**An Empirical Investigation of Analytic Process: Contrasting a Good and Poor Outcome Case**

Francesco Gazzillo\*, Sherwood Waldron\*\*, Federica Genova\*, Federica Angeloni\*, Chiara Ristucci\*, Vittorio Lingiardi\*

\*Department of Dynamic and Clinical Psychology, “Sapienza” University of Rome

\*\* Psychoanalytic Research Consortium, New York

**ABSTRACT**

The aim of this paper is to assess the differences in the analytic processes between two treatments of patients with very similar personality profiles, who were in analyses during the same time, by two analysts with a very similar training and working in a very similar setting. We explored patients’ personality and changes with the Global Assessment of Functioning Scale (GAF; APA, 2000) and the Shedler-Westen Assessment Procedure-200 (SWAP-200; Westen, Shedler, 1999a, 1999b) applied by two pairs of independent raters to sixteen sessions. In addition, we assessed therapeutic processes with the Analytic Process Scales (APS; Waldron, Scharf, Hurst, Firestein, & Burton 2004) and the Dynamic Interaction Scales (DIS; Waldron, Gazzillo, Genova, Lingiardi, 2013) applied by three independent raters to twenty sessions, as well as the Helping Alliance Rating Scale (HAR; Luborsky, Crits-Cristoph, Alexander, Margolis, & Cohen, 1983) applied to eight sessions from the beginning of each therapy. Our results showed striking differences between the outcomes of these two psychoanalyses that are paralleled by differences in their therapeutic processes. We provide verbatim clinical interactions to illustrate these differences and explore the potential implications of these findings.

KeyWords: analytic process, APS, DIS, SWAP

In this paper, by *psychoanalysis* we mean long-term psychodynamic treatments with a frequency of at least two sessions per week, without a pre-established duration, more than two years long, and delivered by practitioners who completed training in psychoanalysis at a psychoanalytic institute. We have adopted this definition for practical purposes, and not because we think that psychotherapy can be described as psychoanalytic only under these conditions, nor because we think that setting criteria are the most relevant for differentiating the various kinds of dynamic psychotherapies[[1]](#footnote-2). This definition will give a context to our study.

We will briefly review empirical studies on psychoanalysis conducted from 2000 onward based on the assessment of transcribed sessions with reliable empirical instruments. Empirical studies applying reliable measures to transcriptions of psychoanalytic treatments generally support the idea that a good outcome psychoanalysis increases the capacity of mentalization and referential activity of the patients (Gullestad, Wilberg, 2011; Mariani, Maskit, Bucci, De Coro, 2013), fosters more adaptive ways of dealing with conflicts and stressful situations, and helps the development of a healthier overall functioning (Waldron, Moscovitz, Lundin, Helm, Jemerin, & Gorman, 2011; Perry, Bond, 2012). In order to obtain this goal, it seems important that the analyst works on the core relational conflicts of the patient (Albani & al., 2003, Siegel & Demorest, 2010) and on his or her defenses, focusing in particular on his or her experience of the therapeutic relationship (Porcerelli, Dauphin, Ablon, & Leitman, 2009; Banon et al., 2013 ). However, it also seems that it would be a mistake to think that good psychoanalysis is based on the use of one or a few specific kinds of interventions; in fact, it is the quality of each kind of interventions, as used in that specific moment of that specific treatment, that is the more relevant therapeutic factor of psychoanalysis (Waldron, Helm, 2004; Waldron, Scharf, Hurst, Firestein, & Burton 2004, Waldron, Scharf, Crouse, Firestein, Burton, & Couse, 2004; Lingiardi, Gazzillo, Waldron, 2010). Furthermore, it seems that in real-world psychoanalytic treatments, a better use of classical interventions—such as clarifications and interpretations of conflict, defenses, and transference—goes hand-in-hand with a more relational attitude (Waldron, Gazzillo, Genova, Lingiardi, 2013).

The study published in 2013 by Waldron, Gazzillo, Genova, and Lingiardi was one of the few attempts to investigate the therapeutic factors of psychoanalysis on the basis of the bottom-up assessment of transcribed sessions of psychoanalysis comparing the therapeutic process and treatments of good and bad outcomes clinical cases. However, the main aim of that study was to introduce the reader to a new instrument for assessing the interactional and relational aspects of psychoanalysis, the DIS, and the patients assessed for this purpose showed very different personality profiles at the beginning of the treatment and were treated thirty years apart by two therapists with different theoretical orientations. In this paper, we will report data on the treatments of two patients with a very similar personality profile who were in psychoanalysis in the same period with two similar analysts who had received their analytic training in the same years and in the same institute, had a very similar level of post-training experience (more than five and less than 8 years), worked in the same town, in the same research group, and in a similar setting. The comparison between these two cases is particularly interesting because one of them had a very good outcome, while the other one shows quite poor results[[2]](#footnote-3). Therefore, comparing the processes of these two analyses can useful in better understanding the naturalistic aspects of this approach to treatment. Given all the similarities between the two patients and the two treatments’ frames, the difference of their outcomes may be attributed, at least in part, to *what happened during these treatments between patient and analyst*. The results of these empirical comparisons, if combined with findings from other research on processes and outcomes of psychoanalyses, can help us to identify the effective therapeutic components of this specific clinical approach.

**Method**

**Sample and Raters**

We assessed twenty sessions of each treatment: the first four sessions, four sessions from the 6th week of therapy, four sessions from the middle of the therapy, four sessions from the 6th week before the termination of the therapy, and the last four sessions. To analyze the data we have then aggregated the first four sessions plus the four sessions from the 6th week as representative of the “beginning period,” and the last four plus the four sessions from the 6th week before the termination as representative of the “termination period.”

All the sessions were assessed by three independent raters with the *Analytic Process Scales* (APS; Waldron, Scharf, Hurst, Firestein, & Burton 2004) and *Dynamic Interaction Scales* (DIS; Waldron, Gazzillo, Genova, Lingiardi, 2013). The first eight sessions and the last eight sessions were also assessed by two independent raters with the *Shedler-Westen Assessment Procedure-200* (SWAP-200; Westen, Shedler, 1999a, b) and by two other independent raters with the *Global Assessment of Functioning* *Scale* (GAF; APA, 2000); the first eight sessions were assessed also with the *Helping Alliance Rating* method (HAR) (HAR; Luborsky, Crits-Cristoph, Alexander, Margolis, & Cohen, 1983). The SWAP raters also assessed the first eight sessions and the last eight sessions with the *Diagnostic and Statistical Manual of Mental Disorder, IV edition–Text Revision* (DSM-IV TR) (APA, 2000) Axis I criteria and used a consensus procedure for establishing Axis I diagnoses.

The two SWAP raters were two psychologists: the first had a doctorate in dynamic psychology, more than five years of clinical experience as a psychoanalytic psychotherapist, and training in the assessment of personality with the authors of the SWAP (Drew Westen and Jonathan Shedler). The second rater was trained by the first rater in the assessment of personality with the SWAP on the basis of transcribed sessions of psychotherapy of a patient not involved in this study. The three APS and DIS raters were: a doctoral psychologist with more than five years of clinical experience as a psychoanalytic psychotherapist, and two doctoral students. The latter two had 12 hours training in the assessment of therapeutic processes with APS and DIS from the first rater. The two GAF and HAR raters were two doctoral students. For the analysis of the data, we have averaged the assessment made by the different raters on each of these instruments. For comparing the analytic and relational processes of the two cases assessed with APS and DIS, we used the Mann-Whitney U test for non-parametric measures.

INSERT TABLE 1

**Instruments**

**Global Assessment of Functioning Scales (GAF).** This measure is the fifth axis of the DSM-IV TR. In a sample of 10 cases already assessed at the beginning and at the end of their analyses (N=20), including the two cases presented in this study, the intraclass correlation coefficient (ICC) of the assessments of two independent raters is .65(Gazzillo, Genova, Ristucci, Angeloni, Mellone, 2013) (Gazzillo, Genova, Ristucci, Angeloni, Mellone, 2013). As for all the cases we are analyzing, these cases are propriety of the Psychoanalytic research consortium.

**The Shedler-Westen Assessment Procedure-200 (SWAP-200).** The SWAP-200, a widely researched assessment instrument (Westen & Shedler, 1999a, 1999b, 2007), is composed of 200 jargon-free items describing both healthy and pathological personality features, to be completed by a clinician with knowledge of the patient. The SWAP-200 utilizes a Q-Sort method, which requires the rater to assign the 200 items so that a fixed distribution is attained (Block 1978; Westen & Shedler, 1999a), which helps to improve the reliability of ratings. The rater assigns a score from 0 to 7 to each according to how descriptive the item is in that particular patient’s functioning (0=not descriptive, 7=most descriptive). The SWAP-200 provides a common vocabulary that organizes clinical observations and inferences about a patient’s personality and provides a “snapshot” of a patient’s psychological functioning (Shedler, 2002; Lingiardi, Shedler, & Gazzillo, 2006; Lingiardi, Gazzillo, & Waldron, 2010). Moreover, 24 of the 200 items express aspects of positive mental health, providing a corrective to a focus only on pathology. One of the outputs that the SWAP-200 software provides is a profile of twelve personality prototypes that closely parallel DSM-IV Axis II diagnoses (the personality disorder (PD) factors). The correspondence between the patient profile and the different PD factors is standardized as a T-score (average=50, standard deviation=10) in comparison with a nationwide sample of personality disordered patients. When the T-score for a given prototype is 60 or more, the patient is considered to have that personality disorder, and if the score is 55 to 59, the patient is considered to have clinical features of the disorder. In this study, the ICC of the SWAP-200 assessment, based on the assessment by two independent raters of 20 groups of eight contiguous sessions of the patients involved in this study (Gazzillo, Genova, Ristucci, Angeloni, Mellone, 2013), is .79.

**The Helping Alliance Rating method (HAR).** The HAR (Luborsky, Crits-Cristoph, Alexander, Margolis, & Cohen, 1983) is based on a model of the helping alliance as articulated in two broad subcategories: the helping alliance of Type 1, defined as the perception of the availability of the therapist, depicts in what measure the patient experiences the therapist as capable of giving the necessary help; and the helping alliance of Type 2, defined as a cooperative bond between patient and therapist, assesses in what measure the patient feels a good cooperation with the therapist for reaching the therapeutic goals. The HAR is composed of four subscales for the assessment of the helping alliance Type 1, and three subscales for assessing the helping alliance Type 2. In this study, we have calculated both HARs on the basis of the assessment of the 8 beginning sessions. The inter-rater reliability of HAR subscale calculated with the Pearson r as reported in the literature ranged from .47 to .82. The average correlation between the HAR type 1 and HAR type 2 is .68 (see also Cecero, Fenton, Frankenforter, Nich, & Carroll, 2001). On the basis of the assessment of 16 patients, including the cases presented in this study, the ICC of HAR assessments is .54

**The Analytic Process Scales** (APS). The APS (Waldron, Scharf, Hurst, Firestein, & Burton 2004 are 32 Likert scales (0–4) aimed at the assessment of different dimensions of the therapeutic process on the basis of audio-taped and transcribed sessions of psychotherapy. The patient’s contribution to the therapy is assessed with 14 scales and the therapist’s contribution is assessed with 18 scales. Definitions and examples of each of these scales and their different levels are assembled into an 81-page coding manual (Scharf et al., unpublished). The anchoring of clinical judgments made possible by the APS coding manual facilitates accurate and reliable measurements. The patient scales assess the degree to which the patient is able to convey his or her experiences, self-reflect on them, and convey his or her feelings, both in regard to the therapist and therapeutic relationship and in regard to other relationships: how extensive are his or her communications about romantic and sexual themes, assertiveness, aggressiveness, hostility, self-esteem, and developmental experiences; to what degree is he or she able to respond to the therapist in a useful manner; and the overall productivity of his or her communications, i.e., to what degree the patients’ communications show a deepening in self-awareness, contact with own feelings, and cooperation with the therapist. The APS therapist scales assess the level of articulation of different kinds of intervention (encouraging elaboration, clarification, interpretation, support); different targets of these interventions (defenses/resistances, transference, conflicts), and of different themes dealt with by them (romantic and sexual, self-esteem, and development). Therapist scales enable also the assessment of the degree to which the therapist communications are shaped by his or her feelings, are confrontational, amicable, or hostile; and finally there is a specific scale aimed at the assessment of the overall goodness of therapist interventions, i.e., their aptness in kind, content, language, and timing. The APS variables were originally developed to be applied to segments of each session, but the procedure has been expanded to rate the variables applied to each session in its entirety, so that we could accomplish a study of a much larger number of sessions. As a consequence, the final scores do not represent an average, but reflect the highest level reached in that session on any given variable. The average ICC of the APS patient scales applied by three independent raters with this procedure to 120 sessions is .76 (ranging from .67 to .83); the average ICC for APS therapist scales is .77, ranging from .63 to .85.

**The Dynamic Interaction Scales (DIS).** The DIS (Waldron, Gazzillo, Genova, Lingiardi, 2013) are 12 Likert (0–4) scales aimed more specifically at the assessment of some global, relational and interactional aspects of the therapeutic process on the basis of audio-taped and transcribed sessions. DIS therapist scales assess the degree to which the therapist is straightforward, warmly responsive, responsive moment-to-moment to the patient’s feelings, the degree to which he or she conveys aspects of his or her subjective experience or subjective response to the patient, and how well the therapist is working with, and helping the patient work with, his or her typical patterns of relating and feeling. DIS patient scales assess to what degree the patient flexibly shifts to and from experiencing and reflecting, shows a flexible interplay between conscious waking life and dreams, and how well the patient is working with his or her typical patterns of relating and feelings. The DIS interaction scales assess the degree to which: the patient experiences the therapist as empathic; the therapist’s contribution leads to the further development of the patient’s awareness; there is an integration of understanding of the relationship with the therapist to other relationships; and to what degree the engagement in the therapeutic relationship by the two parties is brought forward or experienced in an emotionally meaningful way. The average ICC for the DIS scales assessed by three independent raters on 120 sessions is .68, ranging from .60 to .88.

**Brief description of Penny’s treatment[[3]](#footnote-4)**

Penny, who worked as a teacher, began her analysis in 1969, when she was 40 years old. She describes herself as a woman who spends all her life controlling herself in order to convey to other people the image of a strong, outgoing, effective woman, but she adds that, as a matter of fact, she doesn’t trust her abilities and feels herself to be a fraud. She feels a sense of inner disorder and says that too many of her relationships are “unresolved.” She fears becoming “crazy” like some of her relatives, who suffered from psychotic disorders. Penny is the youngest of three sisters and thinks that her sense of being “meaningless” is the consequence of the fact that she has spent all her life feeling that her parents loved her sisters more than herself. She feels that her mother has always rejected her, criticizing her shyness and her need for reassurance, while she describes her father as “absent” for most of her childhood because he was completely devoted to his business and was not interested in his children’s life. Penny is married to a man who is two years older. They have three children from middle childhood to middle adolescence. She is frustrated by her relationship with her children, and feels herself to be impotent and incapable of controlling her feelings and impulses.

The beginning period of her analysis is dominated by her fear to fail also her second analysis and to be rejected by the therapist, toward whom she feels an attraction similar to the attraction felt toward his former analyst. Another relevant theme of this period of therapy is her need to be admired by authoritarian men and the sense of frustration, humiliation and rage she feels when she does not succeed in attracting their attention. The analyst helps Penny to connect her sense of impotence, her jealousy and her fear of being rejected, both inside and outside the analytic relationship, with her infantile relationship with her father, by whom she felt rejected and toward whom she is full of rage and resentment, and with her child relationship with her sisters.

During the middle period of her psychoanalysis, Penny reports feelings of inferiority toward her analyst, she is afraid to be “a patient like all the other patients,” and her transference continues to be dominated by romantic and sexual feelings and a poor self-esteem. The analyst interprets her sense of inferiority as derived from such feelings in childhood directed at her parents. During this period of the treatment, Penny’s difficulty having an orgasm comes into the foreground, and the analyst connects her difficulty to “let herself go” to her need to have everything under control, so as to protect her vulnerability and not be humiliated.

In the last period of the treatment, several weeks before the termination, Penny states that she has solved most of her problems and wants to end the treatment. Now, talking about the analyst, she says that she wishes she would have had a father with whom she could talk as freely and deeply as she has done with him. She now knows that her difficulties with men, including with her husband, were due to her incapacity to ask for care and protection for fear of being rejected, and understands how her need to be special is childish and irrational, something she has to abandon. She is sad at the perspective of the termination of the analysis, but feels more in control of her life. She is more assertive with her husband and is not afraid anymore to show her feelings and needs; she feels more love from her children, notwithstanding the difficulties of her relationship with them, now adolescents, and is more secure in the love of people she cares. She is more able to modulate her feelings and to understand other people’s feelings, and seems more at ease with her own sexual life.

**Brief description of Nora’s treatment**

When Nora began her first analysis, in 1971, she was 22 years old. She describes painful feelings in response to the recent losses of a job and of a romantic relationship and feels deeply depressed. She also feels confused and helpless and wants to be hospitalized. She is afraid of being alone and of having a breakdown, and for these reason she would like to have sessions every day. Nora also has some eating problems, and thinks that her eating so little results from being alone, because she doesn’t like eating when alone.

Nora has an older sister and a younger brother, and has always thought that her parents were one of the most beautiful couples in the world, while feeling that she was a fat, ugly and unattractive girl. Nora describes her mother as a very strong woman who does not tolerate any weaknesses, while her father is described as a clever and bright man. She feels she has a “special” supportive relationship with him, even if they have often fought because he doesn’t want to admit that his daughter has psychological problems. Nora feels also often guilty for having hurt other people, in particular her parents. The main reason of complain for Nora is her discontent for her romantic life. She says that every romantic relationship of her life begins in the same way, with her idealizing the man, and ends for the same reason, because she discovers that the other person is different from what she thought he should be. Another way she describes this is that the person she wants and the person she is attracted to are totally different. For example, her last boyfriend, Ken, was sexually attractive and attracted to her, but not loving, and she contrasts him with Ira, an idealized older man whom she met when she was eighteen years old; with Ira, she felt relaxed and without any sense of guilt.

Both the beginning and the middle period of her treatment are dominated by the difficulties that Nora encounters in romantic relationships, her sense of guilt, her low self-esteem and her desire to be the “perfect patient” for her analyst, with the analyst trying to connect these feelings with Nora’s infancy. Moreover, from the beginning of her therapy Nora tries to engage her analyst in a more dialogic relationship and seem in search of concrete suggestions because she is afraid that her analyst will end up being bored by her and she seems not to be sure that understanding herself better will help her also to feel better. Finally she is not sure of being capable of reflecting productively on her mental life.

During the last period of her therapy, Nora no longer wants the analysis and feels as if now she lives in a bubble, completely surrounded by her negative feelings. She has discovered that her last boyfriend is going to get married and for this reason she is very angry with him; she would like to be back with him and is very angry with herself for this desire because she was the one who decided to leave him. She continues to be unable to imagine herself having a satisfying romantic relationship and adds that, without her suffering, she cannot imagine herself at all. The analyst tries to help her reflect on the meaning that she attributes to being rejected and her negative image of herself, and tries more and more to connect her suffering over the end of this last relationship to the feelings of a little child who feels unloved by his or her parents. But Nora stresses only that she feels worse than in the past.

In the last weeks of her analysis, Nora loses another job and gets back with Ira, whom she experiences as a father figure and to whom she feels deeply inferior. She feels that the analysis is a waste of time and that the analyst is similar to her mother in being so obstinate and insisting. The analyst tries suggests that her leaving the former boyfriend for Ira could be seen as a sign of an improved self-esteem, but she goes ahead and drops out of her analysis.

**Penny and Nora at the Beginning of their Analyses**

In the following sections of this paper we will show how the SWAP-200 can help us to describe Penny and Nora’s personalities and changes, and how the APS and DIS can help us in discovering several differences in the therapeutic processes of these two treatments. It is worth remembering that they had analysis with two very similarly aged, trained and experienced analysts, in the same period (Penny from 1969 to 1974 and Nora from 1971 to 1977), and with a very similar setting (four times a week on the couch for Penny and three and four times a week on the couch for Nora). For Penny, this was the second analysis, while for Nora it was the first one. Given that it was possible that Penny, in her second analysis, older and probably wiser than Nora, could have showed a greater capacity to participate productively in the analytic process, and that this could be at least of one the reasons for the differences in the outcome of the two treatments, we have focused our study on a detailed comparison between the analytic process of our patients.

During the beginning of their analyses, both Penny and Nora showed a *histrionic* and a *borderline* personality disorder according to the PD profiles in their SWAP-200 scores (respectively, T=71.5 and T=68.1 for Penny; T=70.2 and T=65 for Nora). Penny also showed a *paranoid* personality disorder (T=60), and passive-aggressive and antisocial traits (T=55.7 and 55.1), while Nora showed also strong narcissistic (T=59.8) and dependent traits (T=56.4). The level of *high-functioning* factor was T=50 for Penny and T=46 for Nora, i.e., they both had a level of overall functioning comparable to the average level of functioning of patients with personality disorders (see Figure 1 for Penny’s and Nora’s SWAP profiles). To sum up, Penny showed three personality disorders, and pathological features of two other personality disorders, while Nora showed only two personality disorders, and showed pathological features of two more disorders.

INSERT FIGURE 1

Major disorders diagnosis, according to DSM-IV categories, showed Penny as suffering from a somatoform disorder, insomnia, and a sexual disorder (dyspareunia), and Nora from a depressive disorder. Penny’s GAF showed a level of functioning of 59 while Nora showed a level of 62.5, both indicating a mild to moderate level of symptoms and difficulties in relationships and work life. The strong similarity between Penny and Nora, clearly outlined by their SWAP-200 and GAF assessment and evident in Figure 1, is supported also by the comparison between their level of helping alliance as assessed in their first eight sessions of analysis: 5.5 for helping alliance 1 for both patients and, for helping alliance 2, 5.5 for Penny and 6 for Nora. Based on these similarities, it would have been hard to anticipate that these two patients could have had a *very* different amount of benefit from their analyses. The examination of the therapeutic processes of the two patients may help us to understand this difference.

**Comparing the Therapeutic Processes of Penny and Nora**

On the basis of the APS and DIS comparison of the two analytic processes as showed by the 20 sessions assessed, we can say that Penny was more able than Nora to *communicate her experience of the therapist and the therapeutic situation* so as to help the raters (and presumably the analyst) to understand her conflicts (mean rank 25.4 vs. 15.6; U=102, p = .007), was more able to *reflect on the experience* with the therapist (mean rank 26.1 vs. 14.9; U=87.5, p = .002), and to communicate her *feelings* about this relationship in an informative way (mean rank 14.9 vs. 16.5; U=111, p = .015). No difference was found in their capacity to communicate, and reflect on, the experiences they were having outside the therapeutic relationship (mean rank 19.5 vs. 21.5; U = 179.5; p =.53; mean rank 19.4 vs. 21.6; U = 177.5; p = .52 ). Penny tended to communicate in a more sophisticated and articulated way about her *childhood and adolescence* (mean rank 26 vs. 14.9; U=89, p= .002), while Nora was more articulated in communicated about her *romantic and sexual life* (mean rank 17 vs. 29.9; U = 131; p = .021) and no difference was found in their ability to communicate about their *self-esteem* (mean rank 23.6 vs. 17.3; U = 137; p = .08). Penny, however, was also more able to *respond to her therapist’s interventions* in a more informative way (mean rank 24.2 vs. 16.8; U=126, p=.046). These differences on the APS were accompanied by other differences on the DIS patient scales, in that Penny was also more able than Nora to *oscillate between experiencing and reflecting* on her experiences (mean rank 24.6 vs. 16.4; U=90.5; p= .002) and to *work effectively on her typical patterns of affects and experiences* (mean rank 25.2 vs. 15.8; U=106.1, p= .01). To sum up, Penny seems *more communicative* and *reflective* about her *transference experience* and her *developmental years*, more *able to shift to and from experiencing and reflectin*g on her experiences and more able to *understand and work through her problematic patterns* of emotion and behavior.

The analyst of Penny, as viewed through the lens of the APS therapist scales, was able to make higher level *encouragements to elaboration* (mean rank 24.5 vs. 15.5; U=99.4, p = .006), *clarifications* (mean rank 27.05 vs. 16.95; U=69, p= .000) and *interpretations* (mean rank 25.8 vs. 15.5; U=93, p= .003). He made interventions rated higher on addressing *transference* (24.2 vs. 16.8; U=126; p= .046) and addressing the patient’s *conflicts* (mean rank 25.1 vs. 15.9; U=108.5; p= .012). Penny’s analyst made interventions centered on *self-esteem* at a higher level as well (mean rank 24.2 vs. 16.8; U=125, p= .043). With Penny, the analyst seems also more able to communicate his *feelings* (mean rank 26.4 vs. 14.6; 25.7 vs. 15.2, U=81.5, p =.001), both *amicable* and *hostile* (mean rank 25.7 vs. 15.2, U=84.5, p =.004; ; 25.4 vs. 15.5; U = 101, p = .007 ), and the work he did with her, session by session, was judged also as of much *better quality* (mean rank 27.1 vs. 13.9; U=68, p .000). To sum up, Penny’s analyst was more exploratory (his clarifications, confrontations, and interpretations on conflicts, transference, and developmental material were more extensive), and his communications were more affectively laden and of higher quality than in Nora’s case. The DIS assessment of the therapist’s work amplifies these findings: Penny’s therapist was more *straightforward* (mean rank 27.4 vs. 13.6; U=61.5, p= .000), more *warmly responsive* (mean rank 28.2 vs. 12.8; U=46.5, p= .000), more able to *follow the moment-to-moment shifts* in her affective experiences (mean rank 25.7 vs. 15.2; U=95, p= .004), more available in sharing with the patient his *subjective reactions, reflections, and technical choices* (mean rank 27 vs. 13.9; U=69, p= .000) and more able to work effectively on his patient’s *typical and problematic patterns* of feelings (mean rank 29.14 vs. 11.8; U=118, p= .000). Finally, the DIS interaction scales show that Penny, in her analysis, was more able than Nora to *become more aware* of her feelings thanks to her analyst’s interventions (mean rank=26 vs. 15; U=90.5, p= .002) and to *integrate her understanding of the therapeutic relationship with other relationships*, past and present (mean rank=25.8 vs. 15.2; U=93.5, p= .003).

To sum up, with a certain degree of approximation, we could say that the analyst was more able to help Penny to understand herself better, being more active, engaged and less silent. Further, Penny was more able to make good use of the analyst’s work for understanding herself, in particular in the relationship with the analyst himself.

At this point, we may ask ourselves if these differences were present early in these therapies or were a consequence of an extended therapeutic relationship and work. Comparing APS and DIS scores only in the beginning eight sessions of the two patients, we can observe that *almost all our scales demonstrate the same differences we have described above (Figures 2 through 4)*; the only differences which are not present in the beginning period and *emerge* during the course of treatment are: the greater capacity for Penny to *communicate her feelings toward the analyst* and the analytic relationship in an informative way, to *respond to her therapist* in informative ways, and her greater capacity to *oscillate between experiencing and reflecting* on her experiences. Penny’s analyst, for his part, seems to be progressively more able to offer more sophisticated *encouragements to elaboration*, *clarifications, and communications centered on transference and self-esteem*[[4]](#footnote-5), and he was rated as *more amicable*.

INSERT FIGURES 2, 3, 4

**Excerpts from the Analyses of Penny and Nora**

In order to illustrate how these two patients worked with their therapists, we will present some verbatim excerpts from their analyses. The first is taken from the 6th week after the beginning of Penny’s analysis:

*Analyst : So the question for both of us is what’s the fantasy underlying the question. What’s the wish, what’s the fantasy underlying* (P sighs) *the question of whether Dr. \*Lewis* (Penny’s previous analyst) *asked about you or have I spoken to him about you. / / The question is what does he think about, feel about you, what do I feel about you* (encouragement to elaboration on transference and implicitly on romantic themes and self-esteem).

*Penny :* (p:00:13) *I can’t stand the, the uh . . . the feeling of needing to know the answers to that. I, to say that I hate myself for it and, uh, is an overstatement but I, uh, I wish that I could, uh, could genuinely feel, you know, the hell with what you think and the same thing with him but .. . and really the hell with anybody thinks really (p:00:16) but I can’t do it and I, it’s just too, it’s just too difficult for me to, uh . . . . . well I mean I don’t know that there’s anything to explore because it’s all simple and uh…* (here the patient show a conflict she is experiencing in the relationship with the therapist and difficulties in self-esteem)

*Analyst : But there is something to explore* (confrontation). *You say that your feelings about Dr. \*Lewis were largely those of a daughter toward her father and your fantasy was of sitting on his lap with your arms around him and yet I think there’s something obviously more involved because you wonder that he’s going home and laughing with his wife about you, you wonder, and in the dream* (a dream that Penny presented in the first part of the sessions) *whether the policeman, uh, attacks you sexually, you have fantasies about wanting to seduce Dr. \*Lewis obviously. There are all sorts of conflictual feelings involved. (p:00:10)* (clarification and interpretation of romantic themes and explication of the data on which the analyst bases his comment) *And just, just as you, as you said in the dream, I think you said something like this, you know, that it’s safer to project your own feelings onto the other person and get him to respond. In the dream the policeman’s attacking you sexually so you said here today that it, it’s really safer to, to know how I feel or how somebody else feels rather that your sticking your neck out and taking a chance of getting rejected, getting turned down.* *(Penny: Mm-hm.) So* in *getting me to talk about what, uh, Dr. \*Lewis feels about you you’re avoiding the danger of being rejected* (warm interpretation of defense and conflict about romantic themes and implicitly self-esteem; connection established between dream and wakeful like)*. I still wonder about the headache though. You know there’s gratification in this dream, it’s exciting. You’ve always equated the headache with control, not being in control of a +relationship* (interpretation of a defense and of a symptom and implicit encouragement to elaboration delivered in a straightforward way)*.*

*P: Yeah, mm-hm.+ (p:00:13) think it’s too confusing for me. I, I can’t (sighs) I can’t figure it out. I certainly couldn’t control the feelings of, uh, of excitement that I felt +in the dream.*

*T: No,+ and I don’t know that you wanted to. I think the control that you need, that the, that the control we’re speaking of has to do with controlling a relationship, it’s when you don’t have, you know, when you’re not controlling your husband or something like that that you get the headache* (interpretation of defense, conflict and of a symptom connected to romantic and sexual themes with explication of the analyst’s subjective thoughts)*.*

*P: / Hostility got to do with it all. That’s what you said I, I possibly get a headache because I’m not going to come here on, for three days, that I get my headaches on Thursday or Friday. Wasn’t that a thought you had?* (the patient convey more of her feelings toward the therapist and starts reflecting more about their meaning)

*T: Mm-hm. mm-hm.*

*P: You still feel that way?*

*T: Sure, sure. The head-, the, the, in other words the headaches have something to do with rejection over the sense of not being able; you know, you might control a relationship to avoid loss, to avoid losing the person* (interpretation of defense and conflict connected to romantic and sexual themes delivered in a straightforward way)*.*

*P: Want to come home with me on Fridays?*

*T: That’s another good question, huh? What’s the fantasy under that?*(support and encouragement to elaboration of transference made in a warm way)

*P: (Chuckles) oh god. + / / / /*

*T: Fantasy, then you might not lose me+ and then you wouldn’t have to get a headache then*  (interpretation of transference and conflict, and connection to a symptom)*.*

*P: Well I can find out for sure. (p:00:25) You know what I, what I, I’ve told you this I guess sixty-five times by now, when I talk about sex here, I feel very free about it . . generally. I, I was even propositioned yesterday but it was, you know, nothing really exciting to tell. (p:00:13) My husband’s worried about me. He says I, (chuckles) I’m uh . . . . he thinks I’m serious about . . . . . well, he thinks that I, I would seriously pursue an affair at this time.*

*T: Why does he think that ?* (encouragement to elaboration of romantic themes)

*P: . . . well because he says that I, I openly flirted with our friend on Saturday night and uh yesterday at lunch he thinks that I was . .+doing the same thing*

*T: Is that a recent development* (implicit interpretation of transference and defense – a displacement of the desire to seduce the analyst for coping with the fear of losing him before a separation – made in a supportive a warm way)*?*

*P: Where are you going? (Both laugh)* (the patient connects her transference feeling with what she does in her life outside the therapeutic room)

This excerpt starts with the analyst interpreting and encouraging Penny’s elaboration of transference, connecting what Penny felt toward her previous analyst with what she feels toward him. The patient confirms his interpretation while adding that feeling such a strong need of other people’s approval and love is very difficult to admit and humiliating for her. The analyst at this point confronts then Penny with the opportunity of a deeper exploration of what it is happening and propose a quite sophisticated interpretation that put together what Penny told about her previous therapist and some passages of a dream. In this intervention, he clarify both her desires and her projective defense, together with the relational consequences of this defensive strategy, inside and outside the therapeutic relationship, and with the hypothetic meaning of one of her psychosomatic symptoms. Penny seems again uncertain about confirming or refusing the analyst’s hypotheses, but after the following analyst’s interpretations on her way of dealing with romantic feelings, Penny confirms the analyst’s interpretation, deepens the analytic explorations and starts “playing” with her analyst about her need to be loved, manifested both in and outside the therapeutic relationship. It is clear that this “playing” supports the further deepening of the analytic exploration of the transference. Both Penny and her therapist seem well involved early on in their joint work and in their relationship, and both seem productive and well attuned. It is worth noting that establishing this sort of process early on is a good sign of connection and engagement on key issues that will be a consistent focus across the treatment.

The second excerpt is taken from the 6th week after the beginning of the therapy period of the analysis of Nora :

P: *I just can’t talk with him* (Ken, his last boyfriend) *about anything else. And I don’t understand why I just let it go on and why it’s so hard for me. Now would be the perfect time to let go. Well I mean the perfect time to let go was when I did let go and I shouldn’t have started it up again.*

*T: Uh, let me ask you: What, you, you were going to talk about, what led you to ask for another session of regular therapy* (previously in this session)*. What were you feeling?*(encouragement to elaborating what she feels and thinks about the therapeutic relationship)

*P: Uh, because I just, I really wasn’t expecting for you to tell me anything. You know, I knew you wouldn’t, I knew you wouldn’t give me advice, but I just thought maybe you could tell me what I can think about like… first of all there’s something about Ken and second of all, ‘cause I keep thinking if I didn’t have to come in here and talk about Ken all the time, I mean if I could get my mind on something else I’d be so much better off and I just wouldn’t have to, I mean if I just didn’t think about him he wouldn’t exist anymore. huh.*

*T: You know, that fits in I think with the dream* (a dream told at the beginning of this session) *also because when you feel like this, what you want is somebody else to help you with it and really to do, do it for you. In the dream you had Ira come in. Ira, what we said was you but Ira was really doing it for you, you know, he was taking care of Ken. Then the fantasy with me was that maybe I would be able to tell you and in a way do it for you, you know. And I think maybe part of what happens is that you want someone to fight the problem with Ken for you or at least help you* (interpretation centered on the therapeutic relationship, on a conflict and a defense and on romantic and sexual themes)*.*

P: *Well I mean nobody can say that I’m not, that I don’t, that I haven’t fought this myself, I really have.*

*T: Mm-hm.*

P: *But it gets to a point where it’s, it’s not going to accomplish anything to re-think this and / /. Last night when I didn’t let myself think about it very much I really just came / / everything else but him and started to watch a TV show. And I used, I used to cry a lot at every TV show but I haven’t cried for a long time. And it was, and I just, at the end of the show I just started to cry again. Well it wasn’t even at that show, I mean it was / / / I think it was Patty Duke I was watching at six o’clock or something, and at the end of Patty Duke I mean, huh, I started to cry because I can’t just make myself stop thinking about him unless I’ve got something else to take over, like at work I’m fine and I don’t think about him at all at work except when I take a break or when there’s a lag or I’m not doing anything, then I think about him. But it’s not that I really want you to tell me what to do but just that if I’m supposed to find out what he represents and everything, there must be a way of finding it out, there must be things I should think about, think, you know, different tracks I should get on and I don’t know what they are. But I just, I just don’t, you know, I don’t real- I mean I do want you, I’d like you to hypnotize me just to wipe his mind, his name out of my mind. A friend of mine at the o- well he’s not just a friend, actually he’s a lawyer that I’m working under on one of his cases, cases, his name is Ken and it’s funny everybody calls him Mr. Unger. I don’t know why I call him Ken. I mean he is young, he’s only thirty or something, in his thirties, thirties. But the other paraprofessionals, you know / / call him Mr. Unger. But I just started calling him Ken and he, you know, he told me to, I asked him after a while, you know, I realized what I was doing and he said `No, don’t be ridiculous, you’re supposed to call me Ken.’ But every time I say his name I just get so, I mean it’s like I really have to avoid seeing him. It’s really a psychological thing and it’s affecting my work. ‘cause I’m supposed to be working on this deposition.//*

The patient, then, keeps on talking about different subjects for three pages of transcription, and the analyst makes only a couple of question on specific point, such as “Does that play a role?*”*, referring to the fact that one of the girls Nora was talking about was the best friend of Ken’s sister.

In this excerpt from the first period of Nora’s analysis, the patient starts talking about her difficulty in letting go her feelings toward Ken, her former boyfriend, and about her desire to have one more regular session of analysis. When the analyst asks her why she would have wanted to come one more time, she seems to imply that another session could help her to think and talk about some other subject, “forgetting” Ken for a while. At that point the analyst, connecting what Nora was saying with the content of a dream, interprets Nora’s whish that another person could deal with her problem freeing her from them. Nora, however, seems to feel her analyst’s words as a reproach, denies a tendency to delegate the responsibility to other people and talks about her need to be involved in something or not think at all for not keeping thinking about Ken, and then stresses how her difficulties with Ken are problematic also for her work life. She shows the denial attitude the analyst interpreted, but seems not able to recognize it. In general, the analyst’s interventions do not seem particularly sophisticated and attuned, and Nora’s communication do not help the deepening of the analytic work; moreover, it is not clear if Nora believes that exploring the meaning of her relationships could really help her to feel better and seems to be afraid of not being capable of good self-reflection.

The following excerpt is taken from the middle period of Penny’s analysis:

*Analyst: I think you’re trying to turn, uh, adversity into benefit or something or other. I think you’re trying to, you’re telling yourself you, you, that there’s advantage to being the, the little daughter, the little sister* (interpretation of defense and implicitly of a conflict and of self-esteem issues)*. You know, it’s kind of like in the dream* (a dream previously referred)*, you, uh, everybody pairs off and you don’t have anyone to dance with and so you go off and, and dance alone for \*Helen and her friends and entertain them. That’s not what you really wanted to do. (p:00:28)*(the analyst connect dream and waking life and add a little confrontation) *As angry and as disappointed as you were in your father and as hurt by him as you were, he’s still, he’s still your father and you still wished for something. (p:00:20) In fact you married a man who had some, has some of your father’s qualities. This is what drives you nuts sometimes about \*Bob, the boorishness and making an ass of himself a couple of weeks ago that was so disturbing to you. But you know, it suggests that you, simply you wanted a second chance at winning your father and what is so terribly difficult to, to accept sometimes now is that you can’t really influence \*Bob any more than you could your father and it’s frustration and disappointment all over again, and uh, there’s even the fear that \*Bob might not love you in return* (clarification and interpretation of conflict, defenses, romantic and aggressive themes, developmental themes and self-esteem issues associated with a little empathic support) */ /.*

*Patient: ... yeah, it’s a beautiful picture isn’t it. (p:00:32) (sighing) So (p:00:08) does that mean that the feelings that I, that I developed originally were based on reality even if, if I’m not working with reality today?*

*Analyst: Now I don’t understand you, what feelings?*

*Patient: The feelings of, uh, uh, of rejection.*

*Analyst: Sure.*

*Patient: Because I was rejected.*

*Analyst: Sure. Sure, he did disappoint you over and over again.* (support of self-esteem connected to

 the developmental period)

*Patient: . . . and that’s of course why I’m so very much concerned with, you know, padding myself against rejection which uh, which also means that it, it’s difficult to love somebody, to uh and give yourself because . . . because of the, that awful fear. (p:00:08) It’s like, you know, this time it just won’t happen again*. (the patient connect past and present issues and reflects on her conflicts and on how the past influences the present)

*Analyst: Yeah.*

*Patient: But the frustrating part of this whole thing is that, you know, this, this hasn’t been a mystery to me for a long time, it’s something that I understand but I can’t shake off, so you know, what, what good does it do to uh, to understand things clearly?*

*Analyst: Well nobody ever shakes anything off, it’s going to take time to just, to work it out over and over and over again until, until you develop, until you really can put it aside. But you know, you, as much as you say ‘who wants him’ and ‘who cared about him’ and ‘he was such a disappointment’, you know, you’re still talking as though, as though somehow you’re very much tied to your father because you expect that everybody else is going to treat you the same way. You’ve never really relinquished him, you’re still kind of keeping yourself in some sort of subservient position by thinking of yourself as someone inferior, as by not being able to develop a perspective about what he was like and what you were like and you really haven’t relinquished him yet. (p:00:10) And that takes some work and that’s what you’re doing*(support and confrontation associated with an interpretation on how the child relationship with the father keeps on influencing her present life and self-esteem; the analyst explains also what he thinks he and Penny should do in order to help Penny to feel better)*.*

In this excerpt we see how the analyst clarifies and interprets one of the main core problematic relational patterns and conflicts in Penny’s romantic life, connecting her present and past relationships, explaining the defensive function of some of her romantic proclivities and empathizing with her past and present suffering. Moreover, the analyst explains to Penny one of the mutative factors of psychoanalysis, the working through (Freud, 1914), and is slightly confrontational toward her difficulty in relinquishing the infantile link with her husband. He is straightforward, warm, attuned, and engaged. Penny, for her part, after having implicitly asked for recognition of her infantile suffering, seems able both to recognize the truth present in the analyst’s words and to communicate and share with the therapist her difficulties in changing long-lasting proclivities.

 The fourth and last excerpt is taken from the middle period of the analysis of Nora:

*Analyst*: *You must have been longing for warmth and closeness for years and years. It’s a, I mean I say you must have, we know that you did. When you said yesterday ‘fat little Nora’, you know, that, that is hard to picture but when you do picture it, then you can picture a kid who must have just been yearning for something like this* (clarification, interpretation and empathic support of her self-esteem issues connected to developmental themes)*.*

*Patient: hmm, yeah. . . . oh, son of a bitch, and then it does not help to see all these, all these single girls around, because I mean if they’re my age but when they’re, they’re four years older than you and they’re still wandering around looking and not finding anybody. I’m really cold. (chuckles) That scares me. I mean / / / / / with that girl seven years. Of course that’s her own choice but still it just scares me so much that I’m, that I’m not going to have anything that. And I keep thinking, you know, like remember that time you said `oh / /’ you said ‘Within a year’, I just, I asked you, I’m really pinning you down on that. Remember you said within a year you’re sure that I would have some kind of involvement again. You said you didn’t know if it was going to be a good one or a bad one. But you know at this point I didn’t feel this way when I walked in here today, but at this point right now I mean I don’t even know if it’s bad, if it’s another married man or just anything. Socially I have things that are better than I ever had. Now it’s a question of, do you know, I mean I used to, I think I told you this, but I used to get home every day and take a nap and everything. I don’t have time for any of that now, I’m always busy. Or I find I just, I just don’t want to . . . but . . . you know or, I’m just - I’m busy, and of course that’ll calm down, you know, I’m sure. But it’s not, you know, friends are great and it’s wonderful and I’m very excited about Liza. Oh by the way I assume you’re not going to be here Thursday and Friday, are you, next week?*

*Analyst: I am.*

*Patient: Oh you are?*

*Analyst: Yes.*

*Patient: I’m not.*

*Analyst: Okay.*

*Patient: I have but you can - you know you, you can’t be upset with me at that. (chuckles) I*

*mean it’s …*

*Analyst: I can be upset at you for anything I want to, Nora.* (confrontation)

*Patient: No, you can’t be upset with me for the, for the hi- I know you can but you won’t be, right?*

*Analyst: Right.*

In this passage, the analyst tries to interpret Nora’s low self-esteem as a consequence of her generally not having felt loved during her infancy, and Nora replies, stressing her lack of confidence in the possibility that one day she will have a better romantic life. Then she pauses to talk about the incorrectness of one of the analyst’s forecasts, and about a conflict she feels in herself: now she has a better social life, but feels that this social life does not give enough space for her own previous personal habits. Finally, she seems to show another more explicit conflict toward the therapy: she thought that the analyst would have not been present the following two sessions, but when the analyst denies this, she says that, in any case, *she* will not come to those sessions. At this point, Nora says she hopes that the analyst won’t be upset by her absence, but says so in a controlling way, and the analyst replies with an indirect confrontation of her tentative control, but reassures Nora that he will not be upset.

In general, Nora seems not to be able to deepen very much her understanding of herself, and the analyst seems not to be able to help Nora to understand more of her psychic life. The analyst’s communications are in general straightforward and warm, and follow the moment-to-moment shifts in Nora’s feelings, but seem also quite general and not very articulated, even if centered on one of Nora’s core themes. Nora, for her part, talks about her conflicts in romantic and sexual life and shows some aggressive feelings toward the analyst and a man she is engaged with, but her statements are not very complex and precise, and this lack of articulation and depth can also be seen in her communications about her low self-esteem.

At this point, we will examine the differences in the outcomes of these two psychoanalyses, remembering that, at the beginning of their therapies, the two patient scores on the SWAP-200 and GAF were fairly similar.

**Penny and Nora at the End of the Treatment**

 At the end of their therapies, Penny does not have a personality disorder or significant pathological personality traits. Her high-functioning capacities are now two standard deviations *above* the average score of a sample of PD patients (T=70); Penny does not show any clinical disorder, and her GAF score is 72, 13 points higher than at the beginning. By contrast, Nora shows histrionic (T=73.1), borderline (T=69.2), dependent (T=63.4), and passive-aggressive (T=63.4) personality disorders. Her functioning level is in the average of a sample of patients with personality disorders (T=47.9) and compared to her clinical picture at the beginning of the analysis, she remains depressed, and her GAF score is 60 (2.5 less than at the beginning).

INSERT FIGURE 5

Penny’s and Nora’s SWAP assessment shows that, during her treatment, Penny learnt to use less primitive defenses such as splitting, projection, and somatization, and to be more insightful, amicable, creative, conscientious, effectively assertive, and able to develop love and caring relationships; she became less angry and hostile, less competitive and envious, and less jealous and seductive; her identity became more clearly defined and she felt less inferior and emotionally more in control, while her representations of other people became more coherent and complex, and she appeared to have come to terms with painful experiences of her past. Also, in Nora’s personality it is possible to see some changes, such as her becoming less suggestible and preoccupied with death, but we see also negative changes, such as her becoming less able to find pleasure in her life[[5]](#footnote-6); however, Nora’s changes are quite few, and the overall picture of her personality did not change substantially from the beginning to the end of the treatment.

**Discussion**

At the beginning of the their psychoanalyses, Penny’s and Nora’s diagnostic presentations were very similar. Nora was younger than Penny, showed only one major disorder and two personality disorders, but was also a little bit less psychologically resourceful (SWAP high-functioning scale), even if her GAF score was a little bit higher than Penny’s. Penny was older, showed three personality disorders and three major disorders, but was also slightly more psychologically resourceful, even if her GAF was a little bit lower, and had had a previous analysis. Yet, the treatment of Penny had a good outcome, while Nora did not benefit from her analysis, or if she did the benefit was not visible at the end of treatment. The empirical assessment of their therapeutic processes, however, shows substantial differences that we may summarize by saying that Penny was more able to *convey her experience of the therapeutic relationship* and to *reflect about it*, and Penny’s analyst *made higher quality classical interventions* (i.e. clarifications and interpretations of conflicts and transference) *and adopted a more relational attitude* (he was warmer, more straightforward and more available to show his subjective feelings and thoughts), a combination that, on the basis of previous data collected on 340 sessions from 17 analytic treatments has been correlated with better therapeutic outcomes (Gazzillo, Genova, Ristucci, Angeloni, Mellone, 2013). Since the first month of treatment, therapists of good outcome analyses are better at using classic analytic interventions such as communications on conflicts and development; at the same time, patients of good outcome treatments seem more able to productively communicate and self-observe what they think and feel in their relationships with the therapist, and to integrate these understandings with the experiences they have in their relational experiences outside the analytic room (see also Waldron, Gazzillo, Genova, & Lingiardi, 2013). If these findings will be confirmed by the assessment of the remaining 14 cases, this may indicate the possibility of identifying psychoanalyses and psychotherapies which are not likely to succeed based upon careful study of a sample of early recorded sessions. This may be compared to the findings of Lambert and co-workers (Lambert & Shimokawa, 2011) that becoming aware of limitations in the treatment from structured feedback provides a valuable means of identifying and “adapting” treatments that are not working well.

In any case, this study seems to support most of the findings of the research discussed in the introduction of this paper, stressing the relevance of the analysis of inner and relational conflicts and of the relationship between patient and therapist, of a good analytic process in general and of the overall quality of therapist interventions in particular, i.e. of the adequacy of the kind, content, timing and language of the communication chosen for that moment of that particular therapy. This further supports the therapeutic value of a warm and attuned relationship between therapist and patient and the capacity of a good analysis to increase the maturity of the patients’ defenses.

However, it is worth noting that this study has some limitations: it is based on only two cases and on the assessment of only 20 sessions from an average number of more than 600 sessions for each treatment and we have not yet collected follow-up data. Moreover, the level of ICC for the HAr assessment is only fair (.54), perhaps also for the limited number of data points for its calculation, and this suggest to be cautious about the significance of our data on the therapeutic alliance. However, as already stated, the results of the analysis of 15 additional cases seem to support the data presented (Gazzillo, Genova, Ristucci, Angeloni, Mellone, 2013), giving them greater reliability, and it is our intention to collect follow-up data on most of the treatments considered in this research.

**Conclusions**

The empirical research conducted until now on the process and outcomes of psychotherapy has showed the prognostic relevance of factors such as level of personality organization (Kernberg, 1984; Koelen et al., 2012), level of the global functioning of the patient (Luborsky& Luborsky, 2006), and level of therapeutic alliance, in particular as assessed by the patient at the beginning of the therapy (Luborsky, 1994; Horvath & Bedi, 2002). However, our two patients did not differ on any of these dimensions at the beginning of their treatment. Therefore, we could try to explain the differences in the outcomes of these two treatments on the basis of the results of more specifically psychodynamic research: using the findings from Blatt & Shahar (2004) on the introjective and anaclitical psychopathologies, we may argue that both Penny and Nora showed anaclitical personalities (histrionic and borderline), so that with both cases a more relationally oriented psychotherapy might be expected to be more effective than a more classical approach. And the analyst of Penny, our good outcome case, did *behave in a more relational manner, i.e. he was more available to show his subjective thoughts and feelings, warmer, and more engaged,* but he used also *more “classical” interventions such as clarifications and interpretations of conflicts, defenses and transference*. Thanks to the Wallerstein (1986) study, then, we are aware of the relevance of supportive work in all kinds of dynamic psychotherapy, but we did not find any relevant differences in the amount of support given to Penny or to Nora: the APS scale on supportive interventions shows no significant difference on this dimension between the two treatments (23.3 vs. 17.6; U=143, p = .13), and this conclusion is further supported by the lack of difference in the empathy perceived by Penny and Nora as assessed with the DIS (mean rank 22.5 vs. 18.5; U=369.5, p =.27). While it seems reasonable to question the ability of raters to code patient levels of empathy they felt for the therapist, we feel the excellent levels of reliability for this scale provide some support for this possibility.

Taking into account the strong similarities between the two patients’ personalities at the beginning of the treatment, their GAF levels, the levels of their therapeutic alliance, the fact that the analysts were very similarly trained and their setting was virtually identical, our tentative reading of the data presented in this study is that the quality and the effectiveness of the analytic process depends less on the overall severity of patients’ psychopathology at the beginning of the treatment than on the capacity of the patient to be involved and communicate what he thinks and feels toward the therapist, and on the capacity of the therapist to use good classical analytic interventions such as clarifications and interpretations of conflict and transference with a relational attitude, i.e. in a warmer, more straightforward way and with a greater availability to refer one’s feelings and thoughts . Along these lines, there seems to be no need for a harsh debate between “classical” or “relational” analysis, because both kinds of approaches can be very useful, and our findings support such technical flexibility with regard to positive outcomes in psychoanalysis (Waldron, Gazzillo, Genova, Lingiardi, 2013).

**References**

Albani, C. Pokorny, D., Blaser, G., König, S., Thomä, H., & Kächele, H. (2003). Study of a Psychoanalytic Process using the Core Conflictual Relationship Theme (CCRT) Method according to the Ulm Process Model. *European Psychotherapy*, 4, 1, 11-32.

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Diseases – IV edition Text Revision*. Washington, DC: American Psychiatric Publishing.

Banon, E., [Perry](http://www.tandfonline.com/action/doSearch?action=runSearch&type=advanced&searchType=journal&result=true&prevSearch=%2Bauthorsfield%3A(Perry%2C+J+C)), J.C., [Semeniuk](http://www.tandfonline.com/action/doSearch?action=runSearch&type=advanced&searchType=journal&result=true&prevSearch=%2Bauthorsfield%3A(Semeniuk%2C+T)), T., [Bond](http://www.tandfonline.com/action/doSearch?action=runSearch&type=advanced&searchType=journal&result=true&prevSearch=%2Bauthorsfield%3A(Bond%2C+M)), M., [de Roten](http://www.tandfonline.com/action/doSearch?action=runSearch&type=advanced&searchType=journal&result=true&prevSearch=%2Bauthorsfield%3A(de+Roten%2C+Y)), Y., [Hersoug](http://www.tandfonline.com/action/doSearch?action=runSearch&type=advanced&searchType=journal&result=true&prevSearch=%2Bauthorsfield%3A(Hersoug%2C+A+G)) A.G., [Despland](http://www.tandfonline.com/action/doSearch?action=runSearch&type=advanced&searchType=journal&result=true&prevSearch=%2Bauthorsfield%3A(Despland%2C+J)), j.n. (2013). Therapist interventions using the Psychodynamic Intervention Rating Scale (PIRS) in dynamic therapy, psychoanalysis and CBT. Psychotherapy Research, 23, 2, 121-136. DOI: 10.1080/10503307.2012.745955

 Blagys, M.D., Hilsenroth, M.J. (2000). Distinctive Features of Short-term Psychodynamic-Interpersonal Psychotherapy: a review of the comparative psychotherapy process literature. *Clinical Psychology: Science and Practice*, 7, 2, 167-188. DOI: 10.1093/clipsy.7.2.167

Blatt, S.J., Shahar, J.(2004). Psychoanalysis – with whom, for what and how. Comparison with psychotherapy. *Journal of the American Psychoanalytic Association*, 52, 393-447. DOI: 10.1177/00030651040520020401

Block, J. (1978). *The Q-sort method in personality and psychiatric research*. Palo Alto, CA: Consulting Psychologists Press.

Cecero, J. J., Fenton, L. R., Frankenforter, T. L., Nich, C., & Carroll, K. M. (2001). Focus on therapeutic alliance: The psychometric properties of six measures across three treatments. *Psychotherapy*, 38(1), 1–11.

Freud, S. (1914). Recollection, repetition and working through. *Collected Papers*, Vol.2, 366-376

Gabbard, G.O. (2010). *Long-term Psychodynamic Psychotherapy: a Basic Text* (2nd edition). Washigton, DC: American Psychiatric Publishing.

Gazzillo, F., Genova, F., Ristucci, C., Angeloni, F., Mellone, V. (2013). *Classical interventions or relational approach? The first results of an in-progress empirical research on process and outcome of psychoanalyses*. Annual Meeting of the Italian Association of Psychology. Naples, 27-29 September, 2013.

Gullestad, F.S., & Wilberg, T. (2011). Change in reflective functioning during psychotherapy-a single-case study. *Psychotherapy Research*, 21 (1), 97-111. DOI**:**10.1080/10503307.2010.525759

Horvath, A. O., & Bedi, R. P. (2002). The Alliance. In J. Norcross (Ed.), *Psychotherapy Relationships That Work: Therapist Contributions and Responsiveness to Patients*. New York: Oxford University Press. Psychotherapy. Oxford, New York . 37-70

*Kächele, H. (2010*Distinguishing psychoanalysis from psychotherapy. *The International Journal of Psycho-analysis,* 91, 1, 35-43.DOI: 10.1111/j.1745-8315.2009.00232.x

Kernberg, O. (1984). *Severe Personality Disorders: Psychotherapeutic Strategies.* New Haven/London: Yale University Press.

Kernberg, O.F. (2004). Aggressivity, *Narcissism and Self-destructiveness in the Psychotherapeutic Relationship*. New Haven/London: Yale University Press.

Koelen, J. A., Luyten, P., Eurelings-Bontekoe, L. H., Diguer, L., Vermote, R., Lowyck, B., &

Bühring, M. E. (2012). The impact of level of personality organization on treatment response: A systematic review. *Psychiatry*, 75, 355–374.

Lambert, M.J., Shimokawa, K. (2011). Collecting client feedback. *Psychotherapy*, 48, 1, 72-79. DOI: 10.1037/a0022238

Lingiardi, V., Gazzillo, F., & Waldron, S. (2010). An empirically supported psychoanalysis: The case of Giovanna. *Psychoanalytic Psychology*, 27, 190–218.  DOI: [10.1037/a0019418](http://psycnet.apa.org/doi/10.1037/a0019418)

Lingiardi, V., Shedler, J., & Gazzillo, F. (2006). Assessing personality change in psychotherapy with the SWAP-200: A case study. *Journal of Personality Assessment*, 86, 23–32. DOI:10.1207/s15327752jpa8601\_04

Luborsky, L. (1962). Clinicians’ judgments of mental health: A proposed scale. *Archives of General Psychiatry*, 7, 407–417. DOI:10.1001/archpsyc.1962.01720060019002

Luborsky, L., Crits-Christoph, P., Alexander, L., Margolis, M., & Cohen, M. (1983). Two helping alliance methods for predicting outcomes of psychotherapy: Counting signs vs. a global rating. *Journal of Nervous and Mental Disease*, 171, 480–491. DOI:10.1097/00005053-198308000-00005

Luborsky, L. & Luborsky, E. (2006). *Research and Psychotherapy: The Vital Link*. Lanham, MD: Jason Aronson.

Mariani, R., Maskit, B., Bucci, W., & De Coro, A. (2013). Linguistic measures of the referential process in psychodynamic treatment: The English and the Italian version. *Psychotherapy Research*, 23, 4, 430-447. DOI: 10.1080/10503307.2013.778437

Perry, J.C., & Bond, M. (2012). Change in defense mechanisms in long-term dynamic psychotherapy and five year follow-up. *American Journal of Psychiatry*. 169, 9, 916-925. DOI 10.1176/appi.ajp.2012.11091403

Porcerelli, J., Dauphin, V. B., Ablon, J. S., Leitman, S., & Bambery, M. (2009). Psychoanalysis of avoidant personality disorder: Systematic case study of process and outcome. *Journal of the American Psychoanalytic Association, 57*, 444-449. DOI: 0.1177/00030651090570020906

Rey, J. M., Starling, J., Wever, C., Dossetor, D. R., & Plapp, J. M. (2006). Inter-rater reliability of global assessment of functioning in a clinical setting. *Journal of Child Psychology and Psychiatry*,*36,* 787–792. DOI: 10.1111/j.1469-7610.1995.tb01329.x

Shedler, J., & Westen, D. (2007). The Shedler-Westen Assessment Procedure (SWAP): Making personality diagnosis clinically meaningful. Journal of Personality Assessment, 89, 41–55. doi:10.1080/00223890701357092

Shedler, J. (2002). A new language for psychoanalytic diagnosis. *Journal of the American Psychoanalytic Association*, 50, 429-456. DOI:

Siegel, P., Demorest, A. (2010). Affective script: a systematic case study of change in psychotherapy. *Psychotherapy Research*, 20, 4, 369-387. DOI:10.1080/10503300903544240

Waldron, S., Moscovitz, S., Lundin, J., Helm, F., Jemerin, J., & Gorman, B. (2011). Evaluating the outcomes of psychotherapies: The personality health index. *Psychoanalytic Psychology*, 28,363–388.

Waldron, S., Gazzillo, F. Genova, F., Lingiardi, V. (in press). Relational and Classical Elements in Pyshcoanalyses: and Empirical Study with Case Illustrations. *Psychoanalytic Psychology*.

Waldron, S., & Helm, F. (2004). Psychodynamic features of two cognitive-behavioural and one psychodynamic treatment compared using the Analytic Process Scales. *Canadian Journal of Psychoanalysis*, 12, 346–368.

Waldron, S., Scharf, R. D., Crouse, J., Firestein, S. K., Burton, A., & Hurst, D. (2004). Saying the right thing at the right time: A view through the lens of the Analytic Process Scales (APS). *Psychoanalytic Quarterly*, 73, 1079–1125.

Waldron, S., Scharf, R. D., Hurst, D., Firestein, S. K., & Burton, A. (2004). What happens in a psychoanalysis: A view through the lens of the Analytic Process Scales (APS). International Journal of Psychoanalysis, 85, 443–466.

Wallerstein, R. (1986). *Forty-two lives in treatment: A study of psychoanalysis and psychotherapy*. New York, NY: Guilford Press.

Westen, D., & Shedler, J. (1999a). Revising and assessing Axis II: I. Developing a clinically and empirically valid assessment method. The American Journal of Psychiatry, 156, 258–272.

Westen, D., & Shedler, J. (1999b). Revising and assessing Axis II: II. Toward an empirically based and clinically useful classification of personality disorders. *American Journal of Psychiatry*, 156, 273–285.

**Tables and Figures**

**Table 1. Sessions assessed, instruments, and focus**

|  |  |  |
| --- | --- | --- |
| **Period and sessions** | **Instruments** | **Focus** |
| Beginning(first 4 sessions + 4 sessions from the 6th week) | SWAP, PHI, GAFHARAPS and DIS | Personality and overall functioning, helping alliance, therapeutic process |
| Middle(Four sessions from the middle of the analysis) | APS and DIS | Therapeutic process |
| Termination(Four sessions from the 6th week before the termination and last four sessions) | SWAP, PHI, GAFAPS and DIS | Personality and overall functioning, therapeutic process |

F**igure 1. Penny’s and Nora’s SWAP PD profile at the beginning of their therapies**

**Figure 2: Differing patient levels of working early in treatment**

****

**Figure 3: Therapist relationship to the patients early in treatment**

**Figure 4: Therapist technique difference early in treatment**

****

**Figure 5. Penny’s and Nora’s SWAP PD late personality profiles**

1. The debate on what can be considered psychoanalysis and on the distinction between psychoanalysis, psychodynamic or psychoanalytic psychotherapies, and other psychotherapeutic models is wide and long-standing, but it is far beyond the scope of this paper. The interested reader may read Blagys and Hilsenroth, 2000; Kernberg, 2004; Kächele, 2010; and Gabbard, 2011. [↑](#footnote-ref-2)
2. We studied these two cases as part of 17 already studied in an ongoing project to assess processes and outcomes of 31 fully recorded psychoanalytic cases in the collection of the Psychoanalytic Research Consortium (www.psychoanalyticresearch.org). Several different psychoanalysts have contributed these cases over the past 40 years in order to facilitate research on psychoanalysis, and ours is the first systematic empirical study of processes and outcomes of all of these cases. [↑](#footnote-ref-3)
3. The two descriptions of Penny’s and Nora’s treatment have been independently developed by two clinical psychologists synthesizing, without making any inference, the same 20 sessions of each treatment assessed with our empirical instruments. All names relating to the patients described are pseudonyms. Our patients gave their written consent to have their sessions audiotaped, confidentialized and transcripted for research purposes, being aware that confidentialized excerpts from their treatments could have been published in scientific papers. [↑](#footnote-ref-4)
4. All the data comparing Penny’s and Nora’s analytic process are available from the first author. [↑](#footnote-ref-5)
5. The SWAP of Penny and Nora are available from the first author. [↑](#footnote-ref-6)