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AN EMPIRICALLY SUPPORTED PSYCHOANALYSIS

The Case of Giovanna

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Psychoanalysts have long relied on the case study method to support the validity of their theoretical hypotheses and clinical techniques and the efficacy of their treatments. However, limitations of the case study method have become increasingly salient as the medical-scientific community and policymakers have increasingly emphasized the need for empirical data. This article describes the progression of an analysis from the perspective of both the treating analyst and an independent research team using empirical methods to study verbatim session transcripts. Empirical measures include the *Shedler-Westen Assessment Procedure-200* (Westen & Shedler, 1999a, b; Shedler & Westen, 2006), the *Defense Mechanism Rating Scale* (Perry, 1990a) and the *Analytic Process Scales* (Waldron, Scharf, Crouse, Firestein, & Burton, 2004, and Waldron, Scharf, Hurst, et al., 2004). The article illustrates one way in which clinical and empirical methods can complement each other synergistically and lead to a deeper and more precise understanding of analytic process and psychological change.

Keywords: case study, personality assessment, psychoanalytic process, defense mechanisms, therapeutic factors

As the history of science attests (and, as recently emphasized by the American Psychological Association in their guidelines defining "evidence"), scientific evidence includes and often

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> begins with sound descriptions, such as case studies (*Psychodynamic Diagnostic Manual*, 2006, p. 3)

Psychoanalysts have historically tried to demonstrate the validity of their hypotheses and the efficacy of their therapies through clinical reports of illustrative cases. The cases of "Dora" (Freud, 1905), the "Rat-man" (Freud, 1908), the "Wolf-man" (Freud, 1918), "Richard" (Klein, 1960), "Piggle" (Winnicott, 1977) and "Mr Z" (Kohut, 1979) are some classic examples of this rich tradition. But in recent decades, psychoanalysts have increasingly been called upon to provide empirical evidence for the efficacy of their treatments that goes beyond the anecdotal. In fact, the clinical case report has failed to meet the burden of proof demanded by philosophers of science, the medical-scientific community, third party payers, and the public (Fonagy, 2006).

In our opinion, the problem is well described by Drew Westen (2002): "Narratives [case reports] . . . are invariably compromise formations. We hope they include a heavy dose of relatively accurate perception and memory. But as compromise formations, they are likely to reflect a variety of wishes and fears: to make a particular point . . . convincingly, to appear intelligent and clinically talented to one's colleagues, to establish one's identity as a member of the analytic community (or a subset of it), to express identification with admired others and with those whose admiration one desires, to express competitive or hostile impulses toward those with whom one disagrees or dislikes, and so forth . . . Among the most important limitations are lack of replicability, lack of reliability of inference, lack of control over variables that would allow causal inference, and unknown generalizability." (p. 883)

Similar opinions have been expressed by Wallerstein and Sampson (1971); Pulver (1987); Fosshage (1990); Spence (1992) and Schachter & Kächele (2007): on the basis of the same clinical material, analysts with different theoretical orientations draw different conclusions and find evidence supporting their favorite theoretical models and disconfirming alternative models. For these reasons it is not possible to use clinical case studies as compelling evidence in support of a specific theory, although they are still fine sources of new clinical hypotheses (Westen & Muderrisoglu, 2003; Kächele, Schachter, & Thoma, 2008).

To address these issues and overcome these limitations, psychodynamic researchers have begun to apply systematic research methods to single case studies (Jones, Parke, & Pulos, 1992; Kächele et al., 2006; Lingiardi, 2006; Lingiardi, Shedler, & Gazzillo, 2006; Porcerelli, Ablon, Dauphin, & Leitman, 2007; Bucci & Maskit, 2007; for a methodological discussion on single case research, see Kazdin, 2007).

The use of session transcripts and the development of empirical instruments for the assessment of different dimensions of patient functioning and therapeutic process have facilitated this task. It is now possible to identify the relation between symbolic and subsymbolic processes in patient and therapist communication (Bucci, 2007), the problems addressed in treatment (Weiss, Sampson, and the Mount Zion Psychotherapy Research Group, 1986; Luborsky, Crits-Cristoph, 1990; Kächele, 2008), the types of changes that occur in therapy (Lingiardi et al., 2006), the most effective therapeutic interventions (Jones, 2000; Waldron, Scharf, Hurst, Firestein, & Burton, 2004a; Waldron, Scharf, Crouse, et al., 2004) and relational factors (Diamond et al., 2003) that contribute to change, and so forth.

A combination of qualitative and quantitative methodologies has been used successfully to evaluate the process and outcome of psychoanalytic/psychodynamic treatments (Stiles, 1993). These two methodologies are reciprocally enhancing: on the one hand,

qualitative methods (such as clinical case presentations) can offer subtle insights and evocative descriptions of what happens in and between the minds of therapists and patients (Aron, 1996); quantitative methods, on the other hand, can verify clinical hypotheses and give empirical support to technical options and psychoanalytical clinical statements (Jones, 2000).

The aim of this article is to illustrate the integration of a qualitative approach based on the therapist's perspective, and a quantitative approach based on data gathered by external raters using empirical instruments and statistical methods, to a single case of psychoanalytic psychotherapy, the case of Giovanna. With this paper we wish to help bridge the gap between clinicians and researchers and to develop a clinically sophisticated and empirically grounded psychoanalytic practice (see also Moran & Fonagy, 1987; Cooper, 2008; Porcerelli et al., 2007; Kächele et al., 2006; Shedler, 2002).

In order to accomplish this goal we have chosen well-validated empirical instruments that are both clinically sensitive and statistically sound. By *clinical sensitivity* we mean the capacity to measure constructs that are relevant from a psychodynamic point of view without interfering with the psychoanalytic process "as usual"; by *statistical soundness* we mean a high level of validity and reliability. A description of these instruments will follow, but it may be helpful if we explain the rationale of our choices first.

We have chosen to investigate both process and outcome dimensions of a clinical case in order to identify the features of therapist interventions which foster better functioning in patient personality (see also Wallerstein, 2002b). Patient personality has been evaluated with the *Shedler-Westen Assessment Procedure* (SWAP-200; Westen & Shedler, 1999a, 1999b), a methodology for the systematic assessment of personality structure that has shown a very good construct validity in terms of capacity to assess and predict relevant features of psycho(patho)logical and social functioning (see, e.g., Marin-Avellan, McGauley, Campbell, & Fonagy, 2005; Di Lallo, Jones, & Westen, 2009; Powers & Westen, 2009), and a high level of reliability and validity (Westen & Muderrisoglu, 2003; Westen & Weinberger, 2004; Bradley, Hilsenroth, Guarnaccia, & Westen, 2007).

Defense mechanisms, a crucial personality function in a psychodynamic perspective, have been assessed with the *Defense Mechanism Rating Scale* (DMRS; Perry, 1990a), an instrument validated in an Italian population (Perry, Lingiardi, & Ianni, 1999; Lingiardi, Lonati, Fossati, Vanzulli, & Maffei, 1999) with good clinical sensitivity and statistical soundness (Perry, 2001; Bond & Perry, 2004; Drapeau, De Roten, Perry, & Despland, 2003; Perry, Beck, Constantinides, & Foley, 2009). Lastly, for the empirical investigation of microanalytic features of therapeutic process we have used the *Analytic Process Scales* (APS, Waldron, Scharf, Hurst, et al., 2004; Waldron, Scharf, Crouse, et al., 2004b), which enables a reliable moment-by-moment assessment of different dimensions of patient and analyst contributions to the therapeutic process, and a quantitative analysis of the relation between therapist interventions and patient immediate responses and vice versa (see also, Waldron& Helm, 2004). The application of these instruments enabled us to describe the therapeutic process and its outcome, as well as to investigate the relation between therapist interventions and specific patient communications and their different contributions to the outcome of the treatments.

In line with previous research (Perry et al., 1999; Waldron, Scharf, Hurst, et al., 2004; Waldron, Scharf, Crouse, et al., 2004; Waldron & Helm, 2004; Lingiardi et al., 2006), our general hypothesis is that the empirical assessment of session transcripts will show that the capacity of a patient to contribute to the analytic process during the sessions (as measured by APS) is a good indicator of his or her overall personality functioning (as measured by the SWAP), and of his or her healthy defensive style (as measured by the DMRS) in that

moment of the therapy. Furthermore, we suggest that this capacity is fostered by the *quality* of analyst interventions, measured with the APS, beyond the specific technical nature of those interventions.

The APS assessment of the *capacity of the patient to contribute in a productive way to the analytic process* is based on the presence of "a sense of forward movement . . . in the depth or breadth of the patient's . . . emotional understanding, in the intensity of the patient's involvement and collaboration with the therapist, or in the quality of other emotional expressions" (Waldron et al., 2003 p. 30). It is a complex construct that takes into account different patient dimensions: the capacity for emotional insight (Castonguay & Hill, 2007), the presence of a good therapeutic alliance (Safran & Muran, 2000; Colli & Lingiardi, 2009a) and the capacity to communicate one's own emotions in both moving and clear ways (Bucci, 2001). For these reasons, we think that the *capacity of the patient to contribute in a productive way to the analytic process* can reflect both the overall personality functioning and the maturity level of the patient's defensive style.

Also the *quality of therapist interventions* assessed by the APS (i.e., "the aptness of the type of intervention, the usefulness of its content, and the skill with which the comment is made"; Waldron et al., 2003, p. 78) is a complex construct, reflecting both technical and personal skills of the therapist: from the ability to understand the most appropriate target of the interventions (self-esteem, defense mechanisms, transference or extratransference reactions, sexual life, aggressivity, and so on) and the most useful kind of intervention (clarification, interpretation, confrontation, etc.) in that specific moment of the therapy, to the capacity to communicate in a timely, empathetic, and understandable way. For these reasons, in our opinion, the *quality* of therapist interventions could be thought of as an indicator of the therapist's attunement with the patient's state of the mind in the different moments of the therapy.

It is this attunement that helps the analyst to choose the "right" content and type of intervention, and the way to best communicate it to the patient. Along this line, we think that a moment-by-moment attunement with the patient's state of the mind can be considered the principal therapeutic factor of psychoanalysis (see also Sander, 2007; Tronick, 2008).

Method

We asked a colleague to give us a narrative description of a patient being treated for less than 2 weeks who sought psychoanalytic treatment for personality-related relational problems (in other words, without DSM Axis I diagnoses, and clinically diagnosable as personality disordered). The patient-chosen is named Giovanna.

Along with the description of Giovanna's psychological functioning and analytic process, we asked our colleague to give us brief examples of their interaction every 12 months of treatment. These accounts are the basis for what we will call "the analyst perspective."

The "empirical research perspective" is based on five groups of four audio-taped sessions from the beginning of the analysis and then every 6 months for 2 years, all assessed with APS and DMRS (see Table 1). SWAP data have been gathered only on the sessions taped and transcribed every 12 months given that it is highly improbable that changes in personality functioning would be observed after less than 1 year of therapy (Westen, personal communication, December 2005; Lingiardi et al., 2006). To sum up, we have assessed 20 sessions, 4 every 6 months, with APS and DMRS, while 12 of these

Table 1
Research Plan

	Beginning of analysis	6th month	12th month	18th month	24th month
Number of taped sessions	4	4	4	4	4
SWAP-200	X	—	X	—	X
DMRS	X	X	X	X	X
APS	X	X	X	X	X

sessions (four every 12 months) have been assessed with SWAP. Each group of four sessions has been evaluated as a "single unit" of analysis, representative of the analytic process of that period (beginning, 6th month, end of first year, 18th month, and end of second year). For a valid SWAP and APS assessment, in fact, it is not possible to consider less than three to five contiguous sessions (see Westen & Shedler, 1999a, 1999b; Waldron et al., 2003). It should be pointed out that, at the beginning of her therapy, Giovanna gave her consent to audio-record some of the sessions.

As reported also in the conclusions of this article, the restricted number of session transcripts is one of the main limitations of this study. Indeed, objection could be made that 20 sessions are not a representative sample of a three-times-a-week, 2-year psychoanalysis (about 240 sessions). Of course, a fully recorded treatment would be the best option, but, at least in Italy, recording sessions is not yet a common practice in the psychoanalytic community, and Giovanna's therapist agreed to participate in this project recording only a prescheduled and limited number of sessions. It should be pointed out, however, that many clinical cases reported in the literature consist of even fewer than 12 sessions per year, reported almost verbatim, and that the earlier excellent research on a patient with avoidant personality disorder in a 5-year psychoanalytic psychotherapy was based on 15 sessions (Porcerelli et al., 2007). Moreover, in our study we asked the clinician to describe the most salient features of every year of the therapy, information which we have used for a more complete qualitative representation of the analytic process.

Two raters scored the SWAP-200 from the transcribed sessions independently. Two other raters assessed the transcripts with the DMRS and two others evaluated them with the APS. Every rater was blind to the results of the other raters' assessment, to the period of analysis from which the sessions were extracted, and to the analyst's account of Giovanna's analysis.

Three raters (2 psychologists and 1 psychiatrist) had more than 5 years of clinical experience and were expert in the use of the instruments employed. Each was paired with an advanced doctoral-level student of the Faculty of Psychology 1, "Sapienza" University of Rome, who received intensive ad hoc training.

The two raters' SWAP-200 assessments were averaged to obtain a single set of ratings, as were the two raters' APS assessments. A single DMRS profile was obtained by a consensus rating procedure following the independent assessments of the two raters.[1] The average interrater reliability of SWAP assessments in this study was Pearson $r = .61$; the reliability of APS scoring was .65 for the patient scales and .59 for the therapist scales; DMRS interrater reliability was .62. All these scores indicate a satisfactory reliability of the instruments implemented in this study.

[1] Statistics were calculated using SPSS 13.

Case Illustration of Giovanna: The Analyst's Perspective at the Beginning of the Therapy

Giovanna is a 28-year-old Caucasian woman of average height, with lively eyes, and a body deliberately concealed by oversized clothes. A very academically successful college student, she is working as a biologist in an international research center. She goes to an outpatient center known for its psychodynamic approach where she has been consulting a male psychoanalyst with more than 20 years of analytic experience.

Giovanna describes her mother, a high-school teacher, as a "Calvinistic," "cold," and "detached" woman. She describes her father, who works abroad for a multinational company, as "impulsive" and "unpredictable." He "comes and goes and I never can say where he is." She has a younger sister, still attending college, and an older brother, a married engineer with no children.

In the first interview Giovanna states that, when she was about 5 years old, her grandfather molested her, making her touch his penis. At about 12, two boy classmates showed her their genitals after having trapped her in the men's bathroom.

During the intake sessions, Giovanna seemed emotionally overinvolved in her problems, and the way she explained her request for an analysis was somehow confused and overworked: "I don't know what to do anymore, somebody has to help me. I can't stand the painful chains holding my life anymore!" This generic call for help is connected to a desire (very ambivalent, indeed) to split up with a man she has been involved with for 5 years. Giovanna described this relationship as "a prison . . . but I can't live outside of it . . . He is not able to take care of himself and I couldn't live with the feeling of letting him down!" At the same time, Giovanna was afraid to become the target of her boyfriend's rage.

Another reason why Giovanna was looking for analysis was the progressive deterioration over the previous months in her capacity to work. Her mild emotional dysregulation led her to painful and heightened affective states that prevented her from working productively.

After the first two intake sessions, the analyst proposed a three-times-a-week psychoanalysis using the couch, a recommendation which Giovanna readily accepted. The initial clinical diagnosis was hysterical personality disorder with depressive-masochistic and obsessional traits functioning within a neurotic level of personality organization (Kernberg, 1984; PDM Task Force, 2006). The *DSM–IV–TR* (American Psychiatric Association, 2000) diagnosis was personality disorder not otherwise specified (PD-NOS).

In his case formulation, the analyst stressed the significance of Giovanna hostile and suspicious attitude toward men, probably a defense against the unconscious expectation that every man would prove similar to her abusive grandfather and unpredictable father. Difficulties in enjoying sexual experience and devaluation of her femininity had at least partially the same origin.

Another relevant topic was Giovanna's masochistic attachment to her dependent and emotionally abusive boyfriend. The analyst considered this attachment both as a repetition compulsion of her infantile relationship with her father and grandfather and a sort of omnipotent commitment to change the abusive masculine object (and at the same time, her own past). In this sense, the analyst hypothesized that Giovanna felt her boyfriend as a sort of "infantile self" of herself, needing to depend on a reliable object, able to take care of that self unconditionally. Giovanna felt that her cold and detached mother had never given her the opportunity to live this kind of experience, and in fact she ended up playing the role of the caring and saving person in most of her meaningful relationships.

Eventually, the analyst thought that his patient's work difficulties were largely due to the conflictual relationship with her "boss" (a woman), whom Giovanna felt very similar to her mother, with all the associated feelings of being dependent, neglected, and angry. The recognition and modulation of these feelings was very difficult, especially given that Giovanna made use of defense mechanisms such as projection, projective identification, passive aggression, displacement, and intellectualization, becoming very intense in conflictual moments of her relationships with the boyfriend and the "boss."

Instruments

What follows is a brief description of the content and psychometric properties of the three instruments we used in this study.

Shedler Westen Assessment Procedure-200 (SWAP-200)

The SWAP-200 (Westen & Shedler, 1999 a, b; Shedler & Westen, 2007) is a set of 200 personality-descriptive statements. A clinician who knows a patient well can describe him or her by sorting the statements into eight categories, ranging from those that are not descriptive of the patient (assigned a value of "0") to those that are highly descriptive (assigned a value of "7"). Thus, the method yields a numeric score from 0 to 7 for each of 200 personality-descriptive variables.

An interactive, computer-based version of the SWAP-200 that translates the item scores into a complete personality diagnosis and case formulation is available in both English and Italian (Westen, Shedler, & Lingiardi, 2003). A web-based version of the instrument may be previewed at www.SWAPassessment.org. The instrument is based on the Q-sort method, which requires arranging the items into a fixed distribution (Block, 1978).

SWAP-200 items are written in straightforward, experience-near language (e.g., "Tends to be passive and unassertive" or "Has an exaggerated sense of self-importance") and statements that require inferences about internal psychological processes are written in plain language, not jargon (e.g., "Tends to see own unacceptable feelings or impulses in other people instead of in him/herself").

Clinicians or investigators can obtain a case formulation of the patient by examining the 30 statements that receive the highest rankings in a patient's SWAP-200 description (i.e., items with scores of 5, 6, and 7). This formulation takes into account the three broad domains of psychological functions described by the SWAP items: 1) motivations, ideals, anxieties and conflicts; 2) psychological resources; and 3) experiences of self, others and relationships between him/herself and other people.

The SWAP-200 assessment can also be translated into two kinds of diagnosis:

1) A personality diagnosis expressed as the matching of the patient assessment with 11 Personality Disorder factors (PD factors), which are prototypical descriptions of *DSM–IV* Axis-II disorders obtained by asking 237 clinicians with various theoretical orientations and experience to use the SWAP to describe a prototypical patient with one of the 10 DMS-IV Axis II disorders (Westen & Shedler, 1999a, 1999b). Similarly, in addition to the description of prototypical patients with personality disorders, the clinicians were asked to use the SWAP to describe the prototype of a psychologically healthy, "high functioning" patient (see Table 2).

2) A second kind of SWAP personality diagnosis is based on the correlation/matching of the patient SWAP description with 11 Q-factors/styles of personality. Q-factors have been empirically derived by the application of a Q-factor analysis on the descriptions of

Table 2
The Most Descriptive Items of the High Functioning PD Factor

68.	Appreciates and responds to humor.
2.	Is able to use his/her talents, abilities, and energy effectively and productively.
175.	Tends to be conscientious and responsible.
37.	Finds meaning in belonging and contributing to a larger community (e.g., organization, church, neighborhood, etc.).
200.	Is able to form close and lasting friendships characterized by mutual support and sharing of experiences.
106.	Tends to express affect appropriate in quality and intensity to the situation at hand.
101.	Has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings.
183.	Is psychologically insightful; is able to understand self and others in subtle and sophisticated ways.
121.	Is creative; is able to see things or approach problems in novel ways.
120.	Has moral and ethical standards and strives to live up to them.
32.	Is capable of sustaining a meaningful love relationship characterized by genuine intimacy and caring.
19.	Enjoys challenges; takes pleasure in accomplishing things.
55.	Is able to find meaning and fulfillment in guiding, mentoring, or nurturing others.
63.	Is able to assert him/herself effectively and appropriately when necessary.
196.	Is able to find meaning and satisfaction in the pursuit of long-term goals and ambitions.

494 personality disordered patients (Westen & Shedler, 1999b). While PD factors are the SWAP descriptions of prototypical patients with the *DSM–IV* Axis-II disorders, Q factors are empirically derived clinical descriptions of "personality styles" similar to the neurotic styles described by Shapiro (1965). Unlike PD factors, Q factors nosology does not point out the presence of schizotypal and borderline personality disorders, and it takes into account some personality styles which are *not* present in *DSM–IV* Axis II, such as a high-functioning depressive or hostile style. Finally, the obsessive Q factor is much healthier than the obsessive personality disorder of PD factor and *DSM–IV* Axis-II nosology, and the dependent-masochistic Q-factor is much more severe than the dependent personality disorder of Pd factors and *DSM–IV* Axis II (Westen & Shedler, 1999b).

PD and Q factor scores, that is, the correlations/matching between the single patient assessment and the PD and Q factor prototypes, are expressed as *T* scores ($M = 50$, standard deviation = 10) based on norms established in a large sample of patients with *DSM–IV* personality disorder diagnoses (Westen & Shedler 1999a, 1999b; Westen & Shedler, 2000). The presence of a personality disorder can be assigned when the SWAP assessment points out one or more PD and/or Q scores higher than $T = 60$ and the high functioning factor is under $T = 60$. PD and/or Q scores higher than $T = 55$ reveal the presence of a subclinical trait of that personality disorder (Westen & Shedler, 1999a, 1999b).

The high functioning scores have shown very good correlations with different independent measures of psychological well-being, both in adult and adolescent samples (Thompson-Brenner, Eddy, Satir, Boisseau, & Westen, 2008; Westen & Muderrisoglu, 2006; Thompson-Brenner & Westen, 2005).

In prior studies, SWAP has shown very good interrater reliability and convergent and discriminant validity (Westen & Shedler, 1999a,b; Westen & Weinberger, 2004), as well as excellent clinical sensitivity and the capacity to depict the personality functioning associated with different clinical syndromes in a complete and complex way (Russ, Shedler, Bradley, & Westen, 2008; Blagov & Westen, 2007; Di Lallo, Jones, & Westen, 2009; Powers & Westen, 2009).

DMRS

The DMRS (Perry, 1990a; Perry & Kardos, 1995; Perry, 2001; Lingiardi & Madeddu, 2002) manual describes how to identify 28 individual defense mechanisms in videotaped or audiotaped sessions or transcripts. The introduction includes general directions for the qualitative and quantitative identification of defenses, along with suggestions about handling problems presented by different data sources. The body of the manual consists of directions for identifying 28 individual defenses. The manual includes a definition of each defense, a description of how the defense functions, a section on how to discriminate each defense from near-neighbor defenses (e.g., suppression vs. repression vs. denial), and a three-point scale. Each scale is clearly identified with specific examples of (0) no use of the defense, (1) probable use, and (2) definite use of the defense. The examples provide prototypical instances of the defense which expand and complement the formal definitions.

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

High adaptive level (also called "mature"): Affiliation, altruism, anticipation, humor, self-assertion, self-observation, sublimation, suppression;

Obsessional: Isolation, intellectualization, undoing;

Other neurotic: Repression, dissociation, reaction formation, displacement;

Minor Image-distorting (also called "narcissistic"): Omnipotence, idealization, devaluation;

Disavowal: Negation, projection, rationalization, autistic fantasy;

Major-image-distorting (also called "borderline"): splitting of others' image, splitting of self-image, projective identification;

Action: Acting-out, passive aggression, hypochondriasis.

Not included in the manual but included in an appendix, still under revision, are the so-called psychotic defenses. This ordering is based on a series of empirical studies (reviewed in Perry, 1993) which utilized both the DMRS and other methods (Perry & Cooper, 1989; Perry 1990b; Perry, Kardos, & Pagano, 1993; Perry & Kardos, 1995; Perry & Høglend, 1998; Perry & Ianni, 1998; Perry et al., 1999).

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

All of the defense scores are summarized by an Overall Defensive Functioning (ODF) score[2] (Perry & Høglend, 1998). If all defenses were at the "1" level, the ODF score would be 1, and if all were at the "7" level the ODF would be 7. In clinical samples based on whole interviews, scores usually range between 2.5 and 6.5. Approximate reference scores for ODF are as follows:

[2] Calculated by multiplying the instances identified for each defense by its level (1 to 7) on the overall 7-point hierarchy of defenses, summing the results for all the defenses, then dividing by the total number of defenses identified.

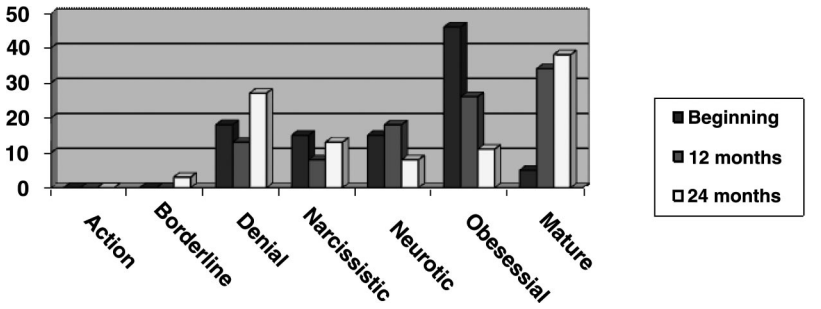

Figure 1. Changes in defensive functioning by year of psychoanalysis (defense groups are ranged from left to right, levels 1 through 7, and total defenses at each period add up to 100%).

1) Scores below 5.0 are associated with personality disorders, severe depression, or borderline conditions;
2) Scores between 5.0 and about 5.5 are associated with neurotic character and symptom disorders;
3) Scores from 5.5 to 6.0 are associated with average healthy-neurotic functioning, while
4) Scores above 6.0 are associated with superior functioning.

The psychometric reliability of DMRS and its capacity to discriminate different disorders and levels of functioning make it an excellent instrument for the assessment of patients in psychodynamic psychotherapy (Perry et al., 2009).

APS

The APS (Waldron, Scharf, Hurst, et al., 2004; Waldron, Scharf, Crouse, et al., 2004b) is a methodology for assessing psychodynamic (or psychoanalytic) features in treatments. The instrument is suitable for the study of psychodynamic features of any psychotherapy (Waldron & Helm, 2004).

Variables are formulated to assess the psychoanalyst or psychotherapist contribution, the patient contribution, and the interaction between the two, using reliable ratings of key psychoanalytic dimensions.

Recorded sessions are divided into appropriate segments, each capturing a meaningful piece of the patient's or therapist's contribution. Then each segment is rated, depending on the speaker, using the 14 patient variables or the 18 therapist variables or both, on a five-point Likert-type scale from 0 to 4. An 80-page coding manual provides the definitions of each variable, with clinical illustrations at the level scored 0, the level scored 2 and the level scored 4.

The raters estimate the degree to which each of the analytic activities rated[3] is present in a given segment, specifically disregarding the aptness or skill with which they are

[3] The ratings of analytic activity include the four types of intervention (encouraging elaboration, clarifying, interpreting, and other supportive remarks). Also included are assessments of addressing resistance, transference, and conflict. Then the degree to which the therapist addresses issues touching on the patient's self-esteem and on the patient's developmental period is assessed. How confrontational the therapist is, and how much the therapist shows amicable and hostile feelings are evaluated. Finally the quality of the therapist contribution is rated.

employed, since the quality of the analyst communication is rated separately. Each of the features is rated independently, so that, for example, a given intervention could be rated 4 for clarification, 2 for interpretation, and 1 for addressing transference.

The APS also collects clinician judgments of the *quality* of the therapist's communication in each segment. This is important since studies have shown that clinicians vary their approach within any given therapeutic modality to meet the needs of patients, and this variation may in fact be the most important ingredient leading to therapeutic benefit (Hamilton, 1996). The assessment of the quality of a communication rests on the aptness of the type of intervention, the usefulness of its content, and the skill with which the comment is made, including tact, timing, and language appeal.

The APS also permits the study of patient response to therapist communication and the patient's participation on their own initiative in the treatment, collectively called patient productivity. The coding manual definition of patient productivity is as follows:

Score a segment 0 when there was no apparent progress in understanding, nor in the involvement or collaboration in the analysis, nor in the nature of other developing emotional responses;

Score 2 when there was moderate progress in the depth and breadth of understanding, or in emotional involvement and collaboration in the analysis, or in the nature of other emotional expressions;

Score 4 when the patient made strong progress.

Each of these levels is illustrated by a clinical vignette.

The patient productivity variable correlates highly with all the other patient variables, hence it appears to provide a valid general indicator of raters' appraisal of patient functioning. It is noteworthy that such a general clinical variable can be rated reliably.[4]

Clinical and Empirical Account of Giovanna's Psychotherapy

Giovanna at the Beginning of the Therapy From the Empirical Perspective

This is the *SWAP-200 case formulation* of Giovanna's personality functioning at the beginning of the therapy, constructed by listing the 30 SWAP items that received the highest ranking:

Giovanna tended to be hostile toward members of the opposite sex (21)[5], had little or no interest in having sexual experiences with another person (58) and tended to see sexual experiences as revolting or disgusting (119). She appeared afraid of commitment to a long-term love relationship (158) and tended to deny or disavow her own needs for caring, comfort, or closeness, considering them unacceptable (159).

Giovanna tended to blame others for her own failures and shortcomings (14) and to be angry or hostile (16), but then she felt guilty (57). Tended to express aggression in passive and indirect ways (78) and to be critical of others (114), managed to elicit in others feelings similar to those he or she is experiencing (76) and then had difficulty making sense of other people's behavior, often misunderstood, misinterpreted, or was confused by others' actions and reactions (29).

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[4] In the original report (Waldron, Scharf, Hurst et al., 2004) the median alpha coefficient for the therapist variables was .71, and for the patient variables .82. Inexperienced and experienced clinicians were reliable after minimal training.

[5] In brackets the SWAP item number.

Giovanna appeared inhibited about pursuing goals or successes (33) and had difficulty acknowledging or expressing anger (25), in part because her emotions tended to spiral out of control, leading to extremes of anxiety, sadness, rage, excitement, and so forth(12). She tended to be anxious (35).

Giovanna tended to feel life has no meaning (50), to felt unhappy, depressed, or despondent (189) and to be insufficiently concerned with meeting her own needs (88). Giovanna had difficulty allowing self to experience strong pleasurable emotions (148), tended to avoid confiding in others for fear of betrayal (105) and to elicit dislike or animosity in others (96). Her beliefs and expectations seemed cliché or stereotypical, as if taken from story-books or movies (83).

Giovanna expected self to be "perfect" (174) and tended to seek out or create interpersonal relationships in which she was in the role of caring for, rescuing, or protecting the other (197).

She often tended to think in abstract and intellectualized terms, even in matters of personal import (100) and had little psychological insight into her own motives, behavior and so forth and was unable to consider alternate interpretations of her experiences (167).

However, Giovanna was able to use her talents, abilities, and energy effectively and productively (2), tended to be conscientious and responsible (175) and was articulate, could express herself well in words (92).

In diagnostic terms, at the beginning of the therapy Giovanna showed obsessional traits (T = 55.01) in PD factor terms, and externalizing and hostile (T = 57.5), paranoid (T = 56.6), and obsessional traits (T = 55.4) in Q factor terms. Her high functioning score was of 49.34 (the average in *T* scores is 50) indicating an average level of functioning relative to a sample of patients with personality disorder diagnoses.

From the DMRS perspective, Giovanna showed an ODF score (Overall Defensive Functioning) at the neurotic level (5.05 out of a possible maximum score of 7) with a prevalence of the defenses of intellectualization (33%) and displacement (15%). On the basis of the DMRS profile, it is possible to state that Giovanna showed a personality disorder of neurotic level and relied on obsessional and neurotic defenses when confronted with stressful situations and conflicts.[6] In other words, she tended to isolate thoughts from feelings and/or to disavow painful feelings and impulses, connecting them with people and things different from those that triggered them, or abstracting and generalizing the psychological meaning of the trigger situations.

These findings converge well with those from the defenses identified in the SWAP case formulation and diagnosis, considering that *DSM–IV* Axis II and SWAP PD and Q factors do not take into account any hysterical personality disorder with neurotic functioning, while this kind of disorder is present both in Kernberg (1992) and in PDM (PDM Task Force, 2006) nosology. The hostility expressed by the Q factor traits seems to be descriptive of Giovanna's attitude toward people of opposite gender, as outlined by PDM about people with hysterical personality disorders (PDM Task Force, 2006; p. 61).

To sum up, from the empirical research perspective, the main focus of Giovanna's psychotherapy should be her tendency to use projection, projective identification, passive aggression, displacement, and intellectualization for managing angry and painful feelings, her tendency to devaluate men and sexuality, and her inhibition of sexual desire and need of relationships characterized by reciprocal dependence and normal assertiveness.

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[6] The proportion of defenses at each level of the DMRS is shown in Figure 1.

The Analyst's Account After the First Year of Giovanna's Psychotherapy

During this year, Giovanna's relationship with the analyst was characterized by emotional intensity, swinging from idealization to avoidance. Her analyst helped her to regulate her overwhelming emotions, going from rage ("Who are you to keep on spotting my contradictions?") to acting out with challenges ("Never! I will never tell you what happened"). In this role, Giovanna felt the analyst either as an idealized father, loving and responsive, or as an idealized mother, caring and helpful in soothing painful emotions. Every confrontation or frustrating interaction (e.g., a silence longer than usual, a little delay in the beginning of a session, a tentative explorative intervention instead of the "requested" supportive comment, and so on) caused a belittling and hostile reply, with Giovanna shifting from idealization to persecution: in those moments, the analyst was perceived and depicted as cold, belittling and abusive, just as her bad and neglectful parents.

Giovanna's analyst reports feelings of empathic protectiveness toward her, but he also tells of being annoyed by the patient's efforts to engage him in a heavily intellectualized hostile relationship; the typical content was that all men, and implicitly also the analyst, were bad and dangerous for her psychological well-being ("All men are dirty and lustful, all men!"). The only good male presence was that of God ("Our body is nothing but a burden which prevents us from feeling the presence of God in our life"), a presence who asked Giovanna to deny any sexual thoughts. In order to help Giovanna to analyze and reduce her tendency to intellectualize, the analyst tried to "speak her language," using examples and terms from philosophy, movies, and novels, making them the object of their joint reflection. In this way, he tried to play on the same turf as the patient, while at the same time bringing her tendency to talk of personal matters using abstract terms and cultural examples into the analytic focus.

Giovanna also tended to play a sadomasochistic script where she was the innocent victim and the analyst was a sort of masculine intellectual abuser. Here is a typical interaction: Giovanna arrives 20 minutes late for the session, and in a hurry, because "it was such a busy day, I spent all my time doing this and that," listing all the things she has been doing for other people all day. Incidentally, she adds that she needed to do something for herself too: "but my time never comes," she says almost crying. "I am so tired, nobody takes care of me." She did not seem to think that her frequent late arrival to the sessions was a problem for her analysis and deprived her of being cared for, nor did she appear aware that if she is late, someone is waiting for her (and again, in that sense, taking care of her).

The therapist is annoyed, and falls into criticizing Giovanna, saying that her bending over backward to help other people is also a way to have control over them, preventing their supposed criticisms and attacks. He adds his impression that she is too enraged, and that makes it hard to believe "she's doing all that out of altruism." "To me," says the analyst, "it seems more an effort to convince yourself and people around you that you are a social worker, a nurse, and a saint in one person!"

At this point, leaning on her victimistic repertoire, Giovanna says the therapist is right. She seems to feel a hidden pleasure: now the therapist is one of the victimizers. He apparently gets this dynamic: "Now a part of you is happy because you can keep on thinking that all the bad is in the other people—mainly in men you feel forced to stay with—and all the good in you." Giovanna starts crying and after some minutes says, "I don't know what to do, I would like to change my attitudes but it is so hard . . .". The conviction that all men are abusive, a vestige of Giovanna's infantile experience, was also used as a defense against awareness of her own hostile feelings, and in the end, against her need for love and dependence, which evoked the powerful fear of being used and abandoned (Ferenczi, 1933).

Sometimes Giovanna could be intrusive, though always acting as if she were "the altruistic one" (she sought to make a gift to the analyst: "I spent all Saturday looking for this special edition of poems by Cavafi. I am really exhausted, but I am sure you will love to read them during your vacation and I am looking forward to seeing him in your bookcase") and her intrusiveness sometimes seemed colored by a wish to create an idealized, almost "mystical closeness" with the analyst.

During the first year of treatment, Giovanna started to become aware of these relational patterns and sometimes of their psychological meanings and infantile origins. Changing them was still very difficult, but in more than one occasion Giovanna managed to understand and modulate her feelings toward the "boss" better: she was surprised to discover that her work productivity improved ("a little miracle," she said). The greater awareness of her feelings of hate and mistrust helped Giovanna to reduce her "fight-and-flight" reactions toward men and sexual life.

The Empirical Perspective After the First Year of Analysis

At the end of the first year, SWAP assessment of Giovanna high functioning factor indicated a substantial increase in her overall personality health, ranging from 49.4 to 57.9. This represents an improvement of almost 1 standard deviation, which is a large and clinically meaningful improvement. In PD factors terms, there was a little decrease in the obsessional trait (from 55.1 to 53.84), while from the Q factor point of view, we noted a decrease in paranoid and hostile traits (from 56.61 to 53.36 and from 57.50 to 50.17, respectively) with an increase in the obsessive (from 55.45 to 61.43) and the depressive (from 50.89 to 58.91) Q factor. It is worth noting that obsessional and high functioning/depressive Q factors are the factors *more* correlated with high functioning and that, as we have said, the Q factor obsessive style is quite different, and much healthier, than the obsessional PD factor and the obsessive personality disorder of *DSM–IV* Axis II (Westen & Shedler, 1999b), indicating a good personality functioning with some emotional coarctation and high moral standards. At this point in the therapy, Giovanna no longer met the criteria for a diagnosis of personality disorder; the increase in obsessional and depressive features in Q factor terms could be due to the fact that during the course of the first year of analysis, there was a reduction in impulsivity and a more focused attention on psychic contents and self observation (DMRS and APS data showed below support this hypothesis).

From a clinical point of view, it seems that Giovanna's improved psychological functioning was connected to a decrease in her externalizing and projective attitude, an increase in her awareness of her own mistrust and hostility toward people, with its consequent sense of guilt, and a growing tendency to rely on defenses such as intellectualization and undoing to cope with it.

Similarly, the DMRS ratings after 1 year of analysis generated a higher ODF score, remaining in the neurotic domain, but shifting nearer to the more mature level (from 5.05 to 5.60). This change of more than one-half point on the DMRS is rather significant. The prevalent defenses were now in the cluster of mature mechanisms, in particular: self-observation: (37%), followed by intellectualization (14%), and undoing (14%).[7] The DMRS profile showed a substantial reduction in obsessional, narcissistic, and denial defenses and an increase in the neurotic and mature clusters.

[7] At this point in her analysis, Giovanna's defense distribution was the following: mature 34%, obsessional 26%, neurotic 18%, narcissistic 8%, denial 13%, borderline 0, action 0.

From the analytic process point of view, after 1 year of psychoanalysis, the overall productivity of Giovanna's contribution to the therapy on a 0-to-4 scale improved from 1.10 to 1.86, a nearly 12.5% increase ($F = 12.25$; $p = .001$), in line with the increase of the SWAP high functioning factor and the healthier ODF score. Giovanna also showed an increasing capacity to reflect about herself in the DMRS assessment, confirmed by changes in the self-reflection variable (from 0.97 to 1.71 on a 0-to-4 scale; $F = 8.28$; $p <$ 005) and in the capacity to communicate the conflict she experienced in her life in an understandable and vivid way (from 1.5 to, 2. 46 on a 0-to-4 scale; $F = 26.09$; $p < 001$), as assessed with APS. Both these capacities are highly correlated with the overall productivity of patient contributions ($r = .696$; $p = .000$ and $r = .652$; $p = .000$). These results are in line with our general hypotheses, as well as with previous results (Gazzillo & Lingiardi, 2007), and seem to support the idea that patient analytic productivity, assessed with the APS, is a good "intrasession" indicator of psychological health.

But how were patient and analyst working together? Previous research (Waldron, Scharf, Hurst, et al., 2004; Waldron, Scharf, Crouse, et al., 2004) found that the overall therapeutic productivity of patients' communications is fostered by the quality of previous therapist interventions, as assessed with the APS, more than by specific kinds of intervention per se.[8] The same positive working relationship is shown here by the correlation between *the quality of the immediately previous therapist intervention* and Giovanna's increased *productivity in the next segment of the session* ($r = .42$; $p = .001$). This correlation is independent of any other feature of therapist interventions and of the productivity of previous patient interventions (r partial = .24; $p = .014$). It is worth noting that in this first phase of the analysis, only 13% of patient communications and 13.8% of therapist communication had a score of 3 or 4 on the APS productivity and quality scales.

In other words, and in line with our general hypothesis, good interventions by the therapist seem to strengthen Giovanna's capacity to participate productively in the analysis and to reflect about what she feels and thinks, and this capacity to reflect on what happens in her mind seems associated with a decrease in her externalizing attitude and in better overall psychological functioning.

From a descriptive point of view, the APS data also show the positive impact of therapist interventions such as clarifications, encouragements to elaborate, and interventions centered on conflict and self-esteem (see Table 3). Encouraging elaboration is particularly important in developing a working alliance early in treatment; attentiveness to the patient's self-esteem issues is important at any time in treatment, but particularly during the vulnerable early phase.

Brief Clinical Example From the End of the First Year

Analyst

It is hard to put together these two facets of your personality: the woman about whom we were talking yesterday, who doesn't want to invite a man home for a coffee because her home is a mess and the man is an executive; and the woman who comes here with a big

[8] To determine the role of the quality of interventions, it is helpful to hold constant the effect of the other core analytic activity variables by calculating a partial correlation (see Waldron, Scharf, Hurst, et al., 2004). In previous studies on American and Italian samples, the partial correlations ranged from .17 to .44 between the quality of the intervention and the productivity of the patient's subsequent communication, and quality of analyst communications seems to be the variable which best predicts the productivity of subsequent patient communications.

Table 3
Correlations Between Therapist Communication Dimensions and Subsequent Patient Productivity in the First Year of Analysis (116 Pairs of Analyst Communications Followed by Patient Communications)

Analyst's APS score on each variable	Analyst encourages elaboration	Analyst clarifies	Addresses conflicts	Addresses self-esteem	Good intervention
Correlation with subsequent patient productivity	.38**	.24*	.22*	.34**	.42**

* Correlation is significant at the 0.05 level (2-tailed). ** Correlation is significant at the 0.01 level (2-tailed).

gift package for a friend, and who loves beauty and luxury but thinks she can't have them for herself. Who is the one talking with me now, the ascetic social worker or the "pretty woman" who longs for a status she will never have? And what are these women trying to say to me?

Giovanna

I am both these women . . . and my life reflects this contradiction . . . I was raised by my mother to love beauty, it's a matter of education, even if in this respect my mother is more consistent than me . . . and now it's too much, now I almost insist that other people share this imperative with me . . . at the same time, I cannot stand all the things that follow from this love for beauty . . . because I feel excluded from the world of beauty . . . also this hate has grown in the last few years . . . and both these sides of my personality are present in my life . . . a kind of religious asceticism . . . that refuses material goods and beauty . . . Maybe a way not to feel inferior, and excluded . . .

The example reflects an increasing therapeutic alliance, no doubt attendant upon the analyst's increasing knowledge of how he can successfully talk with his patient about her problems, and a corresponding increasing trust on the part of the patient, who elaborates upon important issues and feelings in herself, of which she appears to become increasingly aware. A connection also seems to emerge between Giovanna's conflictual attitude toward beauty, wealth, and pleasure, and her early conflictual relationship with a cold and critical, though admired, mother, in addition to the negative impact of her experiences with the father and grandfather.

The Analyst's Perspective After the Second Year of Analysis

During this period, the "feel" of the sessions reflects a good patient-analyst attunement. The analyst had the impression that it was Giovanna's experience of this "maternal" attunement that helped her to use his interventions to understand herself and other people better.

Not incidentally, Giovanna's mother had great difficulty recognizing and validating her daughter's wishes and needs. Giovanna often told her therapist that she "had to do everything by myself." She recounted, "When I had my period for the first time, I didn't understand what it was, and when I asked my mother she seemed to be annoyed, as if I had asked something bad."

During the first years of adolescence, Giovanna's mother rarely satisfied her daughter's desire to buy make-up or new clothes. Even during Giovanna's infancy, every time she expressed a desire for a doll or new clothing, her mother stressed how there were many people—the daughter of their condominium caretaker, a child of the neighborhood, and so

forth—who needed it much more then she did and who could not buy it. A more detailed analytic investigation of the infantile experiences with the grandfather and the classmates revealed that their traumatic impact was increased by the fact that Giovanna never talked with her mother about what had happened. "It was impossible, my mother was not the kind of parent you can talk with about bodily or sexual experiences or feelings. The body was "sin"; just imagine bringing "sexual discourse" into the family stuff. And in my family, sin could not exist, not even in conversation. I think I even deleted it from my conscious thoughts. My fears and inhibitions are a sort of imprint, together with my memories."

From this perspective, the emotionally attuned and nonjudgmental attitude of Giovanna's psychoanalyst toward sex-related subjects seems to be a sort of "corrective emotional experience" that has facilitated her psychological development and the questioning of her representation of "all men" as dirty and lustful and of her internal mother and her boss as inevitably unattuned and hypercritical authorities.

The year was characterized by progress in Giovanna's capacity to work together and to share analytic goals and tasks. The therapist felt quicker in recognizing and drawing her attention successfully to her attribution of her own feelings to others (projective identifications), and in approaching her intellectualizations in such a way as to help her to become more aware of her experiences and to describe them directly. For example, she said: "I am realizing that people are selfish." "Always making big statements, Giovanna . . ." She laughs, and says: "All right. I have a problem at work and I start to think that people who don't help other people are selfish." "Why don't you tell me what happened? If both of us know the facts, it is easier to understand their meaning." "OK, I will let analysis transform me from a philosopher to a novelist . . .", and eventually she recounted what was going on in her office.

As can be seen by these vignettes, session by session, Giovanna seemed more in touch with her own needs and desires, and more able to perceive the link between the search for their satisfaction and her feelings of guilt. She has started to feel more comfortable with her sexual fantasies, permitting an analytic focus on sexual conflicts. She also seems more capable of insightful self-observations, talks more freely and deeply about her past, and is more able to use humor when describing herself. Her productivity at work has returned and stabilized to usual levels, and her social life seems enriched. For the first time in her life, Giovanna planned a holiday with a male friend.

The Empirical Research Perspective After the Second Year of Analysis

There was an additional gain of 2.9 points in the SWAP-200 high functioning score during her second year, resulting in a total gain from 49.34 to 60.81. This increase shows a significant effect of treatment and is reflected also in changes in the SWAP formulation of the case of Giovanna, presenting a quite different picture than at the beginning of treatment. Here is Giovanna's case formulation, based again on the 30 top SWAP items:

Giovanna has moral and ethical standards and strives to live up to them (120) and tends to be conscientious and responsible (175). She is articulate (100) and able to find meaning and satisfaction in the pursuit of long-term goals and ambitions (196). Giovanna is able to use her talents, abilities, and energy effectively and productively (2), enjoys challenges, takes pleasure in accomplishing things (19) and appreciates and responds to humor (68). She appears to have come to terms with painful experiences from the past; has found meaning in, and grown from such experiences (89) and has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings (111).

However, Giovanna tends to feel guilty (57) and appears to want to "punish" self - creates situations that lead to unhappiness, or actively avoids opportunities for pleasure and gratification (163). She tends to be insufficiently concerned with meeting own needs (88) and to be inhibited or constricted; has difficulty allowing self to acknowledge or express wishes and impulses (119), in particular if they are pleasurable (131). Sometimes tends to feel misunderstood, mistreated, or victimized (127), to blame self or feel responsible for bad things that happen (1). Giovanna tends to be self-critical; sets unrealistically high standards for self and is intolerant of own human defects (91) and appears to find little or no pleasure, satisfaction, or enjoyment in life's activities (56).

She tends to be hostile toward members of the opposite sex (21), to see them as "all bad" losing the capacity to perceive any positive qualities they may have (79) and has little or no interest in having sexual experiences (58). Tends to fear she will be rejected or abandoned by those who are emotionally significant (98) and to see sexual experiences as revolting or disgusting (118).

She sometimes tends to be critical of others (114) and to avoid confiding in others for fear of betrayal (105). Her emotions tend to change rapidly and unpredictably (191) and she manages to elicit in others feelings similar to those she is experiencing (76). Finally, Giovanna tends to seek out or create interpersonal relationships in which she is in the role of caring for, rescuing, or protecting the other (197).

Tables 4 and 5 show SWAP-200 items whose score changed more than to 2 T points from the previous SWAP assessment.

This depiction of changes on the basis of SWAP items has the complexity we would expect in an ongoing psychoanalysis moving forward well, but still far from termination, and with many interesting questions posed by the clinical course.

Table 4
SWAP-200 Items Whose Score Decreased More Than 2 Points From the Beginning to the End of the First Year of Psychotherapy

Item number	Item text	Score change
5	Tends to be emotionally intrusive; tends not to respect others' needs for autonomy, privacy, etc.	From 4 to 1.5
11	Tends to become attached quickly or intensely; develops feelings, expectations, etc. that are not warranted by the history or context of the relationship.	From 3 to 0
12	Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, excitement, etc.	From 6 to 3
29	Has difficulty making sense of other people's behavior; often misunderstands, misinterprets, or is confused by others' actions and reactions.	From 4 to 1
91	Tends to be self-critical; sets unrealistically high standards for self and is intolerant of own human defects.	From 3 to 6
129	Tends to be conflicted about authority (e.g., may feel s/he must submit, rebel against, win over, defeat, etc.).	From 4 to 1
158	Appears afraid of commitment to a long-term love relationship.	From 7 to 4
159	Tends to deny or disavow own needs for caring, comfort, closeness, etc., or to consider such needs unacceptable.	From 6 to 2
167	Is simultaneously needy of, and rejecting toward, others (e.g., craves intimacy and caring, but tends to reject it when offered).	From 5 to 0.5
179	Tends to be energetic and outgoing.	From 3 to 0
184	Verbal statements seem incongruous with accompanying affect, or incongruous with accompanying non-verbal messages.	From 3 to 0

Table 5
SWAP-200 Items Whose Score Increased More Than 2 Points From the Beginning to the End of the First Year of Psychotherapy

Item number	Item text	Score change
77	Tends to be overly needy or dependent; requires excessive reassurance or approval.	From 0 to 3
114	Tends to be critical of others.	From 2.5 to 6
178	Is preoccupied with the feeling that someone or something has been irretrievably lost (e.g., love, youth, the chance for happiness, etc.).	From 0 to 4
191	Emotions tend to change rapidly and unpredictably.	From 1.5 to 4
196	Is able to find meaning and satisfaction in the pursuit of long-term goals and ambitions.	From 2 to 6.5
197	Tends to seek out or create interpersonal relationships in which she is in the role of caring for, rescuing, or protecting the other.	From 2 to 5

It seems that Giovanna is in the midst of a predominantly positive, not idealized transference, perhaps feeling the presence of a benign parental presence who had historically been quite absent, and in this setting her underlying longings for love and care have become more tolerable. Her capacity to regulate her emotions is greater than at the beginning of the therapy and so is her capacity to understand what she and other people feel and think. Giovanna self-critical attitude is less intense and she has a better capacity to tolerate depressive feelings.

From the SWAP point of view, we can conclude that during the first 2 years of her treatment, Giovanna learned to rely less on externalization, self-victimization, and hostility, becoming less intrusive. Giovanna is now trying to come to terms with her hidden rage and with her need for love and care in a more realistic way. She is more authentically empathic, insightful, and able to cope with conflicts and fears through humor. However, her difficulty in experiencing pleasurable feelings, her sense of guilt, and difficulties in her sexual and romantic life are still incompletely worked through, even if it is no longer possible to make a diagnosis of personality disorder.

From the DMRS perspective, at the end of the second year of psychoanalysis, Giovanna has retained her defensive style in the neurotic domain, with an ODF of 5.65, slightly higher than that obtained at the end of the first year. The most prevalent adaptive strategies and defenses are self-observation (24%) and intellectualization (22%)—just as at the end of the first year of psychoanalysis—but she still has a tendency to rely on denial defenses in particularly stressful situations. Figure 1 shows the changes in Giovanna's defensive functioning from the beginning to the end of the second year of analysis. The decrease in neurotic and obsessional defenses and the marked increase in mature defenses provides an independent assessment of the nature and extent of progress of the treatment thus far.

From the APS perspective, Giovanna's overall productivity continued at about the same level, and again there was a substantial correlation between quality of the therapist's communications and her continuing productivity ($r = .35$; $p = .01$) (see Table 6). During this second year of analysis, 27.4% of Giovanna's communications and 21.8% of her therapist's communications were scored 3 or 4 for the APS productivity and quality variables. At this point, interpretations of sexual themes start having an impact on patient productivity.

The changes in Giovanna's SWAP high functioning score, DMRS ODF and APS overall therapeutic productivity (from 1.10 to 1.98; $F = 6.81$; $p < .001$) share the same

Table 6
Correlations Between Therapist Communication Dimensions and Subsequent Patient Productivity During the Second Year of Treatment (87 Pairs of Analyst Communications Followed by Patient Communications)

Analyst's APS score on each variable	Analyst interprets	Addresses conflict	Addresses love &/or sexuality	Attuned to patient's emotional focus	Good intervention
Correlation with subsequent patient productivity	.30**	.27*	.23*	.45**	.35**

* Correlation is significant at the 0.05 level (2-tailed). ** Correlation is significant at the 0.01 level (2-tailed).

trend as the changes in APS quality of therapist intervention (from 1.33 to 2.34; $F = 18.5$; $p < .001$), increasing from intake to the 24th month of analysis (See Figure 2).

These positive processes are well established by the end of the first year of treatment, and continue in a very similar fashion and at a similar level through the second year. Our systematic measures indicate that particularly effective in the first year, encouragement of elaboration and clarification, such as addressing issues affecting her self-esteem, as shown by increased productivity after such analyst communications. By the end of the second year, we saw more benefit emerging from interpreting and from addressing issues of love and sexuality, as Giovanna became able to cope with these issues. In both years there was evidence of immediate benefit when the analyst addressed the patient's conflicts. And throughout, the quality of the analyst's remarks as judged by the APS raters showed an important impact on Giovanna's analytic productivity.

To summarize these first 2 years of psychoanalysis: the therapist encouraged elaboration, and clarified and interpreted in an emotionally attuned way, and Giovanna responded by becoming more productive, and especially more self-reflective, which goes hand in hand with better psychological functioning. In other words, it seems that what worked with Giovanna was fostering her capacity to think about herself, helping her self-analyzing capacity by "saying the right thing at the right time" (Waldron, Scharf, Hurst, et al., 2004).

Below follows an exchange between analyst and patient illustrating some of these characteristics.

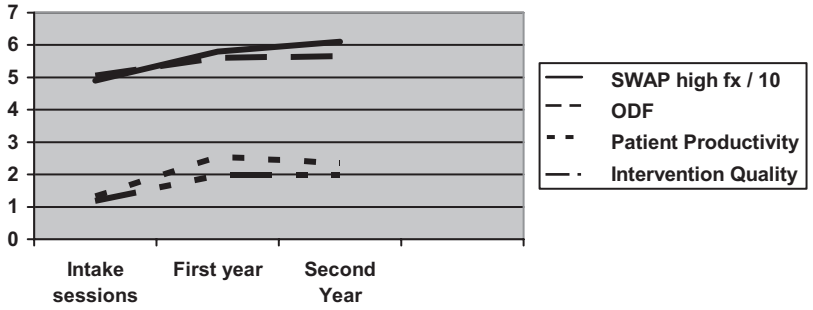

Figure 2. Changes in SWAP High-functioning score, ODF, Patient Productivity and Therapist Intervention Quality in the first two years of analysis. In this table, we change the SWAP high functioning values, dividing them by 10 in order to place them on the same scale as the ODF, good intervention and patient productivity.

Brief Clinical Example From the End of the Second Year

Analyst

You seem to think about yourself in two different ways: on one hand, you wear an armor of cynicism, mistrustful of the possibility of an authentic relationship; but on the other hand, you have discovered in yourself a lot of romantic dreams of ideal love. It seems that you are caught, and in your body too, between these two images. You say that you have never been really attracted to any man, but in the last session you told me that as soon as you see a man you like (and I know that you like masculine and introverted kind of men), you think you have to take care not to get involved and have your feelings hurt. And I think you are afraid that, if you accept the risk of a relationship, the other person will refuse and hurt you . . . so you ask your bodyguard of cynicism to dry up your emotions so that you can take control of the situation.

Giovanna

Yes . . . that's probably true . . . I have been consolidating the ideal image of myself as wearing a kind of armor of cynicism for so many years . . . when I was a teenager I spent so much time in romantic and desexualized daydreams . . . but I soon stopped dreaming . . . It was just a waste of time, and nobody could love me . . . Now I try to resist every kind of relationship, even anything similar to love and attraction . . . I keep away from men . . . because I think they are bad, and dangerous . . . and sex probably has something to do with it, and with the problem of being in control . . . So I am always afraid of being hurt . . . and this self-protection turns out to be even more hurtful . . .

Conclusions

On the basis of Wallerstein's periodization of the history of psychoanalytic research (2006), this single case empirical study of the process and partial, early outcome of a psychodynamic therapy can be collocated among the microanalytic studies of the fourth generation of empirical research on psychoanalytic psychotherapies.

Empirical research on psychoanalytic single cases originated in the 1950s with Luborsky (1953) and was followed in the 1970s with some important studies by Sampson, Weiss, Mlodnosky, and Hause (1972); Graff and Luborsky (1977), and Horowitz (1977). It has been expanding, however, since the 1990s, thanks to the work of clinician-researchers such as Jones (see, e.g., Jones & Winholz, 1990), Spence (Spence, Mayes, & Dahl, 1994), Fonagy and Moran (1993), and Kaechele (see, e.g., Kächele & Thomä, 2001).

Even if still a "*rara avis,*" the empirical study of single case seems to be a particularly useful research strategy for psychoanalysis because, quoting Fonagy and Moran (1993, p. 75): "The observation of variability across time within a single case combines a clinical interest to respond appropriately to changes within patients and a research interest to find support for a causal relationship between interventions and changes in variables of theoretical interest." Many researchers now share the view that the empirical study of individual cases is complementary to group study[9]: while the former enables an "inten-

[9] For a recent review of meta-analytic studies on the efficacy of psychodynamic psychotherapy, see Shedler, 2010.

sive" (Chassan, 1979) investigation of specific variables and control of changes and intervenient variables using accurate measures repeated over time, the group studies enable more statistically sound generalizations derived from "extensive" investigation, although on their basis "nothing can be said about the contribution of individual patient and nothing about the variation in the examined variable in individual patient" (Kächele, Schachter, & Thomä, 2008 p. 10).

In the last 20 years, the empirical single-case research on psychoanalytic treatment has been enriched by the possibility of using clinically sensitive and empirically sound assessment instruments such as CCRT (Luborsky & Crits-Christoph, 1990), DMRS (Perry, 1990), SWAP (Westen & Shedler, 1999a, 1999b), PQS (Jones, 2000), RA (Bucci, 2001), and APS (Waldron et al., 2003), leaving out the family of computer-based instruments of conversational and linguistic analysis, developed in particular by German psychodynamic researchers (see, e.g., Kächele & Thomä, 2001). Also worthy of note are the conversational approaches developed in recent years by different researchers from a socioconstructivist point of view (see, e.g., Martin, 1994). Another important psychoanalytic research strategy that we have chosen not to take into account in this paper is the effort to build a clinically based grid for the comparison of different theoretical and technical approaches to clinical material (Canestri, 2006; Tuckett et al., 2008).

In this study, we have tried to empirically investigate the changes in personality and defensive functioning of a patient in psychodynamic psychotherapy and their relationship both to her contributions to clinical exchange and to the therapist's communications. At the same time we did not abandon the "classical" clinical case description—what we have called "the therapist perspective." While we disagree with the opinions expressed by André Green (2000) and Roger Perron (2006), who state that empirical research is not useful and is even damaging for clinical psychoanalysis, we *do* think that some dimensions of psychoanalysis are very hard to investigate from an empirical point of view (e.g., unconscious fantasies, latent dream content, the unconscious meaning of a specific transference and countertransference reaction, some complexities of conscious and unconscious communication operating in the analytic space, and so on) and can be grasped only by the analyst's and patient's minds at work. At the same time we believe that some other psychoanalytic dimensions (e.g., type, content, and formal expression of analyst and patient communications, defense mechanisms, personality structure, recurrent patterns of interaction between the patient and his or her significant others, the targets of analyst interventions, components of the therapeutic alliance, and so on) can indeed be investigated with empirical and quantitative research, and that this kind of research can be very useful for the development of psychoanalytic knowledge and practice (Gabbard & Westen, 2003). In our opinion, this type of approach should be complemented by conceptual research such as that conducted by Ursula Dreher and her group (Sandler & Dreher, 1996; Dreher, 2000).

We chose in this case not to use the complex grid developed by German dynamic researchers (Kächele et al., 2008) for systematizing clinical descriptions of patient functioning and therapeutic process for research purposes; instead, we let Giovanna's psychoanalyst describe the psychotherapy process and patient functioning in the way he found most informative. This choice derives from our conviction that "classical" clinical descriptions are still very important as sources of new clinical hypotheses, and that not all of the clinical understanding can be replaced by empirical findings. While the latter are part of the "context of justification," the former is central in the "context of discovery" (Popper, 1959). Clinical thinking can make use of inferences that are neither linear not logical, but are often based on implicit/unconscious "parallel" thought processes and

emotional responses. In other words, if it is true that the analyst understands the unconscious of the patient with his or her own unconscious (Freud, 1922), it is equally true that the scientific value and the generalization of what has been understood should be tested by empirical study.

We share the view of those psychotherapy researchers who claim that it makes little sense to study the effects of the simple frequency of specific kinds of intervention (Hill, et al., 1988; Hill, 2009; Orlinsky, Rønnestad, & Willutzki, 2004; Piper, Azim, Joyce, & Mccallum, 1991; Piper, Joyce, Mccallum, & Azim, 1993), and that the effectiveness of every kind of therapist communication depends on its quality, timing, patient's personality, therapeutic relationship, and so on (see, e.g., Bond, Banon, & Grenier, 1998; Waldron, Scharf, Hurst et al., 2004; Waldron, Scharf, Crouse et al., 2004; Høglend, Johansson, Marble, Bøgwald, & Amlo, 2007). In our opinion, this "contextual model" is more similar to real practice and is in keeping with Enrico Jones's concept (2000) of the existence of a variety of idiomatic therapeutic processes.

As for single case research in general, our findings cannot be generalized—and consideration of a larger number of sessions is always recommended. Moreover, we think that our study could be refined through assessment of other dimensions of the clinical process, such as therapeutic alliance (Colli & Lingiardi, 2009a), reflective capacities (Fonagy & Target, 2001), transference-countertransference patterns (Betan, Heim, Zittel Conklin, & Westen, 2005; Bradley, Heim, & Westen, 2005). More specifically, the main limitations of this study are the relatively small number of sessions taken into account and the lack of empirical data about process dimensions such as transference-countertransference patterns, shifts in therapeutic alliances, changes in mentalization capacities, and in the well-being subjectively perceived by the patient (Ryff & Keyes, 1995). It is our intention to overcome these limitations in future studies about process and outcome of open-ended psychoanalytic psychotherapies collecting a major number of transcripted sessions (a couple of weeks of sessions per month), implementing transcript-based instruments for the assessment of the above mentioned process dimensions (see also De Bei, Miccoli, Tanzilli, Lingiardi, 2009; Colli & Lingiardi, 2009b) and taking into account also systematic information about the conscious well-being experienced by the patient in different phases of psychotherapy.

Using such a systematic research strategy, we may also be able to develop ways of identifying cases that are not progressing well. Recent contributions by psychotherapy researchers have supported the value of assessment of psychotherapies and feedback to therapists (Harmon et al., 2007) and practitioners of cognitive analysis (Bennett & Parry, 2004) in improving results.

Moreover, there is reason to believe that the use of such clinician-rated instruments as the SWAP, DMRS, and APS during psychoanalytic training would have great educational value for candidates in psychoanalytic institutes, and perhaps even for faculty. If such data collection in psychoanalytic treatment centers were combined with the use of patient self-ratings such as the Symptom-Checklist-90 (SCL-90; Derogatis, 1995), which have become standard in psychotherapy research and are used in psychoanalytic research as well—that is, in Sandell et al.'s extensive outcome study in Sweden (Sandell et al., 2000) and the German Psychoanalytic Association study (Leuzinger-Bohleber, Stuhr, Ruger, & Beutel, 2003)—there is a potential for truly interesting comparisons, which could also provide ways of substantiating the successes and failures of psychoanalytic treatments.

Finally, we believe that this way of assessing and presenting a clinical case also has didactic implications and can help psychoanalysts to communicate their clinical wisdom on the basis of objective and replicable data to students and practitioners with different

theoretical orientations. These ways of presenting the data can also help the therapist to clarify and articulate what happens during an analysis or psychotherapy, what dimensions of his or her interventions are truly effective with that specific patient, and what defense mechanisms and healthy functioning capacities are prevalent in that patient at that specific moment of the treatment. Again, this provides a possible strategy to bridge the gap between science and practice (Shedler & Westen, 2006).

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