization. (2022). World mental health report: transforming mental health for all. Available from: https://iris.who.int/bitstream/handle/10665/356119/9789240049338-eng.pdf?sequence=1.

Zanarini, M. C., Frankenburg, F. R., Hennen, J., Reich, D. B., & Silk, K. R. (2004). Axis I comorbidity in patients with borderline personality disorder: 6-year follow-up and prediction of time to remission. *American Journal of Psychiatry*, *161*(11), 2108-2114. doi: 10.1176/appi.ajp.161.11.2108.

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