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PSYCHOPATHOLOGY, PROCESS AND OUTCOME

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／# RESEARCH IN PSYCHOTHERAPY
PSYCHOPATHOLOGY, PROCESS AND OUTCOME

Journal of the Italian Area Group of the
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Returning to the roots. A Comment on the Paper "Alliance in Common Factor Land: A View through the Research Lens"

Antonello Colli[1]

It is an honor for me to comment on a paper by Adam Horvath, who is considered one of the most important therapeutic alliance researchers of our time.

In his interesting paper "Alliance in Common Factor Land: A View through the Research Lens," Horvath (2011) takes us through the critical aspects of therapeutic alliance research and the challenges that researchers still have to face. The author discusses several complex issues – from the historical background of the construct to the critical aspects of its measurement, and concludes with the proposal of a research agenda.

The key topic of Horvath's (2011) paper is the necessity for a better definition of *therapeutic alliance construct*, one that would (a) recognize the similarities and differences among the different kinds of therapeutic alliance definitions; and (b) differentiate the components of the therapeutic relationship. As Horvath reminds us in his paper, the problem of differentiation between therapeutic alliance and other components of the relationship originates from Greenson's (1965) tripartition of therapeutic relationship in transference, working alliance, and real relationship.

Some authors refute this tripartition and think that the psychotherapy relationship is the product only of patient's transference: There cannot exist a conflict-free part of the Ego. Other authors believe this tripartition is possible as well as useful. Last, some authors equate the alliance with the therapeutic relationship.

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If the distinction among the three elements of the therapeutic relationship – in terms of mutually exclusive categories – seems possible on a theoretical level, then from a clinical perspective, this differentiation appears more difficult, with the boundaries blurred among the constructs (Hatcher, 2009).

It is not useful or clinically meaningful to debate the elements of a therapeutic relationship in terms of mutually exclusive categories: transference or therapeutic alliance or real relationship (Hatcher, 2009). Conversely, it is more important to reflect on the way we view the psychotherapy relationship. Horvath (2009) suggested a possible solution to classifying relational constructs along a three-layered hierarchy: feelings, relational inferences, and relational processes (p. 276). Another possibility could be looking at psychotherapy relationship components as different levels of the relationship experience (Lingiardi & Colli, 2010; Meissner, 2006; Modell, 1990). Every patient-therapist sentence – for example, “You do not love me” – can be interpreted concurrently as the expression at a first level of something of the reality: the patient and the therapist as persons; at a second level: the “I” and the “You” referencing the patient and the analyst; and, finally, at a third level: interpreted as the expression of transference, with the “I” and the “You” referring to figures in the patient’s past.

The question from this point of view is: On what level – transference, therapeutic alliance, or real relationship – are the therapist and patient mainly working?

Hatcher suggests considering the three components of the relationship as different perspectives of observation. In this way “Anything that happens in the relationship can be evaluated from the alliance point of view, suggesting such questions such as: In what way [does] this behavior indicate the quality of the work in therapy? . . . Does this behavior promote or detract from the work?” (Hatcher, 2010, p. 22).

This way of conceptualizing and working on the relationship is in line with Horvath’s (2011) proposal about the necessity to “discover and docu-

ment more clearly the kind of interactive processes that most likely foster the alliance" (p. 131).

The investigation of how the patient and therapist construct the therapeutic alliance, to depict "the idiosyncratic interactional patterns that unfold between patient and therapist" (Charmann, 2004, p. 18), suggests promoting studies based on the evaluation of micro processes between patient and therapist (Colli & Lingiardi, 2009).

Restarting from what the patient and therapist do during psychotherapy sessions could contribute in giving us "a clearer classification of the relationship constructs currently in use. . . . [and] the recognition of both the similarities and the differences among the constructs currently labeled alliance" (Horvath, 2011, p. 132). As Horvath (2011) observed, the problem is also recognizing the differences among the therapeutic alliance definitions. These differences are more evident if we take into consideration that "less than 50% of the variance was shared among these most commonly used measures" (Horvath, 2011, p. 129). One possible explanation for this data, as Horvath proposes in his paper, could be that the most commonly used measures are based on different conceptualizations of the therapeutic alliance. Conversely, this data could be the result of some problematics in therapeutic alliance measures; for example, a critical aspect of therapeutic alliance measures – how clients and therapist "use" the Likert scale – could affect the interpretation of the low agreement of these measures. As observed by Jenkins and Dillman (1997), researchers who create questionnaires do not always know how respondents will answer them. This is also the case in therapeutic alliance. Despite using different instruments to assess the client-therapist alliance, authors of studies frequently comment that both clients and therapists tend to rate the alliance highly (i.e., Hilsenroth, Peters, & Ackerman, 2004; Lingiardi, Filippucci, & Baiocco, 2005; Tryon & Kane, 1995). For example, Hatcher and Gillaspy found that clients tend not to use the lower 5 points of the 7-point Working Alliance Inventory (WAI) (Hatcher & Gillaspy, 2006). Thus, clients used just the top 30% of the rating points of the WAI when evaluating their alliance with therapists. An-

other study of differences in the use of the Likert scale between patients and therapist showed that clients tend to use only the top 20% of rating points and therapists tend to use only the top 30% of rating points on alliance measures (Tyron, Blackwell, & Hammel, 2008).

A further critical aspect that could affect the variance among these measures is represented by several biases in self-report measures. The evaluations of therapeutic alliance could be affected by the influence of other relational variables, including transference and countertransference, the therapist's theoretical preferences, or the influence of other variables related to the patient's level of functioning, such as reflective functioning capacity (Colli & Lingiardi, 2009).

All critical aspects of therapeutic alliance construct seem to aggregate when we focus our attention on the construct of alliance ruptures and resolutions.

As Horvath (2011) noticed for therapeutic alliance (p. 126) as well as for therapeutic alliance ruptures and resolutions, we have a "Tower of Babel" effect. In fact, several terms have been used to describe this phenomenon: challenges (Harper, 1989a, 1989b), misunderstanding event (Rhodes, Hill, Thompson, & Elliott, 1994), impasses (Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996), alliance threats (Bennett, Parry, & Ryle, 2006), transference-countertransference enactments (Safran & Muran, 2006), and rupture interactions (Colli & Lingiardi, 2009). At the same time, for therapeutic alliance ruptures and resolutions, we have a Tower of Babel problem in reverse: We use the same words but mean different things.

In his paper, Horvath (2011) observed that in the research literature on therapeutic alliance ruptures and resolutions, "The kind of data that is interpreted as evidence that a rupture has taken place varies significantly with the researcher's method of assessment" (p. 130) and that "at one end, almost any sign of momentary tension between therapist and client is assumed to signal some kind of rupture . Near the other end of the continuum, there are significant fluctuations in self-reported alliance between sessions as the criteria that trigger a rupture" (Horvath, 2011, p. 130).

These differences in assessing therapeutic alliance ruptures and resolutions could reflect radical differences at a theoretical level. These theoretical differences can be summarized into two opposing positions: the totalistic/relational and the restricted/rational. From a totalistic/relational point of view, the therapeutic alliance is seen as "an ongoing process of intersubjective negotiation" (Safran & Muran, 2000, p. 165). The object of this negotiation could change from author to author: For example, for Safran and Muran (2000), patients and therapists negotiate agency and relatedness needs. For other authors, patients and therapists negotiate about self and interactive regulation (Beebe & Lachmann, 2002). From this view, the psychotherapy process can be conceptualized as a process of ruptures and resolutions of the syntonization between patient and therapist, a process that takes place at both conscious and unconscious levels (Lyons-Ruth, 1999). As a consequence, also momentary and subtle fluctuations in the collaboration level are considered relevant.

From a restricted/rational position, therapeutic alliance ruptures and resolutions are one of the elements of the psychotherapy process but do not represent the *essence* of the psychotherapy process. This perspective has a greater relevance for *what* the patient communicates rather than *how* the patient communicates. If we adopt a rational point of view, we could consider it a rupture or breakdown in the collaboration process if a patient does not agree with his or her therapist about a task of therapy (for example "I don't think it is important for me to speak about my childhood"). Conversely, if we adopt a relational point of view, the content of the communication (the disagreement) is less important than the way the patient communicates about the disagreement and negotiates it with the therapist.

In conclusion, I believe that the routes traced by Horvath (2011) indicate the necessity to return to the roots of conceptualizations and our clinical work. This return could permit us to partially mark and reflect about the boundaries of therapeutic alliance, reducing naïve assumptions and especially not transforming therapeutic alliance from an aspecific factor into an "umbrella" factor.

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Dynamics of subjective change in psychotherapy. A Comment on the Paper "Dynamics of sense-making and development of the narrative in the clinical exchange" by Alessandro Gennaro, Miguel Gonçalves, Inês Mendes, Antônio Ribeiro, & Sergio Salvatore

Mariane Krause[1] & Claudio Martínez[2]

The following comment has been divided into four sections that present a critical discussion on: (1) the theoretical background of the paper; (2) the two methods used: Discourse Flow Analysis (DFA) and Innovative Moments Coding System (IMCS); (3) results; and (4) conclusions.

Theoretical background

The article is based on a widely accepted notion of psychotherapeutic change, which considers that change takes place in the representational sphere (Fonagy, 2001). This notion of change is derived from the Theory of Subjective Change (Krause, 2005) and has been referenced through concepts such as: changes in the frames of reference (Duncan & Moynihan, 1994), changes in personal constructs (Anderson, 1997a, 1997b), or change as a "re-writing" of aspects of one's life story (McLeod, 1998; McLeod & Balamoutsou, 1996).

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The authors allude to this idea of change through the concept of "sense making." In fact, they define "psychotherapy as an intersubjective dynamics of sense-making aimed at changing a patient's symbolic (affective and/or cognitive) modality of interpreting his/her experience" (Gennaro, Gonçalves, Mendes, Ribeiro, & Salvatore, 2011, p. 91). This definition fully matches that of subjective change (Krause, 2005), which regards a change in meanings as the core of psychotherapeutic change. The concept of "sense making" is closely associated with the hermeneutic or interpretive epistemological tradition, and leads to the use of methodologies capable of unlocking the meanings that therapeutic communication has for its participants.

When they focus on the process, the authors articulate the interpretive perspective with a constructionist one, characterizing psychotherapy as " 'transformative dialog' (Gergen, 1999, p. 250), where new meanings are elaborated, new categories are developed, and one's presuppositions (Chambers & Bickhard, 2007) are transformed within and thanks to the interpersonal context" (Gennaro et al., 2011, p. 91). In this regard, two notions highlighted by the authors are noteworthy. One of them is Gergen's notion of "transformative dialog" –quoted by the authors– which implies the idea of dialogic transformation. This idea seems to be coherent with the notion of flow in the DFA system and with the implicit idea of two minds constructing meaning together, that is, in a dia-log. In other words, the DFA system seems to incorporate a concept of change which highlights the possibility that two minds transform when sharing a novel experience in a dynamic space. The second remarkable idea, which complements the former, is that of "semiotic novelty," since it stresses the power of the co-constructive in the form of construction of the dialog, rather than in its meanings. Novelty may be said to act as a lever of change for the patient; it is the different way in which something is told or narrated, and new meanings are thought to emerge from such narrative novelty. This can also be understood based on the notion of alterity (Bakhtin, 1986), which highlights the richness of strange voices in the way of telling something. The

other (alter) provides the difference, which becomes novelty, just for being somebody else and thinking differently. Therefore, this experience of novelty with an other sets the stage for the transformation of an individual's own experience. The transformation can be expressed, for example, in the new way that a patient finds to narrate his/her experience. This is coherently illuminated by the IMCS system, which values the expression of change based on the narrative novelty expressed by the patient, which is heard (read) by an observer-researcher, who then transforms it into a new narration in the form of ordered categories. The key part of these processes appears to be the presence of an other (alter) who, as a dialogic actor, sanctions this novelty and incorporates it, making it his/her own in the form of psychological change.

Consistent with this manner of focusing on the process, the authors believe that "sense-making could be depicted as a dynamic process, that is a process depending on time" (Gennaro et al., 2011, p. 91). The idea of the evolution of change over time is also supported by theoretical and empirical information, especially concerning the progression of stages, for example, in Stiles' model of assimilation of problematic experiences (2002), in Hill's Three-stage Model of Helping (2001), in the Generic Change Indicators developed by Krause et al. (2007), or in the transtheoretical model of Prochaska and Norcross (2002).

Fortunately, given the proliferation of methods to assess change during the process (and in terms of outcome), psychotherapy research has reached a point of conceptual consensus about the essence of the product of psychotherapeutic change and of its construction process. This consensus makes it possible to advance in the development of a generic and inclusive theoretical model, which is capable of articulating specific studies and giving coherence to its multiplicity. This also fosters the connection between research and clinical practice, since a clinical professional will prefer a study that delivers more comprehensive results instead of being swamped with hundreds of specific and microscopic studies.

Methods

The article presents two methods: the Discourse Flow Analysis (DFA) and the Innovative Moments Coding System (IMCS). The DFA searches for the "dynamics of sense-making", looking at connections of meanings. IMCS, in contrast, seeks unique and novel content in therapeutic discourse, in the form of narrations which emerge over the course of the therapeutic process. Through the application of both methods to a case, the authors intend to establish "the relationship between the formal and functional mapping of a psychotherapy case and the content of the patient's narrative" (Gennaro et al., 2011, p. 94). "The main aim is to chart out which kind of movements at level of narrative content corresponds to the dynamics of sensemaking carried out by the clinical dialogue as depicted by the DFA" (Gennaro et al., 2011, p. 94).

In theoretical terms, DFA involves two phases in the evolution of the change of meanings during the therapeutic process: a deconstructive stage followed by a constructive one. Dysfunctional meanings are deconstructed so that new meanings can emerge afterwards. This means that, at the beginning of the therapy, meanings should be more rigid; then, they should become unfrozen, and, finally, a new consolidation should take place, made up by meanings constructed in the therapy. A parallel can be drawn between this notion and the evolution of Generic Change Indicators, which also involve an early "melting" moment followed by the consolidation of new meanings in later phases (Krause et al., 2007). Therefore, the rigidity of meanings is thought to evolve over the therapy in a U-shaped fashion.

Methodologically, "DFA assumes that sense-making depends on the associations for temporal adjacency between meanings […]. Accordingly, DFA maps the psychotherapeutic dialogue in terms of associations for adjacency between semantic contents (i.e. the fact that one meaning comes just after another) occurring within the clinical exchange" (Gennaro et al., 2011, p. 97).

DFA works with (previously segmented) textual transcriptions which then undergo computer-aided content analysis. The second step of DFA is

sequential: "This procedure calculates each semantic content's probability of coming straight after every thematic content" (op. cit., p. 99). The third step is the establishment of super-ordered nodes, based on their frequency of occurrence and their association with other nodes. The presence of such super-ordered nodes is what results in the "U-shape trend" visible over the course of the psychotherapy.

The heart of the DFA method seems to be in its third step, that is to say, the analysis of the formal characteristics of the discursive network through the identification of the main nodes (semiotic set or semiotic entity), followed by the quantification of the connections between these two nodes, their distribution, and their connective trajectories. In this analysis, the key element appears to be the Super-Ordered Nodes (SN), which group connections according to their frequency and type. This is interesting because it can be a way of describing regulatory and self-regulatory instances in discourse. Depending on the trajectory or direction of the connections, it may be possible to identify predominantly self-regulatory nodes and nodes that tend to participate as regulators of interaction with the other. Also, it might be feasible to identify more or less active regulatory patterns depending on the stage of the therapeutic process. This would make it possible to observe changes through the flow of connections and disconnections of these patterns during the process, and to establish the direction of such changes along with the influence of interaction in all of these movements.

In terms of its coherence with the epistemological background discussed in the first section of this commentary, DFA does not deal with the meanings of the patient's discourse or narrative in depth; instead, it supposes that a given frequency of signs or repeated trajectories of connections of signs (words, utterances) result in the meaning of a given sign or set of signs. In this regard, the method deviates from the hermeneutic tradition.

The second method –The Innovative Moments Coding System (IMCS)– is introduced in the article as a qualitative procedure which analyzes the contents of the patient's narrative. This analysis is conducted using

Innovative Moments (Gonçalves, Matos, & Santos, 2008, 2009), which, based on a conception of psychotherapy as narrative, refer to a discursive content which emerges as a novelty in the story that the patient usually narrates about his/her problem (White & Epston, 1990). Consequently, IMs reflect a clinical change from their expression in the patient's narrative, and are therefore consistent with a *semiotic* conception of the psychotherapeutic process and with the idea of *novelty* as a precursor of therapeutic change.

Both conceptions are shared by the DFA method, but where this method seems to define a "skeleton" in the form of a discursive network, the IMCS adds the "flesh" of content. Furthermore, the two methods conceive novelty in epistemologically different ways. While in DFA semiotic novelty emerges through the connection of symbols which acquire meaning as they form spatially significant groups, novelty in the IMCS method is sanctioned by a third party (researcher) who uses pre-established representational categories to do so.

In terms of their assumptions (which are used as hypotheses in this study) about the evolution of the psychotherapeutic process, both methods are comparable, given that the U-shape in the evolution of the super-ordered nodes proposed by DFA is compatible with the type of I-Moments suggested by IMCS. According to the latter, out of the five types of I-Moments (Action, Reflection, Protest, Re-conceptualization, Performing Change), the first three can be grouped under a category "that represents a rupture in respect to the dominant narrative" (Gennaro et al., 2011, p. 106), while the last two can be seen as being part “of an elaborative process producing a consolidation of the new perspectives" (op. cit., p. 106). Thus, both methods propose two general phases in the "ideal" course of good outcome psychotherapies. The study, then, seeks to link "reactive innovation" with the deconstructive phase of DFA, and "elaborative" innovation with its "constructive" equivalent–this is the central hypothesis about the complementation of the two methods.

One of the virtues that these methods share is their appropriateness for the sequential analysis of the psychotherapeutic process. According to the

authors, the methods not only reveal what is said, and how it is said, but also *when* what said is said (what comes before and after what is said). This allows us to achieve a profound and dynamic understanding of psychotherapeutic change.

Regarding their differences, the authors point out that IMCS, in contrast to DFA, focuses on the content level. However, to a certain extent, both methods deal with content, not only IMCS. In fact, the starting point of DFA is the definition of topics (content) and their frequencies, followed by the establishment of cross-sectional connections (in a segment) along with longitudinal ones (between segments, over time). The difference between them is that, in DFA, contents are used without an a priori "sense-making" point, as is the case of IMCS, and become sets of signs grouped by frequency or lemmas. Thus, in DFA, initial contents become formal structures and flows. In contrast, IMCS stays mostly within the dimension of contents which become relevant when a coder grants a "novel" place in discourse to a certain narrative. The transit towards formality only occurs in the classification stage of types of I-Moments and then in the determination of the salience of IMs within a session or group of sessions. This transit towards the formal dimension allows the combination of methods and supports the study hypothesis.

Results

The study hypotheses were: In the first stage of therapy (sessions 1 to 10): (a) "a negative association between the SN [Super-Ordered Nodes] trend and the duration of the [...] reactive i-moments" (Gennaro et al., 2011, p. 108); (b) no association "between the SN's trend and the elaborative i-moments" (op. cit., p. 108). In the second stage of therapy (sessions 11 to 15); (c) a positive association between the SN and the elaborative IMs [Innovative Moments]; (d) the same negative association between the SN and the reactive i-moments.

Firstly, it is important to note that the results generated with the DFA support the U-shape in the evolution of Super-Ordered-Nodes (SN) in this

successful therapy. In this context, the aforementioned hypothesis could be tested. The results obtained with IMCS reveal that reactive IMs (their duration) show an inverse U-shape, while elaborative IMs increase only in the second stage of therapy. Furthermore, SNs have a negative correlation with reactive IMs during both stages of therapy, and a positive correlation with elaborative IMs only in the second stage. These results support the main hypothesis of the study. In other words, they show that both methods are capable of "drawing" the trajectory of this therapy, and are consistent with respect to each other.

In conceptual terms, the authors conclude that the "weakening of the initial patient's assumptions have created the room for the emergence of innovative meanings challenging the dominant narrative [...]. After and thanks to this first phase, that has lasted two thirds of the therapy, Lisa has had the opportunities to elaborate new super-ordered meanings" (op. cit., pp. 113–114). This causal interpretation may be disputable, especially considering that it is a single case. Another debatable point is the implicit assumption that, if something is deconstructed, something better will be constructed in its place. At this point, it is worth focusing on the lower portion of the U-shape, since what is constructed afterwards depends on what has happened there.

Conclusions

The results are relevant in many ways: a) they have methodological value, as they "cross validate" two different analysis techniques; b) they show the evolution of the therapeutic process; c) they provide an in-depth analysis of the changes of meaning in therapeutic dialog. Regarding their contribution to the understanding of therapeutic change, in terms of the notion of motion and time, especially DFA makes it possible to "draw" this temporality, mapping the paths that crisscross it. The contribution of the system lies in mapping such flows and movements. What is complex is to make sense of these flows, of this transit. This is attempted through IMCS in

the article, with the objective of adding "narrative meat" to the forms and functioning of the dialog.

In spite of these undeniable contributions, two aspects deserve a more critical discussion, since they allow for points of view different from those of the authors.

The first one, already mentioned in our comment about the study results, refers to how dynamics are understood in comparison with contents, and how both dimensions are connected. According to the authors, "findings highlight the association between the formal and functional characteristics of the clinical dialogue and the content of the narrative" (op. cit., p. 90). The problem is that, if we consider the methodological procedure of DFA in detail, it becomes clear that the method is based on the contents of therapeutic discourse. Therefore, both methods are –to some extent– based on the contents of clinical dialog. Why the association between contents –which is the specific contribution of DFA– should be conceptualized as "formal and functional characteristics of the clinical dialogue" or (only) as dynamics is not self-evident, although the reason may be that, in DFA, contents are not used as representations but as signs. Semantic contents are only relevant for DFA as they warrant the use of a computer mechanism to group them, but this grouping loses all its referential meaning due to the deconstruction of the patient's discourse that the method entails.

Regarding the relationship between dynamics and content, the authors hold that their results describe the dynamics of sense-making sustaining the psychotherapy process provided by DFA and the contents of the narrative that such dynamics produce. Can dynamics and content be separated? (Especially considering that the method that focuses on dynamics is supported by contents); is not this tantamount to separating dancing from the dancer? (Orlinsky, 2007). To pursue the metaphor: the dynamics of therapeutic dialog do not "cause" contents, just as dancing does not "cause" the dancer. The separation of the two dimensions has mainly methodological aims, and is the most artificial part of the method.

Finally, the authors explicitly intend for their results to have clinical relevance. The question is whether the I-Moments methodology is enough to establish this clinical relevance. In other words, the authors assume that Innovative Moments are equivalent to "clinical value," and therefore, that the connection between the methods can be regarded as a "clinical validation" of sorts that IMs grant to DFA. Needless to say, both methods (like all methods) have a certain degree of artificialness, and thus lack an immediate connection with the clinical dimension; however –and we agree with the authors concerning this point– IMs are qualitatively closer than DFA to the meanings that the actors intend to transmit through their discourse.

On the other hand, regardless of the abstractness of DFA results or I-Moments categorization, they can have clinical relevance because they represent therapy evolution models. So, it can be relevant for every psychotherapist to know that the first phase of the therapy must accomplish the permeability of super-ordered meanings, to then assist the patient in constructing new meanings which are more functional to his/her psychological wellbeing.

In contrast, a researcher will find it interesting to discover the formal structure of psychotherapeutic change trajectories, and check whether it repeats itself across different therapy types, or if it changes depending on the success of the therapy. The contribution of the methods in this regard is to provide evidence that the dynamics and flow of dialog are not random or spontaneous, but that they are a construction of meaning which is shaped over time. Although these paths may seem emergent and chaotic, they can attain a novelty of meaning through analysis. Some questions that the researchers can explore in the future: Despite novelty and emergence, are there any paths that repeat themselves in all psychotherapies? Are there any similar trajectories beyond individual novelty? Does the therapeutic process follow similar lines over time? Ideally, the results that emerge from these studies will also nourish clinical practice, if they manage to be translated into a clinically meaningful language.

Thus, we must ask ourselves about the level (in the theoretical-practical dimension) to which these results should be taken for them to be truly useful for clinicians. A new step in this direction could be to link the trajectories of change with therapeutic work, so that clinicians may also obtain information about how the initial phase is "deconstructed" and how the final one is "constructed." For example: Is the interpretation of resistance at the beginning of the therapy useful as a way to force the "deconstruction" of old patterns? Or, are the therapist's actions unimportant because the initial Super-Ordered Nodes are fed by the patient him/herself?

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The Psychotherapy Process Q-set from the perspective of the Italian research in psychotherapy: Commentary on a Paper by J. Stuart Ablon, Raymond A. Levy, and Lotte Smith-Hansen

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Abstract

In their review, Ablon, Levy, and Smith-Hansen (2011) showed that the Psychotherapy Process Q-set (PQS; Jones, 2000) has been applied to a large range of studies with different methods and aims, from Randomized Control Trials (RCT) to naturalistic studies and single-case designs. Focusing on our colleagues' work, we will highlight the contribution of the PQS to research in psychotherapy, not only in process-outcome studies, but also into the therapeutic action debates, the specific *vs* common factors discussion, and the insight *vs* relation dialect. According to our studies, PQS has played the most relevant and innovative role in psychoanalysis. Ablon et al. showed how Jones left the clinical inheritance of his empirical method. One of PQS's strengths deals with the Q-sort methodology (Block, 1961; Stephenson, 1953) that enables both an empirical study of human subjectivity (McKnown & Thomas, 1988) and the application of rigorous data analysis for single-case designs, such as the P-technique and time series analysis. PQS, as colleagues have shown, is useful in single-case designs that, despite their limitations in the generalization of the findings (Kazdin, 2002), capture the richness and complexity of the clinical dialogue and describe the uniqueness of the patient and therapist dyad and interaction structures.

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The comprehensive and detailed review with which Ablon, Levy, and Smith-Hansen (2011) described the PQS studies in the past 25 years demonstrates its widespread applicability and usefulness for a large range of process studies in psychotherapy.

Jones is regarded as a pioneer of the "fourth generation," as Wallerstein (2002) defined the researchers in psychotherapy who began to satisfy the requirements for submitting psychotherapy to empirical validation, focusing on process-outcome studies, "practiced as usual," and applying advanced tools to sample of transcripts or whole sessions (Lingiardi & Dazzi, 2008). The "dodo bird verdict" decreed the so-called "equivalence paradox" in psychotherapy (Luborsky, Singer, & Luborsky, 1975), according to which only common therapeutic factors promote the process of change; this paradox involves an important fault: It ignores that many technical and specific factors can predict the change. As Ablon et al. (2011) showed, the pantheoretical orientation of the *Psychotherapy Process Q-set* (PQS; Jones, 2000) enabled Jones to validate the hypothesis that "key processes" operate in treatment within different theoretical orientations; it also allowed researchers to indagate "what works for whom?" (Roth & Fonagy, 2004). Jones recognized specific factors would not be very informative about "how" patients really improve. Comparing different schools of psychotherapy and studying the adherence to prototypical treatment (Ablon & Jones, 1998, 1999, 2002, 2005; Ablon, Levy, & Katzenstein, 2006) called into question the uniformity myth of patients (Kiesler, 1966) and underlined the importance of "tailoring" (Horwitz, Gabbard, & Allen, 1996): Beyond theoretical orientations, what happens in clinical practice concerns much more than the patient's characteristics.

Hence, Jones went over the rigidity of the specific *vs* non-specific dualism, outlining the role of each dyad of "interaction structures" and "specific processes" that Ablon et al. (2011) defined as "unique, ideographic and idiosyncratic" (p. 15). We agree with colleagues that any attempts in specifying a treatment process ideally conducted appear necessarily superficial and reductive.

Focusing on Ablon et al.'s (2011) review, we will point out some PQS characteristics in order to demonstrate PQS's qualities, its versatility in studying treatment processes, and its clinical implications.

PQS structural and methodological characteristics

First, we want to comment on some PQS structural and methodological characteristics that enable its wide application in psychotherapy research and its clinical implications.

As already pointed out, PQS provides a pantheorical approach with a descriptive, transtheoretical and non-slang language that allows researchers to analyze transcripts with different theoretical orientations. Jones proposed a rigorous and empirical methodology, starting from a bottom-up approach (Westen, Novotny, & Thompson-Brenner, 2004) that suggests that theory would result from empirical and naturalistic observations of phenomena. As Ablon et al. (2011) described, PQS items are anchored in observable and objective, verbal and nonverbal markers. This structure improves the "clinical inference," allows "guided" clinical evaluation, and increases its validity and inter-raters' reliability, as different studies have demonstrated. The new manual revision by the Ablon and Levy research group (2009) clarifies some uncertain descriptions and operationalizations;[1] the electronic version facilitates and accelerates the scoring procedures. This rating procedure also increases the value of videotape coding, which facilitates a naturalistic observation of patient-therapist interactions and reduces biases from clinical inference.

Ablon et al. (2011) underlined the role of the entire hour as the unit of analysis, as a distinctive feature and methodological characteristic of PQS; indeed, it allows researchers to see "in vivo" what really happens in the patient-therapist interactions. Even if we believe in PQS validity in looking at a macro level of the treatment process and interactive and relational features, combining PQS coding with other mycroanalyitc measures could

[1] In the new version, item 1, for example, describes not only the verbal factors, but also the non-verbal expressions of emotions.

facilitate the observation of individual patient-therapist interactions during the global process. In this regard, the psychotherapy research literature suggests the importance and the utility of using synergistically macro or molar and micro or molecular levels of analysis (Heaton, Hill, & Edward, 1995) in order to describe therapeutic impasses and the way patients and therapists co-construct dyadicaly their relationship (The Boston Change Process Study Group, 2010). An Italian in progress study, for example, has combined PQS analysis with the Collaborative Interactions Scale (CIS; Colli & Lingiardi, 2009) in order to evaluate both the global features of the dyad interactions and, at a micro-level, therapeutic alliance ruptures and collaborative processes between patients and therapists during session (Colli, Trecca, & Lingiardi, 2008).

Focusing on Levi, Ablon, Ackerman, & Seybert (2008), Ablon et al. (2011) zeroed in on the limitations of some PQS items that have temporary and momentary characteristics in the clinical dialogue.[2] Also in this case, ratings of unique and clinically relevant segmentations or episodes could facilitate the identification of point and/or waving phenomena of the interaction; it can also remedy data loss, concerning events coded by problematic items.

Finally, although Ablon et al. (2011) do not refer directly to it, the most important and innovative PQS methodological characteristic concerns the Q-sort methodology (Block, 1961, 1978; Stephenson, 1953), which is regarded as one of the strengths of the Jones's instrument (Blatt, 2005; Fonagy, 2005; Hauser, 2005). The recovery of the Q-sort method has allowed the usefulness and applicability of PQS in process studies in the past 25 years. Q-sort has been "rediscovered" for measuring multiple psychological constructs as personality assessments (Shedler & Westen, 1998; Westen & Shedler; 1999; Westen, Shedler, & Lingiardi, 2003), attachment processes (Block & Kremen, 1996), identities and self-images (Hauser, Jacobson, Noam, & Powers, 1983), coping and defense processes (Haan, 1977; Vaillant,

[2] In the Case of Amalia X, colleagues underlined the difficulties in some items' coding, as Q11 (Sexual feelings and experiences are discussed), Q12 (Silences occur during the hour), Q42 (Patient rejects therapist's comments and observations), and Q58 (Patient did not examine thoughts, reactions, or motivations related to his or her role in creating or perpetuating problems).

1992), and peer and close relationships (Allen, Hauser, O'Connor, & Bell, 2002). Q-sort offers a rigorous technique for the study of human subjectivity while maintaining the integrity of individual expression within a specific context (Colli & Gazzillo, 2006; McKeown & Thomas, 1988). Q-sort methodology in psychological assessment (Block, 1961, 1978; Hauser, 2005; Stephenson, 1953) enables researchers/judges to integrate clinical complexity with measurable purposes, assuming a forced normal items distribution, as Ablon et al. (2011) described. This method not only reduces raters' biases and the influence of response style, it also lends itself to single-case design research, in which the subject's experience is assessed at different times across the therapy process. The method can also be used for dynamic factor analysis, comparing multiple subjects, in order to describe process causal, instead of only correlational analysis (Ablon & Jones, 1998, 1999, 2002, 2005; Block, 1961, 1978; McKnown & Thomas, 1988). PQS therefore represents an ideal approach to the single-case studies in which the same patient-therapist dyad is examined multiple times during the therapeutic process, as Ablon et al. (2011) described in the cases of Mr. A, Mrs. C, Ms. M and Amalia X (Albani, Blaser, Jacobs, Jones, Thomä, & Kächele, 2002; Jones, Ghannam, Nigg, & Dyer, 1993; Levy et al., 2008; Porcerelli, Dauphin, Ablon, Leitman, & Bambery, 2007). In other single-case designs, therapy processes from a specific treatment approach is compared with prototypes of ideal treatment, as in the cases of Beth and Maria (Katzenstein, 2007; Pole, Ablon, O´Connor, & Weiss, 2002). In these single-case studies, Ablon et al. (2011) show examples of different statistical analysis to PQS data: P-technique (Luborsky, 1953, 1995) is a version of repeated measures factor analysis to the patient-therapist dyad data in order to capture the interaction structures. Time series analysis (Gottman, 1981) is a technique for changing the evaluation along a time dimension. Abilities to measure "therapeutic processes" and unique and dyadic interaction structures involve multiple implications in clinical and therapeutic practices and in psychoanalysis research, where in the past

single-case studies were analyzed by anecdotal reports (Ablon, 2005; Kächele, Schachter, & Thöma, 2009; Levine, 1994; Lingiardi, 2006).

PQS among research and practice: the clinical heredity of an empirical method

Ablon et al. (2001) described the chronological and methodological evolution of PQS applications, taken into consideration the Randomized Control Trials (RCT) studies, for outcomes and processes and they investigated different treatment approaches and single-case studies to which they dedicated much more time, according to PQS's usefulness in this kind of research. Focusing on these research branches, we will comment on the relevant aspects, suggesting questions and propositions for future psychotherapy research.

Group process and outcome research

In the first part of review, Ablon et al. (2011) describe that Jones' belief at the beginning of his work with PQS was concerned with demonstrating that common or non-specific factors were not solely responsible for therapeutic change, but rather that distinct processes might operate differently in predicting outcomes depending on the patient and therapist characteristics, symptom severity, and phase of treatment. Hence, Jones' contribution arises from psychotherapy research requirements to formulate questions and responses about "therapeutic action" (Gabbard & Westen, 2003) as a detailed set of goals, strategies, and techniques operating in the therapist and patient interactions and promoting change. PQS is based on the assumption that there are no ideal or universal treatments. Otherwise, we might give credence to two implicit and doubtful premises: a) interpersonal processes have a fixed and context-independent meaning and b) different treatment outcomes depend only on the ideal and "universal" process.

While Ablon et al. (2011) described the chronological and empirical evolution of PQS research from RCT studies about treatment outcomes and processes by comparing therapy between different treatment orientations

and developing prototypes of ideal treatments for single-case studies, they also retraced implicitly the debate about “what works for whom” (Roth & Fonagy, 2004) and the demand of “tailored psychotherapy” (Horwitz et al., 1996), focusing both on the patient’s and therapist’s characteristics and interaction features.

In this regard, in the process-outcome studies, mentioned by Ablon et al. (2011), PQS applications established that psychodynamic treatment for depression (Ablon & Jones, 1998, 1999, 2002, 2005; Fonagy, 2006) and panic disorders (Ablon, Levy, & Katzenstein, 2006; Levy & Ablon, 2009; Kaztestein, Ablon, & Levy, 2009) are empirically supported. Also, the PQS application also facilitated a description of treatment processes of patients with PTSD – Post Traumatic Stress Disorder (Jones, Cumming, & Horowitz, 1988) and avoidant personality disorder (Porcerelli et al., 2007). To this end, our interest in future research is on developing prototypes for the treatment process of patients with different diagnoses and multiple types of controtransference (Tobin, 2006). We also hope to expand PQS process-outcome studies for patients with personality disorders, as Porcerelli et al. (2007) have already done.

Ablon et al. (2011) touched on studies about patients and therapist characteristics, particularly patients’ emotional experiences and expressions (Coombs, Coleman, & Jones, 2002) and reflective functioning (Karlsson & Kermott, 2006) associated with treatment outcomes and processes. All of these PQS studies, detailed by colleagues, have not only contributed to the “what works for whom” debate (Roth & Fonagy, 2004), but they have also noted the importance of treatment-specific/non-specific factors, positioning between Empirically Supported Treatment – EST *vs* Empirically Supported Relationship – ESR (Nathan & Gorman, 1998; Norcross, 2011).

As we have discussed, Jones and PQS went over the diatribe, highlighting what happens in the clinical practice: Findings from studies of adherence to ideal treatment processes allow talking about “empirically supported change processes” (Ablon & Jones, 1998, 2002; Ablon et al., 2006; Jones, Parke, & Pulos, 1992; Jones & Pulos, 1993), as specific “processes” affecting

treatment outcomes. As Ablon et al. (2011) pointed out, studies that look beyond brand-name therapy and analyze therapy transcripts are much more informative (Ablon & Jones, 1998, 2002). Studying treatments according to their brand names could be quite misleading. Wachtel (2010) noticed that PQS was not designed to detect the presence of the brand-name therapy "packages" that are the focus of the "EST" approach, but rather of very specific kinds of comments and behaviors operating in the actual process. As we know, beyond treatment brands and theoretical approaches, the "real" therapy process is much more different and heterogeneous, compared with an "ideal" prototype (Ablon & Jones, 1998, 2002; Ablon et al., 2006). As Westen (Westen et al., 2004) highlighted, EST limitations concern the adherence to manualized treatments and the uniformity myth of patients, as if we could use the same treatment protocol —i.e., a gold standard— across patients with different diagnoses and in several phases of treatment. Shedler (2010) underlined that the "active ingredients" of therapy are not necessarily those presumed by the theory or treatment model. For this reason, Randomized Control Trials (RCT) that evaluate a therapy as a "package" do not necessarily provide support for PQS's theoretical premises or the specific interventions that derive from them. At the same time, PQS did not indulge in ESR proposals, which proclaim relational factors and denigrate the influence of technical and specific treatment factors.

Starting from these assumptions, the future of psychotherapy research with PQS should focus on the active ingredients of the treatment process, combining, as we have already stated, micro and macro analyses as CIS (Colli & Lingiardi, 2009), as noted *Psychotherapy Relationship Questionnaire*–PRQ (Bradley, Heim, & Westen, 2005), *Countertransference Questionnaire*–CTQ (Betan, Heim, Zittel, & Westen, 2005), *Working Alliance Inventory*–WAI (Horvath & Greenberg, 1989), *Session Evaluation Questionnaire*–SEQ (Stiles, Gordon, & Lani, 2002).

It may be of great importance, for example, to deepen studies on therapeutic alliance and interaction structures, as shown by Price and Jones (1998). It might also be useful to study the association between

process features and good therapeutic alliances and vice versa, the negative quality of collaborative processes between patients and therapists during sessions. Our recent study (Lingiardi, Colli, Gentile, & Tanzilli, 2011) has examined specific and non-specific dimensions of the psychotherapy process, investigating the relationship between the therapeutic alliance, as measured by Working Alliance Inventory–Observer (Horvath & Greenberg, 1989) and depth of elaboration during session, coded with the *Depth Scale of Session Evaluation Questionnaire* (Stiles & Snow, 1984). The results are in line with findings by Price & Jones (1998), Coombs et al. (2002), and Karlsson & Kermott (2006).

Multi-method evaluations have the advantage of combining measures of multiple dimensions (therapeutic alliance, ruptures and repairs, transference and countertransference, therapist interventions, and defenses, etc.). The cross-checking of different treatments and dyadic process variables may be the main way to study outcomes and therapeutic relations.

PQS, single cases and clinical practices

In this review, Ablon et al. (2011) gives more time to single-case studies by highlighting that “PQS represents an ideal instrument for such research” (p. 26). We agree about the relevance of single-case studies, which provide an essential view of treatment not captured by group and aggregated data. The usefulness of single-case research designs, despite limitations in the generalization of the results, has been underlined by many researchers (Gottman, 1973; Jones, 1993a, Kächele et al., 2009; Kazdin, 2002; Lingiardi, 2006). The methodology of intensive single-case studies may capture the ideographic nature of the patient and therapist dyad and their specific interaction structures (Ablon & Jones, 2005; Jones & Windholz; 1990; Porcerelli et al., 2007). Single-case designs enable accurate descriptions of how changes happen over time and which ingredients are active in the therapeutic process (Albani et al., 2002; Jones et al., 1993; Katzenstein, 2007; Pole & Jones, 1998).

Combining Randomized Control Trials (RCT) and single-case studies, Jones and PQS have provided to psychotherapy research with an empirical and valid method with various clinical implications. They have also paved the way for innovative considerations on therapeutic action, insight *vs* relation dialectic, and interaction structures (Gabbard & Westen 2003).

The single-case design has been useful, in particular, for measuring the construct of "interaction structure" developed with a bottom-up approach, starting from multiple data coded with PQS on session transcripts. Although Ablon et al. (2011) did not underline this concept, their "interaction structure" allows us to go over the dialectic insight *vs* relation. PQS's applications to single cases, described by colleagues, demonstrates empirically that insights and relations cannot be separated. In the case of Mrs. C (Ablon & Jones, 2005), for example, the patient's psychological experience of self developed inside the relational context with the therapist, who tried continuously to understand the patient's mind through mutual interaction and acceptance of the patient's self-exploration.

There are no therapeutically ideal processes. Individual dyads of therapists and patients are characterized by repetitive interaction structures that represent both subjects' functioning. In the cases of Mr. A and Ms. M (Jones et al., 1993; Porcerelli et al., 2007), colleagues have shown the development and transformation of these structures in promoting therapeutic changes. The PQS's efforts in measuring empirically and effectively single-case dynamics and phenomena not only enhance research in psychotherapy, but they also positively contribute to the development of research in psychoanalysis based on anecdotal reports before Jones' studies (Kächele et al., 2009; Lingiardi, 2006). Jones widely wondered about the psychoanalytical need for experimental and quantitative studies using reliable and practice-oriented methodologies (Jones, 1993b). Research in psychoanalysis is only possible with rigorous instruments applied to the transcripts of sessions that capture the richness and complexity of therapeutic processes. The contributions of the PQS, as a robust instrument for single-case phenomena, to psychoanalysis research have been widely

appreciated (Fonagy, 2002; Kächele & Thöma, 2001; Leuzinger-Bohleber & Target, 2002; Roth, Fonagy 2004). Although colleagues have highlighted the pantheorical approach of PQS, the therapies they described are essentially psychoanalysis-oriented.

Finally, another important theoretical clue to Jones' approach concerns the application of PQS to "individual case formulation," according to patient characteristics and resources (Jones, 1998; Pole et al., 2002). Even if Ablon et al. (2011) did not focus on this aspect, Jones suggested an assessment approach that takes into account the patient's capabilities to collaborate with the therapist in order to plan the treatment (Jones, 2000). It assumes that both psychopathological characteristics and psychological resources may be assessed more broadly by using what occurs during the actual treatment process (Jones, 1998). Only after some sessions, according to the process information, can the therapist decide which treatment orientation might be reliable for a specific patient to promote a good outcome. This assessment approach, needing only a few sessions, has the advantage of linking patient evaluation and treatment. Focusing on the nature of the ongoing treatment is essential for a more comprehensive, effective, and fruitful assessment of the patient's psychological functioning. It should be also investigated with the application of single-case design, as an ideal methodological approach.

In the past 20 years, several research and clinical psychodynamic-oriented groups have tried to develop reliable, valid, and outcome-oriented instruments for diagnostic purposes. In fact, PQS is one of the selected tools by Wallerstein (2005), together with *Shedler-Westen Assessment Procedure–200* (SWAP-200; Westen, Shedler, & Lingiardi, 2003), the *Operationalized Psychodynamic Diagnosis* (OPD; OPD Task Force, 2001), and the *Karolinska Psychodynamic Profile* (KAPP; Weinryb, Rössel, & Asberg, 1991a, 1991b), and others, which created the Psychodynamic Diagnostic Manual (PDM; PDM Task Force, 2006, p. 75).

In our opinion, other future purposes in psychotherapy research might deal with the application of PQS to the definition of prototypical processes

for different personality diagnoses and to the analyses of initial phases of treatment and assessment processes in order to investigate interaction structures that characterize therapeutic processes and promote outcomes.

Conclusions

As we have pointed out, the review by Ablon et al. (2011) allows us to retrace the theoretical and empirical evolution of PQS and the main debate developments in the history of psychotherapy and psychoanalysis research: Randomized Control Trials (RCT) and single-case studies; EST and ESR; specific and common factors; therapeutic actions, and interaction structures.

The comprehensive and consecutive reviews about PQS studies, from RCT to single cases, demonstrate that group and single-case studies are both methodological strategies a researcher should know and use, according to actual research characteristics and needs (Lingiardi, 2006). As Kazdin (2002) stated, the variability and richness in clinical research has implications for the method to use. It is not always possible to apply an ideal methodology. Operationalization of clinical constructs is one of the most difficult aspects of research in psychotherapy. Jones, as prime mover, succeeded in beginning multiple works about rigorous and clinical practice-oriented instruments.

Beyond diatribes about specific *vs* non-specific factors and insight *vs* relation, the PQS answers the pluralism of therapeutic orientations with the theory of "therapeutic action" in order to capture what changes (goals of treatment) and which strategies promote changes (treatment techniques).

As Ablon et al. (2011) stated that we should not describe an individual process, but "therapeutic processes" or better "borrowed processes" (Ablon et al., 2011, p. 44). "None of this is surprising," according to Fonagy (2005), who commented, "What was remarkable was that such everyday clinical wisdom could be demonstrated in an empirical study. This is the magic of the PQS […] It taps the range of therapy techniques in a way directly relevant to one's work as a clinician" (p. 581).

As colleagues have stated, it is our hope that future research in psychotherapy, during its theoretical, methodological, and empirical evolution, will be conducted with open-minded perspectives as it is a bridge between practice and research.

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Supportive psychotherapy and defense mechanisms: A Comment on the case of Matilde

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The “Case of Matilde” provides us with an important example of how the in-depth study of a single psychotherapy case can shed light on concepts that lie at the very heart of the psychotherapy debate. The therapeutic relationship, patient defense mechanisms, and therapeutic technique are foundational elements of psychodynamic psychotherapy, understanding their interaction will help guide research and practice.

Although the case study enjoyed a central role in the early days of psychotherapy research, randomized controlled trials (RCTs) have replaced case studies as the “gold standard” of empirical psychotherapy research. Nonetheless, Di Riso, Colli, Chessa, Marogna, Condino, et al. (2011) offer a comprehensive analysis that allows readers to get a true sense of what transpires at the clinical level, without ignoring the need for reliable measurement of psychotherapeutic phenomenon.

The first issue of clinical relevance in this case is whether or not Matilde actually received strictly “supportive psychotherapy” during her treatment.

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Although the authors, using a Log-linear model, showed that supportive interventions were used more frequently in the first two phases of treatment, there is a spike in expressive interventions during the two middle phase of the therapy, questioning to what degree the treatment was strictly "supportive." Although some variability can be expected during the middle phase of therapy, the fact that the therapist used more interpretive interventions than supportive ones suggests that this may have been a "mixed" supportive/expressive treatment in the way Luborsky (1984) suggests. In fact, when there was a serious threat to the therapeutic alliance in middle phase of treatment (t3 & t4), the therapist opted to make more interpretations not less as would be expected from established supportive acumen.

Whether or not this new focus in the treatment was actually responsible for resolving the breakdown in the therapy is not clear from the case, but changes during the two middle phases may be either due to, or the result of this increase in interpretive interventions by the therapist or rather a correct "balance" of interpretative and supportive techniques when fundamental conflicts emerged in the middle of psychotherapy. The idea of balancing therapeutic interventions will be explored in greater detail in the next section of this article.

Winston, Winston, Samstag, and Muran (1993) suggest that sustained interpretation is necessary for defense mechanisms to change toward a more adaptive level of functioning in psychodynamic psychotherapy. However, in the case of Matilde we see that therapeutic interventions whose primary aim is not to uncover but rather to support, may play an important, and often overlooked role in the structure and change of a patient's defensive functioning. For example, supporting a patient's defenses is purported to strengthen them thereby increasing their use. However in this case, we see the exact opposite, namely defenses decrease at the end of therapy which is hard to make sense of theoretically and could potentially be due to several causes.

First, it is possible that the decrease in defense mechanisms witnessed in the case of Matilde is not actually due to the treatment and thus is a product of some other extra-therapeutic event or is the result of measurement error. Since only one DMRS rater was used in the study, it may possibly be the result of inconsistencies in the manner in which the psychotherapy transcripts were rated or rater bias.

Second, it is possible that, as mentioned above, the therapy was actually less “supportive” and more “expressive” than one would expect. As a result, defensiveness changed as expected through the course of therapy. Further evidence for this premise can be found in the fact that Matilde no longer needed to use a “consistent pattern of defenses” (p. 24) by the final timeframe of the treatment. However, and more problematic, is that mature defenses also decreased during this period. It is not clear why this would be the case. Although research has shown that patients who undergo psychodynamic treatment tend to employ less defenses overall (Perry & Henry, 2004), this does not apply to the mature category of defense mechanisms. In fact, mature defenses typically increase with successful treatment (Hersoug, Bogwald, & Høglend, 2005). This finding was also supported when a heterogeneous group of treatment was examined in psychiatric practice (Perry & Henry, 2004). Thus, the case leaves clinicians wondering what exactly happened that would explain this decrease in mature defenses seeing as the defense of self-observation was common at the onset of treatment and that overall, the patient seems to have experienced a positive outcome.

Finally, it is also conceivable that the decrease in defensiveness observed in the case of Matilde was the result of a resolution in central conflicts that signaled the need for the patient to employ a defense. If the therapeutic dyad was working on separation during the final timeframe, this defensive presentation could signal that Matilde is no longer bringing dynamically relevant material to the sessions. This is furthered corroborated by the fact that, as the authors point out “at the end of treatment, defensive

mechanisms are usually activated" (pp. 24-25), which did not occur with Matilde.

Using supportive interventions with defense mechanisms: What should clinicians do?

While usually not considered to be as important or curative as the interpretation, supportive techniques make up a large part of what dynamically oriented therapists do in session. They differ from interpretations in that supportive interventions do not confront or make mention of unconscious material. Instead, they aim to support clients' behaviour and generate practical solutions to problems. McWilliams (1994) proposes that when using supportive techniques the therapist interprets feelings and life stressors as opposed to interpreting defenses. McWiliams also indicates that this is especially true for patients who are more disturbed. This may, for example, require the therapist to have the patience to sit and listen to the patient's frustrations or tirades without jumping in to interpret defenses that arise during this process. This probably was not a major concern with Matilde since she did not employ a great deal of immature defenses in therapy. Additionally, supportive techniques such as these sometimes require the therapist to "collude" with the patient's distortions and resistances; however, it does not mean that the therapist agrees with patient's understanding of events.

In the case of Matilde, this would be mean that the therapist did not interfere with her intellectualized understanding of problems and would typically avoid making comments that highlight the lack of emotional meaning in Matilde's descriptions. When Matilde used immature defenses, she typically would rely on disavowal defenses like denial, rationalization, and projection. This presents a more challenging task for the therapist who must both side with the defense without reinforcing its use, as immature defenses are not usually associated with adaptive functioning in life. The therapist must strike a balance between supporting the use of the defense

while still pointing out to Matilde that she is engaging in a “process” to deal with her intrapsychic conflict.

The idea of combining supportive and interpretive interventions has been studied empirically by Despland, de Roten, Despars, Stigler, and Perry (2001). They proposed that “at each level of a patients’ defensive functioning there appears to be some specific range of more exploratory (interpretative) interventions that will be optimal to facilitate growth of the alliance” (p. 162). Although they stated that support alone was not enough in psychotherapy to form a strong alliance, the correct mixture of support and interpretation by therapists was considered necessary for an optimal therapeutic alliance. Despite the fact that Despland and colleagues were interested mostly in alliance, due to the strong link between alliance and outcome in psychotherapy research (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000), it is clear these findings also have implications for outcome as well. In that study, 12 patients seen in ultra-brief (four sessions) were assessed for alliance and defenses. Therapist interventions were also examined and then placed on a continuum from supportive to expressive (ESIL), with expressive techniques considered to be more interpretative than supportive techniques. Thus, the group used this notion to calculate a ratio between the average technique level (supportive versus expressive) and defense level, which was based on maturity level. The results indicated that adjustment scores in-session one predicted alliance scores at session three and four. This result was independent of differing defense scores initially. That is, patients who started off with lower defense scores were still able to form strong alliances when they were well adjusted.

Siefert, Hilsenroth, Weinberger, Blagys, and Ackerman (2006) echoed the sentiment of the Despland group years later when they also concluded that therapists did in fact adjust their supportive and interpretative techniques to patients’ defenses early on in Short-term Psychodynamic Psychotherapy (STPP). Siefert and colleagues found that overall defensive functioning predicted the use of both cognitive behavioral and psychodynamic interventions indicating that therapists are using patients’ defenses as a

guiding principle in this form of psychotherapy. However, they were not able to reproduce the results of Despland and colleagues (2001) with respect to defensive functioning and therapeutic alliance. Furthermore, Hersoug, Sexton, and Høglend (2002) confirmed this finding when they found that initial defensive functioning did not predict either alliance or outcome on its own.

In another study, Hersoug, Høglend, and Bogwald (2004) questioned the earlier notion by Despland and colleagues (2001), which assumed that therapist supportive and expressive interventions could be placed on a continuum and then compared to the defensive hierarchy. They concluded that what was assumed to be a "poor" adjustment ratio was correlated with a stronger alliance score in some cases. They also found that when support strategies were given to patients with more adaptive defense scores alliance tended to improve also. This is counterintuitive when we consider that support strategies match with the lower end of the defense continuum to form a more "well adjusted" dyad.

In the case of Matilde, this would mean that she would fall into a "poorly adjusted" category since she receives mostly supportive strategies but her defensive functioning is more in the mid-range. Hersoug and colleagues (2004) explain these discrepancies by suggesting that because Despland and colleagues (2001) studied an ultra-brief form of therapy, it was not necessarily comparable to their naturalistic design, which examined sessions seven and sixteen. None of the above mentioned studies used control groups or experimental manipulation and most used a naturalistic design. All of these factors limit the degree to which these studies can be readily compared because there are a number of factors that could theoretically account for the differences among them.

Hersoug and colleagues (2005), following their previous work, found that interpretations but not support strategies were associated with a decrease in maladaptive defenses over the course of therapy. This relationship was not replicated with respect to adaptive or mid-level defenses. Although adaptive defenses did increase in the sample, neither the use of support nor the use

of interpretive techniques explained the change. This could help us to understand why Matilde's mature defenses increase at the end of therapy. For example, Drapeau, de Roten, Beretta, Blake, Koerner, and Despland, (2008) studied ultra-brief psychodynamic psychotherapy using sequential analysis, and found that supportive interventions are typically used by therapists to "prepare" patients before making defense interpretations. They also indicated that there are predictable ways in which psychodynamic therapists structure and use therapeutic interventions.

As such, it appears that the relationship between defensive functioning at the beginning of therapy with the therapeutic alliance and outcome is dependent on the therapist's ability to understand and use defenses as part of treatment planning. For example, all of the above mentioned studies did not find a direct relationship between ODF and alliance, only the Despland and colleagues (2001) study found an effect when the concept of adjustment was added. Therefore, it seems that the relationship between defense, alliance, and therapeutic technique is determined at least in part by the therapist's ability to tailor the treatment to patient's characteristics but the role played by supportive interventions is still open for discussion.

Di Riso et al. (2011) have pushed the adjustment debate one step further by calculating the Interaction Adjustment Ratio (IAR), which refers to the ratio of expression level of intervention and the patient's defensive level and is an approach aimed at calculating adjustment in a moment-to-moment fashion in psychotherapy. Most previous studies lack this interactive component thereby ignoring the negotiation that transpires at the human level. An important future step would be to expand this methodology beyond a single case. In doing so, researchers could potentially develop a useful marker for identifying alliance ruptures in psychotherapy.

The authors work highlights the need to quantifiably capture the moment-to-moment aspects of therapeutic adjustment. This process must go beyond simply lining up one averaged variable with another over the course of entire treatments. Research by Petraglia, Perry, Janzen, and Olsen (2009) has also adopted a similar approach for measuring the accuracy of

defense interpretations. They found that when therapists interpreted patients' defenses in-session from the same DMRS level or higher, that it was associated with a significant increase in the maturity of the defenses used by the patient immediately following the interpretation. Work is currently underway to expand upon these results as only six cases of open-ended psychodynamic psychotherapy were used in that analysis.

Overall, Di Riso et al. (2011) show that the in-depth quantitative study of a single case is a valid and useful avenue of study for psychotherapy researchers. The strength lies in the considerable amount of data that was collected by the authors to give the reader a true sense of how multiple variables of interest change and interact over the course of treatment.

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Speaking about therapists...
Old questions and some answers derived from empirical evidence

Santo Di Nuovo[1]

Abstract

The paper presents a review of the therapist's role and characteristics with reference to issues regarding general and specific training, theoretical and personal background, the capacity to initiate and maintain therapeutic alliance, the setting, differences between 'novices' and 'experts', the need for the clinical psychologist to be an active researcher within his/her practice. The concept of 'responsibility' as effective integration of technical competencies and ethical values is outlined. Each of these issues is accompanied by a brief synthesis of the research evidence.

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Introduction

In clinical research, after an initial period where great attention was paid to the specific psychotherapist's role, the successive debate and related empirical studies focused on other factors, e.g. analysis of the therapeutic process and its relation to outcomes, according to the different theoretical and methodological models; the most suitable instruments and techniques for attaining the proposed goals. For a long time the figure of the psychotherapist was considered a "neglected variable" (Orlinsky & Rønnestad, 2005) in psychotherapy research.

However, in the light of the problems posed by the need for a more effectively organized training of therapists so that their engagement in health policies is designed not only to address clinical pathologies, it seems appropriate to renew debate regarding the figure of the therapist on the basis of recent evidence derived from empirical research.

This article will propose a synthesis through an overview of the literature, establishing a premise for a meta-analytic study on the main aspects of this complex topic and will discuss some major themes, offering for each one a brief synthesis of relevant evidence.

General vs specific training

How can a clinical psychologist become a therapist? How can psychotherapy be learned? The answers to these questions are discussed in some textbooks (Beitman & Dongmei, 2004; Bender & Messner, 2003; Cozolino, 2004); the Journal *Psychotherapy Research* dedicated a special issue, edited by Rønnestad & Ladany (2006), to specific psychotherapeutic training and its impact on therapeutic efficacy/efficiency.

The training of a mind which takes care of another mind must take into consideration the "reflexive function" and "awareness" implemented during professional training. But when and how can the management of the mind be trained in order to contrast or prevent pathology?

This issue is currently a subject of debate, especially in Italy, where research with contradictory results has been published (e.g., Bani,

Strepparava & Rezzonico, 2010). It seems there is general agreement that the training of a therapist should be based on a general clinical training, focusing on knowledge of all the clinical models and approaches; among these, one in particular will be further particularly trained and utilized in practice. What we mean by "clinical" intervention should be well-defined and obviously formulated on specific scientific criteria rather than on "mystical" or even "magical" alternative approaches, which was the situation for a long time, and which still has its advocates in certain areas of the profession and psychotherapeutic training.

Psychotherapy as a science is grounded on a series of interconnected hypotheses:

- the psychotherapy process is a mindful action, aimed at changing and preventing the pathological and maladaptive components of personality, with specific aims stemming both from the patient's own personal problems, and from the therapist's theoretical and methodological model;
- the aims defined are pursued in each model using specific techniques, the most suitable and economical in terms of the client's specific situation and context;
- change has to be produced inherent to a relation between 'subjects' (therapist, client), whose specific dimensions can be evaluated and should be comprehensible in both theoretical and factual terms.

However, in this field the scientific approach finds persistent resistance, deriving from the assumption that therapy is a complex multi-determined system which leaves no possibility for mechanic causal deductions or predictions. As a result, quantitative analysis of linear relationships among observed data would be misleading and reductive. Surely, many years of empirical research in clinical psychology have demonstrated that the space allocated for this kind of research is not defined either by deterministic forecasting nor by a purely quantitative logic (for a synthesis on these issues: Wampold, 2001). Even if therapeutic work by its very nature is a very

complex discipline, its regularities can be inferred through the systematic study of the indicators representing its core aspects, permitting a formulation of the sense of unease that therapy aims to "deconstruct" and of the well-being it wants to "reconstruct."

The specific training of the therapist, in postgraduate courses of specialization, necessarily follows a basic training to acquire –during the degree course– the necessary competencies in wide-range clinical work and in related clinical scientific research.

The theoretical background: single or 'blended'?

A direct consequence of the previous discussion on proper training becomes a dilemma if the theoretical model each therapist follows must remain fixed, i.e. the same in every occasion, or if it should vary according to the requirements of the client or the context. For example, will the therapist use the same model both in his/her own private and public practice, e.g., when it has to be applied in juridical or penitentiary contexts? Or will he/she be able to integrate the basic model with approaches and techniques derived from other models more suitable for these contexts?

In other words, the problem to solve is whether the model which influenced the therapist in training and of which he is an expert can always be strictly applied or rather if the model can be modified when needed, by implementing the so-called "integrated therapy." In this perspective, it is needed to avoid the risk that this integration will become an ineffectual mixture of methods and techniques assembled without scientific rigor, but only based on (possibly faulty) personal intuition that may cause great confusion and useless procedures.

According to Castonguay, Boswell, Constantino, Goldfried, & Hill (2010), very few formal training programs or guidelines exist with the premise of systematically guiding clinicians to develop a competent integrative practice. Despite this, a recent web-based survey involving about 2000 therapists (Cook, Biyanova, Elhai, Schnurr, & Coyne, 2010) showed that the majority of them use a "mix" of at least two different models and practice a therapy

defined as *eclectic*. The methodological integration mainly concerns techniques oriented to the relation whereas are the integrations of biofeedback, neurofeedback, body therapies, hypnotherapies with more traditional treatments are less frequent. Similar results were obtained in a survey conducted in the United States, demonstrating that almost all the interviewees endorsed techniques quite different from those typical of their respective orientations (Thoma & Cecero, 2009).

Flexibility, including a change of model, and theoretical and methodological perspectives, is an essential function of an efficient therapist. At the same time, however, these changes or integrations have to follow strictly scientifically based criteria and not casual or subjective fluctuations (Goldfried, 2001; Orlinsky & Rønnestad, 2005). Very significant in this sense is the role of training and supervision (Boswell, Nelson, Nordberg, McAleavey, & Castonguay, 2010; Farber & Kaslow, 2010). These are issues that will be examined in the following sections.

In a recent article, Buckman & Barker (2010) discussed whether the preference shown toward a certain therapeutic approach compared with an alternative showed factors mainly related to personality or training previously received. They showed that psychodynamic therapists are more influenced by specific training while cognitive-behavioral therapists are influenced by personality traits, and systemic therapists by both factors. Other authors (Topolinski & Hertel, 2007) found differences linked to the temporal distribution of the training process: at the beginning the training variables are more important for the therapeutic approach in practice, whereas personality factors have more influence on the subsequent phases, e.g. the orientation toward insight is influenced by intuition, openness to experience and need for cognitive "closure." The congruence between personality and therapeutic approach also influences the degree of therapist work satisfaction.

The personal cognitive and emotional style of the therapist has a positive impact on the outcome of the therapy based not only on theoretical and technical expertise, but also on flexibility in taking into account the patient's

specific needs, disturbances, and the particular contextual variables (Castañeiras, García, Lo Bianco, & Fernández-Alvarez, 2006).

The therapist's personal background

Personality factors, aptitudes, cognitive and emotional style, personal constructs, interpersonal sensitivity, relational competencies, ability to work in a team or network, ability to manage impasses and errors, and to learn from experience, are the main variables involved in giving greater support to the expertise of a therapist. The nature of the therapist's professional development, adopting different approaches including the correlates and the personal and contextual determinants perceived as relevant, have been extensively studied in different countries and cultures in a multicentric study conducted by Orlinsky & *SPR Collaborative Research Network* (1999).

Wampold (2001) outlined that the individual differences among therapists, and their particular ways of establishing their personal identity, are the main factors in explaining the variability of therapeutic results. The therapist's personal factors affecting his/her daily work have been studied by various authors (e.g., Anastasopoulos & Papanicolaou, 2004; Beutler, Crago, Arizmendi, 1986; Hill, 2006; Okiishi, Lambert, Eggett, Nielsen, Dayton, & Vermeersch, 2006). Caspar (1997) underlined the need to make a deeper study of the thinking processes that motivate the therapist to formulate hypotheses about the patient and the therapeutic program. A recent issue of the Journal *Psychotherapy: Theory, Research & Practice* was devoted to the different social status of the therapist, e.g. racial and ethnic factors, that can influence the work especially with patients belonging to different ethnic groups, as ever more frequently occurs in practice (Gelso, 2010).

Other studies focused on how the therapist must take great care of himself to maintain the personal well-being necessary to flourish in a difficult and emotionally draining "helping" profession (Baker, 2003).

An old but still topical question is whether, in order to control all these factors, the psychotherapist's training has to include personal therapy,

differing from the usual supervision process.

Geller, Norcross & Orlinsky (2005) confirmed that personal therapy (that 70% of therapists admit having undertaken) is extremely useful for maintaining the therapist's personal sense of well-being while also promoting the enhancement of the client-therapist relationship. According to Daw & Joseph's (2007) data, two thirds of the therapists did personal therapy, the motivation being to encourage personal growth and the need to control stress. In 1987, a national survey in the United States examined how therapists chose their own therapist; the study, repeated after a 20-year interval, confirmed that the theoretical orientations most frequently chosen are integrative, eclectic, cognitive, and psychodynamic, more rarely behavioral or systemic; the choice is based mainly on traits of competence, warmth, experience, openness and good reputation (Norcross, Bike, & Evans, 2009).

But, even if not all approaches consider it always necessary to carry out psychological "work" on oneself, no one can doubt the essential centrality of the supervision process, i.e. the monitoring, with external support, not only of the techniques adopted but also of emotional reactions and relations (Ogden, 2005; Strozier, Kivlighan, & Thoreson, 1993). While Falender and Shafranske (2004) underline the importance of an approach to supervision based on competencies, other authors point out the need to work through the perceptions of the experiences, including those linked to an emotional transferernce (Fink, 2007), and others emphasize the managing of the critical events occurring in the supervision itself (Ladany, Friedlander, & Nelson, 2005).

Different studies have examined the factors that determine how well the supervision intervention works (Ladany, 2004; Wheeler & Richards, 2007). Results demonstrate that meaningful self-disclosure, and attention to the supervisory working alliance, promote efficacy, while lack of adequate feedback and excessive directivity diminish its utility. The importance of supervision is stressed by therapists dealing with extended numbers of patients, by those in training, and by women (Grant & Schofield, 2007).

Group supervision and peer confrontation, including Balint groups, have been adopted successfully over a long period of time (Benshoff, 1992; Rabin, Maoz, & Elata-Alster, 1999; Robiner & Schofield, 1990).

Whether the therapist opts for his/her own psychotherapy, or for the constant support of a supervisor, in the training of a helping professional personal enrichment is necessary for the best use of one's technical abilities. The deontological norms suggest retaining permanent and updated professional training, referring to the enrichment not only in scientific knowledge, but also in the growth of the professional as an individual (Giusti & Pastore, 1998). This personal growth is the core of the therapist's professional development (Orlinsky & Rønnestad, 2005) and may be the antidote against possible psychological breakdowns due to the persistent stress inherent to working with pathologies. This stress is due to emotional involvement in the client's problems, typical of the helping professions but particularly relevant in psychotherapy, in conditions leading sometimes to potential burnout (Baker, 2003; Mahoney, 1997; Raquepaw & Miller, 1989).

We have to remember that among the helping functions of the therapist, one is to "hold back" the client's problems, supporting and reassuring him/her at the appropriate emotional level. Another concurrent function is to "perturb" a psychological system which is often rigidly balanced, consequently managing the reactions. Responding to these reactions and to their internal resonances, the therapist who aims to represent a secure base for the patient risks losing his/her own basis of safety.

Metacognitive and interpersonal competencies –acquired also during the training process and supervision– help the therapist to express and accept feelings and emotions, to solve the problems posed within the therapeutic relation, while increasing its therapeutic value (Hill & Knox, 2009): this is a core theme in the therapeutic process, brought into focus in the next paragraph.

Several labels for the "Holy Alliance"

What happens within the psychotherapeutic process, i.e. between the therapist and the client (single, couple, family, group), has come to be conceptualized in different ways over time and subject to differing therapeutic approaches (Horvath, 2005).

The concept of *self-disclosure* of the therapist has been considered important for establishing an effective relationship, since it produces a corresponding disclosure on the part of the client (Barry, 2006; Roncari, 2001). According to Bottrill, Pistrang, Barker, and Worrell (2010), the therapist's tendency to disclosure is linked with his/her training and with the "philosophy of therapy," and it has become a means to define the professional's personal identity.

Psychoanalysis has proposed the constructs of *transference* and *counter-transference* to define the affective and emotional dynamics involved in the relationship as grounding factors and sources of change, and many studies have addressed these constructs (Eagle, 2000; Hayes, 2004; Levine, 1997; Murdin, 2009; Wiener, 2009; Zetzel, 1956).

Pessier and Stuart (2000) suggested a new method to investigate therapist and patient transference: A characteristic pattern of lags may be hypothesized between the transference interpretations and their therapeutic effects. The authors, in three consecutive sessions taken from each of three different psychodynamic therapies, studied the effects of the patient's answers to the transferral interpretations considered as relational episodes. They found that often the transference work appeared to have an initial inhibitory effect, but facilitated progress over the course of the entire session.

With regard to counter-transference, Normandin and Bouchard (1999) proposed an integrated approach comparing three models of counter-transferral activities: objective-rational, reactive, and reflexive (i.e., a conscious attitude with an interpretive function). The psychologists following a humanistic and psychodynamic approach prove to be more reflexive, while behavioral therapists adopted more frequently an objective-rational attitude.

Other authors introduced the concept of *empathy* as an a-specific factor in terms of the techniques, determining positive progress in the therapy (Bolognini, 2002; Morandi, 2002; Patterson, 1983). Empathy is defined as a sudden and spontaneous exchange of meanings (Gandino, 2003) and, in neuroscientific terms, as a capacity to understand the affective and emotional states of another person through the activation of a neuronal architecture producing these states, even if other factors intervene, like the capacity to monitor cognitive and emotional processes useful to prevent confusion between self and others (Decety & Jackson, 2006). Empathy was associated with *emotional reciprocity*, but a clear distinction between the two constructs is needed in the complex cognitive systems approach (Reda, 1986).

The aspect of communication and interaction crucial for the psychotherapeutic process and for determining beneficial outcomes is called *cooperative bond*. But how does this cooperation occur?

An essential contribution to the definition of the relational bond produced by the therapy, based on models of pre-existing bonds renewed or reconstructed within the sessions, was offered by the *attachment* theory (e.g., Bowlby, 1988; Cassidy & Shaver, 2008; Wallin, 2007; moreover, Oppenheim & Goldsmith, 2007, Obegi & Berant, 2009, respectively for child and adult therapies). Dozier and Bates (2004) defined attachment as a “state of mind” influencing the therapeutic relation. Saypol and Farber (2010) connected the styles of attachment with the client’s capacity of disclosure, and found a negative relationship between the unpleasant feelings associated with the disclosure and the “secure” style of attachment, whereas the opposite occurred in the “anxious” attachment style.

The Journal *Psychotherapy Research* devoted a monographic issue to the therapeutic relationship, edited by Hill and Hentschel (2005). Hill and Knox (2009) reviewed the relevant literature, concluding –based on empirical evidence– that if therapists and clients are able to directly analyze their relationship and the problems occurring inside its confines (including “here and now” feelings about each other), the expression and acceptation of

feelings is easier, the bond is reinforced, and the patient will transfer the learned abilities to other relations outside of therapy.

To study how the therapeutic relationship is improved by communication, Lepper and Mergenthaler (2007) analyzed the transcripts from all eight sessions of a successful brief psychodynamic psychotherapy by means of conversation analysis, observing the turn-by-turn analysis of the talk in combination with a computerized text analysis following the therapeutic cycles model locating clinically significant events. The data showed that the coherence of sequences in the communication enhances the bond and is significantly related to the productive process of the therapy.

The possibility of critically analyzing what occurs within the therapeutic process is in turn connected to *relational meta-cognition*, i.e. the capacity (both of therapist and patient) to be thoughtful regarding the relationship itself; the *personal construct system* in Kelly's terms has been considered as the basis for the reciprocal understanding between therapist and client through the cognitivist and structuralist approaches (Bara, 2005; Chiari e Nuzzo, 1998). These processes have been explained more recently according to the *theory of mind* (e.g. Mundo, 2009).

The term most frequently used to define the "healing relational bond" is *therapeutic alliance*. It involves an agreement between therapist and client about the aims and the functions of the treatment, and implies a positive relation both in affective and interpersonal aspects (among the many studies on this issue: Gaston, 1990; Horvath, 2005; Horvath & Greenberg, 1994; Lingiardi, 2002; Meissner, 1996; Safran & Muran, 2000; Verga, Azzone, Vigano', & Freni, 1999).

Hatcher (1999) studied the alliance as perceived by the therapist, underlining that a collaboration termed "confident" (i.e., trust-based) shows high correlations with therapist's and patient's estimates of improvement, and therefore has to be considered a key element of the alliance construct.

Rubino, Barker, Roth, and Fearon (2000) demonstrated that the therapist's typical styles of attachment influence the manner in which he/she manages the breakdown phases, i.e. the negative changes in the

quality of alliance, analogous to what Kohut called “failure of empathy.” The more anxious therapist responds less empathically to the problems occurring in the critical moments; moreover, the patient’s style of attachment stimulates different answers from the therapist, according to his/her own attachment style.

In general, empirical evidence confirms a consistent correlation between alliance and a positive psychotherapeutic outcome (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Norcross, 2002): A positive alliance enhances the compliance to the treatment (Blackwell, 1997), and prevents early drop-out from therapy (Tryon & Kane, 1995). But this correlation, although consistent in several studies, is of moderate size, since it shows very high variability, depending on the different kind of therapy, patients and settings. Moreover, a relevant difference was often found between the individual perceptions of alliance from both therapist and patient (Horvath & Bedi, 2002). Even though several explanations have been hypothesized for this difference (e.g., Horvath & Luborsky, 1991), few of them are based on controlled studies. Surely this discrepancy in the perception of alliance could influence the negative outcome of therapy, and therefore should be taken into account in the monitoring of the therapeutic process.

Obviously, the alliance is even more complex when it is evaluated in group, couple, or family therapy, and/or when it involves a co-therapy (Hoffman, Gafni, & Laub, 1995; Roller & Nelson, 1991).

Considering the diversity in conceptualization and evaluation of the alliance, and consequently the great variety of assessment instruments (individual or joint self-report, participant observation, external evaluation), we can explain the variability and the discrepancies found in the cumulative analyses on the alliance (Lambert, 2003). After the alliance is carefully defined, a multi-modal and possibly multi-level evaluation –by the therapist and at the same time by the client and external observers– is needed to reliably study concordances and divergences among different models and contexts.

Setting: preferred vs forced?

The setting of psychotherapy, e.g. where the work takes place with a single client, group or family, in a private or public consulting room, is generally chosen by the therapist himself. But often the therapist is compelled to work in a setting not chosen but imposed, e.g. when clients are involuntary institutionalized, as in penitentiary contexts. The therapy with an abused child, or a detainee who attempted suicide in prison, have very different features compared with those the therapist is used (or trained) to treating.

Moreover, the therapist may be required to work with clients belonging to other cultures. This problem, which has long been present in other contexts, has also become important in Italy.

The setting may be connected with the client's motivation. It is well known that patients whose therapy has been solicited by third parties (families, criminal court, etc.) often do not share the motivations which prompted the referrals to the therapist in question and who then has to re-orient (i.e., manipulate) the client's needs or to modify the aims proposed by the sending party. At any rate, as suggested by Tjeltvet (1999), when third parties directly pay or indirectly fund the therapy, they tend to influence time contexts and aims of the treatment; the therapists treating unwilling clients, such as antisocial adolescents or convicted individuals or "designated patients" in a family system, know this problem well.

In these cases, the patient and the commissioning party may have a sharply contrasting view of the aims of the treatment, challenging the therapist's responsibility and professional ethics (see the concluding section). It is not sufficient to follow slogans like "client's motivation has to be enhanced" –i.e., to share the aims of the unwanted intervention– or "client's rights over all," contrasting the requests made by the party that sent the client. To manage these situations, specific therapist's attitudes and skills are required that should be trained in advance, along with the technical competencies.

Novices vs experts

Okiishi, Lambert, Eggett, Nielsen, Dayton, and Vermeersch (2006) have studied in a wide sample of therapists the incidence of expertise in determining the outcome of treatments, obtaining non significant results. The therapist's experience instead appears to influence the modalities of formulating the diagnosis, planning the subsequent therapeutic program (Eells & Lobart, 2003) and the capacity for "metabolizing" the case, using "theoretical and clinical knowledge in an intuitive, flexible manner that responds and adapts to the unique and complex context of the treatment" (Betan & Binder, 2010, p. 141).

Certainly, the experience helps the therapist to focus on the main patterns of dysfunctional relationships, i.e. the core elements that lead to a positive outcome of the treatment (Scognamiglio, Capelli, Fava, Taglietti, Conserva, & Schadee, 2006).

Moreover, Hickman, Arnkoff, Glass, and Schottenbauer (2009) have verified, in a sample of 24 therapists with an average of 32 years of experience, that expert therapists find it easier to integrate different techniques, incorporating new treatment methods into the main approach they already use.

Expertise plays an important role in the capacity of overcoming situations of impasse, and helps to cope with unwilling patients, less motivated to the treatment. But experience can play a negative role when it leads to pre-judicial evaluations based on schemas that were previously functional, but are not correct in the present case. By paradox, the novice who has less stabilized schemas derived from experience shows a more open attitude in discovering what the case at hand allows to emerge, without overlapping his/her own conceptualizations.

Both novices and experts should maintain the *research attitude* which means, in the terms of "phenomenological mind" according to Gallagher and Zahavi (2008):

- not permitting pre-conceptual schemas, although useful in other cases or contexts, to influence the present evaluation;

- in contrast, finding what is original and particular in the case in question, planning the treatment on this basis;
- establishing the correct goals to verify the efficacy and efficiency of the treatment itself.

In a word, the therapist should be –in all senses– also a 'researcher'. This is the essential theme for the final point in this discussion.

Clinicians vs researchers

In an essay published many years ago, the Author, reviewing the possibilities of implementing in clinical practice psycho-social models based on empirical research, concluded that clinicians must not try to cross over into research which is not their area of expertise. According to this view, basic researchers and professionals should be in a productive, symbiotic relationship: researchers indicate the general models; clinicians apply them in the real world (Brehm, l976).

But the old separation between those who produce research and those who apply it, is widely contradicted by recent findings in the social sciences. Moreover, from a normative point of view, the law which in Italy regulates the psychology profession declares in its first article that experimentation and research are among the typical duties for professionals in psychology. The figure of the clinician who is also researcher is greatly needed; one who is able to integrate therapeutic work in an action-research perspective where the professional is directly engaged in monitoring and verifying the efficacy and efficiency of his/her own work. In this approach therapeutic work is grounded on both research and application; the figure of the professional-scientist is also necessary for progress of the therapy (Lane & Corrie, 2006).

At present the test of efficacy is considered a core issue for encouraging scientific debate in clinical psychology, since it both allows the monitoring of what occurs within the confines of therapy and favors exchange among psychotherapists from differing theoretical approaches, which also fosters their external visibility in the scientific community and in a wider social context.

Castonguay, Nelson, Boutselis, Chiswick, Damer, et al. (2010), analyzing a sample of psychotherapists who collaborated with researchers in designing and conducting a psychotherapy study within their own clinical practices, have reported benefits both at the scientific level and in efficacy of the therapy itself, identifying a number of strategies used by psychotherapist-researchers to address obstacles that they encountered. The time and effort required to integrate research protocol into routine clinical practice were rewarded by the useful information derived from research, which improved working relationships with clients, and gave rise to the idea that it would be useful for other psychotherapists to know about their scientific efforts. The experience is defined as a promising pathway for building a stronger link between practice and research.

In another interesting book on the “bridge” among research and real life, the work of 28 distinguished psychotherapy researchers was studied, showing how their research programs changed the way psychotherapy came to be practiced (Castonguay, Muran, Angus, Hayes, Ladany, & Anderson, 2010).

We should avoid limiting research on psychotherapy exclusively to academic researchers, who are used to laboratory procedures and inclined to consider the clinic as a kind of laboratory. Research opportunities should be extended to include a network of professional therapists who day by day attempt to “think through” and apply their research skills utilizing fundamental scientific aims and methods.

Technical vs ethical issues (as a conclusion)

In conclusion, we hypothesize that the common element in the various aspects of psychotherapeutic treatment, focusing attention on the therapist, could be the concept of *responsibility*, defined as:

- taking care of, and managing, the specific problems of the client and the relationship with the therapist (i.e., “alliance”), avoiding defensive closure, prejudicial evaluations or use of inappropriate techniques and manipulative “shortcuts” with

unwilling clients;

- applying in the most effective way the techniques learned in training, but with a willingness to integrate them –in a thoughtful and scientific way– with other strategies and techniques more suitable for the client's needs and/or given context, and ready to give up the assignment if the client and the context are not manageable with his/her integrated competencies;
- openness to communication and exchange with colleagues, including forms of regular supervision or peer confrontation;
- complete willingness to respond, for one's actions and their eventual consequences, to the scientific community (assessment and evaluation of efficacy and efficiency of the therapies) and to the professional deontological and juridical norms.

Assuming these responsibilities is essential for correct ethical behaviour by all professionals; in particular they must be the core values of those who use interpersonal relationships as therapeutic tools in clinical work. These aspects should be given a more significant part in the professional training programs than they are at the present time.

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