Assessing personality change with Blatt's anaclitic and introjective configurations and Shedler-Westen Assessment Procedure profiles: two case studies in psychodynamic treatment

Osmano Oasi,[1] Laura Buonarrivo,[2] Alberto Codazzi,[3] Margherita Passalacqua,[1] Gio Matteo Risso Ricci,[1] Francesca Straccamore,[4] Roberto Bezzi[5]

[1]Department of Psychology, Catholic University of the Sacred Heart, Milan; [2]Clinical Psychologist, Private Practitioner, Milan; [3]Private Practitioner, Rome; [4]Department of Dynamic and Clinical Psychology, Sapienza University of Rome, Rome; [5]ASST Ovest Milanese, Milan, Italy

ABSTRACT

A growing body of empirical and clinical research attests to the influence of personality features on the development, course and outcome of psychotherapy. Over the last four decades, Blatt adopted a psychoanalytic and cognitive developmental approach in developing a theoretically and empirically grounded two-configurations model of personality. The main aim of this study was to evaluate possible changes in anaclitic and introjective configurations – as measured by the Depressive Experience Questionnaire (DEQ) (Blatt, D'Afflitti, & Quinlan, 1976) – set against simultaneous changes in personality profile measured by Shedler-Westen Assessment Procedure (SWAP-200). Two young patients, a man and a woman, characterized by different personality profiles – introjective and anaclitic, respectively – were assessed for one year in the context of a psychodynamic psychotherapy. A battery of instruments – Beck Depression Inventory II (BDI-II), Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders I and II, Defense Mechanism Rating Scale, DEQ and SWAP-200 – were administered at the beginning, during the assessment process, and after one year. Both patients displayed lower BDI-II scores, along with evident clinical progress. Defence profiles and Core Conflict Relationship Themes showed interesting developments, in keeping with the evolution of the psychotherapy process. Lastly, while DEQ profiles outlined substantial stability after one year, some important changes in SWAP-200 profiles – in particular with regard to Q factors – were observed. Although these findings should be considered as preliminary, these results appear to be consistent with the description of Self-criticism and Dependency as relatively stable personality dimensions. The potential influence of profile diversity – introjective *vs* anaclitic – on other key variables of the psychotherapy process is also discussed.

Key words: Personality change; Blatt's anaclitic and introjective configurations; Shedler-Westen Assessment Procedure profiles.

Correspondence: Osmano Oasi, Department of Psychology, Catholic University of the Sacred Heart, Largo Gemelli 1, 20123 Milan, Italy.
Tel: +39.02.7234.2284 – Fax: +39.02.7234.2280.
E-mail: osmano.oasi@unicatt.it

Conflict of interest: the authors declare no potential conflict of interest.

Citation: Oasi, O., Buonarrivo, L., Codazzi, A., Passalacqua, M., Risso Ricci, G.M., Straccamore, F., & Bezzi, R. (2017). Assessing personality change with Blatt's anaclitic and introjective configurations and Shedler-Westen Assessment Procedure profiles: two case studies in psychodynamic treatment. *Research in Psychotherapy: Psychopathology, Process and Outcome, 20*(1), 63-80. doi: 10.4081/ripppo.2017.231

Received for publication: 3 December 2016.
Accepted for publication: 10 March 2017.

Research in Psychotherapy:
Psychopathology, Process and Outcome 2017; 20:63-80
doi:10.4081/ripppo.2017.231

Introduction

Personality and depressive disorders: a short overview

The link between personality and depression has been understated for a long time (Hirschfeld, Klerman, Clayton, & Keller, 1983). Amongst others, Klein and colleagues (Klein, Wonderlich, & Shea, 1993) and Widiger (Widiger, 1993) described relations between personality and depression as follows: i) personality can comprise a vulnerability or predisposition to depression; ii) personality can be altered by depression; iii) personality and depression may reciprocally influence one other, chiefly with regards to their expression. Comorbidity between Depressive Disorders and Personality Disorders (PDs) has been pointed out in several studies (Charney, Nelson, & Mac Quinlan, 1981; Pilkonis & Frank, 1988; Pfohl, Black, Noyes, Coryell, & Barrash, 1990; Shea, Glass, Pilkonis, Watkins, & Docherty, 1987; Black, Bell, Hulbert, & Nasrallah, 1988; Koenisberg, Kaplan, Gilmore, & Copper, 1985), establishing a prevalence of personality disorders including borderline, schizotypal, passive-aggressive and dependent (Sato, Sakado, Sato, & Morikawa, 1994; Hirschfeld, 1999). Research by Johnson and colleagues (Johnson, Cohen, Kasen, & Brook, 2005) has proven par-

ticularly relevant, uncovering an association of specific PD traits (Antisocial, Borderline, Dependent, Depressive, Histrionic, and Schizotypal) in early adulthood with the risk of developing unipolar depressive disorders by mid-adulthood. A meta-analysis by Newton-Howes and colleagues (Newton-Howes, Tyrer, & Johnson, 2006) reported double the risk of poor outcome for patients suffering from comorbid personality disorder and depression compared to patients unaffected by PDs. These authors alongside other colleagues have reiterated the findings in their updated systematic review and meta-analysis (Newton-Howes et al., 2014).

Nevertheless, a complete overview of literature sheds light upon studies not backing the notion of a correlation between Affective Disorders and PDs, especially with reference to the alleged negative effects of PDs on depression outcome. For instance, Mulder (2002) has argued that comorbid personality pathology should not be regarded as an obstacle to good treatment response. Indeed, depression outcome is moulded by different factors of personality. In particular: i) the rate of personality pathology varies markedly depending on how it is measured; ii) depressed patients suffering from PDs seem less likely to receive adequate treatment in uncontrolled studies; iii) lastly, studies rarely tend to evaluate characteristics of depression (*e.g.*, chronicity, severity) that may influence outcome and be linked to pathology of personality. To this effect, Blom and colleagues (Blom et al., 2007) found that treatment outcome in depression tended to be associated with symptom severity and duration rather than with personality variables. Other researches (Blatt & Zuroff, 2005; Carter et al., 2011) have stressed the importance of taking into consideration the patient's pre-treatment personality configurations, as well as the quality of the relationship. In addition, in one of his last published papers, Blatt focused in on how personality and therapeutic alliance are both involved in modifications of symptoms and outcome alike in the treatment of depression (Blatt, 2015). Such considerations are of great relevance for our study.

Treating depressive disorders: what works?

Notwithstanding the array of successful treatment options for depression which employ a psychodynamic approach (Abraham, 1911; Asch, 1966; Jacobson, 1971; Arieti & Bemporad, 1978; Stone, 1986), with this kind of treatment symptomatic improvement and diagnostic criteria are not always well documented, nor has it proven effective in placebo-controlled trials.

The first extensive research program on the effectiveness of psychotherapy in treating Depressive Disorders was the Treatment of Depression Collaborative Research Program (TDCRP), sponsored by the National Institute of Mental Health (NIMH) (Elkin, Parloff, Hadley, & Autry, 1985). Initial results urged that interpersonal psychotherapy and antidepressant medication might prove superior to CBT (Cognitive-Behavioral Therapy) with more severely depressed patients (Elkin et al., 1989). Some years later, a group of authors (Elkin, Gibbons, Shea, & Shaw, 1996; Jacobson & Hollon, 1996; Hollon, Thase, & Markowitz, 2002) postulated that the therapist's expertise accounted for a greater difference in determining gaps with other treatment options [in particular, in favour of Interpersonal Psychotherapy (IPT)] as well as with a medication regime in relation to the severity of depression. The Ablon and Jones study (Ablon & Jones, 1999), working on transcripts of treatment sessions of TDCRP, found that both CBT and IPT had closer adherence to the cognitive-behavioral prototype, that produced more positive correlations with outcome measures, than to the reference model. Such overlapping was later corroborated by other studies: CBT and IPT, whether combined or not with medication, should ultimately lead to similar outcomes (Quilty, McBride, Bagby, 2008; Peeters et al., 2013). Other compelling studies based on the TDCRP have laid emphasis on the contribution of the therapist in the psychotherapeutic process, bringing to light the scope of their influence in outcome results (Blatt, Sanislow, Zuroff, & Pilkonis, 1996).

Generally speaking, the psychodynamic approach has proven useful both in severe and mild depressive conditions, whether or not combined with specific pharmacotherapy (Gabbard, 2000). To this effect, some recent studies have attempted to assess the impact of psychodynamic options for different Depressive Disorders in a systematic fashion. For example, Gallagher-Thompson and Steffen (1994), compared psychodynamic psychotherapy and CBT in reducing depressive symptoms in the caregivers of elderly family members, finding them to be on a par. Shapiro and colleagues (Shapiro et al., 1994, 1995) chose to contrast CBT and IPT in a randomized, controlled trial for depression, finding them to be equivalent in efficacy. More recently, Connolly and colleagues (2016) conducted a randomized clinical noninferiority trial that showed the equivalence between dynamic treatment (DT) and cognitive treatment (CT) in changes brought about in depression when treating Major Depressive Disorder in a community mental health setting.

Hilsenroth and colleagues (2003) found a significant reduction in depressive symptoms with psychodynamic treatment and a decrease in symptoms correlated with the use of psychodynamic treatment techniques. A study by Busch and colleagues (Busch, Rudden, & Shapiro, 2004) indicates that focused psychodynamic psychotherapy comprises a valuable complement in treatment of depression, also taking into account vulnerability to recurrence of depression, while in some cases it may be effective on its own. Based on their clinical experience, patients with mild or moderate major depression and dysthymic disorder stand to benefit the most from this approach.

The effectiveness of psychodynamic treatment of depression has also emerged in more recent publications (Luyten & Blatt, 2012; Luyten, 2014; Bastos, Guimaraes,

& Trentini, 2013, 2015; Fonagy, 2015): in particular, when it comes to long-term outcomes no major difference has been found between CBT and Psychodynamic Therapy (PD). But these results are not unequivocal. A trial published by Barber and colleagues (Barber, Barrett, Gallop, Rynn, & Rickels, 2012) failed to confirm that either active treatment performed better than a placebo in treating MDD (Major Depressive Disorder) patients; in addition, Jakobsen and colleagues (Jakobsen, Hansen, Storebø, Simonsen, & Gluud, 2011a; Jakobsen, Hansen, Simonsen, & Gluud, 2011b) have published somewhat discouraging results, with no findings either supporting or contradicting the effect of interpersonal or psychodynamic psychotherapy, or even cognitive therapy for that matter, in comparison with *treatment as usual* for patients with Major Depressive Disorder.

Defensive functioning and depressive disorders

An important perspective within the psychodynamic approach in evaluating the effectiveness of treatment from an empirical point of view is the study of defence mechanisms (Perry, Kardos, & Pagano, 1993; Perry & Kardos, 1995; Perry et al., 1998). Bond and Vaillant (1986) found that patients diagnosed with Major Affective Disorder tend to manifest specific defence patterns in their significant relationships. The stability of defensive functioning and personality organization over the course of psychiatric illness was examined by Mullen and colleagues (1999) by studying a large sample of well-characterized outpatients with a Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) diagnosis of Major Depressive Disorder (MDD) over a defined course and period of treatment. Whereas *image-distorting* and *self-sacrificing* defences did not undergo significant change, a noteworthy drop in *maladaptive* defences in the entire sample was observed. Quite interestingly, *adaptive* defences remained unaltered from baseline levels, and a gradual rise in the use of mature defences was noticed in a group of patients diagnosed with MMD, while in neurotic groups no changes took place in such levels. Bond's literature review on this topic (Bond, 2004) reported that adaptiveness of defence style was associated with mental health and that some diagnoses were characterized by specific defence patterns: specifically, depressive symptomatology proved to be positively correlated with the use of immature defence styles and negatively correlated with the use of mature ones in comparison with controls, while anxiety disorder patients tended to use more neurotic and immature defences than non-patients. A meta-analysis study conducted by Calati and colleagues (Calati, Oasi, De Ronchi, & Serretti, 2010) validated Bond's conclusions, by assessing via three-factor DSQ versions two different psychiatric diagnoses, Major Depressive Disorder (MDD) and Panic Disorder (PD), in order to gauge their potential specificity in terms of defence styles. Perry and Bond (2012) observed changes in the defensive functioning of a group of patients with depressive, anxiety, and/or personality disorders in long-term dynamic psychotherapy that largely adhered to the hierarchy of defence adaptation. More in detail, the lowest (action) and the highest (high adaptive) defence levels improved most notably, as did overall defensive functioning, while remaining below the healthy-neurotic range. On the whole, the use of defence mechanisms and their relationship with psychopathology and change (Bond, 2004) comprises a worthy frame of reference for the assessment and evaluation of the psychotherapeutic process. In particular, as the Psychodynamic Diagnostic Manual (PDM Task Force, 2006) clearly outlines, they provide a guideline for evaluating the mental functioning (M axis) of patients.

Aims and hypotheses

The aim of this work is to identify a possible interaction among personality, mental functioning and clinical syndrome via the comprehensive assessment (Serretti, Calati, Oasi, De Ronchi, & Colombo, 2007) of two depressed patients. The cases of Mr. F and Ms. G are presented, assessing the subjects' psychotherapeutic psychodynamic processes in the context of their personality structures, to evaluate the possible correlation between an evolution of defensive functioning and significant symptom change during the course of one year of psychotherapy. An additional aim is to bridge the gap between clinicians and researchers, and to show a clinically sophisticated and empirically grounded practice in psychodynamic framework (Kazdin, 1982; Moran & Fonagy, 1987; Fonagy, 1993; Wallerstein, 1995; Roth & Fonagy, 1996; Shedler, 2002; Porcerelli et al., 2007; Kächele, Schacther, & Thomä, 2009; Levy, Ablon, & Kächele, 2012). The main hypothesis is that changes in Mr. F's and Ms. G's depressive symptomatology and mental functioning will be observed, through a different configuration of personality features and an evolution from primitive to mature defence mechanisms (Straccamore et al., 2017; Akkerman, Lewin, & Carr, 1999; Bond & Perry, 2004).

The case of Mr. F and Ms. G

Patients' personal details have been included in such a way as to maintain confidentiality and protect privacy. Moreover, it is worth noticing that Mr. F's case is re-examined from a study of the determinants of the psychotherapeutic process in depressive disorders (Oasi, 2015), and here confronted with a new case study in order to develop novel clinical and theoretical considerations. The two patients are presented in what follows.

Mr. F is a 26-year-old man, self-referred to the Community Mental Health Center near Milan in November 2012. He had already been treated by other Psychiatric Centers in 2006 when he was working in a touristic mountain location, where he started to perceive fatigue and sadness. In that occasion, he had been diagnosed with Social Phobia and Obsessive-Compulsive Personality Disorder. Mr. F had already

complained about family problems, in particular concerning his mother's family of origin. Following a car accident, Mr. F had to return to his family in 2007. Since then he had been treated chiefly with antidepressants until May 2010. In this period he enrolled at an evening vocational school, did some work as a metalworker, and took the antidepressants regularly while attending some psychotherapy sessions. He returned to a Mental Health Center of his own accord in November 2012: he had quit his job and was no longer working, had spent a few weeks in a Religious Community and was now living at home *vegetating*. In January 2013 he started a once-a-week psychodynamic psychotherapy. A psychiatrist arranged pharmacological therapy with the antidepressant drug duloxetine (60 mg *die*). It should be noted that the pharmacological therapy remained unaltered during the course of his yearlong psychotherapy. His pharmacotherapy compliance has been good.

Ms. G is a twenty-year-old woman who came to the Community Mental Health Center on accounts of depressive symptoms, in particular constant sadness and crying fits, alongside bouts of undereating with consequent weight loss. She claimed to feel anxious, unstable and indecisive. She was attending her first year of Political Science at university. Her anamnesis revealed a lack of crucial events in her life leading up to the passing away of her mother due to breast cancer when the patient was sixteen. She claimed to be particularly upset about having been kept in the dark with regards to her mother's health by her father and sister. She recalled her puberty as the moment in which she had lost the happy feeling associated with her childhood. Upon arriving at the Community Mental Health Center she was going through a taxing break-up with her boyfriend. Right from her first visit with the psychiatrist she came across as a reserved and quiet young lady, and was prescribed antidepressant medication and psychotherapy. It should be noted that upon starting her once-a-week psychotherapy in December 2014 her medication was discontinued.

Materials and Methods

Method

Data of psychotherapy was collected at different intervals in the entire course of a one-year psychodynamic treatment carried out in a Psychiatric Center. As Table 1 shows, assessment was carried out with diverse instruments in the various phases of treatment: SCID-I and SCID-II in Pre-treatment; BDI-II, Hamilton Depression Rating Scale (HDRS), Depressive Experience Questionnaire (DEQ) in Pre-treatment and in the last month of therapy Re-assessment phase; Shedler-Westen Assessment Procedure (SWAP-200) at the 2nd and 12th month of treatment, in Re-assessment phase; Defense Mechanism Rating Scale (DMRS) monthly over the course of treatment, and Core Conflictual Relationship Theme method (CCRT) in three key moments of therapy, that is to say in the 1st, 7th and 12th month.

Assessment measures

The Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders-IV Axis I and II

The SCID-I (First, Spitzer, Gibbon, & Williams, 1997) is a semi-structured interview utilized in evaluating some of the clinical symptoms detailed in the first Axis of the DSM-IV. It correctly appraises affective disorders, schizophrenia and other psychotic disorders, such as substance-related disorders, anxiety disorders, somatomorphic disorders, eating disorders, and adaptive disorders. The SCID-II (First, Gibbon, Spitzer, Williams, & Benjamin, 1997) is a semi-structured interview used to assess different PDs described in the DSM-IV from a categorical approach in the interest of determining the actual diagnosis. Moreover, each question has four possible answers, allowing to opt for a dimensional approach if preferred.

Table 1. Research plan.

Pre-treatment assessment		Month of treatment											Re-assessment after one year
		1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th
SCID I & II	X												
BDI-II	X												X
HDRS	X												X
DEQ	X												X
SWAP-200			X										X
DMRS		X	X	X	X	X	X	X	X	X	X	X	X
CCRT			X					X					X

SCID I and II, Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders I and II; BDI-II, Beck Depression Inventory-II; HDRS, Hamilton Depression Rating Scale; DEQ, Depressive Experience Questionnaire; SWAP-200, Shedler-Westen Assessment Procedure; DMRS, Defense Mechanism Rating Scale; CCRT, Core Conflict Relationship Theme.

The Hamilton Depression Rating Scale

The HDRS (or HAM-D) (Hamilton, 1960) is a 21-item screening instrument specifically designed to measure the severity of illness in adult patients already diagnosed with depression. The first 17 items are the key items for depression on which severity cut off is established: > 25 severe depression; 8-24 mild depression; 8-17 light depression; <7 no depression. The HAM-D is also one of the most widely employed instruments for measuring outcome in mood disorders, and is known to have high validity and reliability in measuring patients' response to treatment. Requiring approximately 15 to 20 minutes to complete (depending on the interview structure), the HAM-D is routinely administered by a clinician or health care professional during or immediately following a client interview.

The Beck Depression Inventory II

The Beck Depression Inventory (BDI-II) is a self – report questionnaire measuring depression symptoms and their severity. The BDI-II (Beck, Steer, & Brown, 1996), published in 1996, is a substantial revision of Beck's original 1961 version. It was developed so as to conform to DSM-IV criteria for depressive disorders and features items measuring cognitive, affective, somatic and vegetative symptoms of depression. Twenty-one items are evaluated on a 4-point scale quantifying the degree of severity. The recall period for items is the last 2 weeks and the total score ranges from 0 to 63 points. The BDI-II indicates four diverse cut-off scores for different levels of depression: 0-13 minimal range; 14-19 mild depression; 20-28 moderate depression: 29-63 severe depression.

The BDI-II is also one of the most widely used instruments for measuring outcome in the context of mood disorders, having yielded high validity and reliability in measuring response to treatment like the HDRS. Self-administration requires 5-10 minutes; item 9 (suicidal ideation) and item 2 (hopelessness) call for special attention in the scoring process.

The Shedler-Westen Assessment Procedure

The SWAP-200 (Westen & Shedler, 1999a, 1999b) is a set of 200 personality-descriptive statements. The patient is described by arranging statements into eight distinct categories, ranging from not descriptive (pile 0) to highly descriptive (pile 7), hence giving each item a score from 0 to 7. Items are written in straightforward language with no technical jargon. The tool is based on the Q-sort method in which clinicians are required to arrange items into a set distribution. The statements included stem from the theoretical and empirical literature on personality, PDs and defence mechanisms, as well as from the DSM-III and IV. The 30 statements scored highest outline the case formulation, taking into account the three main domains described by the SWAP-200: i) motivations, ideals, anxieties and conflicts; ii) psychological resources; iii) experience of the self, of others and of the relationship between the patient and others. SWAP-200 assessment leads to two kinds of diagnosis: the first expressed in PD factors, resulting in descriptions of the patient's personality with some form of DSM-IV Axis II disorder; the second expressed in Q factors, describing the patient's personality in terms of similarity (proximity) to eleven empirically derived prototypical personality styles. PD and Q factor scores are expressed in T scores: the cut-off for the diagnosis of a personality disorder is 60, while scores ≥55 indicate the patient manifests personality traits typical of a specific personality disorder, but under a clinical threshold. No diagnosis of personality disorders is possible if the Depressive High-Functioning factor is ≥60.

The Depressive Experience Questionnaire

The DEQ (Blatt et al., 1976) is a self-report questionnaire aimed at differentiating between Dependency and Self-criticism, linked to a greater risk of psychopathology in general and of depression in particular. It is a 66-item questionnaire evaluated on a 7 point Likert scale, from 1 (strongly disagree) to 7 (strongly agree). Scoring outcome is on three scales: Dependency, Self – criticism and Efficacy. As the Efficacy scale does not measure one of Blatt's theoretical concepts, it is regarded as less important than the other two scales (which gauge anaclitic and introjective depression, respectively).

Process measures

The Defense Mechanism Rating Scale

The DMRS (Perry, 1991) manual explains how to identify 27 defence mechanisms in video or audiotaped sessions or transcripts. A definition of each defence, a description of how it functions, a section on discriminating each defence from other similar ones, along with a three point scale identifying absence (0), probable use (1) and definite use (2) are all featured. Three different ways of assessing defences are possible on the scale: Individual Defence Score, Defence Level Score and Overall Defensive Functioning (ODF) score. In clinical samples, scores tend to range between 2.5 and 6.5. Defence mechanisms are also hierarchically ranked in 7 clusters, ranging from the most primitive to the most mature: i) acting: acting out, passive aggression, help-rejecting complaining; ii) borderline: splitting of self image/others' image, projective identification; iii) disavowal: negation, projection, rationalization; iv) narcissistic: omnipotence, idealization, devaluation; v) neurotic: repression, dissociation, reaction formation, displacement; vi) obsessive: isolation, intellectualization, undoing; vii) mature: affiliation, anticipation, humour, self assertion, self observation, sublimation, suppression.

The Core Conflictual Relationship Theme method

The CCRT (Luborsky, 1984) used for research purposes is applied to parts of texts extracted from audio-

taped session transcripts, in which the patient details his/her interactions with significant others. Such *Relational Episodes* (RE) are characterized by a specific narrative structure and may refer to a current or past episode, actual or just dreaded or expected. They may concern the patient's relationship with himself or with others, including the therapist. Following a set procedure of steps the Core Conflictual Relationship Theme is formulated: i) relational episodes are identified in the session transcripts; ii) the patient's desires, needs and intentions (W), their relational partner's responses (RO) and the patient's subsequent reactions to these responses (RS) are identified in each RE; iii) each RE is then scored using *standard categories* or *tailored categories*; iv) the CCRT is formulated. At least 10 RE are taken into account in selecting the most representative patterns of W, RO and RS.

Procedures

In November 2012 Mr. F was assessed by the Community Mental Health Center psychiatrist and psychologist. The previous diagnosis of Depression, formulated in the context of his first visit to the Center (from 2007 to 2010 he had only been monitored by a psychiatrist), was confirmed. After this new visit, a weekly session of psychodynamic psychotherapy was proposed, and the patient accepted it. Mr F's psychotherapy started in January 2013.

In December 2014 Ms. G was assessed by the psychiatrist and the psychologist of the Community Mental Health Center. The outcome was a diagnosis of a single episode of Depression.

This Department of Mental Health routinely provides psychotherapeutic treatment plans lasting one year. The psychotherapist for both patients is a middle-aged man, who has worked with this Department for more than ten years. He is member of the Italian Psychoanalytical Society. Consent release for treatment and data collection was obtained in advance for both patients.

Both Mr. F and Ms. G were assessed by the Community Mental Health Center psychologist using SCID I & II, HAM-D scores and the DEQ. After the second and last session (Table 1) the psychotherapist completed the SWAP-200. All sessions were audiotaped and transcribed. Twelve monthly sessions were scored and evaluated via DMRS and CCRT. Both these instruments required evaluation by two different raters via double-blind procedure in order to guarantee inter-rater reliability. With regards to the DMRS, two different DMRS-trained clinical psychologists obtained a very good inter-rater reliability value (Pearson r=0.75). Similarly, with reference to CCRT profiles, two different CCRT-trained clinical psychologists proficient in the standard coding method obtained a good value (Cohen coefficient k=0.80).

After one year of treatment, Mr. F and Ms. G were reassessed with HAM-D and DEQ tests by the Community Mental Health Center psychologist, while the SWAP-200 was administered once again by the psychotherapist.

To ease the analysis of treatment development, the course of therapy for Mr. F was divided into three phases: phase 1, from January 2013 to April 2013; phase 2, from May 2013 to August 2013; phase 3, from September 2013 to December 2013. Likewise, Ms. G's treatment was divided into phase 1 (December 2014-March 2014), phase 2 (April 2014 to July 2014) and phase 3 (August 2014 - November 2014).

Results

Mr. F and Ms. G at the beginning of the psychotherapy: clinical perspective

Mr. F comes across as quite dull, looking older than his actual age. He appears to not be particularly integrated into his family or social life. He is an introvert, unwilling to make himself vulnerable, especially in his relationships, and is very isolated. His only passion is mountain biking. Soon a very marked sensitivity to criticism emerges: he claims in everything he does there is always something wrong. For this reason he has decided to withdraw from the world. On the whole, he seems stuck, unable to make a move. Mr. F has a younger sister, and a better relationship with his father than his mother. He sometimes brings up the topic of euthanasia, which is legal in some countries outside of Italy such as Switzerland and Norway, where he threatens to go, causing great concern amongst his family members.

Ms. G comes across as a good-looking and smartly dressed girl with clear signs of suffering, who initially seems to enjoy undergoing therapy. At the start, she frequently talks about her problems with her boyfriend and her commitment at university, while she appears to have a solid network of friends. On the contrary, she feels her father tends to mind his own business, while her sister is perceived as overbearing and a control-freak with whom there are frequent arguments. She is concerned about the lack of communication, especially with regards to her decision to drop out of university. Luckily, there seems to be a good rapport with her aunt. The transition to university life and consequent adjustments appear to have comprised a critical and unsettling experience for Ms. G.

In the first phase of treatment, Mr. F seems particularly withdrawn and unwilling to challenge his assumptions about the world and his family. His functioning seems by and large quite projective: others have never understood him, and tend to have expectations he knows he cannot match. Still, Mr. F does not dispute he has some qualities, especially in the sporting field, but it seems nobody has ever trusted him. This leads the therapist to wonder whether the patient will be able to trust him and the psychotherapeutic treatment, and to address Mr. F's fear of being considered inadequate by him. Under a depressive surface some personality traits did emerge clearly in the course of the therapy. Mr. F seems sheltered in a narcissistic, untouchable position, chiefly because he avoids

confronting himself with others. Emotional control is very strong and leads to a kind of *flattening* that renders him aboulic, but under which there is a latent aggressiveness, expressed as hostile passiveness.

In the first phase of treatment Ms. G is quiet and not forthcoming, which may represent a mental equivalent of her concurrent undereating. These signs lead the therapist to adopt a very supportive approach, with frequent intervention. While Mr. F has never had significant sentimental relationships, Ms. G starts her therapy in the midst of her breaking up with her boyfriend. On the other hand, Ms. G manifests a clearly dependent behavior, leaning on the therapist but also manifesting good self-consciousness. That said, memories of her past seem blocked or restricted, in particular with regards to her mother, which bring about strong emotional responses difficult to elaborate. The bonding function that the mother played in the family becomes clear. Access to drives is made possible mainly via the interpretation of a series of dreams recounted soon after the start of therapy.

Mr. F and Ms. G at the beginning of the psychotherapy: empirical perspective

When it comes to formulating a descriptive diagnosis (American Psychiatric Association, 2000), on Axis I Mr. F displays the symptoms of a Major Depressive Disorder (F32.1) – primary diagnosis – with a likely mild onset in 2005, as well as a secondary diagnosis of Social Phobia (F40.1). With regard to this, please note that as it is widely recognised that SCID-I and SCID-II clinical interviews are very closely linked to the DSM-IV and DSM-IV TR, we chose to refer to the latter rather than to the more recent DSM 5. On Axis II Mr. F matches the criteria for Avoidant Personality Disorder (F60.6) and Passive-Aggressive Personality Disorder (in Appendix B of DSM-IV TR). In terms of psychodynamic diagnosis (PDM Task Force, 2006), Mr. F is well described by the Depressive Personality Disorder – introjective type (P107.1) – with moderate limitations and alterations of mental functioning (M205) and symptom patterns pertaining both to Depressive Disorders (S304.1) and Adaptation Disorders (S301). The patient scored 28 on the HAM-D test, which indicates a severe depression; the BDI-II shows a score of 25, which indicates a moderate depression. The PD scores of the SWAP-200 at the beginning (T1) of psychotherapy highlight a significant level of Schizoid Personality Disorder (T=62.03) and Avoidant Personality Disorder (T=60.81). Moreover, significant traits of Schizotypal (T=59.40), Borderline (T=54.28) and Dependent (T=53.08) Disorders are present. The Depressive High Functioning score is low, under 50. Q score profiles confirm a significant value for Schizoid Personality Disorder (T=60.44) as well as Avoidant Personality Disorder (T=62.46); lastly, Emotionally Dysregulated Disorder (T=64.55) is also clearly above Disorder threshold. With reference to dimension scores in the DEQ at the start of Mr. F's therapy, the results indicate a prevalence of Self Criticism (0.66) compared to Dependency (-0.59) and Self-Efficacy (-1.13). An introjective depression is outlined, with prevalence of Self-Criticism compared to Dependency. This negative value in the Self-Efficacy dimension is particularly remarkable and matches the general low functioning of the patient.

In terms of descriptive diagnosis (American Psychiatric Association, 2000), Ms. G also displays the symptoms of a Major Depressive Disorder (F32.0) as a primary diagnosis on Axis I, with a secondary diagnosis of Dependent Personality Disorder (F60.7) on Axis II. In terms of psychodynamic diagnosis (PDM Task Force, 2006), Ms. G matches criteria for Depressive Personality Disorder – anaclitic type (P107.2) – with small limitations and alterations of mental functioning (M205). Her symptom patterns satisfy the criteria for Depressive Disorders (S304.1). At the start of her therapy Ms. G's HAM-D scores (15) attest to light depression, while the BDI-II score (26) signals a moderate depression. Interestingly, SWAP-200 results evidence a Dependent Disorder (T=64.05). Significant traits that emerged include Depressive High Functioning (T=56.42) and Avoidant (T=56.18), while other traits remain below the 55 cut-off. What's more, Q-scores were highest for Dependent (T=60,62) traits, with Depressive High Functioning (T=59.99) and Avoidant (T=57.63) clearly present but less significant (scores below T=55). With regards to DEQ scores, there is a clear prevalence of Dependency at T1 (0.55), compared to Self-Criticism (-0.98) and Self-Efficacy (-2.09). As with Mr. F, Self-Efficacy values are particularly low, while manifesting in different ways.

Following Mr. F's and Ms. G's treatment: Defense Mechanism Rating Scale, Core Conflictual Relationship Theme method, and Shedler-Westen Assessment Procedure/Depressive Experience Questionnaire comparison

In this section, the yearlong psychotherapy process and its overall trend is illustrated in terms of three diverse points of view: defensive functioning, typical interactions with significant others, and personality features linked to possible changes in depressive experience.

This three-fold partitioning allows a clear illustration of changes in defensive functioning as measured by DMRS scores for both patients in the three phases of therapy. A first remarkable result concerns the general trend of defence mechanisms (ODF index) in the one year of treatment. With regards to Mr. F, in the first phase of the psychotherapy an important fluctuation in the use of defence mechanisms is present (mean value=3.5). The patient's highest level in the use of defence mechanisms is in the central phase of psychotherapy (mean value=3.8), probably coinciding with the key transformative psychological work. In the last phase of the year, we witness a stabilization in the defensive functioning, which remains at a clinical level, albeit rather low (mean value=3.2). Ms. G shows a very different use of defences in the course of treatment.

Along the three phases rationalization defences remain fairly constant. However, it would not be fair to claim that no relevant shift in defence use occurred. Changes in defensive functioning as measured by DMRS scores illustrate how in the final phase Narcissistic (chiefly Devaluation) and Obsessive (Undoing) defences become prominent in dealing with internal and external conflict. Overall Defensive Functioning fluctuates as well. While initial ODF scores attest to relatively mature functioning (4.6), we witness a slight drop as the patient confronts some key issues in the central phase of therapy (4.2), only to return to a more consistently mature pattern in the final phase (4.6), possibly attesting to the resilience of this patient notwithstanding her conspicuous difficulties.

What is striking about Mr. F's trend is the particular prevalence of Disavowal defences as the patient's main way of dealing with inner and external conflicts, as well as correlated emotions. By the same token, in the course of the three phases Ms. G's Rationalization defences remain fairly constant, attesting to the key role of Disavowal patterns all through the treatment. In the final phase Narcissistic (chiefly Devaluation) and Obsessive (Undoing) defences become prominent.

Likewise, the partitioning of the yearlong treatment into three phases proved fruitful in terms of highlighting patients' typical interactions with significant others via CCRT. After each example, a brief psychodynamic comment follows (Tables 2-4). Interestingly, typical interpersonal interactions as

Table 2. Mr. F's and Ms. G's Core Conflict Relationship Theme: phase 1.

	FG	GB
Example 1	P: // W (6, 7) I always wondered what I'm living for, obviously I carry on, staying alive right now is something I just do.// RO (5, 4) Let's say that with my aunt and my mum things are just like that, they have no confidence in me.// RO (5, 4) And then they tell me that they don't understand, they say I don't listen. They told me -especially my mum told me- that it makes no sense, that when I do things they never seem to make sense to them.// RS (7, 6) I don't know what tomorrow will bring, I guess tomorrow morning I'll just wake up, and if I wake up I'll see what I can do! Tomorrow we'll see: it's better to live now than tomorrow, 'cause maybe by mistake you will have a family, you will have a son or maybe you will have to look after a child, who will say *Why is dad is not around? For what reason?*	P: I really have no idea how to tell him any more ... How not to disappoint him … (coughs) I mean, I don't know if he'll just get angrier or… I don't know… T: If he'll just get angrier?! P: Well, yeah, I mean disappointed (W6) T: Hmmm… P: But he also gets mad… T: So a mix of things, right? P: Yeah, yeah, exactly T: Do you suppose that in the past, for other reasons he may have… P: The thing is that when he gets mad he then stops talking (RO5), I mean he completely shuts off, and I definitely don't go looking for dialogue (RS6). Yeah, for sure, it's already happened … that we might argue over something (coughs), I can't remember what now, but the thing about him is that he really shuts off, I mean you can tell something is up because we'll just not talk to each other.
Example 2	P: // W (7, 8) I'm trying to make sense as to why I'm here, on this Earth.// T: // RO (6, 8). . .Perhaps that's something you can't seem to find in the relationship with your parents at this stage, right?// P: // RS (6, 7) That's probably a question nobody can answer, you just need to keep going while you're alive.// T: // RO (6, 8) Why? Do you feel so useless?// P: // RS (7, 6) Well, if I have be the one who ruins people's lives...! I never asked to be born, I just was, then they even told me it was my fault!//	P: You mean Dad's? Well, no, the thing is we're basically the same… but I'm not his favourite, 'cause growing up, I mean… he gets along better with my sister, also because they have the same job so they're always talking about work. So they also have something in common to talk about, while the only thing I used to have to talk about was university, and now not even that. Really… (W6) T: So it's since you were about 11 or 12 that your Dad went to live far away? P: Yeah, but I didn't really notice, also 'cause Mum was there, so I wouldn't notice, and then he got more and more distant (RO5). T: So do you feel all this happened because he had invested in something else? P: No, I don't know. It's like he sees me all grown up and says to himself that I don't need him any more (RS 7).
Comments	Generally speaking, the patient's desires, needs and intentions are frustrated. Nobody, not even the psychotherapist, seems to be able to be helpful for him. Since the maternal figure was probably missing, functions linked to the empathic mirroring of the other seem absent; likewise, there was a lack of mechanisms of identification with the paternal figure. The patient's key reactions include anger and hate, mainly focused on his own self.	While the patient displays a clear need to be loved and understood, her appeal is overlooked and stumped by the object (her father); this rejection subsequently brings out the patient's sense of helplessness, disappointment and anger.

//, sentence unit actually examined in the Core Conflict Relationship Theme scoring procedure.

gauged by CCRT scoring follow a similar deflection. As the tables below detail, Relational Episodes at T1 and T3 showcase similar patterns of (W)-(RO)-(RS), with T2 providing potential signs of change in the form of a novel relational behavior, in particular in relation to the therapist (Table 2).

In order to evaluate the features of personality in connection with some possible modifications of the depressive experience, a detailed comparative analysis between the most significant DEQ and SWAP-200 items was carried out for Mr. F and Ms. G in T1 and T2 assessment profiles. A selection was made by choosing exclusively the DEQ items loading on one of the three factors (Efficacy, Self-Criticism, Dependency) (Blatt, Quinlan, Pilkonis, & Shea, 1995); regarding the SWAP-200, only the most descriptive items of the Q-factors/personality styles (Shedler, Westen, & Lingiardi, 2014**)** characterizing Mr. F's and Ms. G's assessment (Schizoid, Avoidant, Emotionally Dysregulated and Hostile-Externalizing) for Mr. F and Depressive High Functioning and Dependent for Ms. G were taken into consideration. In particular, the items of the DEQ and the SWAP-200 having obtained the highest scores (from 5 to 7) or having shown a significant change (increase of more than 2 points) from T1 to T2 were taken into account. In this way, features of personality connected with some possible modifications of the depressive experience are given clear emphasis. Tables 5 and 6 detail the possible *matching* of some couples of significant items from the two instruments, observing a semantic overlap between respective statements. In addition, in some cases the scoring variations of the matched items are very similar along the course of therapy. It is remarkable that Self-Criticism emerges as the depressive dimension most present in connection with the two different Q Factors/Styles of Personality (Avoidant and Emotionally Dysregulated).

Mr. F and Ms. G at the end of the psychotherapy: clinical perspective

Half way through the first year of his therapy Mr. F began to show the first variations in mental functioning that could be considered possible signs of change. In particular,

Table 3. Mr. F's and Ms. G's Core Conflict Relationship Theme: phase 2.

	FG	GB
Example 1	P: // RO (4, 5) According to mum, I just run away from problems.// W (2) But you need to see who is right, me or you, if I'm right or wrong! // RS (7) Well, if she's right then I'll leave, but I won't leave home, I will leave this life!//	P: Huh? I mean, generally I prefer being with other people, rather than always being on my own … (W5) (…) P: Right… I mean, she gets angry when I touch her stuff, but she used my car, she stole my make-up, she has taken loads of my things… which I only realised later, because even when there's dirty laundry, I'm not an idiot, it wasn't me who put it there, it's not like Dad did it (RO5) … and I'm not even allowed to get angry (RS7)
Example 2	P: // W (1, 3) You see, when I'm wrong it is always my fault, but when you do the right thing then it's thanks to them…! And now we need to take some decisions, and I take them into consideration: either they give me a hand or they face their responsibilities.// T: // RO (8) Well, what I'm trying to say is that you are still in a phase where your parents have got it all wrong: they did not think things through, they have not loved you, and they haven't invested in you. [...] If you keep wanting to be in this in this position, you will need to create continuity, in the sense that you have never really invested in yourself, and this affects you, right? I mean, you don't seem very pleased.// P: // RS (1) No, I'm not.// T: // RO (8) I wonder if we shouldn't consider that there are alternative ways of thinking. Many people decide to live a different life, and what's more you still seem on-track on several fronts, right?// P: // RS (1) You're right, I should remember that I can make different choices.//	P: I didn't want to wait (W1), I mean, we were meant to meet at 7:30, then she tells me that she isn't going to be there before 7:45, and then she's like: *I'm still waiting for that other girl to get here* (RO5) and so at that point I said *No, in that case I'm going home* (RS7). P: Yesterday at lunch I was feeling okay, we were at my aunt's chatting, about this and that, and I would say one thing (W1) and my Dad and sister would say another (RO5), and so my aunt turned around and said: *Can't you ever let this poor girl be right?* … She stood up for me, my aunt is always like that (RS7)
Comments	In this second phase of treatment the relationship with all significant others (and chiefly the mother) continues to be burdened by intense conflict, with signs of regression in mental functioning as the tendency to act out indicates. Conversely, in the clinical setting the patient now shows more willingness to experience emotional validation and meaningful openness with regards to his future which feature in the psychotherapist's interventions.	In this central phase of treatment the object (her friend) tends to react to GB's sporadic assertiveness with scarce consideration, thus leading to a reaction of the subject laden with hopelessness, defeat and anger.

//, sentence unit actually examined in the Core Conflict Relationship Theme scoring procedure.

his aggressiveness is sometimes channelled in novel ways, taking more *mobile* forms: for example, the patient's political involvement, initially merely a generalized accusation against politicians considered unable to understand citizens' real needs, evolves into active participation in the Italian Five Stars Movement. The subject's engagement in sports increases (running and swimming races). He is an active member of his town's Youth Council, where he puts effort into the organization of social events (in particular the Beer Party) with little or no personal advantage. The patient feels too much anger towards his maternal figure, regarding her as a person unable to appreciate his qualities (and perhaps his grief as well), or as extremely anxious and oppressive at best. He believes the only way to maintain a relationship with her is via symmetrical attitudes: he behaves with her in the same way as she tends to do with him, ignoring her. Only during some of Mr. F's sessions does a more depressive (elaborative) organization emerge, but he struggles greatly to remain in this condition. In the course of the year, work with Mr. F is sometimes burdened by the lack of a real motivation for change. His ambivalence in the key affective family relationships (the mother above all) is clearly reflected in the therapeutic work.

Towards the end of the third phase of Ms. G's treatment several unambiguous signs of change are witnessed. The patient, who had started therapy in the midst of a messy break up, manages to brave the start of a sentimental relationship with a new boyfriend. At the same time, she engages in part-time work at fairs. Both can be considered as signs of a less troublesome personal autonomy in a young lady with anaclitic functioning and very marked dependent traits. As was hinted above, the second phase might be regarded as the footing of this behavior, as it is here that more than ever the therapist accompanies

Table 4. Mr. F's and Ms. G's Core Conflict Relationship Theme: phase 3.

	FG	GB
Example 1	P: // W (1) I remember some time ago I had actually tried to make plans, but now all I can think is that today I am here, who knows about tomorrow? I mean, rather than start doing something that tomorrow we will just give up, it makes more sense to just do nothing.// RO (2) What is hard for me is the fact that others just always seem to tell you what you have to do.// [. . .] RS (6, 7) I have no choice, if you don't do what they say, they will just leave you high and dry!/ RS (4, 7) I guess I will see how far they want to take this: I will do my part, but they will have to contribute.//	P: Ah, and another thing about him, which is just unbelievable (RS7), if he says something then it has to be like he says, there's no way of changing his mind… like last Thursday there was this event called *tacco 14* I wanted to go to, well it's not like I really wanted to go, I didn't really care, but I really didn't want (W1) to go to Legnano, I mean we're always going to Legnano and I just wasn't in the mood. And so then he decides (RO5) that I actually want to go to this event… I mean, he's the kind of guy who – if for instance I say *What should we do later?* and I joke about it, I dunno, because maybe I want to talk about something more general linked to that - well, he'll just decide something all by himself and he'll say things are that way even if maybe it's not what I said or what I really wanted… I mean, there's no way of changing his mind, he thinks he's always right, he's like that.
Example 2	P: // W (7) Doing the same thing over and over for several days is boring, I mean besides staying outdoors. I reckon I could only handle very practical work, nothing more than that. // T: // RO (6) How would you characterise yourself, say if you had to write a profile like the ones people use today in social networks? P: // W (7) I would just leave a blank space.// T:// RO (8) Has this blank space has always been blank, or have you decided to make it empty?// P:// RS (5) Probably I have made it empty lately T:// RO (8) Maybe we could say that by leaving it blank then nobody can come and tell you *Why did you leave that thing there?!*// P:// RS (5) Bah, at best they will just bug you about why it is blank… They always have something to say!//	P: So, maybe everything started on Friday, when I got mad at him, and I mean I'm the kind of person who takes a while to cool off, and so Friday I told him you never give me the chance to have my own reactions (RO5), and I mean, I'm also human- I walk, breathe and have reactions (W6)- I'm also a person and I'm not the kind of person who can just disappear, I mean I need to shout, and instead it's like I'm bottling everything up (RS7).
Comments	In this third phase of treatment we witness the emerging of a novel reaction in relation to the psychotherapist's interventions: the psychotherapeutic relationship built up in the clinical setting affords the patient an opportunity to experiment very unfamiliar feelings coming from the other and focused on the self. The patient's *new deal* might well take shape from the *blank space* he himself mentions. Contrastingly, his inner perceptions regarding the situation outside the clinical setting appear to be unchanged after one year of psychotherapy.	In this third phase of treatment the patient continues to manifest a certain need for assertiveness, which continues however to be shunned and rejected. This has likely led the patient to revert to what typified her desire at the onset of therapy (to be loved and understood) in the last sessions analyzed. The reaction of the subject remains unvaried in this third phase as well, revolving around feelings of anger and frustration.

//, sentence unit actually examined in the Core Conflict Relationship Theme scoring procedure.

the patient in her attempt to change. Countertransference includes feeling like the caring father that Ms. G was never granted, as well as the psychotherapist's impression that he actively helped the patient to become less dependent.

Mr. F and Ms. G at the end of the psychotherapy: empirical perspective

After 1 year of treatment, Mr. F scored 4 in the HAM-D, indicating total remission from the Episode of Major Depressive Disorder (F32.1). Furthermore, BDI-II scores decrease to 10, in the minimal range area. All PD scores were under 60, but what proved remarkable was the tendency towards Schizoid Personality Disorder (T=59.32), which was still quite notable at the end of the first year of treatment, as well as towards Schizotypal Personality Disorder (T=56.44) and Avoidant Personality Disorder (T=55.57). However, none of these values reach the Dis-

Table 5. Comparison of the most descriptive Depressive Experience Questionnaire and Shedler-Westen Assessment Procedure items during Mr. F's first year of therapy.

Item	DEQ Factor			Score		Item	SWAP-200 Q factor				Score	
	Efficacy	Self-criticism	Dependency	T1	T2		Av.	Emotionally Dysregulated	Host.-Ext.	Sch.	T1	T2
14. I enjoy sharp competition with others	X			5	4	8. Tends to get into power struggles			X		0	5
64. I tend to be very critical of myself		X		5	5	91. Tends to be self-critical; sets unrealistically high standards for self and is intolerant of own human defects	X				5	3
13. There is a considerable difference between how I am now and how I would like to be		X		3	5	54. Tends to feel s/he is inadequate, inferior, or a failure	X	X			7	6
16. There are times when I feel empty inside		X		5	5	90. Tends to feel empty or bored		X			7	5
17. I tend not to be satisfied with what I have		X		5	4	56. Appears to find little or no pleasure, satisfaction, or enjoyment in life's activities	X	X			7	5
34. I find it very hard to say no to the requests of friends			X	5	4	199. Tends to be passive and unassertive	X			X	5	5
65. Being alone doesn't bother me at all			X	3	5	104. Appears to have little need for human company or contact; is genuinely indifferent to the presence of others				X	4	7
11. Many times I feel helpless			X	5	5	127. Tends to feel misunderstood, mistreated, or victimized		X	X		6	7

DEQ, Depressive Experience Questionnaire; SWAP-200, Shedler-Westen Assessment Procedure; T1, treatment 1; T2, treatment 2.

orders threshold (≥60), with a decrease in T2 of Schizoid and Avoidant traits in particular. The Depressive High Functioning score is slightly higher, but remains under 50. Q score profiles showcase possibly the most important developments in the year of treatment, that is to say a significant decrease in Emotionally Dysregulated Personality Disorder (T=49.85) and in Avoidant Personality Disorder (T=57.25) values, and the significant increase of values for Hostility Personality Disorder (T=65.48). At the end, Schizoid Personality Disorder levels remained stable (T=60.22). Remarkable increases in main dimensions of the DEQ seem to match the trend that emerged in T1. In particular, Mr. F's depressive experience confirms an introjective profile (0,99), featuring the refusal of anaclitic relationships (-1.37) in a perception of low Self-Efficacy (-1.23).

At the end of the yearlong psychodynamic therapy that she underwent, Ms. G's HAM-D scores had dropped down to 6 (no depression). By the same token, BDI-II measures had decreased to 8, with the patient registering in the *minimal range*. What emerged from PD scores was the rise of Depressive High Functioning to T=60.07, while the Dependent trait remains ostensibly high at T=65.52, and the Avoidant grows slightly to T=57.76. All other traits measured by SWAP-200 procedure remain under the 50 cut off score. When it comes to Q factor scores, Depressive High Functioning comprises the most significant (T=63.62), Avoidant the second most prominent (T=59.03) and Dependent the third (T=57.89). Analogously, DEQ results feature an expansion in the Dependency cluster, rising up to 0.64, while Self Criticism drops down to -0.63, and Efficacy falls further to -2.25.

Discussion

It is fair to say that both for Mr. F and for Ms. G alike psychotherapy has attained good results chiefly in the reduction of depressive symptomatology, both from the patients' point of view (BDI-II: a drop from 25 to 10 for Mr.

Table 6. Comparison of the most descriptive Depressive Experience Questionnaire and Shedler-Westen Assessment Procedure items during Ms. G's first year of therapy.

DEQ						SWAP-200				
Item	Factor			Score		Item	Q factor		Score	
	Efficacy	Self-criticism	Dependency	T1	T2		Depressive	High Functioning	Dependent	T1	T2
7. I often find that I don't live up to my own standards or ideals		X		5	3	120. Has moral and ethical standards and strives to live up to them	X			2	5
64. I tend to be very critical of myself		X		7	5	91. Tends to be self-critical; sets unrealistically high standards for self and is intolerant of own human defects	X			4	5
43. I often feel guilty		X		5	5	57. Tends to feel guilty	X			7	6
36. The way I feel about myself frequently varies: there are times when I feel extremely good about myself and others when I see only the bad in me and feel like a total failure		X		6	6	15. Lacks a stable image of who s/he is or would like to become (*e.g.*, attitudes, values, goals, or feelings about self may be unstable and changing)			X	7	6
35. I never really feel secure in a close relationship			X	7	5	77. Tends to be overly needy or dependent; requires excessive reassurance or approval			X	4	7
19. I become frightened when I feel alone			X	7	6	171. Appears to fear being alone; may go to great lengths to avoid being alone			X	5	7
28. I am very sensitive to others for signs of rejection			X	6	5	98. Tends to fear s/he will be rejected or abandoned by those who are emotionally significant			X	6	7
62. I am very satisfied with myself and my accomplishments	X			2	5	2. Is able to use his/her talents, abilities, and energy effectively and productively	X			5	3

DEQ, Depressive Experience Questionnaire; SWAP-200, Shedler-Westen Assessment Procedure; T1, treatment 1; T2, treatment 2.

F, from 26 to 8 for Ms. G) and from the clinician's (HAM-D: a decrease from 28 to 4 for Mr. F, from 15 to 6 for Ms. G). Even though symptomatic remission is considered a fundamental result for a successful therapy, the problem is to evaluate possible change in specific features of personality and mental functioning. Symptoms reduction in itself does not say much about the nature of the therapeutic change (Horowitz, 1993; Blatt & Auerbach, 2003).

Based on the study of two clinical cases we have presented, it should be possible to draw attention to the important areas of stability and change occurring in personality configurations: this is particularly true of Mr. F, where we witnessed a noteworthy reduction of Emotionally Dysregulated Q Factor (see SWAP-200 results), which implies dimensions which are more closely linked to depressive experience and to emotional adjustment and regulation (Ehring, Tuschen-Caffier, Schnülle, Fischer, & Gross, 2010; Carl, Soskin, Kerns, & Barlow, 2013). On the other hand, Ms. G displays scores clearly above threshold for the Dependent factor, both in PD values and Q scores – although the latter does dip below threshold in T2 – along with scores for PD and Q in the Depressive High Functioning factor also above the cut-off. We should also not underestimate the prolongation of Dependent personality traits in this patient. It may be worthy of mention that 3 out of 5 sub-factors of the Dysphoria dimension measured by SWAP-200 resulted above threshold for both Mr. F and Ms. G, but with some remarkable differences. Dysphoria describes patients who are prone to feeling inadequate, inferior or a failure; unhappy, depressed or despondent; ashamed or embarrassed; fearful of being rejected or abandoned; powerless and lacking energy; needy or dependent; prone to being ingratiating and submissive, or passive and unassertive; prone to feeling responsible for bad things that happen and guilty. Mr. F's results feature the following 3 sub-factors: Avoidant, Emotionally Dysregulated (only in T1) and Hostile (only in T2). Conversely Ms. G displays: Avoidant – Depressive High Functioning (only in T2) – and Dependent (only in T1). What's more, only Mr. F manifests a significant and constant presence of Schizoid personality traits: in particular, whilst PD scores sink under threshold in T2, the Q scores remain elevated in T2 (60.44 in T1; 60.22 in T2). Part of existing literature attests to the possibility of relationships between Depressive Disorders and specific Personality Disorders – and more in detail, Schizoid or Cluster A Personality Disorders and Avoidant or Cluster C Personality Disorders (Sato et al., 1994; Johnson et al., 2005; Hirschfeld, 1999).

Blatt's description of the two different dimensions of depression (Blatt, 1974; Blatt & Homann, 1992; Blatt & Maroudas, 1992; Cicchetti & Aber, 1986; Zuroff & Fitzpatrick, 1995) can prove equally useful. More specifically, the stability of Blatt's configurations – introjective for Mr. F and anaclitic for Ms. G – over the course of the treatment (Mr. F's Self-Criticism varies between 0.66 and 0.99; Ms. G's Dependency from 0.55 to 0.64), is ground enough for us to reiterate that these two different basic personality configurations are related to certain personality traits or disorders as well as to self-definitional (or introjective) developmental lines. With this we mean principally those pertaining to Schizoid and Schizotypal Personality Disorders, but also those linked to Dependent Personality Disorder (Blatt & Shichman, 1983; Ouimette & Klein, 1993; Ouimette, Klein, Anderson, Riso, & Lizardi, 1994; Blatt, 2004, 2008).

Having employed an instrument like DEQ also affords us an in-depth analysis of the depressive state: Mr. F appears to be characterized by depression of the introjective type, with predominant scores in self-critical aspects. This form is prevalent in MDD (Major Depressive Disorder) (Blatt, 2004, 2008; Blatt & Levy, 1998; Blatt & Zuroff, 1992; Luyten et al., 2007). From a PDM standpoint (PDM Task Force, 2006), our attention is drawn to the difference between patients with MDD and patients with depressive personality. Some features of this kind of personality appear stable over time in Mr. F: for example, major difficulties in relationships, with the inclination to perceive the self as inadequate or rejected by others, as well as typical defensive arrangements with alternating use of devaluation of the self or of others associated with introjective or projective mechanisms. On the other hand, Ms. G appears to be suffering from depression of the anaclitic type, with predominant scores in dependent aspects. This form of depression is commonly regarded as clinically less severe than the former, and from a PDM standpoint we can stress how in Ms. G features of this kind of personality appear stable over time. For example, the tendency to avoid conflict and the inability to manifest anger in fear of losing the support of the receiver, but also the need to feel loved and accepted to ward off intense feelings of abandonment and helplessness, chiefly via Neurotic defence mechanisms such as Suppression, Rationalization, Undoing and Devaluation (Blatt, 2004, 2008; Blatt & Levy, 1998).

By the same token, it is not far fetched to suppose that Mr. F's manifest Avoidant trait (disorder) might be linked to fearful avoidant attachment, as the relationship with the mother and the psychotherapist leads us to presume. On the other hand, the same Avoidant trait (disorder) that we witness in Mr. F might instead be linked in Ms. G to a form of anxious-ambivalent (worried) attachment (Levy, Blatt, & Shaver, 1998; Meyer, Pilkonis, Proietti, Heape, & Egan, 2001; Reis & Grenyer, 2002; Blatt, 2004, 2008).

Insight offered by CCRT scoring backs the diagnosis of Mr. F as clearly introjective. He feels unworthy of receiving care, and manifests anger towards his family, chiefly the mother. On the other hand, Ms. G's CCRT results, particularly in T1, showcase her perpetual need for the support of others, in keeping with her anaclitic style. What emerges with clarity is her need for a point of reference, which is frequently frustrated and brings about feelings of anger and disappointment. Mr. F and Ms. G

display very heterogeneous ways of dealing with their anger: Mr. F gradually develops a Hostile trait, which is sometimes patent in the therapeutic relationship; conversely, Ms. G empowers her Depressive High Functioning aspect. This may reflect diverse ways of dealing with feelings of inadequacy and guilt. Since its inception – Freud (1915) and Abraham (1911) – psychoanalysis has described these feelings as typical of depression; likewise, Busch and colleagues have stressed (Busch et al., 2004) how dealing with anger and with narcissistic injury represents a crucial step in the psychodynamic psychotherapy of depression. This difference perhaps warrants the conclusion that Ms. G possesses a more adaptable and less complex personality structure than Mr. F, which is backed by the defence mechanisms analysis. Indeed, while both patients display clinically significant ODF levels, Mr. F tends to polarise on Disavowal and experiences an increase in Acting defence mechanisms, while Ms. G's Disavowal holds but also allows her to develop Narcissistic (Devaluation) and Neurotic (Suppression) patterns. Another interesting consequence of CCRT patterns is the diverse use of the therapeutic relationship. To the point, Mr. F employs the setting as the pivotal context in coming to terms with and working through his anger. This confirms Blatt's insight that introjectively depressed patients stand to benefit particularly from psychodynamic approaches. In contrast, Ms. G tends to regard the therapist as merely one of many potentially supportive people, the kind she wishes her father and sister were. Thus the therapy setting is employed chiefly as a form of concrete emotional sustenance, in keeping with Blatt's idea that this kind of patient typically makes use of therapy as a supportive tool.

The comparison of DEQ and SWAP data also yields some interesting findings. The DEQ Self-Criticism factor manifests in very diverse personality configurations as measured by SWAP in the two patients. More in detail, Mr. F's Self-Criticism is most frequently associated with Avoidant and Emotionally Dysregulated behavior, while the same factor in Ms. G is associated almost uniquely with Depressive High Functioning SWAP aspects. Dependency in Ms. G associates very closely to SWAP-200 Dependent Q factors. This DEQ-SWAP comparison may indeed warrant the conclusion that Self-Criticism comprises a more complex polarity than Dependency.

Mr. F and Ms. G's case studies outline how a good psychotherapeutic treatment of Depressive Disorders can develop. Even if admittedly the presence of Personality Disorders might ultimately have a negative impact on the outcome of the treatment of depression (Newton-Howes et al., 2006, 2014), in these case studies the presence and variations of specific traits and personality features were interpreted as a general adjustment of Mr. F and Ms. G's *internal world*, and of their relations with others in an interpersonal perspective (Sullivan, 1953).

As Luyten and Blatt remarked (Blatt & Luyten, 2009; Luyten and Blatt, 2013), self-definition and interpersonal relatedness in developmental stages lay the foundations for two key personality dimensions which may prove useful in understanding pathological as well as normal conditions, along with evaluating psychotherapy outcomes (Blatt & Shahar, 2004; Blatt, Besser, & Ford, 2007). This consideration may explain the stability of Mr. F's and Ms. G's introjective and anaclitic dimensions over time. In particular, the former's introjective personality seems to present greater complexity in reaching a mature integration in latent mental structures (Werbart & Forsström, 2014) – and more so due to Schizoid traits. Consequently, Ms. G displays by and large a more promising prognosis, thanks to the Depressive High Functioning dimensions. On the other hand, for both patients modifications in the psychotherapeutic relationship -as substantiated by CCRT results- may turn out to be a good predictor for the enhancement of adaptive skills (Blatt, Zuroff, Hawley, & Auerbach, 2010).

Conclusions

To sum up, after this period of treatment we may affirm to have witnessed good outcomes in terms of *effectiveness* (Kendall, Holmbeck, & Verduin, 2004; Lambert & Ogles, 2004): compared with the beginning of the psychotherapy, after one year Mr. F displays a more keen awareness of his relationship style and inner conflicts, and has integrated new adaptive strategies into his life. Similarly, Ms. G's behavioral cues attest to less conflict-ridden autonomy, and growing insight into the history and dynamics of her dependent relatedness. She attempts ex-post to correct her defensive reality distortions with repeated use of obsessive symbolic mending, highlighting an increase in self-consciousness garnered in therapy. While both patients yielded encouraging outcomes, generalizations are obviously not warranted and further clinical studies are welcome.

References

Ablon, J.S., & Jones, E.E. (1999). Psychotherapy process in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 67*, 64-75. doi: 10.1037/0022-006X.67.1.64

Abraham, K. (1911). Notes on the psycho-analytical investigation & treatment of manic-depressive insanity & allied conditions. In *Selected Papers on Psychoanalysis* (pp. 137-156). London: Hogarth Press.

Akkerman, K., Lewin, T.J., & Carr, V.J. (1999). Long-term changes in defence style among patients recovering from major depression. *The Journal of Nervous and Mental Disease, 187*, 80-87. doi: 10.1097/00005053-199902000-00003

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR 4th Fourth Edition, text revision.* Washington, DC: American Psychiatric Association.

Arieti, S., & Bemporad, J. (1978). *Severe and mild depression:*

the psychotherapeutic approach. New York: Basic Books.
Asch, S.S. (1966). Depression: three clinical variations. *Psychoanalitic Study Child 21*, 150-171.
Barber, J.P., Barrett, M.S., Gallop, R., Rynn, M.A., & Rickels, K. (2012). Short-term dynamic psychotherapy versus pharmacotherapy for major depressive disorder: a randomized, placebo-controlled trial. *Journal of Clinical Psychiatry, 73*, 66-73. doi: 10.4088/JCP.11m06831
Bastos, A.G., Guimaraes, L.S., & Trentini, C.M. (2013). Neurocognitive changes in depressed patients in psychodynamic psychotherapy, therapy with fluoxetine and combination therapy. *Journal of Affective Disorders 151*, 1066-1075. doi: 10.1016/j.jad.2013.08.036
Bastos, A.G., Guimaraes, L.S., & Trentini, C.M. (2015). The efficacy of long-term psychodynamic psychotherapy, fluoxetine and their combination in the outpatient treatment of depression. *Psychotherapy Research, 25*, 612-624. doi: 10.1080/10503307.2014.935519
Beck, A.T., Steer, R.A., & Brown, G.K. (1996). *Beck Depression Inventory: second edition manual*. San Antonio, TX: The Psychological Corporation.
Black, D., Bell, S., Hulbert, J., & Nasrallah, A. (1988). The importance of axis II in patients with major depression: a controlled study. *Journal of Affective Disorders, 14*, 115-122. doi: 10.1016/0165-0327(88)90053-5
Blatt, S.J. (1974). Levels of object representation in anaclitic & introjective depression. *The Psychoanalitic Study Child, 29*, 107-157.
Blatt, S.J. (2004). *Experiences of depression. Theoretical, clinical, & research perspectives*. Washington DC: American Psychological Association.
Blatt, S.J. (2008). *Polarities of Experiences. Relatedness & Self-definition in Personality Development, Psychopathology, & the Therapeutic Process*. Washington DC: American Psychological Association.
Blatt, S.J. (2015). Depression (pp. 131-151). In P. Luyten, L.C. Mayes, P. Fonagy, M. Target, & S.J. Blatt (Eds.) *Handbook of psychodynamic approaches to psychopathology*. New York, NY: Guilford Press.
Blatt, S.J., & Auerbach, J.S. (2003). Psychodynamic measures of therapeutic change. *Psychoanalytic Inquiry, 23*, 268-307. doi:10.1080/07351692309349034
Blatt, S.J., Besser, A., & Ford, R.Q. (2007). Two primary configurations of psychopathology & change in thought disorder in long-term intensive inpatient treatment of seriously disturbed young adults. *American Journal of Psychiatry, 164*, 1561-1567. doi: 10.1176/appi.ajp.2007.05111853
Blatt, S.J., D'Afflitti, J.P., & Quinlan, D.M. (1976). Experiences of depression in normal young adults. *Journal of Abnormal Psychology*, *85*, 383-389. doi: 10.1037/0021-843X.85.4.383
Blatt, S.J., & Homann, E. (1992). Parent-child interaction in the etiology of dependent & self-critical depression. *Clinical Psychology Review, 12*, 47-91. doi:10.1016/0272-7358(92)90091-L
Blatt, S.J., & Levy, K.N. (1998). A psychodynamic approach to the diagnosis of psychopathology (pp. 73-109). In J.W. Barron (Eds.) *Making diagnosis meaningful: enhancing evaluation & treatment of psychological disorders*. Washington, DC: American Psychological Association.
Blatt, S.J., & Luyten, P. (2009). A structural-developmental psychodynamic approach to psychopathology: two polarities of experience across the life span. *Development and Psychopathology, 21*, 793-814. doi: 10.1017/S0954579409000431
Blatt, S.J., & Maroudas, C. (1992). Convergence of psychoanalytic & cognitive behavioral theories of depression. *Psychoanalitic Psychology, 9*, 157-190. doi:10.1037/h0079351
Blatt, S.J., Quinlan, D.M., Pilkonis, P.A., & Shea, M.T. (1995). Impact of perfectionism & need for approval on the brief treatment of depression: the National Institute of Mental Health Treatment of Depression Collaborative Research Program revisited. *Journal of Consulting and Clinical Psychology, 63*, 125-132. doi: 10.1037/0022-006X.63.1.125
Blatt, S.J., Sanislow, C.A. 3rd, Zuroff, D.C., & Pilkonis, P.A. (1996). Characteristics of effective therapists: further analyses of data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 64*, 1276-1284. doi: 10.1037//0022-006x.64.6.1276
Blatt, S.J., & Shahar, G. (2004). Stability of the patient-by-treatment interaction in the Menninger Psychotherapy Research Project. *Bullettin of Menninger Clinic, 68*, 23-38. doi: 10.1521/bumc.68.1.23.27733
Blatt, S.J., & Shichman, S. (1983). Two primary configurations of psychopathology. *Psychoanalitic Contempemporary Thought, 6*, 187-254. doi:10.1037/11749-006
Blatt. S.J., & Zuroff, D.C. (1992). Interpersonal relatedness & self-definition: two prototypes for depression. *Clinical Psychology Review 12*, 527-562. doi: 10.1016/0272-7358(92)90070-O
Blatt, S.J., & Zuroff, D.C. (2005). Empirical evaluation of the assumptions in identifying evidence based treatments in mental health. *Clinical Psychology Review, 25*, 459-486. doi: 10.1016/j.cpr.2005.03.001
Blatt, S.J., Zuroff, D.C., Hawley, L.L., & Auerbach, J.S. (2010). Predictors of sustained therapeutic change. *Psychotherapy Research, 20*, 37-54. doi: 10.1080/10503300903121080
Blom, M.B.J., Spinhoven, P., Hoffman, T., Jonker, K., Hoencamp, E., Haffmans, P.M.J., & van Dyck, R. (2007). Severity & duration of depression, not personality factors, predict short term out come in the treatment of major depression. *Journal of Affective Disorders, 104*, 119-126. doi:10.1016/j.jad.2007.03.010
Bond, M. (2004). Empirical studies of defence style: relationships with psychopathology and change. *Harvard Review of Psychiatry, 12*, 263-278. doi:10.1080/10673220490886167
Bond, M., & Perry, J.C. (2004). Long-term changes in defence styles with psychodynamic psychotherapy for depressive, anxiety, & personality disorders. *American Journal of Psychiatry*, *161*, 1665-1671. doi:10.1176/appi.ajp.161.9.1665
Bond, M., & Vaillant, J.S. (1986). An empirical study of the relationship between diagnosis and defence style. *Archives of General Psychiatry*, *43*, 285-288. doi:10.1001/archpsyc.1986.01800030103012
Busch, F.N., Rudden, M., & Shapiro, T. (2004). *Psychodynamic treatment of depression*. Washington, DC: American Psychiatric Publishing.
Calati, R., Oasi, O., De Ronchi, D., & Serretti, A. (2010), The use of the defence style questionnaire in major depressive and panic disorders: a comprehensive meta-analysis. *Psychology and Psychotherapy*, *83*, 1-13. doi:10.1348/147608309X464206
Carl, J.R., Soskin, D.P., Kerns, C., & Barlow, D.H. (2013). Positive emotion regulation in emotional disorders: a theoretical review. *Clinical Psychology Review*, *33*, 343-360. doi: 10.1016/j.cpr.2013.01.003
Carter, J.D., Luty, S.E., McKenzie, J.M., Mulder, R.T., Frampton, C.M., & Joyce, P.R. (2011) Patient predictors of response to cognitive behaviour therapy & interpersonal

psychotherapy in a r&omised clinical trial for depression. *Journal of Affective Disorders*, *128*, 252-261. doi: 10.1016/j.jad.2010.07.002

Charney, D.S., Nelson, J.C., & Mac Quinlan, D.M. (1981). Personality traits and disorder in depression. *American Journal of Psychiatry*, *138*, 1601-1604. doi: 10.1176/ajp.138.12.1601

Cicchetti, D., & Aber, L.J. (1986). Early precursors to later depression: An organizational perspective (pp. 87-137). In L. Lipsitt & C. Rovee-Collier (Eds.) *Advances in infancy, Vol. 4*. Norwood, NJ: Ablex.

Connolly, G.M.B., Gallop, R., Thompson, D., Luther, D., Crits-Christoph, K., Jacobs, J., Yin, S., & Crits-Christoph, P. (2016). Comparative effectiveness of cognitive therapy and dynamic psychotherapy for Major Depressive Disorder in a Community Mental Health setting: a randomized clinical noninferiority trial. *Journal of the American Medical Association Psychiatry*, *73*, 904-911. doi: 10.1001/jamapsychiatry.2016.1720

Ehring, T., Tuschen-Caffier, B., Schnülle, J., Fischer, S., & Gross, J.J. (2010). Emotion regulation and vulnerability to depression: spontaneous versus instructed use of emotion suppression and reappraisal. *Emotion*, *10*, 563-572. doi: 10.1037/a0019010

Elkin, I., Gibbons, R.D., Shea, M.T., & Shaw, B.F. (1996). Science is not a trial (but it can sometimes be a tribulation). *Journal of Consulting and Clinical Psychology*, *64*, 92-103. doi.org/10.1037/0022-006X.64.1.92

Elkin, I., Parloff, M.B., Hadley, S.W., & Autry, J.H. (1985). NIMH treatment of depression collaborative research program. Background and research plan. *Archives of General Psychiatry*, *42*, 305-316. doi: 10.1001/archpsyc.1985.01790260103013

Elkin, I., Shea, M.T., Watkins, J.T., Imber, S.D., Sotsky, S.M., Collins, J.F., Glass, D.R., …, & Parloff, M.B. (1989). National Institute of Mental Health Treatment of Depression Collaborative Research Program: general effectiveness of treatments. *Archives of General Psychiatry*, *46*, 971-982. doi: 10.1001/archpsyc.1989.01810110013002

First, M.B., Gibbon, M., Spitzer, R.L., Williams, J.B.W., & Benjamin, L.S. (1997). *SCID-II Structured Clinical Interview for DSM-IV Axis II disorders.* Washington, DC: American Psychiatric Press.

First, M.B., Spitzer, R.L., Gibbon, M., & Williams, J.B.W. (1997). *SCID-I Structured Clinical Interview for DSM-IV Axis I disorders*. Washington, DC: American Psychiatric Press.

Fonagy, P. (1993). Psychoanalytic and empirical approaches to developmental psychopathology: can they be usefully integrated? *Journal of the Royal Society of Medicine*, *86*, 577-581.

Fonagy, P. (2015). The effectiveness of psychodynamic psychotherapies: an update. *World Psychiatry*, *14*, 137-150. doi: 10.1002/wps.20235

Freud, S. (1915). Mourning and melancholia (pp. 243-257). In J. Strachey (Ed.) *The standard edition of the complete psychological works of Sigmund Freud - vol. XIV*. London: The Hogarth Press & the Institute of Psycho-Analysis.

Gabbard, G.O. (2000). *Psychodynamic psychiatry in clinical practice*. Washington, DC: American Psychiatric Press.

Gallagher-Thompson, D., & Steffen, A.M. (1994). Comparative effects of cognitive-behavioral and brief psychodynamic psychotherapies for depressed family caregivers. *Journal of Consulting and Clinical Psychology*, *62*, 543-549. doi: 10.1037/0022-006X.62.3.543

Hamilton, M. (1960). A rating scale for depression. *Journal of Neurology Neurosurgery and Psychiatry*, *23*, 56-62. doi:10.1136/jnnp.23.1.56

Hilsenroth, M.J., Ackerman, S.J., Blagys, M.D., Baity, M.R., & Mooney, M.A. (2003). Short-term psychodynamic psychotherapy for depression: an examination of statistical, clinically significant, & technique-specific change. *Journal of Nervous and Mental Disease*, *191*, 349-357. doi: 10.1097/01.NMD.0000071582.11781.67

Hirschfeld, R.M.A. (1999). Personality disorders and depression: comorbidity. *Depression and Anxiety*, *10*, 142-146. doi: 10.1002/(SICI)1520-6394(1999)10:4<142::AID-DA2>3.0.CO;2-Q

Hirschfeld, R.M.A., Klerman, G.L., Clayton, P.J., & Keller, M.B. (1983). Personality and depression. Empirical findings. *Depression and Anxiety*, *40*, 993-998. doi: 10.1001/archpsyc.1983.01790080075010

Hollon, S.D., Thase, M.E., & Markowitz, J.C. (2002). Treatment and prevention of depression. *Psychological Science in the Public Interest*, *3*, 39-77. doi: 10.1111/1529-1006.00008

Horowitz, M. (1993). Personality Structure & the Process of Change During Psychoanalysis (pp. 1-28). In M. Horowitz, O.F. Kernberg & E.M. Weinshel (Eds.) *Psychic structure & psychic change: essays in honor of Robert S. Wallerstein, M.D.* Madison, CT: International University Press.

Jakobsen, J.C., Hansen J.L., Simonsen, E., & Gluud, C. (2011). The effect of interpersonal psychotherapy & other psychodynamic therapies versus 'treatment as usual' in patients with major depressive disorder. *PLoS One*, *6,* e19044. doi: 10.1371/annotation/d74286e2-e872-4a7b-87d1-dfa230ff612d

Jakobsen, J.C., Hansen, J.L., Storebø, O.J., Simonsen, E., & Gluud, C. (2011). The effects of cognitive therapy versus 'treatment as usual' in patients with major depressive disorder. *PLoS One* 6, e22890. doi: 10.1371/journal.pone.0022890

Jacobson, E. (1971). *Depression: comparative studies of normal, neurotic, and psychotic conditions.* New York: International Universities Press.

Jacobson, N.S., & Hollon, S.D. (1996). Cognitive-behavior therapy versus pharmacotherapy: now that the juri's returned its verdict, it's time to present the rest of the evidence. *Journal of Consulting and Clinical Psychology*, *64*, 74-80. doi: 10.1037/0022-006X.64.1.74

Johnson, J.G., Cohen, P., Kasen, S., & Brook, J.S. (2005). Personality disorder traits associated with risk for unipolar depression during middle adulthood. *Psychiatry Research*, *136*, 113-121. doi:10.1016/j.psychres.2005.02.007

Kächele, H., Schachter, J., & Thomä, H. (eds) (2009). *From psychoanalytic narrative to empirical single case research.* New York: Routledge.

Kazdin, A.E. (1982). *Single case research designs.* New York: Oxford University Press.

Kendall, P.C., Holmbeck, G., & Verduin, T. (2004). Methodology, Design & Evaluation in Psychotherapy Research (pp. 16-43). In M.J. Lambert (Ed.) *Bergin and Garfield's Handbook of psychotherapy and behavior change*. New York: John Wiley & Sons.

Klein, M.H., Wonderlich, S., & Shea, M.T. (1993). Model of relationships between personality and depression: toward a framework for theory and research (pp. 1-54). In M.H. Klein, D.J. Kupfer, & M.T. Shea (Eds.) *Personality and depression: a current view*. New York: Guilford.

Koenisberg, H.W., Kaplan, R.D., Gilmore, M.M., & Cooper, A.M. (1985). *The relationship between syndrome and personality disorder in DSM-II: experience with 2.462 patients*. *American Journal of Psychiatry*, *142*, 207-212.

Lambert, M.J., & Ogles, B.M. (2004). The Efficacy & Effec-

tiveness of Psychotherapy (pp. 139-193). In M.J. Lambert (Ed.) *Bergin & Garfield's Handbook of Psychotherapy & Behavior Change*. New York: John Wiley & Sons.

Levy, K.N., Blatt, S.J., & Shaver, P.R. (1998). Attachment styles and parental representations. *Journal of Personality and Social Psychology*, *74*, 407-419. doi: http://dx.doi.org/10.1037/0022-3514.74.2.407

Levy, R.A., Ablon, J.S., & Kächele, H. (eds) (2012). *Psychodynamic psychotherapy research. Evidence-based practice and practice-based evidence*. New York, Dordrecht, Heidelberg, London: Springer. doi: 10.1007/978-1-60761-792-1_31

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: a manual for supportive-expressive treatment.* New York: Basic Books.

Luyten, P. (2014). Finally moving beyond the horse race: CBT and psychodynamic therapy equally effective for depression. *Evid Based Mental Health*, *17*, 118. doi: 10.1136/eb-2014-101770

Luyten, P., & Blatt, S.J. (2012). Psychodynamic treatment of depression. *Psychiatrics Clinics of North America*, *35*, 111-129. doi:10.1016/j.psc.2012.01.001

Luyten, P., & Blatt, S.J. (2013). Interpersonal relatedness and self-definition in normal and disrupted personality development: retrospect and prospect. *American Psychologist*, *68*, 172-183. doi:10.1037/a0032243

Luyten, P., Sabbe, B., Blatt, S.J., Meganck, S., Jansen, B., De Grave, C., Maes, F., & Corveleyn, J. (2007). Dependency and self-criticism: relationship with major depressive disorder, severity of depression, and clinical presentation. *Depression and Anxiety*, *24*, 586-596. doi: 10.1002/da.20272

Meyer, B., Pilkonis, P.A., Proietti, J.M., Heape, C.L., & Egan, M. (2001). Attachment styles and personality disorders as predictors of symptom course. *Journal of Personality Disorders*, *15*, 371-389. doi: 10.1521/pedi.15.5.371.19200

Moran, G.S., & Fonagy, P. (1987). Psychoanalysis and diabetic control: a single-case study. *British Journal of Medical Psychology*, *60*, 357-372. doi: 10.1111/j.2044-8341.1987.tb02755.x

Mulder, R.T. (2002). Personality pathology and treatment outcome in major depression: a review. *American Journal of Psychiatry*, *159*, 359-371. doi: 10.1192/bjp.189.2.186b

Mullen, L.S., Blanco, C., Vaughan, S.C., Vaughan, R., & Roose, S.P. (1999). Defence mechanisms and personality in depression. *Depression and Anxiety*, *10*, 168-174. doi: 10.1002/(SICI)1520-6394

Newton-Howes, G., Tyrer, P., & Johnson, T. (2006). Personality disorder and the outcome of depression: meta-analysis of published studies. *British Journal of Psychiatry*, *188*, 13-20.

Newton-Howes, G., Tyrer, P., Johnson, T., Mulder, R., Kool, S., Dekker, J., & Schoevers, R. (2014). Influence of personality on the outcome of treatment in depression: systematic review and meta-analysis. *Journal of Personality Disorders*, *28*, 577-593. doi: 10.1521/pedi_2013_27_070

Oasi, O. (2015). Observing the determinants of the psychotherapeutic process in depressive disorders. A clinical case study within a psychodynamic approach. *Frontiers in Psychology*, *6*, 477. doi:10.3389/fpsycg.2015.00477

Ouimette, P.C., & Klein, D.N. (1993). Convergence of psychoanalytic and cognitive-behavioral theories of depression: a review of the empirical literature and new data on Blatt's & Beck's models (pp. 191-223). In J. Masling, & R. Bornstein (Eds.) *Psychoanalytic perspectives on psychopathology.* Washington, DC: American Psychological Association.

Ouimette, P.C., Klein, D.N., Anderson, R., Riso, L.P., & Lizardi, H. (1994). Relationship of sociotropy/autonomy & dependency/self-criticism to DSM-III-R personality disorders. *Journal of Abnormal Psychology*, *103*, 743-749.

PDM Task Force (2006). *Psychodynamic Diagnostic Manual (PDM).* Silver Spring, MD: Alliance of Psychoanalytic Organizations.

Peeters, F., Huibers, M., Roelofs, J., van Breukelen, G., Hollon, S.D., Markowitz, J.C., van Os, J., & Arntz, A. (2013). The clinical effectiveness of evidence-based interventions for depression: a pragmatic trial in routine practice. *Journal of Affective Disorders*, *145*, 349-355. doi: 10.1016/j.jad.2012.08.022

Perry, J.C. (1991). *Defence Mechanisms Rating Scale.* Boston: Cambridge Hospital-Harvard Medical School.

Perry, J.C., & Bond, M. (2012). Change in defence mechanisms during long-term dynamic psychotherapy & five-year outcome. *American Journal of Psychiatry*, *169*, 916-925. doi: 10.1176/appi.ajp.2012.11091403

Perry, J.C., Hoglend, P., Shear, K., Vaillant, G.E., Horowitz, M., Kardos, M.E., Bille, H., & Kagan, D. (1998). Field trial of a diagnostic axis for defence mechanisms for DSM-IV. *Journal of Personalitt Disorders*, *12*, 56-68.

Perry, J.C., & Kardos, M.E. (1995). A review of the Defence Mechanism Rating Scale (pp. 283-299). In H.R. Conte, & R. Plutchick (Eds.) *Ego defences: theory and measurement*. New York: John Wiley & Sons.

Perry, J.C., Kardos, M.E., & Pagano, C.J. (1993). The study of defences in psychotherapy using the Defence Mechanism Rating Scale DMRS (pp. 122-132). In U. Hentschel, & W. Ehlers (Eds.) *The concept of defence mechanisms in contemporary psychology: theoretical, research & clinical perspectives*. New York, Berlin, Heidelberg: Springer.

Pfohl, B., Black, D.W., Noyes, R., Coryell, & W.H., & Barrash, J. (1990). Axis I/Axis II comorbidity findings: implications for validity (pp. 147-161). In J.M. Oldham (Ed.) *Personality disorders: new perspectives on diagnostic validity*. Washington, DC: American Psychiatric Association Press.

Pilkonis, P.A., & Frank, E. (1988). Personality pathology in recurrent depression: nature, prevalence, & relationship to treatment response. *American Journal of Psychiatry*, *145*, 435-441.

Porcerelli, J.H., Dauphin, V.B., Ablon, J.S., Leitman, S., & Bambery M. (2007). Psychoanalysis with avoidant personality disorder: a systematic case study. *Psychotherapy (Chic)*, *44*, 1-13. doi: 10.1037/0033-3204.44.1.1

Quilty, L.C., McBride, C., & Bagby, R.M. (2008). Evidence for the cognitive mediational model of cognitive behavioral therapy for depression. *Psychological Medicine*, *38*, 1531-1541. doi: 10.1017/S0033291708003772

Reis, S., & Grenyer, B.F.S. (2002). Pathways to anaclitic and introjective depression. *Psychology Psychotherapy*, *75*, 445-459. doi: 10.1348/147608302321151934

Roth, A., & Fonagy, P. (1996). *What works for whom? A review of psychotherapy research*. New York: Guilford Press.

Sato, T., Sakado, K., Sato, S., & Morikawa, T. (1994). Cluster A personality disorder: a marker of worse treatment outcome of major depression? *Psychiatry Research*, *53*, 153-159. doi:10.1016/0165-1781(94)90106-6

Serretti, A., Calati, R., Oasi, O., De Ronchi, D., & Colombo, C. (2007). Dissecting the determinants of depressive disorders outcome: an in depth analysis of two clinical cases. *Annals of General Psychiatry*, *7*(6):5. doi 10.1186/1744-859X-6-5

Shapiro, D.A., Barkham, M., Rees, A., Hardy, G.E., Reynolds,

S., & Startup, M. (1994). Effects of treatment duration and severity of depression on the effectiveness of cognitive-behavioral & psychodynamic-interpersonal psychotherapy. *Journal of Consulting and Clinical Psychology*, *62*, 522-534. doi: 10.1037/0022-006X.62.3.522

Shapiro, D.A., Rees, A., Barkham, M., Hardy, G., Reynolds, S., & Startup, M. (1995). Effects of treatment duration and severity of depression on the maintenance of gains after cognitive-behavioral and psychodynamic-interpersonal psychotherapy. *Journal of Consulting and Clinical Psychology*, *63*, 378-387. doi: 10.1037/0022-006X.63.3.378

Shea, M.T., Glass, D., Pilkonis, P.A., Watkins, J., & Docherty, J.P. (1987). Frequency and implications of personality disorders in a sample of depressed outpatients. *Journal of Personality Disorders*, *1*, 27-42. doi: 10.1521/pedi.1987.1.1.27

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

Shedler, J., Westen, D., & Lingiardi, V. (2014). *La valutazione della personalità con la SWAP-200.* Milano: Raffaello Cortina Editore.

Stone, L. (1986). Psychoanalytic observations on the pathology of depressive illness: selected spheres of ambiguity or disagreement. *Journal of American Psychoanalitical Association, 34*, 329-362. doi: 10.1177/000306518603400205

Straccamore, F., Ruggi, S., Lingiardi, V., Zanardi, R., Vecchi, S., & Oasi, O. (2017). Personality factors and depressive configurations. an exploratory study in an Italian clinical sample. *Frontiers in Psychology, 8*, 251. doi: 10.3389/fpsyg.2017.00251

Sullivan, H.S. (1953). *The interpersonal theory of psychiatry*. New York & London: Norton.

Wallerstein, R.S. (1995). *The talking cures. The Psychoanalyses & the Psychotherapies*. New Haven, CT & London: Yale University Press.

Werbart, A., & Forsström, D. (2014). Changes in anaclitic-introjective personality dimensions, outcomes and psychoanalytic technique: a multi-case study. *Psychoanalitic Psychotherapy, 28*, 397-410. doi: 10.1080/02668734.2014.964295

Westen, D., & Shedler, J. (1999a). Revising and assessing Axis II, Part 1: developing a clinically and empirically valid assessment method. *American Journal of Psychiatry, 156*, 258-272. doi: 10.1176/ajp.156.2.258

Westen, D., & Shedler, J. (1999b). Revising and assessing Axis II, Part 2: toward an empirically based and clinically useful classification of personality disorders. *American Journal of Psychiatry, 156*, 273-285. doi: 10.1176/ajp.156.2.273

Widiger, T.A. (1993). Personality and depression: assessment issues (pp. 77-118). In M.H. Klein, D.J. Kupfer, & M.T. Shea (Eds.) *Personality and depression: a current view*. New York: Guilford.

Zuroff, D.C., & Fitzpatrick, D. (1995). Depressive personality styles: implications for adult attachment. *Personality and Individual Differences*, *18*, 253-265. doi:10.108869(94)00136-G