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The Topics of Psychotherapy Research: An Analysis Based on Keywords

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Abstract. A content analysis of the representative Journals in the field of psychotherapy research has been performed. The analysis focused on the articles' keywords. We analyzed 7,086 works published in 17 Journals, in the period 2005-2011, using a two-step multidimensional procedure. Firstly, a cluster analysis led to the extrapolation of 4 groups of keywords, each of them interpreted as the marker of a topic active within the literature. Secondly, a factorial analysis was carried out in order to picture the thematic orientation of the most representative Journals, namely the main topics they focus on and how they differ from each other in this respect.

Keywords: psychotherapy research, content analysis, key words, topics

Psychotherapy research is a dynamic, broad, and variegated area of investigation. Hundreds of works are produced yearly, spreading over a large range of subjects, foci of analysis, theoretical models and methodologies. Such heterogeneity makes it hard to form a comprehensive vision of the state of the art in this field (Manzo, 2010).

This paper intends to contribute to such a task. It provides a map of the main topics in the psychotherapy research area, the relation between them and their distribution among Journals. In so doing, our aim is twofold. On the one hand, our purpose is to provide an empirical analysis of the semantic context characterizing the current state of the field. On the other hand, our intention is to provide an empirical picture of the thematic orientation of the most representative Journals in the field, namely the main topics they focus on and how they differ from each other in this respect. More in particular, the analysis is oriented by the following three main questions:

a) Is the psychotherapy research a single field or does it appear to be a kind of "confederation" of separate areas of investigation having little, if any, overlap with each other?
b) However broad the field's inner differentiation is, how can it be interpreted: as a matter of thematic pluralism or as the result of deeper differentiation, concerning paradigmatic orientation, research goals and the like?
c) How is the research field's articulation represented by the Journals' orientation? Namely, do Journals tend to encompass the differentiations or do they tend to commit to specific sub-areas of the field?

It is worth highlighting the conceptual, methodological and practical interest of these questions. At the conceptual level, one has to consider that any topic is not a neutral fact; rather, it acquires meaning in terms of a particular theoretical framework (Salvatore, 2011). Consequently, the detection of themes of clinical research can tell much about the theoretical orientations that characterize the field. At the methodological level, this paper introduces, in the field of psychotherapy research, a quantitative method of content analysis widely used in various domains of investigation (i.e., social and behavioral sciences, technology, engineering), due to its efficiency in detecting the structure and dynamics of scientific production (Callon, Law, & Rip, 1986; He, 1999; Nederhof & van Wijk, 1997; Rotto & Morgan, 1997). At the practical level, the map of the journals' thematic orientation provides an informative picture which may be of use to scholars when deciding to submit papers.

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Table 1. Journals in analysis and number of articles retrieved for each year

Journals	Classification	2005	2006	2007	2008	2009	2010	2011
Annual Review of Clinical Psychology	Transversal	24	19	17	16	20	25	20
Behavior Therapy	Specialized	41	39	36	38	38	52	67
Behavioral Research Therapy	Specialized	117	139	268	131	154	162	122
Behavioural and Cognitive Psychotherapy	Specialized	44	47	58	69	47	47	47
British Journal of Clinical Psychology	Transversal	47	45	41	33	33	37	33
Clinical Psychology and Psychotherapy	Transversal	42	39	46	40	42	49	52
Clinical Psychology Review	Transversal	52	60	59	95	61	84	107
Clinical Psychology: Science and Practice	Transversal	56	52	47	43	50	39	41
Cognitive Therapy Research	Specialized	46	52	58	59	67	58	63
Family Process	Specialized	34	35	46	38	41	38	39
International Journal Group Psychotherapy	Specialized	35	33	37	30	35	34	45
Journal of Clinical Psychology	Transversal	136	122	101	102	104	95	110
Journal of Consulting and Clinical Psychology	Transversal	126	119	103	106	106	92	87
Psychoanalytic Psychology	Specialized	43	56	63	47	30	31	31
Psychology and Psychotherapy: Theory, Research and Practice	Transversal	33	43	43	31	32	30	32
Psychotherapy	Transversal	49	50	52	44	48	57	52
Psychotherapy Research	Transversal	45	58	68	68	68	65	56

Method

Sample

The analysis adopted a cluster sampling. A sample of 17 Journals (Table 1) taken to be representative of the whole area of investigation were selected. Articles published in such Journals in the period 2005-2011 were selected. We considered this period wide enough in order to provide a reliable picture of the main topics characterizing the current state of the field. Commentaries, brief notes, and book reviewers were not included.

Journals were selected in accordance with the following procedure. First, we assumed as our universe the 104 Journals indexed in the subject category "Clinical Psychology" of the 2010 Journal of Citation Indexes. Second, the four authors of the current paper classified these Journals into three categories: transversal, specialized and not relevant. A Journal was considered *transversal* if: a) It publishes articles of interest for psychotherapy research; b) Such articles are framed in different theoretical orientations. A Journal was classified *specialized* if: a) It publishes articles of interest for psychotherapy research; b) Such articles are framed within a specific theoretical-clinical orientation/approach (e.g., cognitive therapy, psychoanalysis, group Therapy, etc.). Journals that are listed within the subject category "Clinical Psychology", yet without having psychotherapy research among their aims were considered non relevant (e.g., Neuropsychology). Third, we selected the 10 transversal Journals, with the highest 2010 Impact Factor[1]. Finally, we integrated this list with specialized Journals, limiting the selection to those having an Impact Factor higher than the median of the subject category. Thus, 7 Journals were selected: 4 with a cognitive-behavioural orientation, 1 focusing on family therapy, 1 with a psychoanalytic orientation and 1 focusing on group therapy[2].

As a result of the procedure of sampling described above, 7,086 articles were collected. Table 1 shows the Journals under analysis and the distribution of the articles through them.

The analysis focused on the keywords indexing articles. Both keywords defined by authors and independently by SCOPUS were retrieved. A set of 5,516 keywords was composed, corresponding to 174,335 occurrences (token/type ratio: 31.6; about 0.77 types for article, corresponding to more than 24 keywords token for article).

[1] We are aware of the current political, cultural and social debate about strengths and limitations of the Impact Factor (*inter alia*: Hirsch, 2007; Jarvey, Usher, & McElroy, 2012). On the other hand, so far the Impact Factor has been widely used, especially as an index for ranking Journals. Moreover, our use of the Impact Factor has been moderated by a qualitative criterion (i.e., the inclusion of specialized Journals).

[2] The classification was carried out according to the following procedure. First, each judge classified Journals independently. In order to attribute a Journal to a category the agreement of at least three out of four judges was required. In the (few) cases in which independent classifications presented a lower level of convergence, agreement was reached through discussion.

We assumed keywords were a reliable index of the article's thematic content. Even if some authors warn about such faith, the use of keywords as a synthetic way of indexing the content of scientific production is widespread (for a discussion on the point, see Whittaker, 1989). Moreover, while it may raise some criticism when adopted for the sake of specific tasks of data retrieval (e.g., for selecting specific articles), it is worth considering less problematic when, as here, it is used to define a global picture of the whole literature. On the other hand, the choice of integrating the keywords proposed by authors with the ones provided by SCOPUS according to a systematic computational procedure, should further limit the risks of unreliability.

Data Analysis

In order to reduce the data matrix's dispersion, only the most frequent keywords were retained for the following analysis. To this end, we limit analysis to keywords corresponding to more than 50% of the whole occurrences. In so doing, we restricted the analysis to 108 keywords (corresponding to 88,801 occurrences).

The analysis was performed through a two-step procedure.

First, in order to identify patterns of co-occurring keyword, a cluster analysis (CA) was carried out. CA was applied on the data matrix having the 108 keywords as rows and the 17 Journals as columns; each *ij-th* cell reported the relative frequency of the *i-th* keyword in the *j-th* Journal. CA led to group keywords in sets of maximum inner homogeneity and maximum outer divergence. Each cluster may thus be interpreted as identifying one specific topic, as it is depicted by a particular aggregation of co-occurring keywords.

Second, clusters of keywords extrapolated by the CA were used as criterion for detecting the relations among Journals. To this end, a factorial analysis (principal components method) was performed on the matrix Journals (rows) x clusters of keywords (columns), with the *ij-th* cell showing the relative frequency with which the *j-th* cluster occurred in the *i-th* Journal. Factors extracted were interpreted as semantic dimensions of similarity/dissimilarity, making the Journal's orientation among topics easier to establish.

Results

Cluster Analysis

The CA defined 8 clusters as optimal partition of the set of keywords. Yet, as an effect of the highly dispersive distribution of data (i.e., most of the cells reported 0 or very low score) this partition proved to have little significance: 6 clusters have less than 3% of keywords (cluster 1, 2, 3, 4, 5, 7), one cluster (cluster 6) about 11%, and one cluster (cluster 8) about 82%. Therefore, we performed a second CA on the keywords grouped in cluster 8. The second CA broke cluster 8 down into 3 sub-clusters (Figure 1). Thus, as result of the combination of the two CAs, we considered a partition of 4 clusters of keywords, classifying about 93% of the original set of keywords: cluster 6, cluster 8a, 8b, and 8c (Table 2). Each cluster was interpreted as a topic and labelled according to the meaning of the most representative keywords composing it.

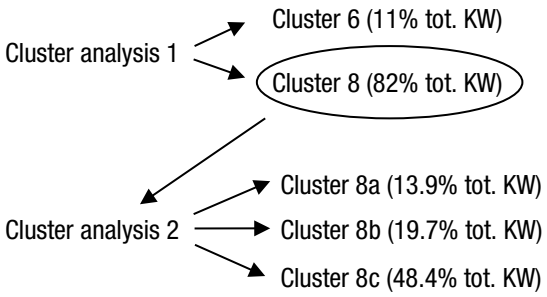

Figure 1. The most representative clusters identified by the two cluster analysis. KW=Keywords.

Topic A. Cognitive and behavior treatments. This topic corresponds to cluster 6 of the first CA (11% of the 108 keywords). It aggregates keywords referring to cognitive and behavior therapy (*Cognitive* and *Behavioral therapy*). Other keywords mark targets of the treatment (*Depression, Anxiety Disorder, Adolescent*) and the model of research adopted (*Major clinical study, Controlled study*).

Topic B. The study of mental disease. This corresponds to cluster 1 of the second CA (13.9%). The most frequent subgroup of keywords of this cluster concerns mental disease (*Mental Disease, Comorbidity, Obsessive Compulsive Disorder, Post Traumatic Stress Disorder*). Other keywords refer to the type of research and its instruments (*Clinical trial, Clinical article, Self-report*). Thus, we are led to interpret the cluster as indicative of the focus on the (clinical and/or experimental) investigation of psychopathology.

Topic C. Intervention on severe mental disorders. This corresponds to cluster 2 of the second CA (19.7%). The most frequent subgroup of keywords concerns field conditions and contextual aspects of interventions (*Social support, Risk factor, Family, Prevalence, Doctor patient relation*). Other keywords define the psychopathological area of interest, in particular defined by psychotic disorders (*DSM, Mental Disorders, Schizophrenia, Bipolar Disorders*). Accordingly, we are led to interpret the cluster as indicative of the focus on interventions on severe disorders (psychosis, personality disorders). This kind of intervention involves contextual dimensions and encompasses several levels of analysis/stand-

Table 2. Keywords characterizing topics

Topic A Cognitive and behavior treatments	Topic B The study of mental disease	Topic C The intervention on severe mental disorders	Topic D Outcome research, methodology and results
Depression	Obsessive-compulsive disorder	Human relation	Adaptation psychological
Adolescent	Self-concept	Methodology	Follow-up
Cognitive therapy	Clinical article	DSM	Outcome assessment
Controlled study	Psychological aspect	Mental disorders	Affect
Treatment outcome	Comorbidity	Psychological theory	Fear
Questionnaire	Clinical trial	Psychotherapist	Psychological models
Psychology	Mental disease	Schizophrenia	Interpersonal relations
Major clinical study	Post-traumatic stress disorder	Clinical practice	Rating-scale
Anxiety	United States	Medical research	Randomized controlled trial
Cognition	Self-report	Social support	Motivation
Anxiety disorder		Risk factor	Depressive disorder
Behavior therapy		Personality	Attention
Priority journal		Coping behavior	Diagnosis
		Behavior	Social phobia
		Mental health	Disease severity
		Bipolar disorder	Group therapy
		Prevalence	Prediction
		Clinical psychology	Follow-up studies
		Meta-analysis	Thinking
		Psychological assessment	Post-traumatic stress disorder
		Doctor/patient relation	Controlled clinical trial
		Evidence-based medicine	Social behavior
			Psychotherapy group
			Psychometrics
			Scoring system
			Severity of Illness Index
			Major depression
			Symptom
			Psychological stress
			Human experiment
			Personality inventory
			Professional/patient relayion
			Analysis of variance
			Quality of life
			Reproducibility of results
			Task performance
			Normal human
			Awareness
			Memory
			Distress syndrome
			Major depressive disorder
			Epidemiology
			Symptomatology
			Correlation analysis
			Patient compliance
			Interview

Table 3. Relative frequency of the occurrences of each topic for each journal

Journals	Topic A	Topic B	Topic C	Topic D
Annual Review of Clinical Psychology	.231	.138	.332	.220
Behavior Therapy	.324	.096	.046	.262
Behavioral Research Therapy	.332	.086	.057	.262
Behavioural and Cognitive Psychotherapy	.395	.121	.080	.218
British Journal of Clinical Psychology	.297	.085	.082	.283
Clinical Psychology and Psychotherapy	.315	.121	.097	.239
Clinical Psychology Review	.287	.134	.231	.253
Clinical Psychology: Science and Practice	.261	.171	.334	.184
Cognitive Therapy Research	.386	.084	.058	.245
Family Process	.140	.181	.173	.158
International Journal Group Psychotherapy	.177	.128	.166	.370
Journal of Clinical Psychology	.274	.131	.154	.193
Journal of Consulting and Clinical Psychology	.343	.052	.072	.267
Psychoanalytic Psychology	.185	.164	.319	.215
Psychology and Psychotherapy: Theory, Research and Practice	.282	.102	.120	.235
Psychotherapy	.245	.109	.278	.191
Psychotherapy Research	.321	.096	.134	.231

Note. Topic A = Cognitive and behavior treatments; Topic B = The study of mental disease; Topic C = The intervention on severe mental disorders; Topic D = Outcome research, methodology and results.

points (*Psychological theory*, *Clinical psychology*, *Evidence based medicine*) as well as forms/logics of action (*Clinical psychology*, *Evidence based medicine*) as well as forms/logics of action (*Clinical practice*; *Medical research*; *Psychological assessment*) thus giving the topic the appearance of a boundary theme between psychotherapy and the broader domain of clinical psychology.

Topic D. Outcome research, methodology and results. This corresponds to cluster 3 of the second CA (48.4%). Several keywords mark articles devoted to the experimental (*RCT, Controlled clinical trial*) evaluation of the outcome (*Follow-up*, *Follow-up studies*; *Outcome assessment*, *Prediction*). Other keywords seem to be markers of studies with a methodological focus (e.g., *Rating scale, Psychometrics, Severity of Illness Index, Scoring-system, Personality inventory, ANOVA, Correlation analysis*). Most of the other keywords specify goal and content of the studies, in terms of clinically relevant criteria/targets of evaluation as well as factors involved (e.g., *Psychological adaption; Affect, Fear, Thinking, Motivation, Attention, Social behavior, Interpersonal relation, Quality of Life*). No reference is made to specific models of psychotherapy.

Factorial Analysis

Table 3 shows the distribution of the 4 topics across the 17 Journals. As we said, this matrix was the one subjected to factorial analysis (FA). FA led to the extraction of two main components, accounting for 84.6% of the total variance.

Table 4 shows the topics' coordinates on factor dimensions (the higher the coordinate, the stronger the correlation between the topic and the factorial dimension). A right polarity of the first factor is associated with topic A (*Cognitive and behavior treatments*) and, to a lesser degree, topic D (*Outcome research, methodology and results*); the opposed polarity is associated with topic B (*The study of mental disease*) and topic C (*The intervention on severe mental disorders*).

Accordingly, we interpret the first factor as a marker of a semantic dimension concerning the aims of scientific works published by the Journals. This dimension is depicted by the opposition between a focus on treatments and their efficacy versus a focus on the study of psychopathology. Needless to say the two foci are not conceptually alternative. Nevertheless, they appear to work as an oppositional relationship defining a kind of figure/background shift. On the one hand the empirical validation of the psychotherapy seems to be the central interest (and with it the associated methodological issues too); on the other hand, psychotherapy—and more in general the clinical intervention where psychotherapy and contextual dynamics are intertwined—as a process aimed at dealing with psychopathology and promoting mental health. We

Table 4. Topics' coordinates for each factor

	Factor 1	Factor 2
Topic A	.81	−.48
Topic B	−.92	.00
Topic C	−.88	−.07
Topic D	.56	−.81

Note. Topic A = Cognitive and behavior treatments; Topic B = The study of mental disease; Topic C = The intervention on severe mental disorders; Topic D = Outcome research, methodology and results.

summarize this semantic opposition in the labels of the polarities: *Validation of models of treatment* versus *Management of intervention on disease.* As one can see, this distinction somehow recalls the classical product/process division. Nevertheless, we prefer not to use the latter in order to avoid confusion between this well-established representation of the literature and the results of our analysis.

As concerns the second factor dimensions, one polarity (up) is associated with topics A (*Cognitive and behavior treatments*), while the other (bottom) is associated with topic D (*Outcome research, methodology and results*). Accordingly, we interpret it as a dimension concerning the extension of the Journals' target of study. This dimension is characterized by the contrast between two approaches: an approach targeted on a specific clinical orientation versus an approach having a more general interest. Thus, we label the up polarity *Restricted target* and the bottom polarity *Generalized target*.

Factorial analysis results allow us to detect the association between factors and also Journals. We represent such relationship in geometrical terms. To this end we refer to the transformation of the measures of association in coordinates on the bi-dimensional space defined by the two factorial dimensions. Figure 2 depicts the semantic frame thus defined and the position of Journals within it. In the final analysis, this semantic frame can be seen as the spatial representation of the similarity/dissimilarity among Journals, as to the topics characterizing them (the closer two Journals on the bi-dimensional space, the more similar they are, as to the topics of articles they publish).

As one can see, most Journals (the only exceptions are *International Journal of Group Psychotherapy* and *Behavioural and Cognitive Psychotherapy*) lie along the first dimension where they can be grouped in three broad classes. A group of 5 Journals (*Journal of Consulting and Clinical Psychology, Behavior Research and Therapy; Behavior Therapy; Cognitive Therapy Research; British Journal of Clinical Psychology*) is placed close the *Validation of models of treatment* polarity; it contrasts with a group of 4 Journals (*Family process; Psychoanalytic psycholo-*

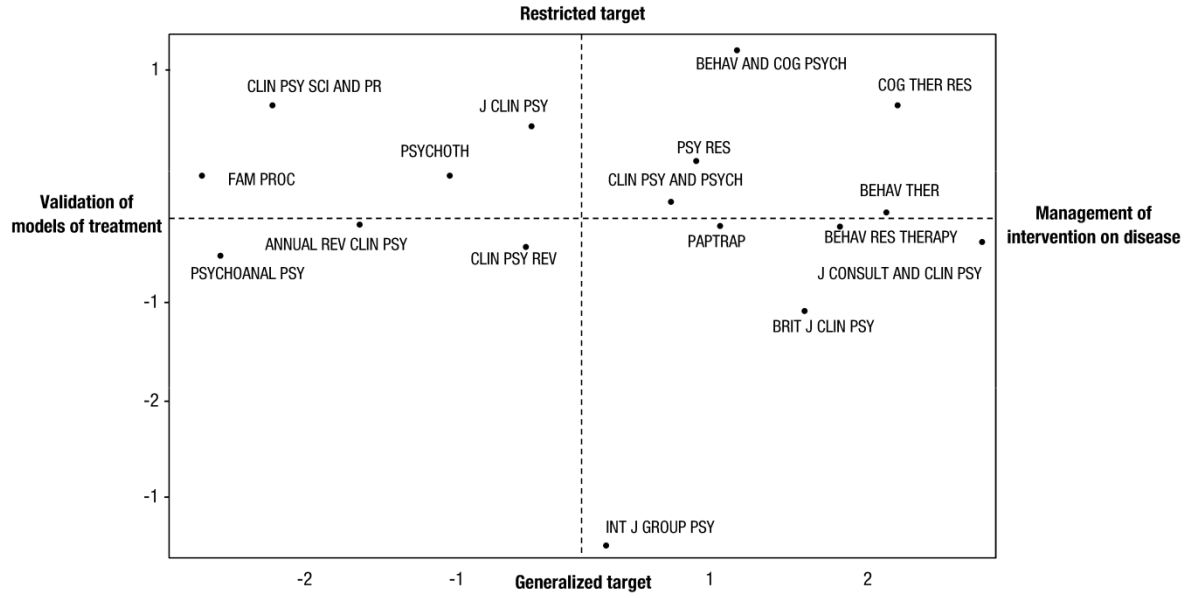

Figure 2. Factorial space and journals' positioning. ANNUAL REV CLIN PSY = Annual Review of Clinical Psychology; BEHAV THER = Behavior Therapy; BEHAV RES THERAPY = Behavioral Research Therapy; BEHAV AND COG PSYCH = Behavioural and Cognitive Psychotherapy; BRIT J CLIN PSY = British Journal of Clinical Psychology; CLIN PSY AND PSYCH = Clinical Psychology and Psychotherapy; CLIN PSY REV = Clinical Psychology Review; CLIN PSY SCI AND PR = Clinical Psychology: Science and Practice; COG THER RES = Cognitive Therapy Research; FAM PROC = Family Process; INT J GROUP PSY = International Journal of Group Psychotherapy; J CLIN PSY = Journal of Clinical Psychology; J CONSULT AND CLIN PSY = Journal of Consulting and Clinical Psychology; PSYCHOANAL PSY = Psychoanalytic Psychology; PAPTRAP = Psychology and Psychotherapy: Theory, Research and Practice; PSYCHOTH = Psychotherapy; PSY RES = Psychotherapy Research.

gy; Annual Review of Clinical Psychology, Clinical Psychology: Science and Practice) associated with the *Management of intervention on disease* polarity. In the middle, the other 7 Journals (*Psychology and Psychotherapy: Theory, Research and Practice; Clinical Psychology and Psychotherapy; Psychotherapy Research; Clinical Psychology Review; Journal of Clinical Psychology; Psychotherapy*) positioned around the origin of the axis, therefore to be interpreted as less characterized by the polarities, namely more pluralistic as to topics of interest.

Discussion

The results presented deserve some comments. Firstly, it is worth noting the way keywords are distributed over articles. The number of types (5,516) is rather high once compared with the number of articles-on average, any type of keyword has the probability of occurring not far from 1 (every 0.77 articles). On the other hand, this datum is the effect of a very asymmetrical distribution: 108 out of 5,516 types (2%) correspond to half of the total occurrences. Thus, according to the picture drawn from the keywords used by authors, psychotherapy research proves to be a quite heterogeneous field, characterized by a very restricted semantic core—the one detected by the most frequent keywords—and, on the other hand, by a very broad collection of specific, quantitatively marginal contents. Two interpretations of this structure are possible. (a) It might reflect the fragmentation of the research interests across the field. According to this hypothesis, the dispersion of the keywords' distribution might be the result of the high heterogeneity of objects and aims informing the scientific practices in the field. (b) The dispersive distribution might be the effect of a linguistic idiosyncrasy in choosing keywords, namely the fact that different authors use different keywords to refer to the same contents. Needless to say, the two interpretations are not alternative; rather, they could work complementarily. Only further analyses will enable us to understand their importance better. Nevertheless, in any case the distribution of keywords provides a clue that leads to see psychotherapy research as a scientific field that is still far from the homogeneity and unitedness (in terms of aims, objects, shared linguistic codes) characterizing the paradigmatic context of scientific enterprises (Kuhn, 1962).

Second, topics extrapolated by the CA provide a picture of the field which is consistent with the common ground representation. Topics seem to reflect the anchoring to three basic semantic references that any clinical researchers would recognize as salient conceptual and pragmatic organizers of the field. As reflected in Topic D, one basic anchoring point is provided by the theme of the evaluation of treatments' effects. We need not spend time pointing out that this theme is at the foundation of psychotherapy research—any history of such a field makes it begin with pioneering studies on the effect of psychotherapy. As topic A (*Cognitive and behavior treatments*) shows, a second anchoring point is provided by the commitment to cognitive-behavioural therapy. Though the extrapolation of topics is not necessarily a marker of quantitative prevalence, it is worth noting the fact that this is the only clinical orientation that is able to "coagulate" a specific topic. We are led to interpret this datum as an indication of the relevance that scientific production on cognitive-behavioural therapy has acquired within the field. Needless to say, the fact that cognitive-behavioural therapy has proved to be able to coagulate a specific topic is, at least partially, the effect of the composition of the sample adopted (4 out 17 Journals were specialized Journals focused on the area of cognitive-behavioural therapy). Yet, the latter observation does not reduce the value of the result at stake. Rather, it adds a further significance to it, namely it highlights how the importance achieved by the cognitive-behavioural approach reflects its capacity to interpret—and therefore be prized by—the current scientific standards of clinical research, the ones reflected in the bibliometric criterion of sampling adopted. Psychopathology represents the third semantic organizer, grounding topics B (*The study of mental disease*) and C (*The intervention on severe mental disorders*). Here it is also interesting to observe the differentiation between *disease* and *disorders*, which marks the linguistic boundary between topic B and topic C. In the context defined by the co-occurring keywords sustaining the topics, this boundary seems to be something more than a mere linguistic variation. Rather, it seems to be grounded on a semantic context: According to our interpretation, topic B (*The study of mental disease*) seems to be focused on less severe forms of psychopathology and their treatment, while topic C (*The intervention on severe mental disorders*) seems to be focused on a broader view of the intervention, encompassing contextual issues as well as addressing more severe psychopathological conditions. Incidentally, this can be interpreted as a sign of a weaker linguistic interpretation of the dispersive distribution of keywords (see above): Insofar as the disease-disorders variation seems to be rooted in a semantic context, it could be plausible that the same happens in the cases of other labels and their variation. Finally, it must be mentioned that this third semantic organizer—psychopathology—may have emerged as a result of a sample bias. As a matter of fact, the procedure of sampling we adopted has filtered Journals, rather than articles in terms of relevance to the psychotherapy research field. Therefore, the set of articles analyzed encompassed a proportion of articles not concerned specifically with psychotherapy research, even though published in Journals (9 out of 17) having psychotherapy research among their aims. Only fur-

ther analyses will allow to check to what extent the presence of this kind of articles has contributed to making topics B and C emerge.

Third, the semantic space modeled by the two-step multidimensional analysis proves to be grounded basically on the opposition between interest in the *Validation of models of treatment* and interest in the *Management of intervention*. As a matter of fact, it is along this dimension that Journals define their reciprocal relationships. Our thesis, which will have to be tested in further analysis, is that such a semantic opposition goes beyond the process/outcome distinction, and more generally concerns the dialectics between an interest focused on the scientific legitimation of the psychotherapy and an interest focused on the understanding/empowering of psychotherapy as a device for addressing clinical issues. These two foci are historically found throughout the scientific cultures and practices within the psychotherapy field; they are not conceptually alternative—yet it is hard to act as if they were immediately complementary (Salvatore et al., 2010).

Fourth, the relationship between topics and Journals lends itself to being interpreted as supporting the distinction we adopted between specialized and transversal Journals. Specialized Journals have the highest level of association with the factorial dimension–namely they tend to be more specific as to topics of interest. On the other hand, they do not appear to work as a separate subset—rather, even if 4 Journals committed to cognitive-behavioral therapy lie close to each other, all but one of the specialized Journals (*International Journal of Group Psychotherapy*) have relationships of similarity with transversal Journals too. Thus, one can conclude that our classification of Journals as specialized is consistent with their semantic content and yet that their inclusion in the sample did not distort the sample; rather it allowed us to encompass a semantic area which otherwise would have been marginalized.

Finally, if one wants to draw a synthetic picture of the Journals' thematic orientations, one can conclude that in the final analysis they can be grouped in three general classes: A class of Journals that prefer to host outcome research, aimed at the *validation of models of treatments*; a class of Journals with a more general orientation, which means aspects concerning psychotherapy are integrated and projected on a broader domain of clinical—psychological interest—a domain where the focus moves (or is extended) to the *management of interventions*, as depending on contextual and processual factors. In the middle, a class of generalist Journals, namely Journals that are sensitive to both the above orientations, and so are not characterized by either of them.

Some specific limits of the current study must be mentioned, because they limit the conceptual breadth of the findings. First, as has already been said, the criterion of definition of the universe of analysis adopted is the fact of being published in a Journal aimed *also* at psychotherapy research. Consequently, it was possible to discriminate articles not specifically concerned with psychotherapy research, yet published in Journals committed, inter alia, to this area. Second, keywords are a significant clue of articles' content. Yet they provide a rather poor, generic representation of it. As highlighted, this limit has prevented us from reaching a reliable interpretation of the semantic structure underpinning the way keywords are distributed among articles. Third, associated with the previous point, it has to be recognized that the current study suffers from the absence of a distinction between keywords defined by authors and defined by independent judges (i.e., provided by SCOPUS). While the use of both is a way of empowering the reliability of this index, the absence of distinction between them removes a major source of information. Anyway, the greatest limit to the current study lies in the structure of data it is based on. The two-step multidimensional analysis was performed on two data matrixes: a data matrix defined by keywords (rows) and Journals (columns) and a data matrix defined by Journals (rows) and clusters (columns). This structure of data defines the meaning of findings. In particular, findings concern the co-occurrence of keywords *in the context of Journals* (first step) *and topics* (second step). This means that the topics extrapolated concern semantic nuclei that take shape at the level of the grouping of Journals, rather than articles. And the same can be said for the second step: the semantic dimensions identified model the relationship among Journals compared to topics, and therefore they cannot be considered a snapshot of the semantic structure of articles.

Despite the limits and the questions raised by the study, it seems to us that the picture of the psychotherapy research field it provides is worthwhile. As the discussion of the findings has showed, the analysis of the semantic structure of the psychotherapy research provides food for thought, highlighting relevant epistemological and theoretical issues (e.g., the unitary nature of the area, the relationship between models of publication and topic's centrality) and at the same time contributing to address them. Moreover, this study has showed that a quali-quantitative method of content analysis, where multidimensional techniques of data analysis ground and support the researcher's interpretative job, rather than substitute it, can provide a meaningful picture even of a quite complex scenario like psychotherapy research. A picture, moreover, that already at the current level of definition may provide hints about the Journals' scientific-cultural politics—a rather important issue with pragmatic implications at the institutional and individual level.

Further studies will try to make progress in the direction of investigation opened by the current work. In particular, we see several objectives that need to be pursued:

a) The move to a more detailed level of analysis, centred on articles, thus identifying patterns of keywords as co-occurring within the same article.
b) The introduction of a longitudinal standpoint, thus analysing the evolution over time of topics and semantic structure of the field.
c) The introduction of the abstract as a further source of information—thus increasing the "resolution" of the analysis as well as to test the reliability of keywords.
d) The enlargement and specification of the universe of analysis, thus increasing its consistency with what the scientific community considers to be psychotherapy research.

Conclusion

This study reports the findings of an analysis of keywords indexing the content of articles published in Journals operating in the psychotherapy research field. The analysis, based on a two-step multidimensional procedure, provided a map of the contents characterizing such a field as well as of how Journals orient their interests towards them. Four main topics were extrapolated, interpreted as the expression of three basic semantic organizers: cognitive-behavioural therapy, outcome evaluation and psychopathology. Topics and their semantic organizers give shape to a semantic space modelled in terms of two semantic dimensions: one concerning the articles' subject and the other concerning with the extension of the target. The former is structured in terms of the opposition between two general aims: the management of the intervention versus the validation of models of treatments; the latter is structured in terms of the opposition between a restricted and a generalized target of research. However, the Journals analyzed proved to differ mainly in terms of the first semantic dimension detected. According to it, Journals can be grouped in three large classes: a group of Journals pursuing the validation of models of treatment as main scientific-cultural interest; a group more interested of the themes concerned with the development of interventions and their management; a middle group composed of Journals whose commitment integrates both interests.

Before concluding, it has to be said that the map provided by the study must not be intended as an objective, detailed representation of the ever-changing scenario of psychotherapy research. Rather, it has to be seen as an interpretative device useful for deepening the understanding of the semantic organization underpinning the current status of research in the field. This is so because content analysis, like any kind of analysis concerning meanings, is inherently abductive and interpretative, also when, as in the case of the current study, it adopts a quantitative method (Salvatore, Gennaro, Auletta, Tonti, & Nitti, 2012).

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When Therapists Do Not Know What to Do: Informal Types of Eclecticism in Psychotherapy

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Abstract. Eclecticism usually arises from the perception of one's own theoretical model as being inadequate, which may be the case in situations of therapeutic stalemate. In need of new strategies, therapists criticize their own approach and take eclectic knowledge onboard. The goal of this qualitative study is to explore basic elements of this informal knowledge, with reference to the theory of social representations and points of view. Episodic interviews were conducted with 40 therapists. Results confirmed that clinical knowledge often turns eclectic, showing different styles of reorganization; a social co-evolution model will be pointed out to explain this personalization of one's own approach. The results achieved might contribute to the amelioration of the therapeutic awareness of one's own knowledge structure and the use of eclecticism in carrying out therapies, leading to significant benefit in treatment effectiveness.

Keywords: psychotherapy, eclecticism, social representations, points of view, qualitative methodology

Clinical intervention is increasingly structured according to an eclectically oriented style of psychotherapy; such eclecticism is encouraged as a way that allows the therapist—through the use of a different theoretical frame—to expand the possibility of understanding the client's issues better (Slife, 1987).

In the literature, three kinds of eclecticism have been described, all supported by the shared belief that clinical practice is more complex than theory and, as such, requires a pragmatic approach from the therapist; such an approach is considered necessary to compensate for the limited knowledge categories that each one-sided theoretical approach provides. The first form of eclecticism is called *theoretical integrationism* (Arnkoff, 1995; Held, 1995; Prochaska & DiClemente, 1984), which combines different theories without worrying about possible epistemological incompatibilities: Its aim is to increase the number of concepts available to the therapist for clinical investigation. A second form of eclecticism is called *technical eclecticism* (Lazarus & Beutler, 1993; Lazarus, Beutler, & Norcross, 1992; Norcross, 1986) and prescribes the use of the most promising techniques after having proven their efficacy through scientific research studies (Beutler & Clarkin, 1990). Making use of objective methods and considering therapeutic techniques as mere instruments to be used, such an approach makes it acceptable to extrapolate such techniques from their conceptual frameworks; that is, from the specific theories from which they originally stemmed (Patterson, 1989). The third kind of eclecticism, widely criticized by the eclectic-oriented movements themselves, does not provide any reasoned response to the topics and issues reported by clinicians and, as a consequence, is named *unsystematic eclecticism*. This kind of eclecticism favours an instrumental use of different theories and techniques in therapy, yet it does not establish any explicit criterion through which to select from among different components of such theories (Gilliland, James, & Bowman, 1994).

Beyond the official, formal categories of eclectic approaches to therapy, the goal of the present work is to explore how therapeutic knowledge is organized when it is most informally put into effect (Hansen, Randazzo, Schwartz, Marshall, Kalis et al., 2006; Romaioli & Contarello, 2012). Assuming that psychotherapists trained within the same approach

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consider input from other theoretical models in a similar way, we compare their narratives about perceived implications of the practice of the chosen clinical model and their strategies to solve impasse situations and more effectively investigate their attitudes toward eclecticism.

On this premise, methodological and theoretical integration, revision and personalization of models can be envisioned as an everyday practice, yet not always recognized and discussed with adequate attention within the broader scientific community (Hoshmand & Polkinghorne, 1992).

Conceptual Framework

The therapeutic intervention cannot be considered as a derivation of a knowledge system that precedes it and from which it is separated (Romano & Quaglino, 2001). What instead has to be recognized is the pragmatic character of therapeutic contexts, and then the vision of the therapist should be questioned as an expert who applies his personal baggage of knowledge, learned at another time and in another place than the clinical practice (Salvatore, 2006). In contrast, the therapeutic action always takes place on the basis of a community of practice: The therapist's knowledge is continually being reorganized because of the heritage of distributed expertise of which the expert is part; these assets result from the incessant labor of informal negotiation of meanings that distinguishes every circumstance of social practice (Iannaccone & Ligorio, 2001; Valsiner & van der Veer, 2000). Professional contexts require therapists to organize and adapt the categories of knowledge available to the unique needs of the situation they are managing.

We also need to consider that each theoretical approach sustained by the scientific community is made up of a shared symbolic system that is intertwined, with different degrees of diffusion, with the theories of common sense (see Moscovici, 1961), which provide the interpretative frameworks through which people orient themselves in the management of interpersonal relationships and problematic situations (Berger & Luckmann, 1966). In these circumstances, it is likely that therapists may tend to incorporate into their own repertoire of professional theories, common sense theories on which they are experts in terms of participating in a social context and sharing a specific cultural frame (Gergen, 1994, 2006). Specialized skills are constantly rearranged within systems of knowledge which are more complex than those prescribed by each psychotherapeutic school (see Hoshmand & Polkinghorne, 1992; Slife & Reber, 2001).

The present research emerges from a social constructivist perspective (Flick, 1998) and refers to social representations theory (Farr & Moscovici, 1984; Wagner & Hayes, 2004). The distinction between social representations (SR) and points of view (POV) is relevant to the present work: The former have been defined as the abstract and standard knowledge background of a social group; the latter consist of a contribution by the individual's cognitive elements (Tateo & Iannacone, 2011; Valsiner, 2003). Social representations are conceptualized as systemic phenomena in themselves, not reducible to individual minds (Chryssides et al., 2009; Harré, 1984; Jovchelovitch, 2007), constituting a social reality *sui generis* (Moscovici, 2000). In contrast, a point of view constitutes a "personal representation" (Breakwell, 2001) and can be defined as a social actor's outlook toward some object or event "expressed as a claim, which can be supported by an argument based on a system of knowledge from which it derives its logic" (Sammut & Gaskell, 2010, p. 49). Points of view are a social psychological phenomenon, held to be the individual counterparts of social representations.

As highlighted by Tomm (1987), a therapist's decisions during a therapy session depend on both his or her development as a professional and on his or her personal history; consequently, the therapist's POV also includes idiosyncratic pieces of knowledge that do not originate from the therapist's reference theory. Namely, the POV includes knowledge the individual borrows from other symbolic contexts, creatively changing it into strategies for a deeper understanding of what happens in his or her daily practice (Jovchelovitch, 2007). Therefore, SR form a widely shared corpus of knowledge that can be roughly categorized according to the formal theoretical reference models (see von Cranach, Mugny & Doise, 1992); however, POV are allocated at different levels of therapists' knowledge structure, resulting either in original production or in the eclectic combination of pieces of knowledge that originate from different psychological models or other branches of knowledge (Romaioli, 2012). As Norcross (Norcross & Goldfried, 2005, p. 1593) pointed out, even if "most therapists have been and continue to be trained in a single approach. . . . Most therapists gradually incorporate parts and methods of other approaches once they discover the limitations of their original approach."

In facing clinical difficulties, therapists are induced to take a stand and view their clinical actions from another perspective. In this way, limitations of one point of view are transcended by including the possibilities offered by other theories, especially when these are encysted in discursive practices of common sense, and might be "translated" in operative terms also by non-experts, both people and professionals not having received specific training in that specific field (Faccio, Centomo, & Mininni, 2011; Faccio, Cipolletta, Dagani, & Romaioli, *in press*).

Therapists become open to more alternatives than their own unaided point of view makes possible. The extent to which a therapist's point of view is open to different ways of conceptualizing, there-

fore, has far-reaching consequences on therapy: It determines the extent to which creative, positive solutions to clinical impasses may be realized. Points of view may be open to others' logicality or they may be open to others' perspective, but not to others' frame of reference. Or they may be closed to others' points of view altogether (Porpora, 2001; Tsirogianni & Gaskell, 2011). Adopting a point of view that is more or less open to alternative theories allows therapists to gain clinical efficacy, optimizing positive contributions from different therapeutic traditions.

Aims of the Study

This work intends to shed light on the way in which the knowledge systems that support therapeutic action are structured and organized (Romaioli & Contarello, 2012). More specifically, the structure of knowledge will be investigated at the level of points of view; that is, by reconstructing the whole set of meanings the participants express and that have no formal allocation in the symbolic universe of theoretical models of reference. Our goal is not only to explore the conditions inviting therapists to shift from the operational criteria suggested by their theoretical orientation, but also to reconstruct the organization of knowledge that enables therapists to manage clinical practice under such conditions. More specifically, the POV we have investigated can be identified as:

- Narrative reports that justify and legitimate eclectic practice;
- Integrations among different operational models and personal re-elaborations of psychological models for clinical intervention.

Method

Participants

The research design is a comparative one and is essentially based on a qualitative methodology (Elliott, Slatick & Urman, 2001; Flick, 2006), mainly linked to the tradition of grounded theory (Glaser & Strauss, 1967) revised in a social constructivist perspective (Charmaz, 2006). Data was collected through an interview protocol conducted with a sample of 40 psychotherapists, both in private practice and public institutions.

Four operational models were considered—cognitive–behavioral, constructivist, psychodynamic, and systemic–relational—forming four groups, each containing eight women and two men. The group of *cognitive therapists* refers to the psychotherapeutic models derived from Beck's theories. The *constructivist therapists* explicitly link to Kelly's theory of personal constructs. The *psychodynamic therapists* mainly belong to the Freudian and Kleinian school. The group of *systemic-relational therapists* refers to the Milan school. Models were selected based on their diffusion in the research areas (Northern Italy) and on belonging to well-established therapeutic traditions. However, there was no conceptual constraint to prevent the same research protocol being successfully applied to other traditions.

Therapists were recruited through an advertisement requesting collaboration published on the official site of the Board of Psychologists of the Veneto region. The prerequisites for the subjects of the sample were a minimum of three years spent in clinical practice, and an affirmation that they follow one of the above-listed psychotherapy models and not—at least not explicitly—an eclectic or integrationist approach. Participants were divided into groups according to their theoretical orientation and other variables we considered relevant to reconstructing the knowledge structures involved in planning therapeutic action. The most important are (see also Table 1):

1) Age (ranging from 31 to 66, with an average age of 42).
2) Professional training: orthodox or pluralist (where the professional attended post-graduate courses based on theories different from his or her theoretical orientation).
3) Whether personal therapy had been undertaken with a therapist who shared—or did not share—the participant's theoretical orientation.
4) Participation in team meetings with colleagues with a different theoretical orientation.
5) Professional experience, measured in years of clinical practice as a professional (ranging from 3 and 27 years, with an average of 12 years of clinical practice).

Episodic Interviews

To collect data, episodic interview protocols were used: This method draws its basic assumptions from narrative psychology (Riessman, 1993) and from episodic and semantic memory studies (Tulving, 1972). We chose episodic interviews as they are considered especially well suited to the unraveling of inner discrepancies and contradictions in the speaker's arguments. The episodic interview is also intrinsically advantageous as it already constitutes a triangulation, a procedure to obtain a better understanding by using different methods: The episodic interview enables a methodological triangulation by using sets of differently structured questions (Flick, 2000).

The introduction to the interview was: "In the following interview, you will be requested to describe situations you have experienced within your clinical practice; you will be asked to focus on the issues you have found significant in a specific case." During this first stage, the participant was explicitly

Table 1. Composition of the sample of psychotherapists

	Cognitivist (n=10)			Psychodynamic (n=10)			Systemic (n=10)			Constructivist (n=10)			Total		
	n	% model	% total	n	% model	% total	n	% model	% total	n	% model	% total	n	% model	% total
Context															
private	4	40.0	10.0	6	60.0	15.0	2	20.0	5.0	9	90.0	22.5	21	52.5	52.5
public	6	60.0	15.0	4	40.0	10.0	8	80.0	20.0	1	10.0	2.5	19	47.5	47.5
Training															
orthodox	6	60.0	15.0	4	40.0	10.0	2	20.0	5.0	7	70.0	17.5	19	47.5	47.5
pluralistic	4	40.0	10.0	6	60.0	15.0	8	80.0	20.0	3	30.0	7.5	21	52.5	52.5
Experience															
3-10 years	8	80.0	20.0	3	30.0	7.5	4	40.0	10.0	4	40.0	10.0	19	47.5	47.5
>10 years	2	20.0	5.0	7	70.0	17.5	6	60.0	15.0	6	60.0	15.0	21	52.5	52.5
Personal therapy															
yes	0	0.0	0.0	10	100.0	25.0	1	10.0	2.5	5	50.0	12.5	16	40.0	40.0
hybrid	1	10.0	10.0	0	0.0	0.0	8	80.0	20.0	0	0.0	0.0	9	22.5	22.5
no	9	90.0	90.0	0	0.0	0.0	1	10.0	2.5	0	12.5	12.5	15	37.5	37.5

asked to talk about personal events regarding his or her clinical experience. Questions included: "Can you describe your client's changes during therapy and how you organize therapy? Can you describe a typical case from your own experience, showing how such an evolution might be explained?" The purpose of these questions is to have the therapist recall actual situations in which they played an active role, bringing out the specific context of his or her clinical experience and the in-generated meanings.

During the second stage, a discussion of topics that emerged from the specific interaction was encouraged (Hermanns, 2004). The question for a therapist expressing theoretical constructs pertaining to a model different from the training orientation model: "How would you describe this issue in cognitive behavioral terms? Your orientation is cognitive behavioral, yet you use a systemic approach; how does it fit in with your reference model?" Such questions could elicit the clinicians' arguments to justify eclectic practice. During the conversation, the therapist was invited to speak about critical areas he or she identified of his or her theoretical orientation:

- Can you tell me about a situation where you had to face the fact that your client's problem still persisted? How would you explain such an impasse?
- Considering your clinical experience, are there issues in your theoretical orientation that, in your opinion, could be expanded, integrated, or modified to improve clinical practice?

The aim of this line of questioning was to make it clear how theoretical assumptions were rendered within clinical practice, pointing out to what extent they suited the actual clinical situations. Whenever the therapist offered arguments going against his or her own paradigm, the interview protocol called for in-depth analysis of how the clinician could cope with the critical situations he or she reported. To a therapist reporting that his or her cognitive training does not enable him or her to deal with the client's emotional issues, the question was asked: "Therefore, in these years what did you do when you had to cope with your client's emotional issues? How did you integrate these aspects?"

Thus, the organization of therapeutic knowledge could be explored at the level of point of view. Then, the study investigated what kind of knowledge enabled the clinician to justify the use of different theories and how he or she explained it. To a therapist with an eclectic training: "You had analytic psychotherapy and systemic training; I would like to know how you could integrate both perspectives into actual practice. If you did, how did you do it? If you shifted from one to another, on what assumptions?"

On average, the interviews lasted one-and-a-half hours. They were conducted by the first author in the therapist's workplace. The textual material collected consists of about 75 hours of audiotapes, transcribed verbatim into word documents. The interviewer has received training in the field of epistemology of psychology and also practices clinical activity with particular reference to constructionist psychotherapies.

Analysis Criteria

The textual material collected was subjected to a thematic content analysis using NUD*IST software.

The whole codification procedure was agreed upon by the author along with two other researchers, each of whom gave an evaluation of the relevance of an identified meaning aspect (code) and the content of the texts analyzed (Strauss & Corbin, 1998). There was 90% agreement rate amongst the researchers when judging how to categorize the texts.

We were able to share a schematic account of the main elements emerging from the interviews (structure laying technique) with some of the therapists to validate the researchers' codification (Flick, 2006; Hill et al., 2005).

The code frame was then adopted as the index of a knowledge structure (Charmaz, 2006); afterwards, the knowledge structures that emerged from the therapists' answers were compared: (a) with the theories of their reference group and (b) with the theories of other groups to discern their similarities and differences. Therefore, for each therapist, we were able to reconstruct the set of codes that belonged to the theory of their reference group and those that, on the other hand, indicated the use of more personal concepts taken from orientations that were not theirs.

The textual material collected was carefully studied to identify: (a) possible critical issues in the reference model; (b) strategies the therapists generated to overcome difficulties within clinical practice; and (c) possible ways of integrating and justifying different theoretical perspectives or kinds of practice.

Results

Critical Aspects in the Application of One's Therapeutic Theoretical Frame

During the interview, therapists were invited to describe the limits (if present) found in applying the theoretical orientation model into clinical practice and the ways they could overcome such limits. Focusing on such critical issues enabled us to identify clinical circumstances that could require a therapist to use representations different from his or her training and, more broadly, from the SR of the orientation model. The most frequently reported issues did not actually pertain to the formal model's own limits but its informal application in practice and the reinterpretation of the model by the therapists interviewed to make it more easily applicable.

The *cognitivist group* reported difficulty coping with the clients' emotional issues (reported by 40% of therapists in the group) and a difficult applicability of cognitive behavioral techniques to obscure or not well-defined issues, or connected to a so-called *existential sphere*.

The *constructivist group* reported few limits with regard to the applicability of the model; a possible reason could be that the constructivist theory is considered abstract enough to be applicable in different circumstances without dramatic revisions (Kelly, 1955). The members of this group, as described later, mainly expressed a kind of knowledge defined not as eclectic but as syncretistic. Nevertheless, one constructivist therapist highlights the difficult applicability of her model in the public context; another therapist points out the need to expand studies and research in the field of couple therapy.

Psychodynamic therapists mostly agree (70%) on poor applicability of their reference model in situations differing from the private context; they also describe urgent or highly incapacitating conditions as quite difficult to deal with. The fast pace imposed by social changes had a modifying effect both on the questions that patients ask therapists and on institutional practice itself, with less time and attention devoted to the requirements of the setting and to the organization of the time schedule—as they are supposed to be, according to psychodynamic orientation.

Therapists in the *systemic relational group* (60%) mostly mentioned problems with carrying out individual therapy, reporting that they possess limited knowledge for dealing with the personal, introspective domain, a deeper understanding of which they consider to be necessary within some specific clinical situations.

Overcoming Difficulties in Carrying Out Clinical Practice

Whenever a therapist reported shortcomings in the use of his or her theoretical frame of reference, the interview protocol prescribed a set of questions to probe how the therapist could overcome the restrictions perceived in carrying out clinical practice—both from an operational and conceptual point of view. Very often, the therapist's response entailed letting go of the situation and either referring the client to a colleague or institution, or else making massive use of supervision as a valuable resource. In other cases, however, therapists reported episodes where personal initiative proved relevant, creative and decisive to solve their problem, actually enabling them to perform original interventions, very often based on an eclectic pattern of practice and (therefore) of the therapeutic knowledge by which it is supported.

As has already been suggested by von Cranach (1992), our findings indicate that therapists utilize inferences from representations unrelated to the SR from their theoretical perspective but that derive especially from psychodynamic and cognitive behavioral theories (Hickman, Arnkoff, Glass, & Schottenbauer, 2009). Such points of view are employed by therapists in particular when therapy is at a stalemate. Representations from a psychodynamic and cognitive theoretical background are prominently used by therapists from different theoretical perspectives where the client has not reported any change—usually a good reason to broaden the rep-

ertory of possible interpretations.

The following concepts are listed according to the frequency with which they are used by therapists to explain an unsuccessful therapy outcome. Such interpretations were used very often by clinicians who followed different theories from those these concepts belong to: "inner conflict" (cited by 37%, not by psychodynamic therapists), "reinforcement" (cited by 33%, not by cognitive-behavioral therapists), change seen as a "conditioning/learning" (17%), the concepts of "defense" (17%), symptom "shifting" and its "cover" effect (17%).

Knowledge Structure and Management of Eclecticism in Psychotherapy

An eclectic knowledge structure was exhibited by 57.5% of therapists. They were divided into three different groups according to the different management of techniques and concepts belonging to paradigms that were different from their theoretical orientation.

The first group consisted of 12.5% therapists who develop a meta-knowledge that organized the use of different theoretical concepts at a subordinate level: The presence of at least two reciprocally discordant elements generated a novel representation that reconciled previously incompatible concepts. In other words, some therapists built a super-ordinate level of justification for the different eclectic procedures used during the therapy session. In terms of Norcross & Goldfried's (2005) definitions, this group seemed to intuitively achieve a kind of theoretical integration where the synthesis of multiple theories was engaged. The content analysis tables were subjected to a Chi-square test using the program SPAD (Systeme Portable pour l'Analyse des Données; Lebart, Morineau, & Becue, 1989): The pluralist formation emerged as the only significant variable among those analyzed for the group that constructs an original knowledge system. The fact that they were able to study the theoretical specifications of different intervention models during their training is likely to have enabled the therapists to integrate them into a fuller, more original perspective. In fact, from a certain point of view, such systems can possibly foresee the future evolution lines for psychological models. Participants of this group (see Table 2) were able to develop a "fusion of horizons" (Gadamer, 2000, p. 398), a process that led to a joint creation of a new understanding through the merging of different theoretical perspectives (Gadamer, 1989a, 1989b; Tsirogianni & Andreouli, 2011). An interview example follows when speaking about psychodynamic and cognitive theories:

> Actually, they are different but have contiguous features. The former [psychodynamic theory] works in depth, whereas the latter [cognitive theory] works on the surface and at a subconscious level. Cognitive behaviorist therapy reorganizes the cognitive dimension, that is, one works in one way and the other in another way, but they are both valid. I am open to all theories, I like to know everything, what one [theory] says, what another one says, I like to learn. They are different filters, one works more at an unconscious level . . . but I also ought to think at a conscious level, that is at a rational level; thus, they are two different levels, and I always have to take both into account. That is more or less how I work, and I realize that it works (Interview 14; female; psychodynamic).

Deviations from the SR of the reference group are usually supported by a point of view that provides a normative system for therapeutic action. Precisely because such a point of view is related to higher individual variability in action, it needs a higher level of conscious representation and more numerous arguments and justifications as well (see von Cranach, 1992). By investigating this conceptual level, we found the therapists of this group mainly refer to the category of theoretical justifications for eclecticism: The eclectic option becomes practicable after a specific evaluation of the status of theories, often seen as lenses to be used together, because they enable us to see different parts of the same object.

> There is a whole set of other theories that help you see the problem from different perspectives, not to make a hotchpotch but to consider the same element from different viewpoints. A person possesses dynamic elements, facets that can be seen from a cognitive perspective; we can intervene at a behavioral level for some steps and use a non-directive mode where, by pressing the issue, you can do more harm than good (Interview 26; male; cognitivist).

The second group was the most numerous and consisted of 37.5% of the 40 therapists. They tended to develop pluralist representation systems that do not overlap and that enable a therapist to perform different interventions according to the specific client's request. In this regard, the concept of *cognitive polyphasia* (see Table 2) can explain how a point of view can oscillate between different belief systems, thus enabling him or her to develop distinct courses of action that are tightly intertwined and with reciprocally antithetical representations (Jovchelovitch, 2008; Moscovici, 1961; Wagner, Duveen, Verma, & Themel, 2000; Wagner & Hayens, 2004). In this case, the belief system is structured according to a set of representations that are independent of each other; actually, cognitive polyphasia is an indicator of the presence of a complex representation system that is not organized at a super-ordinate level but instead operates through the activation of specific interpretive modes, depending on the issues the client has brought to therapy. Specifically, the therapist uses the typology of the problem presented as a discriminating factor

to choose a specific mode of practice. In our sample, the participants who resulted significant in the Chi-square test were those who had a hybrid therapy that was different from their orientation. Working in public structures proved to be almost significant. In Norcross & Goldfried's (2005) distinctions, participants of this group adopted a kind of technical eclecticism where the use of various techniques is supported without regard to the theory that spawned them. Reflection on how theoretical models may be integrated is limited, and the clinicians use them in practice only when specific situations occur. As a matter of fact, these therapists tended to substitute most often their reference paradigm for another one that is considered better suited at that moment to deal with the difficulty the client has brought to therapy. The most significant dimension to cause important changes in the therapist's representation system seems to be the abstract/concrete polarity: That is, when dealing with well defined, disabling, and concrete problems, therapists chose techniques centered on symptom resolution—seen as faster and immediately applicable. On the other hand, when confronting relational or existential issues, therapeutic action strictly complied with the guidelines of other paradigms. In the following excerpt, a therapist describes a situation that induced him to change his approach with clients in therapy sessions by shifting, for instance, from a psychodynamic mode (centered on listening and relationship) to a cognitive mode (more directive and symptom centered).

> Certainly, whenever patients ask to be given support in controlling symptoms and avoid opening a dimension of emotional understanding . . . on the basis of the patient's request, I will use more or less the psychoanalytic method. . . . I tried to investigate the relational dimension through an exhaustive anamnesis the patient allowed me to gather, but he or she was reticent about his or her request, I mean, he or she tried to bring the attention focus of our therapeutic relationship back to his or her specific problem; I complied with his or her request, trying to use techniques referring to cognitive theory, such as systematic desensitization, first trying to give the patient a deeper knowledge of the phobic object, then trying to have him or her study it and approach it (Interview 8; male; psychodynamic).

Regarding justifications evoked for eclecticism, we found this group mainly referred to value-centered and pragmatic categories: In the first case, the eclectic option was considered as a need related to the clinician's personality. Therapists often identified with values such as curiosity and tolerance that were expressed through an open, experimental attitude and a blend of new, enriching, diverse practices. In the second case, the eclectic option was often associated with remarks on how important it is to use more than one theory for the patient's good, pointing out that clinical practice is much more complex than theory.

> I work as a psychodynamic therapist, but I also use other techniques; I am not a closed-minded therapist. . . . Thus, [I go] beyond conventions, I am actually against conventions. At least, I usually do it this way; however, I still continue to read and study, just because I am curious. . . . Anything can help, I can manage to aggregate everything (Interview 12; female; psychodynamic).

The third group's perspective could be defined, in line with Norcross & Goldfried's (2005) distinctions, as a form of assimilative integration; that is, it proposes the use of one model's conceptual frame in which revised procedures from other models could be inserted. Although such a mode of action implies a form of eclecticism, both the therapeutic action and the evaluation of the strategy's effectiveness still refer to one theoretical background. Therefore, assimilative integration is a conceptual operation that enables therapists to elaborate different techniques inside a common theoretical frame. Participants of this group seem to express a dialogical point of view (see Table 2)—one that acknowledges the existence of other orientations but retains its logic as a superior form, so there is only a partial perspective taken from another theory without adopting another frame of reference. Belonging to the constructivist group was found to be a significant variable to single out subjects who utilize this mode to organize their therapeutic knowledge. In addition, because of the history of the rise of constructivism in social sciences itself, therapists in this group used reflections of an epistemological nature more often—reflections with a high level of abstraction that enabled them to carry out a rewriting of other methods within their own reference model.

> In constructivism, there is a facet related to phenomenology, a facet related to systemic theories; if we want to refer to other theories, there is a facet related to relationships, a facet related to the body. [...] If we want to pick something up from psychodynamic theory, there is the unconscious theory: Therefore, from my own perspective, I would say in constructivism, we can find all these facets. Such a widening of my perspective depends partly upon my training, which in my postgraduate school [years] made me plan to learn how to use other, different tools and integrate them into a wider vision (Interview 36; female; constructivist).

Psychotherapy between Dogma and Rigor

Although a large preponderance of therapists exhibit a knowledge structure mainly based on eclecticism, some participants (42.2%) expressed an orthodox system of beliefs (Deconchy, 1984), built up according to the theoretical assumptions typical of the kind of psychotherapy they practiced. Surprisingly, the lack of contradictions in the semantic core of representation predominates in therapists

Table 2. Correspondence between forms of eclecticism and points of view that sustain them (informally)

Structure of Knowledge	Forms of Eclecticism	Types of Points of view	Characteristics
First type	Theoretical integration	Fusion of horizons	Combination of different models that leads to a new understanding
Second type	Technical eclecticism	Cognitive polyphasia	Use of several models in absence of an epistemological overview
Third type	Assimilative integration	Dialogical point of view	Other clinical models are used as subordinated to the main
Fourth type	No Eclecticism	Monological point of view	Other clinical models are not considered at all

who did not undergo personal therapy. This is probably due to the fact that those therapists who do not re-examine their own personal history under the lens of professional categories (as happens in therapy) are able to keep their professional knowledge more distinct from personal common sense awareness. Moreover, regarding the contents, they have arguments to belittle other theoretical orientations, as they have developed critical thinking on the subject. The more such a belief is articulated, the more the clinician will keep within his or her own theoretical integrity. Respondents of this group seem to present what has been called a monological point of view (see Table 2), in which therapists do not grant any legitimacy to alternative points of view and dismiss alternative orientations as wrong or bad (Sammut & Gaskell, 2010). An excerpt follows as an example:

> This is actually one of the typical features of constructivism; whereas other theories deal with all that is built by the patient, constructivism is not concerned with what is being built but with how it is built, with the process through which one shapes his or her stories. . . . Yes, because constructivism is not a therapy using frustration, for instance, like psychoanalysis, where one [the therapist] plays with silence; it is not a behavioral cognitive therapy in a classical sense, where one operates on the other person, and the other is not conscious of what you are doing, as in strategic therapy where you perform some actions, the other person performs some actions as well, but does not know what is going on. . . . Therefore, first I agree with it, because this [process] is aimed to set the person free, instead of jailing him or her inside diagnoses, situations, childhood traumas, defense mechanisms and the like (Interview 22; female; constructivist).

Discussion

Psychotherapy is historically characterized as a strongly plural field, animated by schools of thought operating as self-referential systems (Carli, 1987), able at the same time to become theoretical paradigms. However, the internal variability of conceptions within each school of thought tends gradually to increase and to be more relevant than that between schools (see Salvatore, 2006).

According to the interviews collected, the therapists' knowledge systems seem to be organized into dimensions of meaning that are definitely more articulated than the theoretical frames therapists learned in psychotherapy schools, suggesting that therapeutic activity could actually be carried out as an active, endless elaboration of different knowledge domains—professional, social, and personal—in which an individual participates (Roberts, 2006; Romaioli, 2012). Actually, it often happens that therapists are not always consistent with such theoretical assumptions when reporting on clinical cases, despite expressing a formal agreement with their original theoretical orientation.

With regard to therapeutic work, we found that eclectic issues predominate both in therapists that report a pluralist training and therapists who followed personal therapy routes characterized by a theoretical orientation different from their own training. Such patterns actually invite an evolution of knowledge structure according to unconventional, more open lines informed by eclecticism. Such knowledge structures, however, are endlessly built and confirmed but also reviewed and modified within communicative exchanges among individuals (Gergen, 2006; Romaioli, Faccio, & Salvini, 2008). In fact, having the opportunity to discuss their activities with colleagues apparently affects therapists both in their organization and expansion of their knowledge systems. A considerable inclination to maintain an eclectic attitude, actually, is found in therapists who worked either in institutional practice, teamwork, or had the opportunity to talk often with professionals of different theoretical orientations. Such moments offer therapists a chance to negotiate meanings by discussing the therapeutic process with colleagues and allow them to

participate in new, pluralistic, symbolic universes.

With regard to the above, we can also recall the fact that points of view provide interpretive outlines by organizing individual action and permitting communication and ordered interactions. The relationship between the formation of such points of view and the above-mentioned conditions is bidirectional and not causal; whereas the former organize themselves on the basis of social interaction processes taking place in different contexts, social interaction itself can take place through the structuring of such points of view. Applying the social co-evolution model (Thommen, Amman, & von Cranach, 1988; von Cranach & Harrè, 1992) to psychotherapeutic theories, we could say that the SR on which they are based follow a historical evolution, according to both society's structural changes and different individual elaborations that become points of view (Moscovici, 1976). We can outline the relationship between SR and points of view as a circular process: Within social interactions with colleagues and institutions, as mentioned, professionals tend to reorganize their knowledge systems, not only according to the SR of their reference group (in this case, to the theoretical orientation of their training) but also on the basis of a general knowledge in psychology and implicit theories coming from both common sense and personal experience. Through individual action, the group's SR are replicated, materialized, and made tangible—but also criticized, expanded on, and revised in the unraveling of clinical practice. In fact, among the members of the same group, only a limited consensus can exist with regard to the reference SR's organization; this can elicit conflicts, contradictions, and debates that invite social change. In this case, such a process can lead to modifying the official SR from psychotherapy theoretical models, closing the circle of reciprocal interaction among individual and social levels (see Figure 1).

Conclusions

The progressive internal differentiation within models is leading to a gradual decrease of the boundaries between theoretical approaches and is favoring the emergence of innovative conceptualizations that move transversely, beyond the traditional rigidity that characterized clinical models in the past (see Salvatore, 2006). All this makes it possible to overcome the fragmentation of the traditional clinical psychological debate. Above all, this new framework enables professionals to understand the differences and the utility of different psychotherapeutic perspectives. Obviously, to optimize this pragmatic use of different theories and methods, the therapist must be able to move from one technique to another, or from one theory to another one, acknowledging that they constitute conceptual devices—and not real objects—that might become advantageous to the aims of therapy.

In this regard, it would be important that therapists could develop what has been defined in the literature as a metalogical point of view—that is, a postmodern point of view—in which the certainty of knowledge is doubted, and the point of view is open to alternative truths (Porpora, 2001). A metalogical point of view considers any point of view to be a product of the situation and circumstances and comes with awareness that one's point of view is as fabricated as any other. In this way, it is in a position to consider alternative orientations at par—even those based on a different frame of reference. A metalogical point of view, if applied to the clinical setting, when is able to avoid the risk of creating practices that are not directed by theory, is the only perspective that has the potential to bridge the chasm between divergent schools of psychotherapy based on differently fabricated theories.

This paper has brought to light how—despite the fact that different therapists recognize themselves

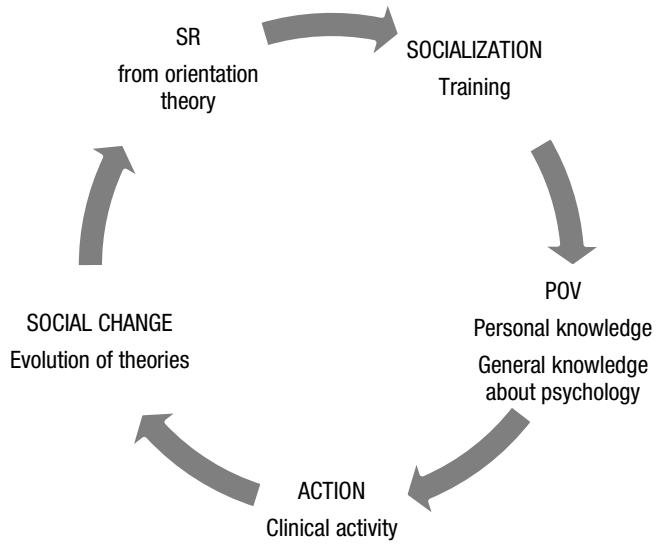

Figure 1. Social co-evolution model for psychotherapeutic tradition. SR = Social Representation; POV = Point of View.

as belonging to a specific school of psychotherapy—many of our participants did express an eclectic knowledge structure. Based on this, it was possible to identify some informal styles of theory management and methods belonging to different traditions. Further studies could be carried out to confirm the appropriacy of the categories explored during this research, increasing the sample size or including psychotherapists representing theoretical models not taken into account during this pilot research. To this aim, it would be interesting to determine, also through quantitative studies, the existence of more specific predictors of the informal types of eclecticism identified; in a qualitative study such as this one, these types of results can only be summarily indicated. It would be equally worthwhile to investigate which of the knowledge structures revealed here are most able to guarantee an increase in the effectiveness of clinical therapy.

In any case, the present research intended to provide some topics for discussion, foreseeing social organization changes that in Italy, for instance, envision the introduction of psychotherapy services in public institutions. As we previously pointed out, public institutions are an important context where a therapist can negotiate meanings related to the organization of his or her therapeutic activity with other, different kinds of professionals. Such a negotiation is becoming a vital issue; however, despite the fact that empirical findings are still ambiguous regarding the matter (Barber, 2009), it is our opinion that pluralism should not become a mere clinical application of eclecticism (Duncan, Parks, & Rusk, 1990). Moreover, discrepancies among points of view emerging from personal narrations and SR from psychotherapeutic theories can prefigure actual evolutionary lines—not yet formalized—according to which models are already changing. It should also be mentioned that the changes in the models are related to clinical practice and to the continuous adaptation of the therapist's knowledge to the cultural and structural changes in contemporary society as well. In this sense, the gap emerging between SR and POV does not necessarily suggest poor clinical expertise in therapists; on the contrary, it can give us an opportunity for critical thinking and a full understanding of the heuristic potential of such forms of knowledge. Sometimes the therapists' contributions originated from a misunderstanding of theoretical issues—that is, were inconsistent from an epistemological perspective (Salvatore, 2011); in other cases, such contributions may represent a well-reasoned attempt to break free from what psychotherapy models risk becoming: normative institutions, inflexible toward any change. With regard to this specific issue, one therapist remarked:

> We ought to distinguish between what it means to be orthodox, to be a good learner in your psychotherapy school, and to be an intellectual. . . . If you are orthodox, you ought to consider a theory, understand it in depth, and practice it. If you are a good learner, you know you ought to interpret such a theory. Actually, you may also be an intellectual, you can consider all the good your psychotherapy school gave you, something good theory gave you, something good inside yourself, and take the risk to begin reasoning about it (Interview 19; female; constructivist).

As a conclusion, we quote Rosati's warning about eclecticism: "If you try to hit a nail in with a spanner, it might work if you have nothing better to use, but it would give a very bad impression if someone tried to unscrew a bolt with a hammer" (as cited in Marhaba & Armezzani, 1988, p. 125).

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Therapeutic Cycles and Referential Activity in the Analysis of the Therapeutic Process

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Abstract. The present study was designed to show the usefulness of a process analysis based on a joint use of two computerized methods – Mergenthaler's Therapeutic Cycle Model (TCM) and Bucci's Italian Weighted Referential Activity Dictionary (IWRAD). This analysis focused on the transcripts of six sessions from the first eight months of a three-year, face-to-face psychodynamic psychotherapy. Both qualitative and quantitative analyses were conducted. Results showed the presence of specific indicators of a good outcome, according to the two approaches, such as the patient's ability to link reflective processes and felt emotions, the occurrence of referential cycles, and the presence of organized and coherent narratives.

Keywords: process analysis, Therapeutic Cycle Model, Referential Activity

The present study proposes an analysis of the therapeutic process based on two computerized instruments for assessing the therapeutic process: Mergenthaler's Therapeutic Cycle Model (TCM; Mergenthaler & Stinson, 1992), and Bucci's Italian Weighted Referential Activity Dictionary (IWRAD; Maskit, Bucci, Bonfanti, Mariani, & Visconti di Modrone, 2004). We will introduce the theoretical backgrounds of these instruments, and underline some similarities between them. Then we will examine the role of some key variables that, according to the two approaches, are supposed to be linked with a good psychotherapeutic process. Finally, we will present a single case study, in order to show the evolution of these variables within each session and across several sessions, by focusing on the significant correlations that emerged among TCM and RA variables. This could provide a useful empirical support for examining the similarities and differences between the two theoretical models.

The literature on the TCM (Mergenthaler, 1996, 1998, 2000, 2003) has shown that the presence of a *connecting* pattern—i.e., the ability to experience appropriate emotional states and, at the same time, to think about them, represents a key aspect of the therapeutic process. According to Karasu (1986), when emotional experience and cognitive control are both significantly present in a given time, a change in the patient is observed. Moreover, connecting events were found associated with good treatment outcomes across different therapies and patients (Mergenthaler, 1996; Mergenthaler & Frost, 2007; Lepper & Mergenthaler, 2007; Nicolò, Mergenthaler, Pontalti, Semerari, & Catania, 2000).

Also the presence of several therapeutic cycles plays a central role in the therapeutic process, because in TCM therapeutic cycles represent clinically significant and productive work. Further, Mergenthaler (1998) observed in successful therapies different phases characterized by a decrease of the pattern *relaxing*—i.e., both low emotional tone and low level of abstraction, which correspond to nonspecific moments that are not directly relevant to the therapeutic process—, and by an increase in both connecting events and number of therapeutic cycles.

The onset of specific fluctuations (i.e., "shift events;" Lepper & Mergenthaler, 2008; Mergenthaler, 2003) in the patient's emotional state plays an important role during the therapeutic process. These shift events indicate, at a microanalytic level, a change in the quality of the patient's affective experience, which shifts from a *deepen-and-provide* state, in which the emotional state is predominantly negative and focused on the problem, to a more positive *broaden-and-build* state, which is focused on the patient's insight and discovery of new opportunities. This transition from a phase of negative experiencing to a more positive one is a necessary precondi-

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tion for connecting. Therefore, we may suppose that the shift events are closely related to the therapeutic change. Mergenthaler (1998) has underlined the active role of the therapist in this process, showing how the therapist can influence the course of treatment by stimulating a series of processes in the patient.

The second method used in this study is the IWRAD (Maskit et al., 2004), a computerized measure of the individual's ability to communicate and transmit his/her own emotional experience to another person. The literature has shown that a good therapeutic process is characterized by an oscillation between a "good hour," related to a high Referential Activity (RA), and a "destabilizing process," involving a low RA (Freedman, Lasky, & Hurvich, 2002). This may depend on the presence—throughout the treatment, but also within any single session (Bucci, 2005a, b)—of a sequence consisting of an activation phase (characterized by a low RA), a symbolization phase (characterized by a high RA), and a reflective phase (in which the RA decreases again). Recent studies (Fogliato, Strappa, Branchini, & Rapisarda, 2009) support the hypothesis that the activation of the referential cycle, or even the presence of several "micro-cycles" within any single session, can be considered useful indicators of a well-organized and well-integrated alternation of the different phases of the referential process.

According to this model, the therapeutic process should encourage a narration of the experience and a reflection (IREF) on it. The referential process can be seen as an alternation of emotional arousal (i.e. the "symbolization" phase, with high IWRAD levels), and narrative restructuring (i.e., the "reorganization" and "reflection" phase, with high IREF levels—i.e., reflexive dictionary). This alternation between symbolization and reflection, which is measured by the IREF/IWRAD negative covariation index, would encourage an improvement of the therapeutic process, by stimulating a better integration between narration and reflection in the patient. In other words, a negative covariation between IREF and IWRAD indicates that the speaker is able to both value words and reflect on his/her experience. In successful therapies, according to Maskit and Bucci (2009), this negative covariation should grow over time.

Some researchers (Bucci & Maskit, 2008; Mariani & De Coro, 2009) showed that the RA is usually higher for patients than therapists, since patients' narratives are characterized by higher levels of emotional activation. However, a study by Rivolta (2009) disconfirmed this finding, and concluded that the therapist, in his mirroring process, uses his/her own affective language in order to facilitate the construction of more integrated narrative of the conflictual topics. In contrast, the literature is unanimous in highlighting that the reflection process is higher for therapists than for patients, since therapist have the task of stimulating reflection processes in patients (Bucci & Maskit, 2008; Mariani & De Coro, 2009).

Aims of the Study

The present study aimed to show the utility of a multi-instrumental analysis of the therapeutic process based on the joint use of Mergenthaler's TCM and Bucci's RA. A first purpose of this analysis was to show the similarities between these two approaches. In particular, both instruments (a) use computerized tools and are applicable to written texts; (b) refer to the narrative form rather than on the text content; (c) consider narratives and linguistic styles as important vehicles of the individual's emotional experience, state of mind, and procedural patterns. Therefore, in both approaches it is important that these narratives involve well-integrated and well-connected elements.

As shown previously, several studies suggest that both TCM and RA are important features of the psychotherapeutic process and may indicate a good treatment outcome. In the present study, we examined in detail some key variables that, according to the two approaches, would be at the basis of a good psychotherapeutic process. We used a single-case approach in order to examine the evolution of these variables within each session and across several sessions, and identify the presence of some indicators of a good psychotherapeutic process.

In particular, our study aimed to:

a) Examine the TCM variables during the therapeutic process, by measuring the presence and increase of the connecting pattern and the therapeutic cycles over time, the transition from a negative experiencing (*deepen-and-provide*) state to a more positive (*broaden-and-build*) state, and the occurrence of shift events;
b) Assess the trend of IWRAD variables during the therapeutic process. In particular, we aimed to explore the presence of referential micro-cycles (activation, symbolization and reflection) within each session, and the progress of narrative style and IREF/IWRAD covariation index across sessions;
c) Measure the correlations between the TCM and IWRAD dictionaries, in order to assess the similarities and differences between the two approaches.

Method

Procedure

The material used in this study is based on the first eight months of a three-year, weekly psychodynamic psychotherapy. Patient's diagnosis was conducted by the psychotherapist herself in the first session, by applying the SWAP-200 (Westen, Shedler, & Lingiardi, 2003) and the QFM-27 (Albasi, Lasorsa, & Porcellini, 2007) and administering the SCL-90-R (Derogatis, 1994) to the patient. As regards the process analysis, three two-session blocks were examined, drawn from different phases of the treatment–more specifically, sessions 4-5, 19-20, and 33-34.

The patient signed informed consent allowing the use of the therapy recordings for clinical and research purposes. The sessions were collected only at the beginning of treatment because, at a certain point of the treatment, the patient asked the therapist to suspend the recording of the sessions because the conversations were more and more intimate and the therapeutic relation was undergoing a turbulent period. Therefore the therapist decided to keep the recordings out of the treatment, in order to guarantee a more collaborative climate.

The audio-recordings of the sessions were transcribed and analyzed according to the TCM and IWRAD standards. In particular, in the case of TCM, the transcriptions were made following standardized transcription rules (Mergenthaler, 1999; Mergenthaler & Stinson, 1992); then we proceeded to submit them to the Cycle Analysis Model software (Mergenthaler, 1998). As regards Bucci's IWRAD, we applied specific transcription rules for the Italian language (Discourse Attributes Analysis Program; DAAP). Then, we obtained IWRAD (Maskit et al., 2004) and IREF (Mariani & De Coro, 2009) indices, and a graphical representation of these variables by means of the Systat Software.

Case Presentation

Bianca is a 29 year-old woman, who requested treatment for anxiety and mild depersonalization states that occurred following the ending of a very problematic romantic relationship. The relationship with her mother was very disorganized and was characterized by aggression, criticism and control. Although the relationship with her father was relatively more stable and positive, overall, Bianca experienced her family as unsupportive and distant. Her experience with her family showed a history of insecure attachment, which may have a role in her internalizing and externalizing problems (e.g., Sarracino, Presaghi, Degni, & Innamorati, 2011).

At the beginning of the treatment, Bianca depended financially on her parents; however, she showed good coping skills and excellent knowledge resources. She graduated with honors in psychology, enrolled in a master's degree and committed to achieving important academic accomplishments. However, despite these cognitive resources, her ability to manage intimate and romantic relationships was highly inadequate. It was in this domain that Bianca showed many problems.

Instruments

Shedler-Westen Assessment Procedure—200. (SWAP-200; Westen, Shedler, & Lingiardi, 2003). This instrument is based on a Q-sort methodology, and is used in the diagnosis and treatment of personality and personality disorders. The 200 items of the SWAP derived from the DSM-IV axis II, and range on a scale from 0 to 7 (from "not descriptive at all" to "very descriptive"); the distribution of items is not free. The SWAP software generates three score profiles. The first profile provides scores for DSM-IV personality disorders (PD Scores). The second provides scores for an alternative set of personality syndromes that were derived empirically through SWAP research (Q-factors). The third provides scores for 12 trait dimensions (factor scores). Several studies (Westen, Shedler, & Lingiardi, 2003) support the reliability and the predictive validity of the SWAP-200 compared to a series of significant indices, such as personality disorders, hospitalization frequency, suicide attempts, and other clinical measures.

Questionnaire on Mental Functioning. (QFM-27; Albasi, Lasorsa, & Porcellini, 2007). This clinician-report questionnaire consists of 27 items, and is designed to guide the assessment of patients according to the PDM (Psychodynamic Diagnostic Manual) M-Axis (capacity for regulation, attention and learning; capacity for intimacy and relationships; quality of internal experience; capacity for affective experience, expression and communication; defensive patterns and capacities; capacity to form internal representations; capacity for differentiation and integration; self-observing capacities; capacity to construct or use internal standards and ideals) and the three levels of personality organization of P Axis (Healthy Personalities, Neurotic-Level Personality Disorders and Borderline-Level Personality Disorders).

Symptom Checklist-90-Revised. (SCL-90-R; Derogatis, 1994). This self-report scale is composed of 90 items that represent the more common symptoms observed in psychiatric patients. It assesses 9 primary symptomatic dimensions: somatization, obsessivity, compulsiveness, sensitivity to interpersonal relationships, depression, general anxiety, hostility, paranoid ideation, and psychoticism. The scale also provides 3 additional psychopathological indices: General Severity Index (GSI), Positive Symptoms Distress Index (PSDI), and Positive Symptoms Total (PST).

The Therapeutic Cycles Model. (TCM, Mergenthaler, 1996, 1998, 2000, 2003). This instrument is grounded on the Resonating Mind Theory (RMT), a clinical theory about the therapeutic change, which is based on a computerized method that allows the detection of clinically significant aspects in each session or during a whole treatment course. It refers to two different change variables (Karasu, 1986), i.e., "emotion" and "abstraction". These two factors are combined together and give rise to four emotion-abstraction patterns; the most important one, in the perspective of change, is "connecting", i.e., the ability to get into personal emotional states and, in the meantime, think about them. In optimal

cases, these patterns follow a specific chronological sequence, called therapeutic cycle, which consists of different phases: *relaxing* (characterized by low emotional tone and low abstraction), *experiencing* (when patient's emotions are aroused), *connecting* (when both emotional tone and abstraction are high), *reflecting* (when the patient starts to think about its feeling), and then *relaxing* again. Mergenthaler (1996) suggests that a therapeutic cycle is a clinically significant event.

Therapeutic cycles are highlighted by a method consisting of two parts: a previous transcription based on standard criteria (Mergenthaler, 1999; Mergenthaler & Stinson, 1992) and a proper computerized analysis that uses a specific software (Mergenthaler, 1998). This software can calculate emotion-abstraction patterns and therapeutic cycles thanks to two dictionaries that measure the frequency of emotion and abstraction words. The emotional tone dictionary includes all those words (adjectives, adverbs or verbs) having a positive or negative value. The abstraction dictionary, instead, includes words indicating general categories of objects or entities. In addition, another dictionary measures the narrative style, i.e., different narration modalities to tell past events throughout specific time connections.

Some empirical studies support the principles of RMT and data issued from TCM. In particular, as said above, some results underline how connecting can be considered as the go-between of the therapeutic change, since significant correlations emerged between the psychotherapeutic intervention and the connecting, and between the connecting and the therapeutic change (Mergenthaler & Gelo, 2007; Nicolò et al., 2000).

Referential Activity Linguistic Measures. (RA, Maskit et al., 2004). This method is based on Wilma Bucci's Multiple Code Theory (Bucci, 1997). This theory of mental functioning identifies three ways to elaborate information: symbolic verbal code, symbolic non-verbal code, and non-symbolic code. These formats are included in the so-called Referential Process, which is operationalized in terms of Referential Activity (RA)—i.e., the ability to express one's non-verbal, emotional or somatovisceral experience in words. In particular, according to Bucci, in a therapeutic process we can observe a referential cycle consisting of an *arousal* phase, characterized by a low RA, a *symbolization* phase, related to a high RA, and a *reflection* phase, where RA becomes lower (Bucci, 1999). Nevertheless, recent studies have revealed the presence of micro-cycles in any single session, rather than one homogeneous referential cycle (Fogliato et al., 2009).

RA is assessed using a manualized codifying system (Bucci & Mc Kay, 1992), and since 2004 has been applied together with a computerized method, the IWRAD dictionary (Maskit et al., 2004). This method analyzes session narratives and compares every word with the occurrences listed in its dictionary. The IWRAD produces micro- and macro-analyses for each session, and calculates a series of indices referring to specific dictionaries—e.g., not-fluent (DF), ref lexive (IREF), and affective (IAFF) words.

Results

DSM-IV, SWAP-200, QFM-27, and SCL-90-R Diagnoses

At the beginning of the treatment, Bianca's DSM-IV-TR (APA, 2000) diagnosis was Anxiety Disorder Not Otherwise Specified (Axis I). Regarding Axis II, in the SWAP-200 Bianca obtained a Q-score of 60.56

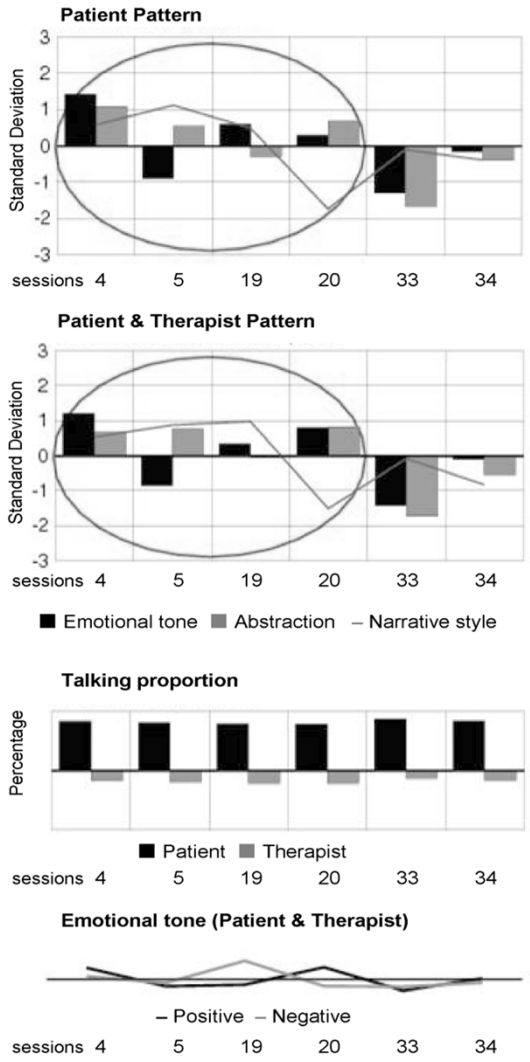

Figure 1. Analysis of six sample sessions in the first eight months of Bianca's treatment. The first graph shows the trend of patient emotion-abstraction patterns. The second graph shows the trend of patient/therapist emotion/abstraction patterns. In both graphs, the x-axis represents the sessions and the y-axis represents the standard deviations from the mean. The circle indicates a therapeutic cycle. The third graph shows, in percentage, the proportion of words spoken by patient and therapist. The fourth graph represents the trend of positive and negative emotional tones for both therapist and patient.

Table 1. Comparison between different groups of sessions in relation to connecting patterns, therapeutic cycles and RA indexes

	Session block						
	A	B	C	A *vs* B	A *vs* C	B *vs* C	B *vs* AC
	Mean (*SD*)	*Mean* (*SD*)	*Mean* (*SD*)	*t*	*t*	*t*	*t*
Connecting P & T	.26 (.44)[a]	.32 (.47)[b]	.27 (.44)[c]	−1.004	−0.151	0.855	−1.080
Connecting P	.20 (.40)[a]	.21 (.41)[b]	.27 (.45)[c]	−0.204	−1.265	−1.042	0.499
Therapeutic Cycles P & T	.38 (.49)[a]	.45 (.50)[b]	.35 (.48)[c]	−1.029	0.553	1.578	−1.507
Therapeutic Cycles P	.30 (.46)[a]	.24 (.43)[b]	.37 (.48)[c]	1.123	−0.989	−2.103*	1.831
IWRAD P	.49 (.05)[d]	.49 (.03)[e]	.50 (.03)[f]	0.221	0.011	−2.464*	1.078
IREF P	.02 (.07)[d]	.02 (.04)[e]	.02 (.05)[f]	2.458*	2.300*	−0.192	1.735
IREF/IWRAD P	−.01 (.38)[g]	−.04 (.40)[h]	.00 (.38)[i]	2.489*	-0.819	−3.070*	3.118*

Note. Block A = sessions 4-5; Block B = sessions 19-20; Block C = sessions 33-34. P = patient; T = therapist; IWRAD = Italian Weighted Referential Activity Dictionary; IREF = Italian Reflection ictionary; IREF/IWRAD = IREF/IWRAD negative covariation index.
[a] $n = 112$. [b] $n = 106$. [c] $n = 112$. [d] $n = 931$. [e] $n = 610$. [f] $n = 654$. [g] $n = 1862$. [h] $n = 1219$. [i] $n = 1312$.
*$p < 0.05$

for the histrionic personality trait and 60.96 for the high-functioning depressive trait.

According to the QFM-27, the patient showed various problems related to intimate relationships. The percentages related to her mental functioning were 45.76% neurotic, 27.12% deficiency, and 27.12% resources. More specifically, Bianca's most problematic area was her ability to form intimate relationships, due to her feelings of ambivalence, and her difficulty in understanding the consequences of the interactive behavior that might affect her involvement in intimate relations.

Finally, the SCL-90-R revealed high scores (T > 50) on the "depression", "hostility" and "paranoid ideation" scales.

Analysis of the Therapeutic Cycles

The TCM analysis (Figure 1) shows the evolution of the emotion-abstraction pattern, and allowed us to identify the presence of key moments in Bianca's treatment. As regards the progress of the connecting pattern and the number of treatment cycles in the course of time, we did not observe a steady increase of these variables in the therapeutic dyad, but rather a more complex pattern (Figure 2).

As regards the percentage of the patient/therapist connecting, there is a "peak" in correspondence with the central sessions, in particular session 20. It should be noted that the percentage of patient's connecting is significantly lower (Table 1) in sessions 4-5 and

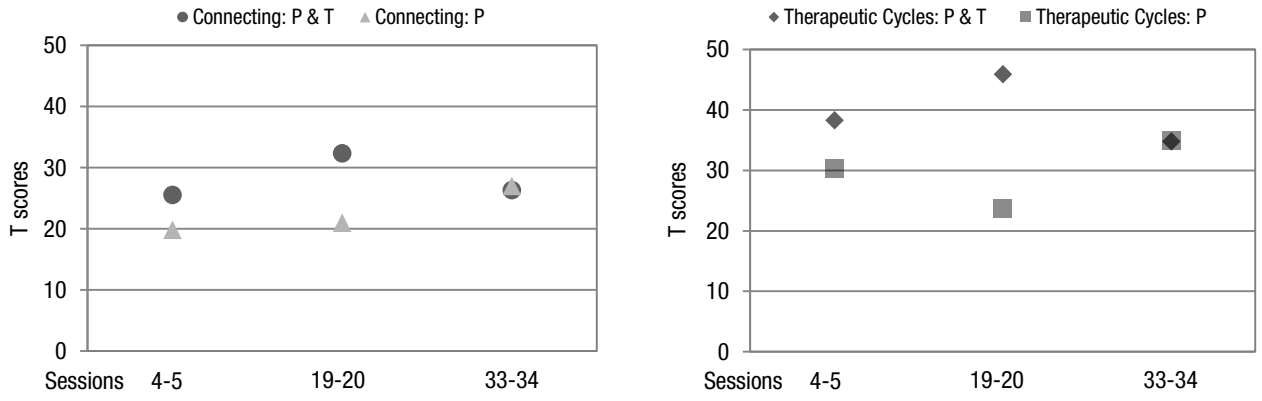

Figure 2. Connecting patterns and therapeutic cycles. The first graph shows, in T scores, the presence of the connecting pattern in patient/therapist (P & T) and patient (P) narratives, during the three two-session blocks considered. The second graph shows the therapeutic cycles in patient/therapist (P & T) and patient (P) narratives.

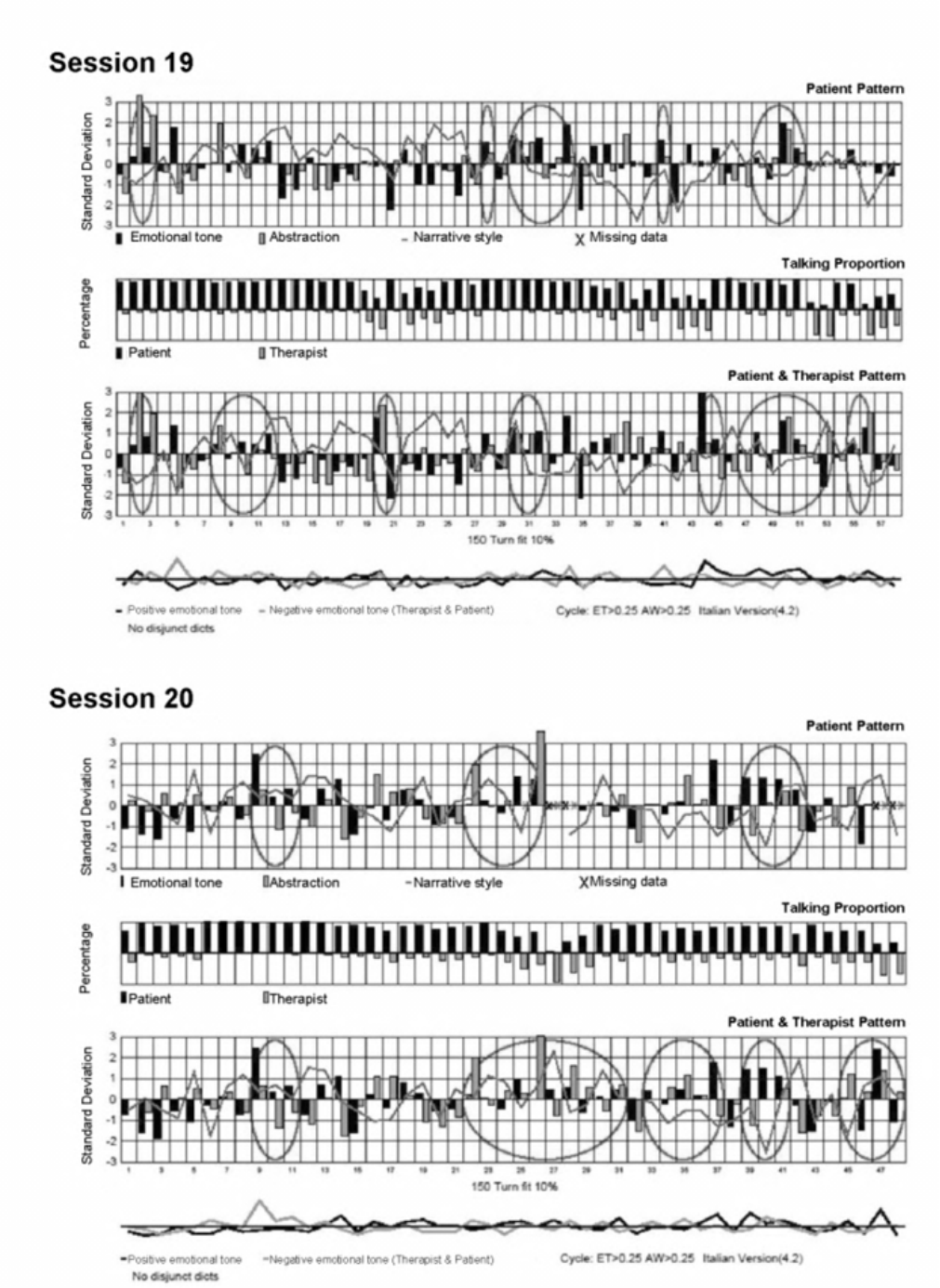

Figure 3. Microanalysis of the therapeutic cycles: comparison between sessions 19 and 20. The figure shows the graphical output of two relevant sessions.

19-20, and "realigns" with the patient-therapist connecting only in sessions 33-34.

We observed a similar trend, even more pronounced, in the percentage of treatment cycles. Also in this case, the patient/therapist score forms a peak in correspondence with sessions 19-20, while the percentage of therapeutic cycles relating to patient's verbalizations is lower (Table 1). However, once again, it "realigns" with the patient-therapist score in sessions 33-34. A more detailed analysis of the sessions examined shows a pervasive presence of connecting events and treatment cycles. Figure 3 shows the graphical output of two relevant sessions.

In session 19 we observe a high narrative style, several shift events and a peak of negative emotions. This may have laid the groundwork for those signs of change detected in session 20, characterized by very positive emotions. Following is an example of a connecting episode, drawn from session 20:

> T*:* So, this impossibility to relate [to her boyfriend] looks like other situations in which you felt ineffective and powerless.
> P: Mmh/hesitation (00:00:05) . . . very often when I try to talk to my parents.
> T: Aha/exclamation.
> P: Generally speaking.

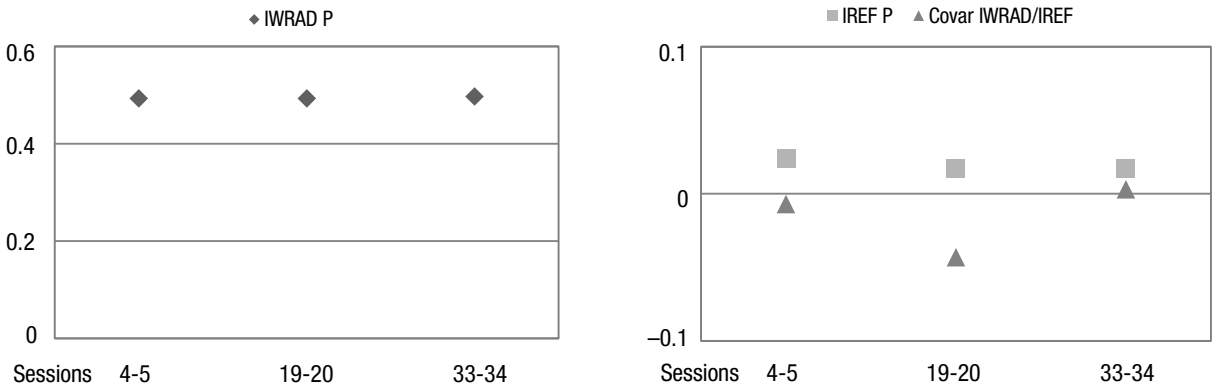

Figure 4. Referential Activity indexes. IWRAD = Italian Weighted Referential Activity Dictionary; IREF = Italian Reflection Dictionary; IREF/IWRAD = IREF/IWRAD negative covariation index. The first graph shows a comparison between the patient's IWRAD values among the three session blocks considered. The second graph shows the IREF values and IREF/IWRAD covariation index in the same session blocks.

In this passage, the therapist asks the patient to reflect on the feeling of powerlessness that she feels when trying to relate to her boyfriend, and allows her to link the relationship with her boyfriend with her family situation. Notably, the patient needs a few seconds to fully understand this.

The presence of connecting events is concentrated mainly in session 20. More in detail, there is a transition between sessions 19 and 20 from a *deepen-and-provide* state, characterized by negative experiencing, to a *broaden-and-build* state, characterized by positive emotions (Figure 3). The *deepen-and-provide* state is stimulated by therapeutic interventions such as the following:

> T: Let's stop on the first point, that [your boyfriend] is unwell, and the very fact that not feeling good leads him to the end of his resources. How do you think a person may feel in this state?

On the other hand, the *broaden-and-build* state is encouraged by therapeutic interventions such as the following:

> T: And yet there was a need for a series of factors, including the fact that . . . you are obtaining academic success . . . and you are starting to open up to others.

Also from a clinical point of view, session 19 appears to be a turning point, which seems to activate in Bianca the ability to make decisions and live out her experiences; this appears to announce the change observed in session 20 (Figure 3). Session 20, in fact, introduces Cristina, a person who will become very important in Bianca's life. The patient felt that she had finally found a friend, and her ability to cope with her relational issues improved. This change in her ability to express positive emotions and connect with emotional and cognitive processes may depend not only on this close friendship but also on a new way of seeing her relational issues. In fact, now she starts to put her parents in the background and have more respect for herself and their current relationships.

Analysis of the Referential Activity

The RA analysis shows that the IWRAD does not increase regularly during the sessions. There is, however, a slight increase in the patient's narrative ability toward the end of this initial treatment period (Figure 4).

If we consider the IREF trend (i.e. those words that suggest "how people think and communicate thoughts"), we can see that it is higher in sessions 4 and 5 compared to subsequent sessions. This presence of reflective processes in the early stages of the treatment may represent a defensive attitude on the part of the patient, who could now use her efficient cognitive functioning to cope with her problems.

Finally, the trend of the IREF/IWRAD covariation

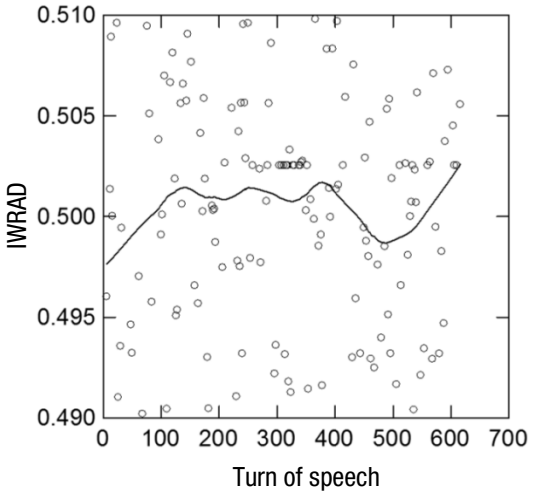

Figure 5. IWRAD trend within session 20. IWRAD = Italian Weighted Referential Activity Dictionary. In this graph, the x-axis represents the turn of speech, the y-axis represents the IWRAD within session 20.

index shows that sessions 19-20 present higher values than sessions 33-34. Therefore, the negative covariation in our sample of sessions does not increase over time.

Within each session, we can see the occurrence of multiple micro-cycles rather than a single referential cycle. Figure 5 shows the trend of these micro-cycles during session 20 across its speech turns. As we can see from the graph, after a slight rise in the IWRAD value, we can identify the presence of three referential cycles.

Comparison between Therapeutic Cycles and Referential Activity Dictionaries

Comparing TCM and IWRAD dictionaries that share similar theoretical definitions, we observed a positive correlation between Mergenthaler's abstract words and Bucci's reflective words ($r = .32$, $p < .001$), a higher positive correlation between Mergenthaler's emotional dictionaries and Bucci's affective words, especially for the positive words ($r = .60$, $p < .00$), and a weak but significant positive correlation between Mergenthaler's narrative style and Bucci's IWRAD ($r = .14$, $p < .01$).

Discussion

In conclusion, the instruments for assessing therapeutic process used in this study where able to show, session by session, some indices of a good therapeutic process hypothesized by TCM and RA approaches, e.g. the presence of a connecting pattern. In our data, this pattern emerged in several sessions, and this, according to the previous literature (Mergenthaler, 1996, 1998, 2000, 2003), may represent a clear sign of the presence of both intense emotional experience and high cognitive resources in the patient.

In contrast, the connecting did not show a steady increase, but a more complex pattern. In particular, the patient-therapist connecting score showed a "peak" in sessions 19-20, whereas the patient's connecting score was lower in the initial and middle sessions, and "realigned" only in the later sessions examined in our study.

It is important to mention a limitation of this study, i.e. the small number of sessions examined. In fact, a complete session-by-session analysis (e.g. Sarracino & Dazzi, 2007) should improve the opportunity to detect any change and micro-change in the therapeutic process. Unfortunately, at a certain point of the treatment, the patient asked the therapist to suspend the recording of the sessions because their conversations were more and more intimate and the therapeutic relation was undergoing a turbulent period. The therapist then decided to keep the recordings out of the treatment, because by agreeing to the patient's request she was able to restore a more collaborative climate.

Another limitation of the study is due to the fact that the first eight months of a long-term psychotherapy may be too short a period to notice a significant improvement in the patient with this specific assessment procedure. Moreover, we should consider that the six sessions examined are not consecutive. Sessions 33 and 34, for example, followed a break due to summer vacation: The absence of connecting, reflecting or experiencing patterns, therefore, may depend on the fact that more sessions were needed to restore a fully productive clinical work.

Moreover, it is also possible that the connecting pattern increases physiologically after a specific phase in which this ability rapidly declines. It is unlikely, in fact, that a linear and constant increase of the connecting pattern is essential to the change; in other words, we suppose that this improvement might occur in several ways, and these different modalities might constitute an interesting argument for future research.

In our set of sessions, the transition from a *deepen-and-provide* state—characterized by a negative experiencing pattern—to a *broaden-and-build* state—characterized by more positive feelings, emerged in the middle sessions. This may indicate that these sessions may have a clinical relevance in this study. The higher number of shift events of session 19 might have a role in promoting the therapeutic change (Lepper & Mergenthaler, 2008; Mergenthaler, 2003). Indeed, shift events indicate, on a micro-analytic level, the presence of a change in the quality of the patient's affective experience, which shifts from an emotional state, mostly focused on patient's difficulties, to a state oriented to the insight and the discovery of new opportunities.

By examining the IWRAD trend, we observed the presence of several referential micro-cycles in each session considered. According to previous studies (e.g. Freedman et al., 2002), this may indicate a good functioning of the therapy, because it implies a correct alternation of the different phases of the referential process-activation, symbolization, and reflection. The orderly progression of these phases observed in our set of sessions, particularly in sessions 19-20, shows that it was possible to elicit in the patient emotional patterns and experiences that were dissociated from their symbolic meaning, to activate a link between the sub-symbolic components and the words, and to reflect on the meanings of the stories narrated and shared by the patient.

Moreover, the affective component of the therapeutic relationship helped the patient to improve the complexity of her self-account, as suggested by previous studies (e.g., Mariani & De Coro, 2009). In fact, in the 8-month period considered in this study, we observed an increase, although slight, of the patient's IWRAD and narrative abilities.

Finally, the negative covariance between IREF e

IWRAD is higher in the "middle" sessions; in contrast, the later sessions examined in this study showed a lower negative covariance, contrary to previous literature. Once again, this might depend on the fact the our data does not refer to the entire treatment but to the first eight months, and this period might be too short to observe such an improvement.

Our study showed, in a preliminary way, the usefulness of a joint use of TCM and IWRAD, two computerized methods that share many characteristics and, therefore, may be considered mutually enriching and, in part, interchangeable. In fact, both TCM and IWRAD are focused on the linguistic style rather than a content analysis. The language used in the narratives is considered an important vehicle of unconscious thought, states of mind, and emotional experiences.

Both TCM and IWRAD require that these narratives are well integrated and connected, although with some differences. In particular, for TCM this linking concerns the ability to experiment an emotional state and, in the same time, to be able to reflect on it. In contrast, for IWRAD this integration is between the verbal and non-verbal experience.

Both Mergenthaler's therapeutic cycle and Bucci's referential cycle are regarded as key aspects of the therapeutic process and indices of a good outcome. Besides the fact that both the instruments are based on the findings and the concepts derived from cognitive psychology and neuroscience, it is important to note another similarity: also TCM includes a dictionary specifically designed to assess referential activity (Mergenthaler & Bucci, 1999). In fact, Mergenthaler originally worked with Bucci in a preliminary version of the IWRAD, called the "Computerized measure of the Referential Activity" (CRA; Mergenthaler & Bucci, 1999). In the CRA, the referential activity was considered as an index of the narrative style, although not equivalent to it. Moreover, the DAAP software calculates some indices of the affective and reflective words that may be compared with TCM's emotion tone and abstraction. In our study, this comparison showed significant positive correlations between Mergenthaler's abstract words and Bucci's affective words, and between Mergenthaler's narrative style and Bucci's IWRAD. The relatively low values, although significant, of these correlations may depend on an imprecise matching between the two dictionaries, which shows how important is to use both the instruments to cover different aspects of the therapeutic process.

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The Model of Sequential Brief-Adlerian Psychodynamic Psychotherapy (SB-APP): Specific Features in the Treatment of Borderline Personality Disorder

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Abstract. Sequential Brief–Adlerian Psychodynamic Psychotherapy (SB-APP) is a time-limited (40 weekly sessions) psychotherapy for a wide range of psychic disorders, delivered in sequential and repeatable module (in each module a different therapist is involved). Its specific features in the treatment of Borderline Personality Disorder (BPD) are presented, concerning setting, technique and therapist's emotional attitude. Four Personality Functioning Levels (PFLs) are focused, in order to provide targeted interventions for more homogeneous subsets of BPD patients. PFLs are assessed by evaluating symptoms, quality of interpersonal relationships, overall social behaviours, cognitive and emotional patterns, and defense mechanisms. Two clinical vignettes describe how SB-APP strategies vary according to patient's PFLs, also with respect to the predetermined treatment end. Preliminary reports of SB-APP effectiveness in the treatment of BPD are summarized and discussed.

Keywords: borderline personality disorder, personality functioning levels, time limited psychotherapy, Sequential Brief-Adlerian Psychodynamic Psychotherapy

According to the literature, Borderline Personality Disorder (BPD) is characterized by self-other representational disturbance (Bender & Skodol, 2007), affect dysregulation and impulsivity with risk of suicide (Herpertz, 2011), severe and persistent impairment in social functioning (Gunderson et al., 2011). The scientific literature suggests that BPD core features should be carefully detected in order to provide patients with a consistent, effective treatment (Zanarini, 2009).

Remarks on BPD Psychopathology

The cornerstone of the psychodynamic approach to personality disorders is that descriptive features of personality pathology that characterize a specific personality disorder should reflect the nature and the organization of underlying psychological structures (Caligor & Clarkin, 2010). According to the bio-psycho-social model of psychiatric disorders (Fassino, Abbate Daga, & Leombruni, 2007), the following BPD pathogenic factors are considered (Fassino, Amianto, & Ferrero, 2008; Ferrero, 2009; Leichsenring, Leibing, Kruse, New, & Leweke, 2011; Livesley, 2008): a) vulnerability, b) relevance of significant life events and c) personality dynamic organization.

a) Concerning vulnerability, both genetic and environmental factors affect the risk of BPD (Kendler et al., 2008). More in detail, considering the altered modalities of processing brain functions, in BPD patients it is possible to observe affective instability, a low threshold for impulsive aggressiveness and impairments in cognitive and emotional empathy (Herpertz, 2011; Wolf et al., 2011). These findings thus support a conceptualization of BPD that includes deficits in both inferring others' mental states and being emotionally attuned to another person (Dziobek et al., 2011).

These alterations in critical regulatory domains influence the way representations of self and others

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are internalized (Siever & Weinstein, 2009). Moreover, psychosocial vulnerabilities have to be considered as mainly rooted in early defective or conflicting experiences. According to an Adlerian psychodynamic model, an adequate development of community feeling, that proceeds from a good quality of primary tenderness relationships (Bolterauer, 1982), has to be considered a favorable factor of self-cohesion and identity. In contrast, depriving or conflictive experiences during childhood may permanently disturb the relational and psychological balance of the individual.

We mould our mind initially in our parents' and other attachment figures' minds. The parent's ability to be responsive to the child, that is to mirror his or her internal state, is the 'core' of affect regulation (Fonagy & Target, 2007).

Thus, disorganization of the attachment system during infancy (Fonagy, Luyten, Batenian, Gergely, Strathearn, Target, & Allison, 2010) predisposes to separateness intolerance, as a core item of BPD pathology (Choi-Kain, Fitzmaurice, Zanarini, Laverdière, & Gunderson, 2009; Steele & Siever, 2010).

b) Individual vulnerability and adverse life events may interact to lead to the disorder (Leichsenring et al., 2011), but the role of trauma in the BPD development remains unclear. Although recent studies suggest that BPD is not a trauma-spectrum disorder and that it is biologically distinct from posttraumatic stress disorder, high rates of childhood abuse and neglect do exist for individuals with personality dysfunctions. Clusters of personality symptoms seem to be unrelated to specific abuses but they may relate to more enduring traumatic aspects of interpersonal and family environments in childhood (Goodman, New, & Siever, 2004).

Adverse non traumatic life events provoking symptoms are not likely to be detected, since their relevance is not directly depending on their real impact, but on their symbolic significance (Adler, 1912). Current social and family dynamics usually play an important role in the pathogenesis of BPD (Rovera, 1996). The identity diffusion observed in these patients must be understood in relation not only to the individual patient's history and inner structures but also to contemporary post-modern culture and social organization (Lasch, 1991; Jørgensen, 2006). It is to be hoped that research on the cross-cultural and intracultural variability between different psychiatric diagnostic groups (Sundbom, Jacobsson, Kullgren, & Penavo, 1998) will be further developed.

c) However, the assumption of diathesis-stress model with traumatization as a necessary but etiologically insufficient condition seems justified (Driessen et al., 2002). The potential role of specific life events in BPD pathology should be assumed to result from the interplay between psychosocial adversities and a maladaptive structure of personality (Livesley, 2008). Consequently, personality disorders should be also regarded as disorders of adaptation and compensation (Adler, 1912), as extreme personality traits are not *ipso facto* dysfunctional (Svrakic, Lecic-Tosevski, & Divac-Jovanovic, 2009). We consider that dynamic personality organization corresponds to the whole set of mechanisms of adaptation and defense of the individual, both in facing inner experiences and interacting with others (Morbach, 2007). The evaluation of the defense mechanisms is one of the most promising fields in the psychodynamically oriented empirical research on personality disorders (Bond & Perry, 2004; Lingiardi et al., 1999; Lingiardi & Madeddu, 2002) and, in contrast to other approaches, a dimensional model based on defense mechanisms is easily applied to personality disorders (Bowins, 2010). Considering patient clinical variables, we refer (Fassino et al., 2008) to three pathological personality organizations, according to Paulina Kernberg (P. F. Kernberg, 1994): Psychotic Personality Organization (PPO), Borderline Personality Organization (BPO) and Neurotic Personality Organization (NPO).

The patients with BPO have an unstable identity: The self-other image is preserved by rigid defenses aimed at safeguarding the subject from the perception of ambivalence (Ferrero, 2009). Borderline defenses are characterized by: splitting, denial, idealization and devaluation, projective identification, omnipotent control and acting-out (P. F. Kernberg, 1994).

It is not only BPD but also other prevalent and severe psychiatric disorders that are related to BPO (Van Asselt, Dirksen, Arntz, & Severens, 2007) and a lot of studies (Presniak, Olson, & Macgregor, 2010) demonstrate important differences in defense use between borderline and other axis II patients across both observer interviews and self-report measures (Defense Style Questionnaire-DSQ; Andrews, Singh, & Bond, 1993).

More specifically, according to recent research (Zanarini, Weingeroff, & Frankenburg, 2009), borderline patients have significantly higher DSQ scores on some immature defenses (Vaillant, Bond, & Vaillant, 1986), namely acting out, emotional hypochondriasis, passive aggression and projection, on some imaging-distorting defenses (Perry & Cooper, 1986), namely projective identification and splitting, and on undoing, that is a neurotic-level defense (Vaillant et al., 1986). Particularly, a trio of defenses (acting out, emotional hypochondriasis and undoing) may explain some core clinical aspects of BPD (impulsivity, demandingness and making amends). On the contrary, narcissistic defenses (Perry & Cooper, 1986) associated to BPO, such as devaluation, omnipotence and primitive idealization, seem not strongly related to borderline psychopathology.

Treatment Problematic Issues

Clinical experience supported by the systematic review of recent literature shows that the severity of

BPD symptoms and of social maladjustment is not sufficiently influenced by medication (Stoffers et al., 2010). There is some evidence that in order to avoid this pattern of high use of drugs, the lack of effective drug treatments should be balanced by the application of structured psychotherapies within the available treatment options (Bender et al., 2006).

Currently, both cognitive-behavioral and psychodynamic specific psychotherapies for borderline disorders seem effective to reduce the severity of psychopathology (Zanarini, 2009). Some evidence suggests that long-term treatments could be useful in avoiding premature ruptures in the therapeutic alliance with patients with attachment disturbances (Choi-Kain et al., 2009), early defective and conflicting experiences. Nevertheless these approaches are often unavailable due to insufficient resources and do not resemble treatment as usual (TAU), which is characterized in general by pharmacotherapy, rehabilitative interventions and unstructured psychological supports, although no research has examined it in detail (Paris, 2010).

On the other hand, shorter psychotherapeutic treatments, which are currently effective for borderline patients, are useful in order to address their specific disruptive behaviors, but they are less effective in reducing their heavy Mental Health Services (MHS) use, that is possibly related to core affective features, such as intolerance of being alone and conflicts over dependency (Choi-Kain, Zanarini, Frankeburg, Fitzmaurice, & Reich, 2010).

In the current literature (Zanarini, 2009; Paris, 2010) the development of briefer forms of treatments that are less complex and have a lower frequency than long term psychodynamic psychotherapies is recommended, in order both to adapt to the extensive problems of borderline patients and to reduce their heavy and non-therapeutic MHS use. However, literature data concerning time-limited psychotherapy effectiveness with BPD patients is not univocal at all. Thus, some possible negative consequences are as follows: low treatment intensity (Leichsenring, 2005), deconstruction of the working alliance (Gunderson, 2008) and risk of traumatic abandon (Koekkoek, van Meijel, Schene, & Hutschemaekers, 2009), due to BPD patients' specific vulnerability (reduced empathy, separateness intolerance) and personality organization (high use of self-other image distorting defenses; Zanarini et al., 2009).

Nevertheless, a time-limited treatment could also enhance some positive factors (Leibovich, 1983; Ferrero & Simonelli, 2006; Paris, 2007): structuring psychic internal boundaries, since BPD patients have deficient psychic structures and lead chaotic lives (Paris, 2010), decreasing omnipotence, expanding time for assimilation and respecting crisis moments. Furthermore, according to a 10-year longitudinal study on BPD (Choi-Kain et al,. 2010) some behaviorally-oriented features that represent clinical priorities, such as recurrent breakups, sadism, self-harm, demandingness and boundary violations tend to remit quickly and do not need long-term treatments. Finally, drop-out of borderline patients (Sledge, Moras, Hartley, & Levine, 1990) in time-limited psychotherapy is lower than those in long-term treatments and short-term treatments without any set time limit.

Aims of the Paper

In order to overcome these problems, a Public Training & Research Network on Adlerian Psychodynamic Psychotherapy (APP) for Personality Disorders (University of Turin, Neuroscience Department, Psychiatry, Eating Disorders Unit; SAIGA School of Psychotherapy, Turin, Healthcare Agency Turin 4, Department of Mental Health, Psychotherapy Unit) has been operating in Turin since 2004 and its main aim is to propose and test a psychotherapeutic technique for the treatment of BPD, taking into account these following objectives:

a) *Accessibility*. This refers to MHS efficiency (Paris, 2010; Zanarini, 2009): a time-limited psychotherapy with a low sessions frequency.
b) *Ductility*. This refers to a model which is not only devoted to treating BPD patients (Paris, 2010; Weinberg et al., 2010).
c) *Continuity*. This refers to dependence and separation (Koekkoek et al., 2009): psychotherapy as a part of a coherent clinical treatment plan.
d) *Specificity*. This refers to appropriate patient/treatment matches (Hadjipavlou & Ogrodniczuk, 2010; Verheul & Herbrink, 2007): a psychopathology-based psychotherapy.

The aim of this paper is to present Sequential Brief-Adlerian Psychodynamic Psychotherapy (SB-APP) which is a treatment for a wide range of psychiatric disorders (Amianto et al., 2011; Ferrero, 2009; Ferrero & Simonelli, 2006).

More in detail, the paper aims at describing its specific features in the treatment of BPD, concerning treatment plan and setting, elements of strategies and techniques, therapist's emotional attitude and countertransference. In order to exemplify some aspects and the results of this psychotherapeutic technique we are going to provide you with two clinical vignettes and the outcomes of a preliminary randomized clinical study.

Sequential Brief-Adlerian Psychotherapy (SB-APP)

SB-APP is a treatment based on overall theory and practice of "Individual Psychology" (IP). The term "Individual Psychology" (IP) refers to the theoretical and clinical contributions to psychotherapy started by Alfred Adler (1870-1937), one of the first

Viennese psychoanalysts, who separated from Freud in 1911. Adlerian psychology is based on different theoretical foundations compared with psychoanalysis (i.e., the importance of the desire for power and social feelings in the individual's lifestyle and intrapsychic dynamics), but it foreshadows some modern psychoanalytical developments, with particular regard to the intersubjective aspects of psychotherapeutic treatments and the importance of social and cultural environment.

SB-APP is a psychodynamic-oriented therapy. It relates the individual's actual symptoms, maladaptive coping and psychological suffering to unconscious dynamics even though the psychic structure or the symbolic meaning of the patient's communications are not necessarily the main targets of the therapist's interventions (Gorton, 2000).

SB-APP is a time-limited (40 weekly sessions) treatment, delivered in sequential and repeatable modules (a different therapist is involved in each module). Like Dialectical Behavior Therapy-Brief (DBT-B) and Cognitive Behavior Therapy (CBT), SB-APP is a shorter therapy compared to twelve or eighteen-month treatments with Dialectical Behavior Therapy (DBT), Transference Focused Psychotherapy (TFP) and Mentalization Based Treatment (MBT). In this way, SB-APP treatment meets criteria of accessibility.

SB-APP was originally conceived for the treatment of a wide range of personality disorders, with or without DSM IV-TR Axis I disorders comorbidity (excluding schizophrenia and mood bipolar disorder), both in private practice and in public Mental Health Services (MHS), as a part of multidisciplinary patient care. In this way, SB-APP treatment meets criteria of ductility and continuity.

SB-APP treatment varies according to different psychiatric disorders. More specifically, strategies and techniques are focused and tailored according to patients' psychopathological functioning. In this way, SB-APP treatment meets criteria of specificity.

Elements of Treatment Plan and Setting

In contrast to the treatment of other less severe psychic disorders, SB-APP for BPD patients is usefully delivered as part of a clinical project, which involves another therapist at least, providing overall clinical management, non-scheduled interventions, crisis interventions and pharmacotherapy, when suitable. This proceeds from BPD symptomatology, including impulsive aggressiveness, risk of suicidal attempts, affective instability, demandingness and depression. Nevertheless, when symptoms are particularly severe and numerous, they are better addressed by a multidisciplinary MHS Team (psychiatrists, psychologists, nurses, educators and social workers).

When a double therapist setting is proposed, or when SB-APP is part of a multidisciplinary MHS clinical project, borderline patients have to know the limits of the psychotherapist's role in order to cope with concrete needs, family support and overall clinical necessities. Setting boundaries produces a corrective emotional experience compared to the patient's previous confusing relationships, which are a major source of vulnerability for BPD.

Thus, as suggested by NICE BPD Clinical Guidance (National Institute for Clinical Excellence, 2009), it's necessary to clearly identify roles and responsibilities of all health and social care professionals involved. In this way they can (1) develop a crisis plan in order to identify potential triggers that could lead patients to a crisis and (2) establish how patients can access services in case of urgency. In this regard, regular communications between SB–APP psychotherapist and other healthcare professionals are particularly important.

Furthermore, MHS Teams (psychiatrists, psychologists, nurses and educators) need to be trained in borderline disorders treatment (Kerr, Dent-Brown, & Parry, 2007) in order to provide coherent care to patients. In our experience in Chivasso, Turin (Italy) this training involves: 1) a preliminary brief educational program concerning borderline disorders etiology, symptoms and care; 2) regular supervisions (every 15 days) in order to promote coherent treatment planning; 3) regular case discussions (monthly).

A coherent treatment plan allows the SB-APP therapist to focus his/her attention exclusively on the sessions, that is, on the patient's ability to mentalize, elaborate and avoid dependency and acting out. Comprehensively, a clearly defined treatment structure is appropriate in order to increase cognitive and emotional regulation in BPD patients (Paris, 2010). They need to be informed in detail about treatment setting rules. Particularly, session frequency and duration, psychotherapy objectives, consequences of therapist and patient's absences are clearly defined.

For BPD patients, in whom pathology tends to remit over time, intermittent rather than continuous therapy could represent an option. These patients are allowed and encouraged to take treatment breaks, but at the same time they may start a new psychotherapy module if further problems need more elaboration or new issues arise (Paris, 2007). If a second (or further) SB-APP module is useful, the patient must first work on the separation and loss of the previous therapist, processing idealization or devaluation.

Elements of Treatment Strategies and Techniques

Some brief remarks on SB-APP strategies and techniques for the treatment of BPD will be proposed here (Amianto et al., 2011; Fassino et al., 2008; Ferrero, 2009; Ferrero & Simonelli, 2006;). Since BPD are characterized by awkward means of managing and expressing their inner pain, which is behavioral and interpersonal in nature (Zanarini &

Frakenburg, 2007), SB-APP takes particularly into account IP considerations about relevance of social-relational dynamics in maintaining mental disorders. When patients talk about events that occurred in their life, SB-APP therapists have to recognize how these stories also represent significant examples of their lifestyle dynamics.

Evidence shows that it is important for therapists to focus their interventions on patient's affect, relational patterns and the "here and now" of the relationship (Lingiardi, Colli, Gentile, & Tanzilli, 2011) before working on the symbolic meaning of the narrative, considering BPD impairment in cognitive and emotional empathy, low levels of mentalization and altered representations of self and others. Consequently, SB-APP therapists first give greater importance to the present than to the past.

On the contrary, compared to classical psychoanalytically-oriented psychotherapies, they do not encourage free associations, because they don't seem to be useful for patients who are constantly in the throes of emotion dysregulation. Moreover, unlike what happens in interpersonal psychotherapies, the SB-APP therapist doesn't limit his/her attention to facts and how to cope with them, because BPD patients have to learn their feelings better before starting to think about alternative solutions to their problems and projects for the future. The therapist chooses whether to search for solutions of existential problems or to perform a reality test on the current traumatic situation the patient is experiencing, or to recall and elaborate early traumas. These issues are combined in a creative perspective according to the patient's personal patterns of apperception (Adler, 1912) and interpretation of reality (Tenbrink, 1998). Particularly, traumatized patients can't cope with stressful thoughts and become increasingly activated and disturbed, when they are re-exposed to trauma (Koenigsberg, 2009).

In general, BPD patients react more to emotional cues if borderline specific schemas are activated (Limberg, Barnow, Freyberger, & Hamm, 2011). The SB-APP therapist may help the patient to tolerate the more stressful external events, both for their severity and their symbolic meaning. For example, this goal can be achieved by attributing a meaning and fostering the acceptance of unavoidable events. Furthermore, at a deeper level, the therapist may lead the patient not to be too affected by the intrapsychic stimuli that are related to those adverse events.

Technical Instruments Axis (TI-AX). The therapist's responses to questions posed by the patient's pathology benefit from the use of Technical Instruments (TI). To this end, SB-APP uses the system proposed by the Menninger Clinic Treatment Interventions Project (Gabbard, 2000) for describing the technical instruments of psychotherapy. This classification is only used to describe TIs and the way they treat the material presented during therapy sessions, and not to distinguish their higher or lower power to induce a change (i.e., interpretations are gold, praises are lead). Thus a distinction between exploratory and validating technical instruments along a functional dimension (TI-AX) was made.

Exploratory TIs promote the connection between patient's verbalizations and other unconscious, subconscious or conscious elements, respectively by: interpretation (TI_1), confrontation (TI_2) and clarification (TI_3). Validating TIs promote the identification and importance of specific experiences, situations, or behaviours (empathic validation, TI_5; advice and praise, TI_6; confirmation and prescription, TI_7). The encouragement to elaborate (TI_4), that sometimes is expressed through the therapist's silence, seems inclusively placed in the middle of the TIs continuum.

Intensive-Supportive Axis (IS-AX). Starting from the patient's request to be helped to change its own clinical condition and increase well-being, psychotherapy has to be conceived as a helping profession. Namely, both into the therapist and patient, an expectation is developing so that psychic pain may be appeased by an emotive correcting experience. More in detail, past relational modalities of the patient will be variously corroborated or hindered during the sessions.

According to Alfred Adler, therapists' responses constitute a way to manage the relational distance (Adler, 1920) during the treatment, including mutual feelings of sharing, release or opposition. Closeness or remoteness are generated by patients' and therapists' experience and recognition of repetitive ways of relating to others (including unconscious aspects of transference).

An expert therapist has to be adequately flexible and able to modify the psychotherapeutic technique according to the patient's needs. The aim is to determine which combinations are expected to promote best outcomes for specific relational problems of BPD patients: affective instability, impulsivity and acting out, demandingness, intolerance to separation. SB-APP therapist will modulate the emotive correcting experience according to intensive strategies or supportive strategies. They differ along a continuum (IS-AX) at the rate of prevailing quality of the relationship.

Intensive strategy is characterized by a dialogic working alliance (WA), while the therapist is fostering patients' elaborations rather than providing one's own opinions. The aim is increasing patient's attitudes to attention, confidence and comprehension of his difficulties, as forerunners of change. Supportive strategy is characterized by a supportive WA, while therapist's contributions are prevailing. The aim is providing new solutions to the patients problems.

Difficulties in building a good WA with therapist

were frequently found in subjects affected by BPD, due to their poor quality of object relations (Piper et al., 2004), which characterizes the patients lifelong patterns of relationship. More in detail, self-other representations are distorted in BPD patients, as a consequence both of their specific vulnerability and defense mechanisms (BPO). Reducing risk of identity diffusion is an early and primary therapist's task with these subjects. Consequently, supportive treatment strategy do not usefully deals with advices and praises (TI_6), but with clarifications (TI_3), empathic validations (TI_5) and confirmations (TI_7).

Analogously, intensive treatment strategy mainly deals with a possibility that BPD patients' thoughts and emotions can be expressed. Therapist has to recognize them before using confrontations (TI_2) and interpretations (TI_1).

Mutative-Conservative Axis (MC-AX). In SB-APP, the therapist's strategies differentiate along another axis based on the patient's main psychopathological functioning modalities. This applies to supportive therapies as well as to intensive therapies.

The importance of a detailed understanding of patients' intrapsychic organization was early emphasised by Alfred Adler as essential for performing psychotherapy (Adler, 1920). Actual research shows that both quality of objects relations and defense mechanisms seem to predict the outcome of therapist's specific technical interventions (Hersoug, Høglend, & Bøgwald, 2004; Piper, Ogrodniczuk, & Joyce, 2004). Consequently, it is recommended that psychotherapy strategies and techniques are based on a careful formulation of the psychodynamics of the patient's presenting complaint, especially when patients with BPD and other personality disorders are treated (Hadjipavlou & Ogrodniczuk, 2010; Verheul & Herbrink, 2007). Mutative strategy seeks to provoke a change in lifestyle and personality organization by changing at least some of the defense mechanisms that are significantly connected with the pathology. Conservative strategy aims to respect and strengthen the patient's compensatory mechanisms, and more specifically it keeps the defenses functioning in a more evolved, healthier and adaptive way for the subject and for other people.

SB-APP doesn't assign *a priori* to each TI a meaning in terms of intensive *vs* supportive strategy or conservative *vs* mutative effectiveness, which depends on patient's pathology and personality organization. Therefore, SB-APP is a psychopathology-based psychotherapy. As opposed to some other psychodynamically oriented psychotherapies, particularly insight-enhancing, SB-APP can combine directive *vs* nondirective treatment issues according to the assessment of the patient's defense mechanisms and their role on the psychic balance.

Therapist's interventions should preserve more adaptive defenses and work on poorly effective ones, which can lead to at-risk behaviors and decrease self-esteem. Differently from NPO patients, advices and praises (TI_6) are pretty useless with BPD patients who consistently distort their interpersonal environment, as well as interpretations (TI_1) are not necessarily useful for change (Paris, 2010). Furthermore, clarifications (TI_3) and empathic validations (TI_5) are essential for BPD patients who are sensitive to the slightest hint of invalidation, while confrontations (TI_2) have to be used tactfully (Paris, 2010), because they can be addressed to splitting defenses.

Specifically concerning transference interpretations, they may decrease WA and be detrimental with patients with a higher levels of defensive functioning. On the contrary, a higher use of interpretations could increase WA in patients with a lower level of defensive functioning, as happens in BPD patients (Hersoug, 2004).

Therapist's Emotional Attitude and Counter-transference

The way borderline patients function is likely to burden the therapist. More in detail, patients intruding, frightening and abandoning modalities are usually re-experienced in the relationship with the therapist. A careful recognition of countertransference is thus necessary, as it develops in the interpersonal therapeutic process (Bender, 2005). Particular attention should be paid to patient's self-other split images that could affect therapist's emotional attitudes and thoughts (Ferrero, 1995; Presslich-Titscher, 1997), by inducing discouragement or omnipotence.

Projective identification as well cannot be separated from dealing with countertransference, since patients unconsciously try to make the therapist take over certain roles and affects. This acting out is of great importance for a deepened understanding of the patient (Matschiner-Zollner, 2004). Furthermore, in case of treatment drop-out, which can frequently occur with borderline patients, the analysis of countertransference can provide a deeper understanding of the psychodynamic causes that led to the premature ending (White, 2007).

In conclusion, the usefulness of explicit technical issues may be conceived in order to increase the awareness of which rules determine the therapist's actions during psychotherapy. In contrast, a strict adherence to a manualized description of the processes could be misleading.

Personality Functioning Levels

Patient's characteristics that have an impact on outcomes are suitable to be detected (Delaney, Yeomans, Stone, & Haran, 2008), in order to provide targeted interventions for more homogeneous subsets of BPD (Lenzenweger, Clarkin, Yeomans, Kernberg, & Levy, 2008; Mc Closkey et al., 2009).

Table 1. Main psychopathological items in the description of different PFLs in BPD

Items	PFL I	PFL II	PFL III	PFL IV
ID	Partial symbolic and pre-symbolic representations of self (nuclear identity)	Splitting and idealization of self and others representations (split identity)	Avoiding consequences of being aware of one's own and others contradictory qualities (anti-ambivalent identity)	Anti-ambivalent and hyper-ambivalent aspects of identity
CO	Impaired comprehension of one's own and others behaviours in terms of thoughts, desires and expectations	Comprehension of one's own and others behaviours, thoughts and emotions, only if they do not upset self-image	Concrete thought When divergent motivations stem from comprehension of one's own and others behaviours, thoughts and emotions, they are not integrated	Poor tolerance of contradictory aspects of one's own and others behaviours, thoughts and emotions
EM	Anger, depression, feelings of emptiness	Irritation, depression, feelings of emptiness	Anger recognition, shame, depression, feeling of emptiness	Guilt, sadness, dissatisfaction, feelings of emptiness
AR	Self-damaging and/or alienating behaviours	Threats of self-harming and/or alienating behaviours	Ideas of self-harming and/or alienating behaviours	At some extent, impulsive and/or blocked behaviours
SO	Poor capability to manage social autonomies	Unstable tolerance for engagements and relations	Attempts to work Low tolerance of loneliness	Poor flexibility in distancing or approaching others
RE	Demanding immediate availability versus oppositional tendencies with the therapist	Dependent and idealized relationship with therapist	Dependent relationship with therapist	Supportive relationship with therapist

Note. BPD = borderline personality disorder; PFL = personality functioning level; ID = identity disturbance; CO = cognitive distortion; EM = negative emotions; AR = action and behavior dysregulation; SO = social skills impairment; RE = quality of therapeutic relationship.

The quality and rapidity of change are influenced by patients' global functioning, including level of defences, quality of the interpersonal relationships, life skills and specific interpersonal problems. Various taxonomy approaches were proposed for reducing the heterogeneity observed among BPD (Lenzenweger et al., 2008).

SB-APP treatment for BPD is specifically focused on four personality functioning levels (PFL), which are differentiated by "prototypical descriptions" (Shedler & Westen, 1998) which refer to five psychopathological items (Amianto et al., 2011; Ferrero, 2009; Ferrero et al., 2006): identity disturbance (ID), cognitive distortion (CO), negative emotions (EM), action and behavior dysregulation (AR), social skills impairment (SO). In addition, they refer to one item concerning the quality of therapeutic relationship (RE). Patient's PFLs psychopathological items (ID, CO, EM, AR and SO) are consistent with the conceptual framework proposed by Livesley that describes BPD based on empirical studies of the phenotypic structure and genetic architecture of personality (Livesley, 2008) and with other recent studies on the main features of BPD (Bender & Skodol, 2007; Distel et al., 2010; Jørgensen, 2006).

Different PFLs characteristics are briefly summarized in Table 1. Patients with PFL I, II and III are more severe and have a prevailing BPO, while patients with PFL IV are less severe and are characterized by the presence of elements of BPO and NPO. Concerning the overall goals of treatment, at PFL I SB-APP is mainly focused on preventing disruptive acting-out by providing reality testing, by strengthening self-reflective functions and identity. At PFL II, the approach is focused on increasing empathy through validating thoughts and emotions and de-

creasing egocentrism, idealization and dependence. At PFL III, therapy aims at reducing the sense of emptiness and increasing continuity and adaptation. Finally, at PFL IV, therapy attempts to develop increased tolerance for ambivalence, help patients overcome conflicts, enhance autonomy, and increase positive attitudes toward projects.

Two Clinical Vignettes

The following clinical vignettes describe the way in which SB-APP therapists differently face some treatment stages according to different PFL patients, paying particular attention to the end of psychotherapy.

Clinical Vignette No. 1: Borderline Personality Disorder (BPD) and BPO (PFL III and IV)

During psychotherapy, fear of separation deals with WA in a wide range of subjects with Cluster C (anxious-fearful) Personality Disorders and NPO. Their self-other image is settled and coherent, but contradictions, conflicts and doubts lead the patient to search for validation and acceptance. Patients are emotionally inhibited and averse to interpersonal conflict (Bender, 2005): So, they are frequently anxious and buried: Even if it is consciously accepted, aggressiveness and pain relating to relationship with the therapist are likely to be repressed. What is usefully done with neurotics, does not seem to be suitable with BPO patients.

Inadequate primary tenderness (Bolterauer, 1982) relationships, that represent a specific BPD patient's psychosocial vulnerability which is connected to a failure of identity construction, lead to a severe disindividuation distress in these patients, while they're facing adverse or complex life events.

Due to their immature and imaging-distorting defense mechanism (Zanarini et al., 2009), borderline patients have unstable self-other images, so their interaction with others is organized around a fundamental need for care that is felt to be necessary for basic functioning (Bender & Skodol, 2007). Consequently, patients are often incoherent, unstable and impulsive.

a) With regard to the treatment plan, the SB-APP therapist has to repeatedly protect setting integrity, facing patients' disruptive acting-out. Therefore, double-therapist setting is strongly recommended in these cases.

b) Concerning treatment strategy and technique, at PFL III, subjects are largely engaged in denying that self-other contradictory images should be considered relevant for their life and behaviors, since at PFL IV this attitude only appears when facing specific tearing emotions and situations. The patient is dependent on the therapist, thus formally accepting his possible absence. The patient's hyperactivity and concrete way of thinking compensate for a lack of symbolic function, which was predisposed by insecure and disorganized attachment during infancy. Consequently, systematic consideration should be paid to all the patient's acting-out and the discontinuities in his/her social relationships involving intimacy. Greater attention should be devoted to setting disruptions during the treatment: These aspects have to be pointed out, explained and foreshadowed in detail, using empathic validation and clarifications. In this way the patient can progressively become aware of the therapist's acceptance when his own uniqueness and diversity are evident, even in the presence of opposition and aggressiveness. This will appear as fundamental when the therapy ends.

c) This process does not relate exclusively to therapists' technique but it also deeply involves emotions and countertransference. Since ambivalence is too frightening for the patient; therapists might tolerate it by avoiding non-integrated intrusive or abandoning reactions.

Clinical vignette. R.F. is a 45-year woman with BPD, suffering from acute episodes of anxiety with transient dissociation of reality after her husband died in a road accident. During adolescence, she was repeatedly abused by her father; subsequently, when she got married, she had three children, but the eldest of them suffered from schizophrenia. Early in the treatment, at session 4, R.F. said to her male therapist: "I'm in trouble because I feel I am in love with my son's psychiatrist." The therapist, refraining from interpreting the symbolic way in which the patient communicated her anguish at being newly involved in sexualized relationships with men from whom she was expecting care, simply affirmed: "I'm confident that you will be able to control your feelings and emotions, according to your will and values." Thus the therapist was primarily supportive and conservative, strengthening the patient's rationalizations instead of her tendencies to use projective identification. At session 6, R.F. showed the therapist a drawing in which a penis was clearly represented; she said: "It's incredible: I was only tracing some colored lines without importance, in order to relax." Then some more aspects of conflicting feelings about father's sexual abuses were explored (by clarifications). After session 15, R.F. was repeatedly explaining to the therapist her incoherent feelings about of her son's therapist. Then, at session 19, she said with an ironic smile: "I'm not so lucky! When I'm starting to forget him, I casually meet him somewhere!" (that was quite true, because they shared many friends and occasions of social encounters.) The therapist perceived that R.F. might preliminary hold in her mind different images of self and her son's psychiatrist (though not of her father) and encouraged acceptance and elaboration of such conflicting thoughts. Two sessions later, R.F.

commented favorably on the treatment course, underlining her ability to think and feel something new, even when not very clear; the therapist, again using empathic validation and praise, answered the patient: "I think it's really hard to explore some vague and complex feeling, but it could lead to an enrichment of your peace and wellness." Even when adopting a mutative strategy and working on splitting defenses, the therapist remained supportive during the whole treatment. At the end of the therapy, an excessive importance of remembering the past was discouraged by the therapist. Moreover, the patient was authorized, with the therapist's advice and supportive strategy, to take a more confident attitude towards her possibilities of thinking and facing life events. In this way, R.F. became sufficiently capable to accept the perspective of the end of the therapy and to look up to the future. Nevertheless, considering that patients at PFL III and IV are usually able to understand others in a constructed rational way rather than in an instinctive and affective one, the therapist gave the patient the opportunity of a a single follow-up session after three months, in order to share the understanding of her difficulties in parting and to reinforce the belief in mutual understanding. Balancing mutative interventions towards some splitting defenses with a supportive emotional experience seems to be the best way to protect the patients from the anguish of being a separated individual at the end of psychotherapy.

Clinical Vignette No. 2: Borderline Personality Disorder (BPD) and BPO (PFL I and II)

However, patients with lower borderline personality organization (PFL I and II) need a different treatment strategy, as they preserve identity by separately representing different aspects of their contradictory experiences.

a) With regard to the treatment plan, a multidisciplinary therapeutic team is necessary to treat patients at PFL I or II. The treatment setting has to be explained in detail before starting SB-APP sessions. Patients are informed that the psychotherapist will be at their disposal only during the sessions and other therapists will be available in order to cope with any clinical emergencies and provide pharmacological therapy or concrete help.

b) Concerning treatment strategy and technique, at PFL I and II, therapists have to consider that patients unconsciously fear that their fragile identity might collapse. In this regard, empathic validation (TI_5) and, to a lesser degree, clarification (TI_3) and affirmation (TI_7) can effectively convey constructive experiences concerning the precarious cohesion of self and the patient's incapacity to think in the presence of others, and to tolerate the therapist as a separate existence (Ferrero, 2009).

c) Therapists' emotions are deeply affected by the patients. All of them, including SB-APP therapist, has to cope with conflicting, split and projective aspects of the patients. So, they need to share and compare their conviction and feelings about the patient, in order to build up a clear therapeutic relationship. Therapists' goals should be viewed by the patient as being strictly on the same wavelength, as part of the same project. An idealized dependence is perhaps the only possibility for such patients to be involved in a trustful therapeutic relationship. Nevertheless, the contagion of patients' idealization has to be prevented by a constant attention to the therapist's transient euphoric emotions.

However, when dependence is established on a group of multiple caregivers playing integrated unequivocal roles, patients may progressively experience diversity within a coherent whole, as protective limits. So patients could also become more confident that they would be helped in other ways after the end of psychotherapy, if necessary.

Clinical vignette. B.C. is a young woman aged 31, with a severe BPD characterized by acute anguish attacks, intermittent bulimia and alcohol abuse, incoherent affective and working projects, recurrent self-harming behaviors (cuts on arms, legs, abdomen and even breast). She is the third child of a couple of parents which are described by the patient as weak and dependent on the opinions and advice of her elder sister, who is living in America. In order to illustrate her conviction, she said to her psychiatrist during a visit: "Once upon a time, when my sister told my parents that it would be better to ignore me, because I'm false and manipulating, they agreed without any opposition and I had to temporarily leave my family home." On the other hand, B.C.'s mother used to complain: "I did all I could to help her, but it was all in vain!"

B.C. was first receiving treatment at Mental Health Service (MHS). Very soon, a daily phleboclysis with benzodiazepines and antipsychotics was prescribed in order to reduce her repeated cutting behaviors. Only during the weekend this therapy was suspended when the patient successfully served as a disc jockey in another village not so far from home. Since this pharmacologic treatment didn't have any efficacy, MHS nurses suggested that would be best to increase it, administering therapy also during the weekend. After two month B.C. started a SB-APP module. After three months B.C. said to her psychiatrist: "I'm very anxious because my sister is coming from America and while she is here she will share my home with me and my parents!" The psychiatrist only reassured B.C. of his own availability and support, but he took no measures to deal with the patient's situation. Next evening an anxiety crisis led the patient to be taken into hospital (also as a symbolic secure shelter).

B.C.'s personality functioning level is very disadaptive and her mentalization attitudes are very poor. Unfortunately, MHS care was repeating the mother's way of care, characterized by a generous

but not selective attention to the patient's needs. So B.C. was initially perceiving psychiatrist and nurses as abandonic and confusing. She became more reactive and less compliant to MHS treatments and more attached to the psychotherapist. In order to restore B.C.'s compliance, a clear change in MHS care planning (with a supervisor's help) was first necessary, before the psychotherapist could describe and explain to the patient the emotions and feelings that had occurred (by using empathic validation and clarification). During a session after the inpatient treatment, B.C. said: "My mother never understood what I felt. For example, once I had a violent fever and she recommended me to eat well... Eating was good for everything!" The therapist responded: "Now you're doing the same: when you're searching for help, bulimia or cuts are good for everything!" A better working alliance with the MHS team was subsequently useful in permit separation from the psychotherapist at the end of SB-APP module. A prolonged dependence on a therapeutic team with a positive reflective functioning seems the most suitable protection for psychotherapeutic work with such severe patients, in order to achieve a better self-image integration.

SB-APP application preliminary reports

A preliminary clinical randomized study (Amianto et al., 2011) showed evidence of SB-APP effectiveness in a sample of patients with BPD. Eighty-one outpatients were enrolled in Mental Health Center of Chivasso (Turin, Italy). They had been treated and clinically managed for at least one year. Thirty-five outpatients who met inclusion criteria were randomly assigned to two treatment groups: 1) Supervised Team Management Group (STM; $n = 17$), 2) SB-APP Group (SB-APP; $n = 18$) and then compared.

In the first group, STM included: (a) medications, (b) unstructured psychological support focused on socio-relational impairment, (c) rehabilitative interventions, and (d) specific MHS training in BPD treatment with regular supervisions. In the second group, SB-APP treatment was provided instead of unstructured psychological support. SB-APP group received the usual treatment plus SB-APP (40 weekly sessions) for 10 or 11 months. At the end of the first year (T_{12}), STM group continued with the as-usual management with supportive weekly sessions whilst the SB-APP group was carried on with psychiatric, nurse and educational management without any individual psychological support.

Clinical Global Impression (CGI; Guy, 1976) and CGI-modified (CGI-M; Perez, Barrachina, Soler, Pascual, Campins, Puigdemont, & Alvarez, 2007) for BPD, Global Assessment of Functioning (GAF; APA, 2000), State–Trait Anger Expression Inventory (STAXI; Spielberger, 1996), and Symptom Checklist-90 Revised (SCL-90-R; Derogatis, Rickels, & Rock, 1976) were repeatedly administered for two years at T_1, T_3, T_6, T_{12}, T_{18} and T_{24}. At T_{12} the Working Alliance Inventory-Short Form (WAI-S; Horvath & Greenberg, 1989) was also completed after one year. Four main results emerged from this study.

a) The branch of the study including specific MHS team supervision in addition to treatment-as-usual (STM) showed an improvement in the symptoms and social functioning compared to baseline, even though a structured psychotherapy was not applied. According to these results, a SB-APP treatment for BPD might be part of an articulated clinical project. MHS team were beneficially trained to provide their interventions in a manner consistent with psychotherapist's objectives. This is quite different, for example, from the setting of TFP (Doering et al., 2010), where the psychotherapist is available for the patients only during the sessions (as also happens in SB-APP), but other clinical tasks are less defined. SB-APP setting is also different from that of DBT (Linehan et al., 2006), in which training for clinicians is provided, but the psychotherapist is more available for the patients outside the sessions.

b) The improvement was found to be stable over time. These findings are consistent with those of DBT, CBT, MBT and TFP (Paris, 2010).

c) SB-APP was more effective than STM concerning some core psychopathological characteristics of BPD (disturbed relationships, impulsivity, suicidal/self-damaging behaviours, and chronic feelings of emptiness). Several treatments (Paris, 2010; Verheul & Herbrink, 2007) are useful to address specific disruptive behaviours of severe BPD, but are less effective in reducing heavy MHS use related to intolerance of aloneness, conflicts over dependency (Choi-Kain et al., 2010) or the tendency of "pushing the limits" in building therapeutic alliance: All this produces a high rate of MHS use and great problems in BPD management. In the above study, SB-APP superiority to STM was possibly related to the specific setting and technique of the structured treatment compared to the unstructured psychological support (Amianto et al., 2011).

Distorted relationships may benefit in general from a well-structured treatment setting, whereas treating impulsivity and self-damaging behaviours needs an accurate identification with patients' cognitive and emotional patterns and defense mechanisms (Zanarini, 2009): This represents the SB-APP specific focus. Moreover, patients' feelings of emptiness are very persistent and have different psychopathological features during evolution of BPD (Gunderson, 2008). Consequently, SB-APP therapists address patients' emptiness with: promoting mentalization (at PFL 1), decreasing splitting defenses (at PFLs 2 and 3) and increasing tolerance for ambivalence (at PFL 4).

d) Furthermore, SB-APP was more effective in building a good and stable therapeutic relationship. Previous studies showed evidence that some specific psychosocial aspects are predictors of WA and

psychotherapy outcome: quality of object relations (Piper et al., 1991), which characterizes the patient's lifelong pattern of relationships, recent interpersonal functioning (*ibidem*), and defense mechanisms (Hersoug, Sexton, & Høglend, 2002). In patients with BPD, both quality of object relations (Gunderson, 2008) and defensive functioning (Perry & Cooper, 1986) are poor. Moreover, process investigations on psychodynamic psychotherapies have already showed that WA is increased by therapist's technical interventions, when they are appropriately used, accordingly to the different level of defense mechanisms (Hersoug, 2004), as emphasized by SB-APP technique.

Conclusion

We may suggest that SB-APP, as a careful psychopathology-based psychotherapy, should be useful with severe borderline patients, even using a time-limited setting. Furthermore, SB-APP is a shorter (about 10 months) and less intensive (one weekly session) therapy, compared to other effective treatments. This could allow a good patient turnover, increasing MHS efficiency. Specifically concerning the end of psychotherapy, there is some evidence that setting a limit to the treatment duration could facilitate the patient's executive attention and increase WA (Levy, Beeney, Wasserman, & Clarkin, 2010). Executive attention is specifically involved in the ability to regulate individuals' responses, particularly when they are in conflict situations where several solutions are possible (Johnson, 2005). Thus, an explicit time-limited setting in psychotherapy could help the patients not to see the end of treatment as an incomprehensible abandon.

However, therapists should be alerted about potential difficulties in working with a time-limited setting with BPD patients. More in detail, SB-APP modules did not show a significant improvement after the first year of follow-up. This may derive from resistances to change, which are typical of patients with severe personality disorders. If necessary, more than one module of SB-APP could be foreseen, in sequence, with different therapists and specific aims and strategies, accompanying the patient's needs and evolution. An adequate continuity of overall clinical care must also be provided, when needed.

SB-APP is overall focused on patient's psychopathology and is not only devoted to BPD treatment. Therefore, therapists have to be trained to carefully recognize PFLs of these patients, due to their non-homogeneity. SB-APP treatment focus is thus somewhat different from the focus of: Mentalization Based Treatment (Bateman & Fonagy, 2009), that is, levels of mentalization; Dialectical Behaviour Therapy (Linehan et al., 2006), that is, dialectical balance between acceptance and behaviour change; Transference Focused Psychotherapy (Doering et al., 2010), that is, transference dynamics; Cognitive Behaviour Therapy (Davidson et al., 2006), that is, dysfunctional beliefs; Schema Focused Therapy (Giesen-Bloo, van Dyck, & Spinhoven, 2006), that is, cognitive and emotional schemas; Interpersonal Psychotherapy (Bellino, Rinaldi, & Bogetto, 2010), that is, relational dynamics; Supportive psychotherapy (Aviram, Hellerstein, Gerson, & Stanley, 2004), that is, patient's level of impairment.

Nevertheless, also non-specific agents of structured time-limited psychotherapy (Paris, 2010), such as a specific setting and a more significant therapeutic relationship may be responsible for improved SB-APP outcome compared to unstructured psychological support in the treatment of BPD. Finally, larger samples and cost/effectiveness analyses are needed in order to compare SB-APP treatment to the TAU and/or other psychotherapies in the real context of MHS clinical practice.

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