Psychodynamic diagnosis and evaluation of the mental state related to attachment: a protocol for assessment and planning of the psychotherapy intervention in the context of the public service

by Elisabetta Iberni[*], Valeria Crisafulli[**], Alessandra De Coro[***].

1. Evaluation and empirical study of psychotherapy in the public services

Since the last quarter of the 20th century, there has been a growing need among professional mental health workers in Italy to use, alongside clinical work, empirical research on the effectiveness of the psychotherapies. This change has not only been imposed by a series of laws designed to evaluate and quantify the quality of the public health service, but it is also the result of the gradual coming together and integration between clinical practice and scientific method in the strict sense.
From the legislative point of view, since the early ‘90s there has been a series of new laws designed to enable the Mental Health Departments (Dipartimenti di Salute Mentale - DSM) to demonstrate the quality, effectiveness and efficiency of the interventions they provide.
Decree n. 502 of 30.11.92, with its later additions in Decree n.517 of 7.12.93, expressed the “reorganization and control of health” introducing managerial criteria for the running of the National Health Service (Servizio Sanitario Nazionale - SSN) and placing particular emphasis on the construction of evaluation systems through “the method of testing and review of quality and quantity” and the use of “indicators of efficiency and quality” (art.10).
It was the legislative level that explicitly introduced terms such as *information flow, quality control, tools and methodologies for the testing of results, systems of indicators, allocation of funds to research and to special programmes concerning management issues, evaluation of services, issues of communication and relations with the citizenry.*
The Higher Health Institute (Istituto Superiore di Sanità - ISS), immediately activated various national research projects funded by the Health Ministry and supported by different scientific associations and local initiatives. This type of evaluation spread very rapidly and is still expanding.
In support of the spread of empirical research work in the public health services there was the next Decree, n.229 of 18.6.99, “Rules for the Rationalization of the National Health Service”, which, as well as confirming the previous approach, emphasises the importance of the role of quality control and review of results, particularly in relation to the concept of Essential Assistance Levels (LEA). The aim of these laws was not only to improve the health services offered, but also to cut costs and, above all, waste.
As far as psychotherapy is concerned, this was of particular interest to researchers: the new discoveries in the neuroscientific and pharmacological field make it necessary to produce *evident* proof of the positive effect of the psychotherapies, which would otherwise be considered superfluous for the purposes of treatment.
On this issue, the Mental Health Objectives Project 1998-2000 underlines the importance of “spreading the culture of evaluation, also by means of indicators, especially concerning process and outcome”, which is indicated as one of the activities that the Health Ministry, the Regional and Provincial Authorities must promote through their own technical-scientific bodies, Universities and other research organizations.
The change and transformations of recent years are not however only political in character; in fact, parallel to these legislative initiatives, for the purpose of promoting the introduction of empirical evaluation in the public services, the scientific community

---

[*] Specialist in Clinical Psychology, PhD. student at the Department of Dynamic and Clinical Psychology, University of Rome “La Sapienza”.
[**] Valeria Crisafulli: scientific collaborator in the Department of Dynamic and Clinical Psychology, University of Rome “La Sapienza”.
[***] Director of the Department of Dynamic and Clinical Psychology, University of Rome “La Sapienza”.

has affirmed a new epistemological paradigm for the analysis of the quality of clinical practice: Evidence Based Mental Health. In this context there is therefore the fostering of the belief that clinical experience, in the mental health sector, must be supported by directions and orders deriving from methodologically appropriate studies and from the debating of properly validated research and experimentation results (Carli & Pintarelli, 2005).
These attempts to change have had quite a strong impact on the situation in the Mental Health Department, in that the operators found themselves managing an area (empirical evaluation) that was not their competence and for which they were therefore untrained; up to then in fact the operator was the only judge of the service he himself had carried out. This revolution, with the limits and difficulties involved in its practical application, introduces an innovation in working style which, although it may seem onerous, guarantees higher quality and a fruitful interest in Continuous Quality Improvement (MCQ).
The psychotherapy research carried out in the public services on the one hand responds to legal requirements, and on the other is witness to a cultural shift both among clinicians working for years in the sector, and among researchers who up to now had almost always conducted their experiments in their laboratories.
The psychotherapy research conducted by the Mental Health Department (DSM) has to reconcile methodological requirements, so as to guarantee a degree of scientific rigour, with attention to the context, respecting the work of care and understanding towards psychiatric and psychological suffering. These considerations make it necessary for the research model to adapt to the context in which it is applied, accepting the methodological constraints that this involves. The goal is to obtain repeatable results without the research becoming an intrusive agent within the service in general, and in particular in the therapeutic relationship.
The goals and the methodology of an investigation carried out in a DSM must take account of various aspects, of which the basic ones are: the researchers' theoretical orientation and their criteria of healing, which must be opportunely expressed, and the various objectives that the service itself fixes for the treatments it offers.
One of the most widely-used models of empirical evaluation of psychotherapy in the public services is the *effectiveness* test: projects of this type respond to the epistemological paradigm of "evidence based medicine". The objective of this model, typical of the early psychotherapy research of the 1950s, is that of identifying the most effective therapeutic technique. The research project is therefore designed with the control of all the variables of the disorder, dividing the experimental sample from the control sample and manipulating only the independent variable, which in this case is the treatment in the public services. Although *randomized clinical trials* are very reliable and guarantee validity in the research, many contemporary researchers believe they lack external validity and risk giving results that do not reflect the reality of the context. A randomized experimental study, in fact, does not consider certain factors typical of the places where treatments are applied, which are major factors in the success of the treatment itself (Fava & Masserini, 2002). On this question, one should mention the five main variables that these studies do not consider: 1) psychotherapy has a variable duration; 2) treatments may self-correct in the course of administration; 3) it is often the patients who choose the type of treatment and the therapist; 4) real patients often present multiple diagnoses; 5) psychotherapy seeks a functional improvement in the patient, not just the disappearance of the symptoms (Seligman, 1995).
More generally, although studies on efficacy are repeatable, use an adequate sample and are economical, they do not consider specific and non-specific therapeutic factors, have difficulty confuting the null hypothesis in a uniform manner, and are exposed to all the risks connected to standardization of treatments (Wamplod, 1997).
In the field of planning and evaluation of the public psychotherapy service there are various attempts to get round these limits: *observational studies*, which have greater internal validity (Rosemberg & Perring, 1996); *long simple trials*, *firm trials*, *projects with selected cohorts*, which try to combine the clinical trial method with studies on the

real effectiveness or on the treatments actually used in the local area (Barbui, 2001; Grossi, 1997); *analysis based on point of view* or *perspective analysis* (Danzin & Lincoln, 2000; Mc Leod, 2000; Seligman, 1995).
These models, however, should be placed among the *studies on the outcome* of psychotherapies and, although they set out to limit the *bias* due to standardization, their goal is always to evaluate the effectiveness of treatment.
Studying the process, on the other hand, while being the safest way to obtain information to improve the quality and specificity of treatments (Luborsky, 1985), is less common in the work of empirical evaluation of psychotherapy offered by the DSM, due to constraints of an ethical and practical type which are difficult to overcome.
On the methodological level, a fundamental decision for research work is that of the choice of tools to adopt (Fava & Masserini, 2002). One limit of research in the public services may be the experimenter's theoretical and ideological orientation; this in fact underlies the decision on whether to adopt one instrument rather than another.
Moreover, the theoretical construct of reference gives a specific meaning to research results which, for this very reason, cannot be extended to projects based on different assumptions.
There are various possible options for the choice of tools: *self-administered* and *hetero-administered*; those that analyse *symptomatic variation* or that make a *functional evaluation*; *one-dimensional* or *multidimensional* tools; tools that are *the same for any type of treatment* or those that evaluate *the goals of a specific treatment;* tools that take account of the *patient's point of view* or those that refer to *standard mental health criteria*; *simpler* or *more complex* tools; *more common* tools or *more particular* ones; tools that evaluate *outcomes* or those oriented towards *process* evaluation; tools that are of high or low *theoretical content.*
If the aim of the study is to evaluate the overall service offered by the DSM, it is preferable to consider tools more suited to *multidimensional* studies, which offer a panorama on the change undergone by the patient on different levels. A public service, in fact, does not provide a single service and often every patient uses multiple treatments directed both to specific improvements and more general aims. These are addressed to the patient's environment and family context, which are variables to be taken seriously during the planning of the research project. A *multidimensional* study can also use different *one-dimensional* tools, as for instance in the Outcome Project started by Mirella Ruggeri (2000) in the Psychiatric Service of South Verona, which measured: the patients' global functioning (GAF), the psychopathology (BPRS), the social disability (DAS II), the need for care (Camberwell Assessment of Needs-CAN), the quality of life (LQL-Lancashire Quality Life Profile) and the patients' satisfaction (Verona Service Satisfaction Scale VSSS-54).
Another example is the study organized by Freni, Azzone, Bartocetti, Verga and Vigono (2000) with the aim of constructing an applicable and administrable protocol in the specific operative conditions of the Psychotherapy Service of the Institute of Clinical Psychiatry at the University of Milan. This study adopts the multidimensional approach to evaluation of the outcomes and processes of treatment and analyses different areas using a plurality of *one-dimensional* tools. For the area of patient personality: Perry and Cooper's Defence Mechanisms Rating Scale (1986), the Core Conflictual Relationship Theme Method of Luborsky and Crits-Christoph (1990), Horowitz's Inventory of Interpersonal Problems (Horowitz, Rosenberg, Ureno, Kalehzan, & O'Halloran, 1988) and Clark's Inventory of Personality Organization (unpublished). For the area of the patient's disorder: Multiaxial Diagnosis according to DSM IV (American Psychiatric Association, 1994), the Symptom Check List Revised (Derogatis, 1977), the Brief Psychiatric Rating Scale (Overall & Gohram, 1962) and the Health-Sickness_Rating Scale (Luborsky, 1975).
Research on the psychotherapies provided by the DSM can also use the *twin_rating system* (self and hetero), to avoid the limits of *self-administered* and *hetero-administered* tools. While the former limit the experimenter's *bias*, they do not get round the problems about the reliability of the patient's responses; on the other hand,

the second type can suffer from the distortions of the *rater* (whether or not s/he is a therapist), who often does not have access to an adequate amount of data about the patient and could "hope for" results of a certain kind.
An ideal study would have measures that are standardized and easy to apply, that give genuinely significant results from a clinical point of view and that have the power to evaluate multiple complex variables (Fava & Masserini, 2002).

2. A proposal for assessment and planning of the intervention in the institutional context: towards the evaluation of the psychotherapy process.

Within the Mental Health Department (DSM), the CSM (Centro di Salute Mentale/Mental Health Centre) carries out activities of reception, diagnosis, case acceptance and of psychological-psychotherapeutic intervention for the local area.
The possibility in an institutional context of providing therapeutic interventions calibrated to the patient's needs is often limited due to the interaction of a great many contextual factors including the lack of structured protocols of psychodiagnostic evaluation. This prevents the goals of the intervention from being clarified and the outcomes of the psychotherapy form being evaluated.
It seems important to underline that a link can be found between this lack of tools and the widespread use, in public service practice, of DSM IV and ICD X.
The international diagnostic classifications present major limitations since they provide no indications for treatment, being based on a descriptive, categorial model.
Westen (1998) observed that the simplicity and ease of classification and recognition of disorders often involves some risks, such as *labelling* and *comorbidity* of disorders diagnosed with reference both to Axis I and Axis II.
The area of personality disorders, in particular, is frequently neglected with the use of the descriptive system, which tends to split the process of formulating the case from that of diagnosis.
Barron (1998) underlined the need to "give the diagnosis a meaning", so that it provides a more accurate evaluation of the affective, cognitive and behavioural functions that interact in certain conditions and that are important for psychological and social adjustment.
In the routine practice of the public services, the effect of the use of the descriptive-categorial system has been the subject of research which highlighted the fact that at times psychotherapy is considered an elective treatment due to a diagnostic custom concerning whether or not to use certain nosographical codes that do not, in themselves, imply any indication or guideline for the work of the clinician (Bittanti, Nazzani, & Gaddi, 1998).
Introducing a methodology for diagnostic evaluation that is useful for the formulation of the clinical case and for the planning of the intervention is fundamental for the later testing of the outcome of the intervention.
Empirical research can be fruitfully introduced in the public service both to fulfil the desires of the institution to introduce indicators and parameters of effectiveness and quality of the service offered, and to contribute to the work of the operators concerning the clarity, coherence and grounded ness of the procedures adopted.

Method

The research protocol is designed to integrate the two methods of observation, borrowing from *single-case* design, best suited to focusing on the complexity of the clinical encounter while maintaining methodological rigour.
In the formulation of the clinical case, use is made not only of a rating tool of psychological psychodynamic aspects (OPD, Operationalized Psychodynamic Diagnosis), but also of the Adult Attachment Interview, in order to integrate the collection of anamnestic information and to formulate hypotheses in an on-going key.

The introduction of the attachment interview protocol is particularly useful for various reasons: 1) it constitutes a space for the narration of one's own story which fosters and supports reflection, revealing the predisposition for a possible psychotherapy intervention (Holmes, 1993); 2) "surprising the unconscious" (Hesse, 1996); it offers a chance to understand the defensive strategies towards one's consciousness and affective regulation in response to stressful or painful events (Solomon & George, 1999); 3) it makes it possible to identify particular disorganized or dissociated mental states established in traumatic conditions, which affect the motivational system of attachment (loss and abuse) determining the development of the psychopathological (Liotti, 2006); 4) it can be a reference point for the evaluation of change and, since intersubjective dynamics play a central role in the connection of dissociated mental states, it is useful for establishing the appropriate psychotherapy strategy (Holmes, 2001).

Sample

The subjects (currently 20), came to a Mental Health Centre to ask for therapy. After the initial reception interview, they agreed to participate in a cycle of four evaluation interviews and they gave permission for their data to be used. The criteria for inclusion in the sample are: age between 21 and 60, evenly spread socio-cultural background, females slightly over-represented, exclusion of psychotic disorders, diagnosis in axis II. The operators are psychiatrists and psychologists with a psychodynamic or systemic-family orientation. They all have over ten years experience.

Tools

The diagnosis of the subjects was evaluated by the clinicians on DSM IV criteria after two interviews. SCID II was used for the evaluation of axis II disorders.
The transcription of the interviews was rated with the *Operationalized Psychodynamic Diagnosis* (Group OPD, 1992); for a precise description of the tools, see the text. The multiaxial organization covers 5 dimensions: 1) experience of illness and assumptions for treatment; 2) relations; 3) conflicts; 4) structure, which in turn regards six sub dimensions: self perception, self-regulation, defences, object perception, communication, bonding); 5) mental and psychosomatic disorders, corresponding to DSM IV Diagnosis or ICD XI.
The *Adult Attachment Interview* was coded using the Main and Goldwyn method (1998) by an expert judge. The coding of the AAI is carried out by assigning a score on 5 scales related to the probable childhood experience with the mother and with the father and with 9 mind scales which provide the final classification on the present mental state concerning attachment in four or eleven categories (distancing, secure, preoccupied, disorganized).

Procedure

The series of four evaluation interviews, after the initial reception interview, included two psycho diagnostic conversations, the administration of the Adult Attachment Interview, an encounter of restitution and reformulation of the case with any therapeutic instructions. The interviews, taped, were transcribed according to the rules (Mergenthaler & Stinson, 1992). Two trained judges evaluated the diagnostic interviews (IIR= .91); the attachment interview was assessed by an expert judge.
The judges also evaluated the attachment interview using the Relational Axis of the OPD.
The data obtained on a point scale were qualitatively analysed in order to formulate on-going hypotheses on the diagnosis.

Results

Michele, 45 years of age, clerk in a multinational, married with two teenage children. The diagnosis made at the beginning of the evaluation, according to the tools and criteria used, reveals the following clinical condition:

Diagnosis according to DSM IV

Axis I: Type 1 Bipolar Disorder, with moderate episode of depression 296.52
Axis II: Narcissistic personality disorder with obsessive traits 301.81 (SCID axis II)
Axis III: High blood pressure
Axis IV: no relevant event
Axis V: GAF 65

Operationalized Psychodynamic Diagnosis

Experience of illness
The *seriousness of the organic and psychic situation* presented seems high since the patient states that he manages his frequent moments of anxiety and depression through the frequent induction of vomiting, a practice which has caused internal intestinal lesions. This condition involves a high level of *subjective suffering*, as well as a highly *compromised experience of self on the physical and psychic plane and in social relations.* The secondary advantage of the illness is low. Capacities of psychosomatic insight appear to be absent, the *somatopsychic insight* is average. The *evaluation of medical treatment* as the most suitable is high, as is the patient's motivation. The *psychotherapy treatment* is not very suitable both in the clinician's evaluation and for the patient's motivation. Compliance appears low, *somatic symptoms* and *psychic symptoms* are both extremely central. The patient's integration in the family, work and broader social context appears to be average, personal resources are average, as is the social support received. The *sense of subjective limitation* before the dimensions of the disorder appears to be limited.

Relations
The *patient's subjective experience* **is based on the habit of helping, caring, and excessively protecting others(3), he feels he submits and adapts to their needs (22) and is resigned to sacrificing himself (24), on the other hand he perceives others as always demanding and expecting from him (5), ready to accuse him or blame him (8) if he does not satisfy them, or to ignore him (14).**
Others*, including the therapist***, feel that the patient, rather than helping and caring, actually tries to dominate and command (6), accusing and blaming others if they do not follow his instructions and arrangements (8), and that he tends to place himself excessively at the centre of attention (19).** Towards the patient, others **tend to react in different ways that may contribute to worsening some of the patient's lived experiences: they tend to let things be, in resignation (15), in order to let the patient see them as he wants, they submit and adapt (22), and the patient feels ignored, or otherwise they oppose and challenge him (16), and the patient feels accused and blamed.**

***The evaluation of the relational axis applied to the attachment interview* gave the following information:** towards the mother**: the patient feels in his own subjective experience that he repeatedly tried to help and care for his mother (17), she placed herself excessively at the centre of attention (19); the patient feels that his mother controlled him suspiciously (7), she looked after him and protected him excessively(3), she humiliated and belittled him (9); he tended to submit and adapt before his mother (22), and to surrender in resignation (24). According to the evaluation of the external observer, the mother cared for and protected him excessively(3), she made demands and had expectations (5), she dominated and commanded him (6). For the present relationship the description of the items is confirmed.**
Towards the father**, he reports in his subjective experience the tendency to admire and**

idealize his father excessively(1), he trusted and depended on him excessively(20), he belittled himself and gave way before him (23); the patient also feels that the father gave him instructions and was patronising (4), he had expectations and made demands of him (5), he ignored him (14); towards the patient, the father tended to reject him (7), he accused and blamed him (8), he gave him orders and instructions (4). In the assessment by the external observer, towards the father, the patient tends (both in the past and at present) to idealize and admire him excessively(1), he tries to reduce and reconcile contradictions and negative experiences (25), to submit and adapt (22) to his demands.

Conflicts
The patient uses both active and passive modes of elaboration, experiencing the *conflict of control and submission* **with respect to his family relations with his mother, his family and his work context. On the plane of consciousness, the patient perceives himself as incapable of saying no, of asserting himself over others' points of view, following the rules of life learnt from his father. From the narrations of relational episodes in different contexts, it emerges that the patient's way of acting out is constantly aimed at the control and management of external situations involving others, in order to help and protect them. The** *second conflict* **which is extremely significant is that of** *self-esteem* **concerning his own value in relation to that of others. It seems that the modality of protectiveness and constant worry for the needs and requirements of others, apart from being the manifestation of a conflict of caring/self-sufficiency, is a strategy to maintain the role of protector and saviour, which increases his sense of inner self-esteem. However, the subject seems to have a slight perception of his own conflicts, which is expressed on the plane of action at the expense of mentalization.**

Structure
The patient has a moderately integrated self-perception **(2,5), he has difficulty developing a coherent image of himself, differentiated from his affects, especially anxiety, rage, self-denigration and ambivalence; the** self-regulatory modalities **appear to be poorly integrated (3) (the practice of inducing vomiting is impulsive and self-punishing, the level of self-esteem is extremely fragile, swinging between the tendency to punish himself and to give grandiose self representations), the main** defences **are located at a low level of integration (3) since they are oriented to distorting his self-image and that of objects and to denying his own inner and outer reality.** *Object perception* **is very limited (3), others are perceived either as persecutors or are extremely idealized. The** *communication capacities* **are however moderately integrated although disturbed, since what prevails is the willingness to communicate his own conflicts and his own state of malaise (2). The** *bonding* **shows little integration (3): few good relations have been internalized, inner objects punish and belittle and there is extreme dependence on external objects.** *The overall evaluation of the patient's structure* **is of little integration (3): inner space and the reflective function are poorly developed, regulatory functions are greatly reduced, conflicts are located in the interpersonal sphere more than in the intrapsychic sphere.**

Adult Attachment Interview

The present mental state towards attachment is U/CC or Not Resolved with respect to his father's death and Non Classifiable given the co-presence of two distinct patterns of attachment. Regarding the relationship with his mother, the mental state is Preoccupied/Entangled with predominantly passive thought processes; regarding the relationship with the father the strong idealization of the relationship clearly prevails, contradicted in many points by incoherent relational episodes.
In particular, the scales considered provide the following information.
Probable infantile attachment scale: experiences of genuine tenderness with the mother and father appear to be moderately limited; towards the father figure there is an attitude of rejection, while towards the mother there is a pattern of entanglement and of role inversion.

Scale of present mental state towards each parent: towards the mother the patient shows passivity in thought processes and there also emerge anger and a pejorative attitude to the relationship. Towards the father there prevails a very high level of idealization.
Assessment scale of present global mental state: the most significant elements found appear to be linked to the absence of metacognitive processes, to the pervasiveness of passivity in thought processes, and lastly to the gaps in the monitoring of cognitive processes concerning the failure to resolve loss and traumatic experiences such as threats and psychological pressures.
In particular, narrative coherence appears to be very low with intense violations of the greatest significance and quantity.
During the conversation, the narration often goes off on a tangent to dwell at length on other subjects far removed from those requested. Above all when there is reference to his own experience and the feelings it aroused in him, the patient is evasive and suspends the discourse by changing the subject.

Discussion

The protocol of diagnostically useful data collection enables different dimensions to be brought into focus related to the understanding of the clinical case.
The diagnosis according to the DSM IV in fact shows a Type 1 Bipolar Disorder, with a more recent episode of moderate depression. In axis II the diagnosis of Narcissistic Personality Disorder alone does not allow the clinician to draw up a comprehensive picture of the patient's psychic functioning and the possible interdependence of the emergence of the two psychopathological conditions.
The Operationalized Psychodynamic Diagnosis provides the clinician with a multidimensional vision of the patient's personality.
The *Structure* axis shows poor global integration, which is manifest particularly concerning the perception of the object, defences, the capacity to self-regulate emotions and communication. The *Conflicts* axis reveals two main conflictual nuclei. The first, concerning control and submission, leads the patient, in relationships, to see himself as passively submissive to the orders and requests of others; the second conflict, concerning self-esteem, leads the patient to continually satisfy external expectations in order to feel that he is capable of retaining a valid coherent sense of self. A third conflict, present but less crucial for the evaluation, concerns the care and self-sufficiency with which the patient tries to take care exclusively of the needs of others, completely isolating the perception of his own needs, which affects his self-regulatory capacities. Since the perception of conflicts is greatly reduced because of the poor capacities for reflection, the instructions for treatment show a low propensity towards psychotherapy.
The attachment interview confirms the observations that can be inferred through the OPD, enabling some on-going hypotheses on the disorder to be formulated, starting from the narratives on the (probable) relational experiences and from the observation of the defensive strategies dominating those characterizing the present mental state towards attachment. This standpoint is extremely important for the clinician who is to take on the case, since the therapeutic relationship can be seen as a relation of attachment. Knowing the patient's mental state towards attachment, as well as his communicative capacities and type of interiorized bonds, provides useful pointers for predicting the difficulties in constructing the therapeutic relationship and for planning fruitful strategies for a working alliance. In particular, the AAI shows points of convergence with the psychodynamic dimensions studied by the OPD in evaluating these areas.

1) *Relational experiences vs present relating pattern*. The application of the circumplex system (Benjamin, 1974) of the Relational axis both to the clinical

conversation and to the attachment interview, showed the continuity of some behaviour patterns and relational modes originating in the parental relationship. For instance the patient reports helping, caring for and protecting others to excess, a modality strongly connoting the relationship with the mother during infancy, featuring entanglement and role inversion. Michele also feels that he submits and adapts to the requirements of others, sacrificing himself. This relational pattern appears in memories and narrations as an adaptive modality for maintaining the relationship with both parents. At the time of the consultation, Michele feels that others have expectations, and either they accuse and blame him if he does not satisfy them or they ignore him.
The experience of being ignored or criticised generates a strong narcissistic anger, which as a consequence fosters a depressive experience concerning his sense of self. This cognitive and emotional pattern reflects the experience of paternal rejection that Michele rationalizes, blaming himself for having failed to live up to paternal expectations. Finally, towards the clinician Michele tends to act out the same relational modes through low level defence mechanisms. What others, including the clinician, experience before the patient is being controlled and pressured by the patient's demands and expectations, while Michele feels that he is generous in offering his care and attention.
The clinician feels he is submitting and adapting to the patient's demands and that he is accused whenever he does not fulfil them, a reaction of counter transference complementary to the patient's inner experience.

2) *Structure axis vs defence strategies*. The level of psychic structuring does not appear to be highly integrated, the defences are organized for low level functioning (narcissistic and borderline) although there remains an obsessive, neurotic level of defence. The mental state towards attachment in fact shows two distinct, contrasting patterns of defensive strategies concerning relational experiences: passivity of cognitive processes (mother) and idealization (father). This may be predictive of the difficulty in setting up a cooperative relationship with the therapist since the capacity to have a relationship of attachment has collapsed and is fragmentary.
3) *Unresolved loss and dissociated areas.* The attachment interview shows the non resolution of (paternal) loss. This situation would suggest the presence of dissociative thought processes (Liotti, 2006), which require particular attention and priority in planning the intervention and its objectives (Holmes, 2001).

4) *Self-regulation and reflective capacity*. The fragile regulation of self-esteem results in actions towards eating behaviour. The psychic space for reflection and tolerance of negative emotions is severely reduced and is also expressed at the level of interpersonal communication.

5) *Narrative incoherence and absence of metacognitive processes*. Interaction in dialogue appears to be particularly unbalanced, Michele talks incessantly, his thoughts either shift rapidly from one topic to another, or he starts long digressions on issues and episodes very remote form the questions. He does not seem to understand the intentions and states of the interlocutor, to whom he spontaneously attributes different intentions. These characteristics specify, in terms of interpersonal communicational dimension, his incapacity to psychologically differentiate himself from the other, and the dominance of projective identification mechanisms.

In conclusion, the observations coming from the combined use of Operationalized Psychodynamic Diagnosis and the attachment interview are designed firstly for understanding the working of the personality of the patient that develops and presents a bipolar disorder.

Secondly, the evaluation of the state of mind concerning attachment offers the clinician the chance to assess in advance the patient's capacity to collaborate with the therapy and consequently, allows him/her to adopt *ad hoc* measures.
For instance, establishing a multiple setting with two therapists as referents might reduce the tendency towards dropping out (Liotti, Farina, & Rainone, 2005); using pharmacological therapy along with psychotherapy can have an effect both of containing the depression symptoms and of supporting the functioning of the personality.
A non-classifiable mental state could be dealt with effectively through a curbing attitude, aimed at the reworking of the narrative episodes, helping to provide a more detailed and coherent description in a calm, secure tone (Holmes, 2001).
The advantages of the present study are related to the introduction of observational research to the institutional context.
This shift to a multidimensional approach is a new criterion for an understanding of the complexity and richness of the clinical reality. The proposal presented establishes an initial attempt at empirical research in this direction, which may open the way to the evaluation of the therapeutic process also within the public services. Apart from the aim of the research, the intention of this work is to apply diagnostic methods structured and organized in a protocol that can have a permanent educative effect also leading towards the self-supervision of clinical operations.
The tools used for assessment (OPD and Adult Attachment Interview) can be applied even if there is no audio-recording, in cases where the clinicians have had specific training.

References

American Psychiatric Association. (1980). *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.). Washington, D.C.: APA.

American Psychiatric Association. (1994). *Diagnostic and Statistic Manual of Mental Disorders* (4th ed.). Washington, D.C.: APA

Barbui, C. (2001). Per l'introduzione di attitudini di ricerca nella pratica quotidiana. *Rivista sperimentale di freniatria*, *125* (1), 13-22.

Barron, J.W. (1998). *Making Diagnosis Meaningful: Enhancing Evaluation and Treatment of Psychological Disorders.* American Psychological Association.

Benjamin, L.S. (1974). Structural analysis of social behavior*. Psychological Rev.*, *81*, 392-425.

Bittanti, E., Nazzani, R.G., & Gaddi, C. (1998). Un protocollo per l' attività psicodiagnostica e psicoterapeutica: Esperienza di registrazione dei casi clinici nell'azienda USSL 39 Milano. *Ricerca in psicoterapia 1* (1), 79-100.

Bowlby, J. (1988). *A secure base*. London: Routledge.

Cerbo, M. (2005). La Valutazione come strumento per il miglioramento della qualità. In M. Vigorelli (Ed.), *Il lavoro della Cura nelle Istituzioni* (pp. 220-223). Milano: FrancoAngeli.

Carli, L., & Pintarelli, M. (2005). Adattamento e uso dell'intervista microanalitica di Stern per l'analisi delle interazioni nel corso delle pratiche educative. In M. Vigorelli (Ed.), *Il lavoro della Cura nelle Istituzioni* (pp. 220-223). Milano: FrancoAngeli.

Dazzi, N., Lingiardi, V., & Colli, A. (Eds.) (2006). *La ricerca in psicoterapia*. Milano: Raffaello Cortina.

Del Corno, F., Lang, M. (1995). *Modelli di colloquio in psicologia clinica*. Milano: FrancoAngeli.

Danzin, N. K., & Lincoln, Y.S. (Eds.). (2000). *Handbook of qualitative research* (2nd ed.). Thousand Oaks: Sage.

Derogatis, L. R. (1977). *The SCL-90-R: Administration scoring and procedures* (Manual I). Baltimore: Clinical Psychometric Research.

Fava, E., & Masserini C., (2002). *Efficacia delle psicoterapie nel servizio pubblico: Il contributo della ricerca valutativa alla clinica*. Milano: Franco Angeli.

Freni, S., Azzone, P., Bartocetti, L.,Verga, M.C., & Vigono, V. (2000). L'esigenza di protocolli clinici adeguati a documentare i processi e gli esiti dei trattamenti psicoterapeutici in un Servizio di Psicoterapia Istituzionale. *Ricerca in Psicoterapia*, *3*, 90-116.

Gislon, M.C. (2002). *Il colloquio clinico e la diagnosi differenziale*. Torino: Bollati Boringhieri.

Grossi, E. (1997). Seminario presso la IV Cattedra di Clinica Psichiatrica dell'Università degli Studi di Milano. Unpublished manuscript.

Group OPD, (1992). *OPD, Operationalisierte Psychodynamische Diagnostik*. Bern: Verlag Hans Huber.

Helstone, F.S., & Van Zuuren, F.J. (1998). Assessment for psychotherapy: A quality inquiry into intake worker's observations and their consequences for therapy indication. *Psychotherapy Research*, *8* (3), 248-263.

Hesse, E. (1996). Discourse, memory and the Adult Attachment Interview: A note with emphasis on the emerging cannot classify category. *Infant Mental Health Journal*, *17*, 4-11.

Holmes, J. (1993). *John Bowlby and Attachment Theory (Makers of Modern Psychotherapy)*. London: Brunner- Routledge, Taylor & Francis Group.

Holmes, J. (2001). *The Search for the Secure Base. Attachment Theory and Psychotherapy.* London: Brunner- Routledge, Taylor & Francis Group.

Horowitz, L., Rosenberg, S., Ureno, G., Kalehzan, B., & O'Halloran, P. (1988). Psychodynamic formulation, consensual response method and interpersonal problems. *Journal of Consulting and Clinical Psychology*, *57*, 599-606.

Lingiardi, V. (2000). *L'alleanza terapeutica*. Milano: Raffaello Cortina.

Lingiardi, V., & Madeddu, F. (2001). *I meccanismi di difesa*. Milano: Raffaello Cortina.

Liotti, G. (2006). La disorganizzazione dell'attaccamento. In N. Dazzi, V. Lingiardi, & A. Colli. (Eds.), *La ricerca in psicoterapia* (pp. 591-606). Milano: Raffaello Cortina.

Liotti, G., Farina B., & Rainone A. (2005). *Due terapeuti per un paziente: Dalla teoria dell'attaccamento alle psicoterapie a setting multipli.* Bari-Roma: Laterza.

Luborsky, L. (1975). Clinicians' judgments of mental health: Specimen case descriptions and forms for the Health-Sickness Rating Scale. *Bulletin of the Menninger Clinic*, *35*, 448-480.

Luborsky, L., & Crist-Christoph, P. (1990). *Understanding Transference*. Washington, DC: American Psychological Association.

Luborsky L, McLellan AT, Woody GE, O'Brien CP, Auerbach A. (1985). Therapist success and its determinants. *Archives of General Psychiatry*, *42*, 602-611.

Main, M., & Goldwyn, R. (1998). *Adult attachment scoring and classifications systems*. Berkley: University of California. Unpublished manuscript.

McLeod J. (2000). Qualitative research in counselling and psychotherapy. London: Sage.

Mergenthaler, E., & Stinson, C.H. (1992). Psychotherapy transcription standards. *Psychotherapy Research*, *2*, 125-142.

Overall, C.J., Gohram, D.R. (1962). The Brief Psychiatric Rating Scale. *Psychological Reports*, *10*, 799-812.
Perry, C.J., & Cooper, S. (1986). A preliminary report on defenses and conflicts associated with borderline personality disorder. *Journal of American Psychoanalytic Association*, *34*, 865-895.

Rosemberg, A., & Perring, G. (1996). Controlled and Randomized trials and naturalistic data: It's time to change. *Human Psychopharmacology*, *2*, 353-363.

Roth, A., & Fonagy, P. (1996). *What Works for Whom?.* London: Guilford Press.

Ruggeri, M. (2000). Risultati preliminari del Progetto Outcome-CGM (Supplemento). *Impresa Sociale*, *58*, 11-20.

Schauenburg, H., Freyberger, H.J., Cierpka, M., & Buchheim, P. (Eds.). (1988). *OPD in der Praxis. Konzepte, Anwendungen, Ergebnisse der Operationalisierten Psychodynamischen Diagnostik.* Bern: Verlag Hans Huber.

Schneider, G., Lange, C., & Heuft, G. (2002). Operazionalized psychodynamic diagnostic and differential therapy indication in routine diagnostics at psychosomatic outpatient department. *Psychotherapy Research*, *12* (2), 159.178.

Schneider, W., & Freyberg, H. L. (2000). *Was leistet die OPD?* Bern: Verlag Hans Huber.

Seligman, M.E.P. (1995). The effectiveness of psychotherapy: The consumer reports study. *American Psychologist*, *50*, 965-974.

Solomon, J., & George, C. (Eds.). (1999). *Attachment Disorganization*. New York: Guilford Press.

Sullivan, H.S. (1954). The psychiatric interview. New York: Norton.

Vigorelli, M. (Ed.). (2005). *Il lavoro della cura nelle Istituzioni*. Milano: FrancoAngeli.

Wamplod, B.E. (1997). Methodological problems in identifying efficacious psychotherapies. *Psychotherapy Research*, *7*, 21-43.

Westen D. (1998). Case formulation and personality diagnosis: two processes or one?. In J. Barron (Eds.), *Making diagnosis meaningful: Enhancing Evaluation and Treatment of Psychological Disorders* (pp.111-137). Washington, DC: American Psychological Association.

Westen, D., Shedler, J., & Lingiardi, V. (2003). *La valutazione della personalità con la SWAP 200*. Milano: Raffaello Cortina.

Wittemberg, I. (1982). Assessment for psychotherapy. *Journal of Child Psychotherapy*, *8*, 131-144.