Mechanisms of change through the lens of two-polarities models of personality development: State of the art and new directions

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This paper is dedicated to the memory of Sidney J. Blatt, who passed away during the process of writing this paper. His creative genius, warmth and playfulness were in our minds when finishing this paper. We also thank Peter Fonagy and Liz Allison for the many discussions on the issues central to this paper.

Abstract

This paper reviews moderators and mediators of therapeutic change through the lens of the two-polarities model of personality development. This psychodynamic model of personality development essentially proposes that personality development involves a continuous dialectic interaction between the development of the capacity for relatedness on the one hand and agency and self-definition on the other. Within this model, vulnerability for psychopathology is thought to result from an excessive emphasis on one developmental line and the defensive avoidance of the other. The two-polarities model also proposes a unified, transdiagnostic approach to therapeutic change in that it suggests that effective interventions, regardless of the "brand name," lead to a reactivation of the dialectic interaction between the development of relatedness and self-definition through experiences of mutuality and understanding as well as separation and misunderstanding in the therapeutic relationship, much as in normal personality development. We summarize research relevant to this view, and illustrate how this empirically based model of personality development and the therapeutic process may inform clinical practice. We focus specifically on recent developments within this model, which have led to a major shift in our thinking regarding the role of specific and common factors in explaining therapeutic change. We illustrate this shift in our thinking by way of a discussion of emerging research findings concerning therapeutic change in both brief and longer-term treatments across different therapeutic modalities. Limitations of the model are reviewed, and suggestions for future research are discussed.

Meta-analyses have repeatedly demonstrated that most bona fide psychotherapies are equally effective (Driessen et al., 2010; Driessen et al., 2007; Leichsenring, Leweke, Klein, & Steinert, 2015; Smith, Glass, & Miller, 1980; Wampold et al., 1997). This famous "Dodo bird effect"—that "Everyone has won and all must have prizes"—has rekindled the interest in *moderators* of treatment outcome (i.e., what factors influence treatment outcome?) as well as *mediators* of therapeutic change (i.e., what are the mechanisms of change?) within and particularly across different types of psychotherapy (Blatt, Zuroff, Hawley, & Auerbach, 2010; Levy, 2008; Roth & Fonagy, 2004; Weisz & Kazdin, 2010). Studies in this this area are often inspired by the *common-factors approach*, that is, that factors that are shared by different types of psychotherapy (such as providing hope, an illness theory, and a warm and understanding therapeutic relationship), are mainly responsible for therapeutic change (Ahn & Wampold, 2001; Laska, Gurman, & Wampold, 2014). Although common factors are undoubtedly important as an explanation of therapeutic change, the problem with this approach is that it still fails to explain *why* these common factors would explain therapeutic change. With regard to the therapeutic alliance, for instance, very few studies have been able to demonstrate that changes in the therapeutic alliance are associated with therapeutic change (Fonagy & Allison, 2014). Further, while common factors may be important, this does not mean that *specific factors* (i.e. the specific types of intervention that are rooted in different theories, such as addressing dysfunctional attitudes in cognitive behavioral therapy, or transference in psychodynamic therapy) are less important—or, as some have claimed, even negligible.

Fonagy, Allison, and Luyten (2014) recently formulated another approach

distinguishing between three hypothetical systems of communication that, in interaction, are thought to be responsible for therapeutic change. The first of these systems refers to the *specific treatment* offered. All evidence-based treatments provide a coherent, consistent, and continuous theoretical framework that offers the patient a way of understanding his or her problems differently, as well as a hypothetical process of change. This, ideally, leads the patient to feel recognized and validated as an *agent*: Basically, the patient feels 'understood' by the model or approach offered. This is thought to lower the patient's *epistemic hypervigilance* (the tendency for one not to trust new information that is provided, or to generalize the information to situations beyond the specific situation in which one is presented with the information), which in turn creates an openness to consider different ways of thinking, feeling, and behaving. There are estimated to be more than 1,000 types of psychotherapy (Lambert, 2013), and the specific interventions that are used by each of these various forms of psychotherapy may all foster the type of change described by System 1; to the extent that a psychotherapy offers a "truthful" view of human nature, it may set in motion a process of change because it engenders feelings of being understood and validated within the patient. Specific techniques and interventions are thus not negligible, nor are they arbitrary. In contrast, it can be argued that the more such interventions are rooted in solid empirical research, the more effectively they may lead the patient feeling recognized as an agent, because the more likely it is that there is some psychological "truth" in the information the therapist conveys.

This leads to the hypothesized System 2, which is the re-emergence of robust mentalizing. Fonagy, Allison and Luyten (in press) argue that all bona fide treatments,

through their recognition of the patient's agency, lead to the development or regeneration of the capacity for mentalizing, that is, the capacity to reflect upon the self and others in terms of mental states (e.g., thoughts, feelings, and desires). In all bona fide psychotherapies, the therapist (or, in the case of internet-based interventions, the virtual therapist) models mentalizing, which fosters learning from experience. That is, the therapist provides a model of reflecting differently on the way the patient feels, thinks, and behaves. To the extent that the patient feels mirrored by these attempts, this can lead to the development or re-emergence of robust mentalizing. This then feeds into System 3, that of social learning beyond therapy (the so-called *extra-therapeutic change factor* in psychotherapy research). Fonagy and colleagues (Fonagy, Luyten, & Allison, in press) propose that robust mentalizing initiates a third—and key—virtuous cycle, in which the patient becomes more open to change as a result of (typically more benign) interactions with others in the social world outside the consulting room. This, of course, presupposes that such benign environmental conditions are available to the patient—and this is often not the case, as many patients are entangled in problematic relationship patterns and/or have grown up in strongly invalidating and even markedly abusive environments. This points to the key role of environmental limitations to the effects of psychotherapy, a factor that has so far largely been neglected in the psychotherapy literature. However, patients may learn to better delimit problematic or painful interactions. Importantly in this regard, research has amply demonstrated the importance of evocative person–environment correlations in explaining resilience to adversity, in that resilient individuals have been shown to actively influence and "select" their environment (as evidenced in changing one's job, breaking contact with "old" friends, etc.)—a process that may also

occur in successful psychotherapy (Fonagy & Luyten, 2009; Hauser, Allen, & Golden, 2006).

Within this view, specific and common factors are thought to interact and are considered to lead to therapeutic change insofar as they also lead to extra-therapeutic changes (and, in turn, are fostered by extra-therapeutic changes). Hence, regardless of the type of treatment, therapeutic change is thought to result primarily from changes in person–environment exchanges opening up the patient to salutogenesis (Antonovsky, 1987) by reactivating an evolutionarily rooted capacity to be open to environmental influences and to be influenced in a productive way by the mind of others in particular.

These new views have led to a considerable shift in our own thinking from the perspective of the two-polarities model regarding both moderators and mediators of therapeutic change. In this paper, we use the extensive re-analyses of the National Institute of Mental Health Treatment of Depression Collaborative Research Program (TDCRP), one of the largest psychotherapy trials, to illustrate the two-polarities approach to moderators and mediators of therapeutic change, as well as the recent shift in our own views. We also discuss recent data concerning the psychoanalytic treatment of personality disordered patients to further illustrate these views.

We believe the research findings discussed in this paper illustrate the possibility of a continuous exchange and interaction among research, clinical practice, and theory to inform psychoanalytic practice. An increasing number of psychoanalytically trained therapists see these domains as being intrinsically linked to each other, rather than as separate domains or endeavors. It is therefore imperative that clinicians stay abreast of research findings and psychoanalytic thinking as summarized in the current paper.

Two-polarities models

For decades, the field of psychotherapy research has been dominated by comparative trials investigating the relative efficacy of different types of psychotherapy. While this focus has contributed to the growing evidence for the efficacy of psychotherapy, including psychoanalytic psychotherapy (Abbass, Rabung, Leichsenring, Refseth, & Midgley, 2013; de Maat et al., 2013; Driessen et al., 2010), it has led to the neglect of a fundamental question: how does psychotherapy work? Or, to ask the same question in more technical language: what factors influence treatment outcome (moderators) and what are the mechanisms of change (mediators)?

The field faces two major obstacles in answering these questions. First, in psychotherapy research there is the (often implicit) assumption of uniformity or homogeneity among patients, that is, the assumption that patients are more alike than different. However, in reality there are many differences between individuals that may influence treatment outcome. Second, with regard to the moderators and mediators of change, it is clear that although demographic and clinical variables, such as gender and the duration of the disorder, may be important, we believe it is more likely that psychologically meaningful variables impact treatment outcome and explain the mechanisms of change (Blatt et al., 2010).

Cronbach (1975, p. 119) pointed out that theoretically comprehensive and empirically supported theories of personality development are needed to avoid entering a "hall of mirrors" of potential predictors and mechanisms of change. In this context, two-polarities models of personality development have provided a productive theoretical

approach to identifying moderators of treatment outcome and mechanisms of change, precisely because they do not assume homogeneity among patients and provide specific hypotheses about how individual differences may moderate treatment outcome and influence the mechanisms of change in psychotherapy (Blatt et al., 2010).

Briefly, these models presume that normal personality development involves a synergistic interaction between the development of a capacity for *interpersonal relatedness* and of *self-definition* across the lifespan (Blatt, 2008; Blatt & Luyten, 2009; Luyten & Blatt, 2013). Further, the models assume that vulnerability for psychopathology stems from exaggerated, distorted and/or defensive emphasis on one of these two developmental lines, in an attempt to find some sense of stability, at different developmental levels. Excessive preoccupation with issues of interpersonal relatedness is typical of so-called *anaclitic* disorders and is expressed in high levels of maladaptive dependency. This group of disorders includes nonparanoid schizophrenia, borderline personality disorder, dependent personality disorder, anaclitic (abandonment) depression, and histrionic personality disorder, and represents disorders marked by struggles with issues of relatedness at the expense of self-definition, at different developmental levels. *Introjective* disorders, by contrast, involve an excessive preoccupation with agency, autonomy, and self-definition at the expense of the development of interpersonal relatedness, and are typically expressed in high levels of self-critical perfectionism (i.e. rigid and critical views of the self and others). This group of disorders, research suggests, includes paranoid schizophrenia and schizoid, paranoid, obsessive-compulsive, self-critical depressive and narcissistic personality disorders.

Although psychoanalytic in origin, the two-polarities models of normal and disrupted personality development are congruent with other dominant personality models in psychology and psychiatry, including contemporary interpersonal and attachment approaches, as well as self-determination theory (Luyten & Blatt, 2011); they thus provide a transtheoretical comprehensive view of personality development.

Because of their transtheoretical and transdiagnostic nature, these models also provide an interesting lens by which to identify moderators and mediators of therapeutic change. Research has suggested that anaclitic and introjective patients respond differently to different therapeutic interventions and often seem to change in ways that are consistent with their general personality orientation (Blatt et al., 2010).

Research in this area has mainly concentrated on depression and personality disorders, although findings from research in other disorders have generally led to similar conclusions (Blatt, 2008; Blatt & Luyten, 2010). In what follows, we summarize this body of research to illustrate the potential of research to inform clinical practice, and to illustrate the recent shift in our thinking concerning moderators and mediators of treatment outcome.

The Treatment of Depression Collaborative Research Program

The Dodo bird verdict once again: Is that all there is?

Consistent with the two-polarities models, a considerable body of research has demonstrated that high levels of self-critical perfectionism and, to a somewhat lesser extent, maladaptive levels of dependency play important roles in the onset and course of depression (Blatt, 2004; Leichsenring & Schauenburg, 2014; Luyten & Blatt, 2012). Both

personality dimensions also influence response to treatment across different therapeutic modalities (Blatt, 2004). Re-analysis of the TDRCP (Treatment of Depression Collaborative Research Program) study played a seminal role in realizing the impact of these dimensions on treatment outcome (Blatt et al., 2010). The TDCRP compared 16 weeks' treatment of patients with Major Depression with (1) imipramine (the antidepressant of choice at the time) plus clinical management, (2) a placebo condition that included clinical management, (3) once-weekly cognitive-behavioral therapy (CBT), and (4) once-weekly interpersonal psychotherapy (IPT). In total, 250 patients were screened and randomized; 239 patients had at least one treatment session and were included in the data analyses. Consistent with the Dodo bird verdict, results showed that there were no differences in outcome among the three active treatments (Elkin, 1994; Elkin et al., 1995). Approximately 35% of the patients recovered, defined as reporting minimal or no symptoms for at least 8 consecutive weeks after treatment termination. Approximately 40% of these "recovered" patients showed a relapse at 18-month follow-up, so only approximately 20% of all patients were recovered at follow-up.

Impact of self-critical perfectionism on treatment in the TDCRP

Further analyses of the TDCRP data showed that patients did not respond homogeneously to the treatments. While no differences in response could be identified across the treatments, self-critical perfectionism (SCP), as measured with the Dysfunctional Attitudes Scale (DAS), was highly negatively associated with all primary outcome measures (i.e., the Hamilton Depression Scale, the Beck Depression Inventory, the Global Assessment Scale, the Symptom Checklist-90, and the Social Adjustment

Scale) across all treatment conditions (Blatt, Quinlan, Pilkonis, & Shea, 1995; Blatt, Quinlan, Zuroff, & Pilkonis, 1996; Blatt, Zuroff, Bondi, Sanislow, & Pilkonis, 1998). The negative effect of SCP became particularly apparent in the second half of the 16-week treatment, with patients with high or moderate levels of SCP making no additional therapeutic progress after the eighth session. The most likely explanation of this finding is that these patients might have felt that their therapeutic progress was insufficient, consistent with their highly self-critical attitudes, and disengaged from the treatment. In addition, they might have experienced the anticipated forced termination of treatment as interfering with their need for control and autonomy. We will return to these speculations later, as further analyses were consistent with these assumptions. First, though, it is important to note that SCP was also negatively associated with therapeutic outcome at 18-month follow-up as rated by independent clinical evaluators and patients' self-reported symptoms and satisfaction with treatment. Clearly, individuals with high SCP derived little benefit from these brief treatments. Interestingly, no such negative effect was found for individuals with high levels of dependency, which even showed a trend toward being positively associated with treatment outcome, congruent with more dependent individuals' tendency to seek professional help and be open to more supportive psychological interventions (Blatt et al., 1995).

Relationship of reduction in symptoms and reduction of self-critical perfectionism in the TDCRP

Re-analyses of the TDCRP data thus showed that patients did not respond uniformly to the same treatment, and this effect seemed to be happening across different

treatment conditions, including the pharmacotherapy condition. In some patients, specific factors of therapy seem to be relatively ineffective, and so are the "common factors"—a finding that has often been replicated (Blatt et al., 2010). Something seems to impede the response to treatment in depressed highly self-critical individuals, but what is it? In an attempt to better understand this phenomenon, Hawley, Ho, Zuroff, and Blatt (2006) used Latent Difference Score (LDS) analysis, a structural equation modeling technique, to evaluate the temporal sequence of change in the TDRCP study. Indeed, one of the crucial, though often neglected, questions in identifying moderators and mediators of change in psychotherapy is to establish whether there is a causal relationship between the proposed moderator or mediator and therapeutic change (Kazdin, 2007). Theoretically, four temporal relations are possible: (1) the change in symptoms and in SCP may be unrelated, (2) the change in depressive symptoms drives the changes in SCP (i.e., the less depressed a patient is, the less self-critical he/she becomes; the *consequence model*), (3) changes in SCP drives the change in symptoms (the *vulnerability model*), and (4) there are reciprocal interactions between changes in depressive symptoms and SCP.

LDS analyses showed a rapid decrease of depressive symptoms early in the treatment process (at least for those patients who responded). Although congruent with other studies reporting an early response (Parker, 2005), these findings suggest that change in symptoms may occur rapidly, *before* any specific interventions are used, arguing for the common factors approach (i.e., that providing hope and empathy, for instance, leads to change). However, in our opinion this would be too simplistic an interpretation of rapid response. The evidence for a more complex model is also demonstrated by the finding that SCP, a known vulnerability factor for depression, diminished only very gradually

during treatment across all four conditions in the TDRCP study. Further, and most important, LDS analyses showed that even despite the rapid decrease in depressive symptoms in all treatment conditions, changes in SCP predicted decreases in depressive symptoms. Stated otherwise, these findings suggest that the failure to effectively address issues related to SCP explained the lack of sustained therapeutic change in the TDCRP in most patients, and particularly in patients with high SCP, suggestive of an interaction between specific techniques and common factors. Above all, these findings demand further exploration, rather than assuming that they support a particular approach.

How does self-critical perfectionism disrupt the treatment process?

How, then, did SCP disrupt the treatment process? Why was it so difficult to change SCP features across the four conditions in the TDCRP? These questions are highly relevant, as all clinicians are only too familiar with the difficulty in engaging patients struggling with negative introjects, as is typical of patients with high SCP, in therapy. Many of these patients drop out of treatment because they become increasingly dissatisfied with their therapeutic progress and with their therapist, feelings that they express either quite explicitly (by stating their dissatisfaction with the interventions of the therapist) or implicitly (i.e., by undermining the treatment), or both. This brings us to the therapeutic alliance. In the TDCRP, all treatment sessions were video recorded, and the Vanderbilt Therapeutic Alliance Scale was used to rate the contributions of both the patients and the therapists to the therapeutic alliance in the third, ninth, and 15th sessions. These analyses yielded an unexpected finding: the contributions of the patient, but not the therapist, to the therapeutic alliance, predicted the therapeutic response at treatment

termination. Further analyses showed that pretreatment SCP negatively predicted the patient's contribution to the alliance in the second half of the treatment (Zuroff et al., 2000). Hence, SCP patients seemed to disengage from the treatment. Shahar, Blatt, Zuroff, Krupnick, and Sotsky (2004) subsequently showed that during treatment, at the same time as disengaging from their therapist, patients with high SCP also reported increasingly lower levels of perceived social support outside the treatment setting, which in turn also negatively predicted treatment outcome. These findings are consistent with the notion of transference: in the second half of the treatment, patients with high SCP tended to unwittingly denigrate interpersonal relationships both within treatment (as evidenced in the deteriorating quality of the therapeutic alliance) and outside the treatment (as evidenced by perceived lower levels of social support). Both factors accounted almost completely for the negative effect of SCP on treatment outcome.

Revisiting the role of the therapeutic alliance and specific techniques in explaining treatment outcome

So far we have seen that SCP had a negative effect on treatment outcome, which seemed to be largely explained by its interference with the establishment of a positive therapeutic alliance and its negative impact on social relationships outside the treatment. Could this negative effect of SCP be mitigated by the treatment? Was there something therapists could do to prevent the negative transference and negative reaction to therapy? Findings from the TDCRP and other studies suggest the answer to these questions is yes, and also point to another interpretation of the role of both the therapeutic alliance (as well as other common factors) *and* specific techniques in explaining treatment outcome,

consistent with the model outlined by Fonagy et al. (in press). Both theorists and research findings suggest that therapists who are respectful, warm, open, flexible, and accepting are most able to foster the development of a positive alliance. In the TDCRP, the Barrett-Lennard Relationship Inventory (B-L RI) was used to assess these qualities. Specifically, the B-L RI assesses the degree to which the patient experiences the therapist as empathic (e.g., "Therapist wanted to understand how I saw things"), as having a positive regard for the patient (e.g., "He respected me as a person"), and as congruent and genuine (e.g., "I felt he was real and genuine with me"). In the TDCRP, patients completed the B-L RI at the end of the second and 16th treatment sessions. Remarkably, the quality of the therapeutic relationship as assessed at the end of the second treatment session was associated with a reduction in both depressive symptoms and SCP at treatment termination and at 18-month follow-up across the different conditions. Hence, the extent to which the therapist was perceived by the patient as understanding and genuine early on in therapy—regardless of his/her theoretical orientation—mitigated the negative effect of SCP on treatment outcome. It is important to note, first, that the B-L-RI does not assess the general quality of the therapeutic alliance, but the extent to which the therapist is perceived as understanding. Second, this effect was related to how the therapist was perceived very early in the treatment process.

In our view, consistent with Fonagy and colleagues' (in press) theory about therapeutic change, these findings point to the key importance of a therapeutic attitude that validates the patient, thus restoring epistemic trust, which may lead the patient to reflect in different ways about him/herself and others, opening the patient up to a social learning process outside the consulting room as we discussed earlier; this is evidenced in

the importance of both the relationship with the therapist *and* relationships outside therapy in predicting the treatment outcome. Crucially, and again consistent with Fonagy and colleagues (in press) views, this feeling of being understood, regardless of the treatment condition, was associated with patients' enhanced adaptive capacities (EACs) in dealing with new life stressors rated at 18-month follow up. Specifically, EACs were assessed using eight items measuring the degree to which patients felt treatment had improved their interpersonal relationships and their ability to cope with depression. Higher scores on this measure, reflecting higher ECAs, were effectively associated with an improved capacity to manage life stress during follow-up (Zuroff, Blatt, Krupnick, & Sotsky, 2003). Pretreatment SCP was negatively related to EACs at 18-month follow-up (Zuroff et al., 2003). Interestingly, the two psychotherapy conditions (CBT and IPT) were associated with greater EACs (Zuroff & Blatt, 2006) and better ability to cope with stress (Hawley, Ringo Ho, Zuroff, & Blatt, 2007) compared to the medication and placebo conditions. Hence, psychotherapy seemed to be more effective than pharmacotherapy and placebo in setting in motion a process of change. Again, these findings do not suggest that specific interventions were of no importance. This would be a logical fallacy, as it cannot be the mere experience of being understood by someone that generates change. More is needed, as evidenced by the observed extra-therapeutic changes (i.e., an increased capacity to deal with life stressors) in patients as a result of treatment, in particular psychotherapy.

Taken together, in our current thinking about these issues, these findings appear to suggest that it is the experience of being understood by another person that opens up the possibility of examining, in the context of a therapeutic relationship, ways of thinking

about oneself and others, which then may lead to different ways of thinking, feeling, and behaving outside the therapeutic setting. Feeling understood and validated is thus the precondition for change. Much of this process can be thought of as a parallel to what happens in normal development, in that normal personality development involves alternating experiences of gratifying involvement or experiences of mutuality and understanding with others, and experiences of incompatibility or separation and misunderstanding (Blatt & Behrends, 1987). In our view, experiences of incompatibility force individuals to reflect on their typical ways of feeling and thinking, and can be seen as the driving force behind psychological change—including change in psychotherapy, regardless of its theoretical orientation. Yet, such experiences need to be alternated with experiences of understanding and mutuality, as in normal development.

Addressing Ruptures in the Theapeutic Alliance

In this context, Safran and Muran (2000; Safran, Muran, & Eubanks-Carter, 2011) have quite helpfully distinguished between two types of ruptures in the therapeutic alliance, *withdrawal* and *confrontation*. Withdrawal ruptures involve the patient denying the importance of specific topics, shifting to other topics, intellectualizing in response to therapist interventions, and/or shifting the attention to other people when the therapist draws attention to significant issues related to the patient's own dynamics. Confrontation ruptures involve attacks on the person of the therapist or his/her competence, or attacks on the treatment (e.g., complaints about the frequency of appointments or the perceived lack of therapeutic progress). Interestingly, for both types, interventions that emphatically discuss the patient's underlying need for understanding, validation, and nurturance seem to lead to a resolution of the rupture, and as a result the patient increasingly gains a sense

of agency and ownership of his/her feelings, leading to a new balance between relatedness and self-definition. These observations suggest that identifying the patient's underlying needs for understanding and nurturance lead to the emergence of the "other voice" in the patient and a better balance between relatedness and self-definition. Stated another way, ruptures in the therapeutic alliance (i.e., experiences of misunderstanding and incompatibility) have the potential to lead to a reactivation of the normal dialectic between relatedness and self-definition if adequately balanced by experiences of mutuality and understanding—much as in normal development. Different therapeutic techniques seem to lead to this outcome.

Does something similar happen in the treatment of patients with severe personality pathology? We address this issue in the next section.

Moderators and mediators of therapeutic change in the treatment of personality disorders

Research based on the two-polarities model and therapeutic change in individuals with personality disorders has been mainly limited to psychoanalytic treatments, so it is unclear to what extent similar processes are at play in other types of treatment. However, at least within psychoanalytic treatments, similar processes appear to be involved to those that have been observed within treatment studies on symptom disorders such as depression and anxiety (Blatt et al., 2010; Luyten, Lowyck, & Vermote, 2010; Vermote, Lowyck, Vandeneede, Bateman, & Luyten, 2012). Research findings suggest that personality disordered patients with highly self-critical (introjective) features seem to benefit most from longer-term, insight-oriented treatment, most probably because this

style of treatment matches their need for autonomy and control and their predominantly cognitive style. As we have seen, this may in part explain why these patients often fail to benefit from brief treatments, as the TDCRP data and other similar studies suggest. Longer-term treatment also allows these patients to gradually develop a positive therapeutic alliance, without the pressure of a fixed ending. We would add that considerable time is often needed to restore epistemic trust in these patients, and thus longer-term treatment might be more suited to them.

Personality disordered patients with dependent (anaclitic) features tend to benefit most from more structured and supportive treatments, congruent with their preference for interpersonal relationships. An emphasis on support and structure may also be experienced as more validating by these patients, leading to a greater likelihood that their capacity for epistemic trust, and thus social learning, is restored. In contrast, more insight-oriented treatments, particularly those that emphasize therapeutic neutrality, are likely to lead to feelings of invalidation, and thus estrangement and disengagement, in these patients. The presence of anaclitic versus introjective features thus seems to be an important moderator in the treatment of personality disordered patients. Furthermore, these findings do not seem to be restricted to adult patients. Feenstra, Laurenssen, Hutsebaut, Verheul, and Busschbach (2012), for instance, investigated the role of self-criticism and dependency in 51 adolescents with severe personality pathology who completed psychodynamically oriented inpatient psychotherapy. Results showed that higher pretreatment levels of self-criticism, but not dependency, predicted poorer symptomatic improvement at treatment termination. But this study did not address the impact of these personality dimensions on different types of treatment, so more work in

this area is needed, both in adolescents and adults. Indeed, while the two-polarities model also suggests important differences in terms of the mechanisms of change in personality disordered patients, much less is known about these mechanisms than for patients with symptom disorders. Even less is known about the differential impact of anaclitic versus introjective features on extra-therapeutic change in patients with personality disorders. We have shown, in a study of 44 personality disordered patients, that hospitalization-based psychodynamic treatment was associated with significant improvements in interpersonal functioning during treatment and at 1-year (Luyten et al., 2010) and 5-year (Lowyck et al., in press) follow-up, with continuing improvement in interpersonal functioning after treatment. However, cold-vindictive and domineering interpersonal features, which are typical of patients with high levels of SCP (Blatt et al., 1998), negatively influenced treatment outcome at treatment termination, particularly at long-term follow-up.

Importantly, this study also showed that symptomatic improvement, particularly during follow-up, was related to changes in both overly nurturant and nonassertive interpersonal characteristics (typical of dependency) and in cold-vindictive and domineering interpersonal behaviors (typical of SCP). Changes in interpersonal features typical of SCP were the strongest predictors of sustained improvement. Hence, the extent to which the balance between relatedness and self-definition was restored, was related to the long-term outcome. But, once again, introjective features seemed to be more resistant to therapeutic change, and the extent to which these features were modified by treatment was most strongly related to long-term treatment outcome.

A recent study provides sheds further light on the role of these personality dimensions in the treatment of patients with personality disorders (Lowyck, Luyten, Vermote, Verhaest, & Vansteelandt, 2015). Specifically, in 150 personality disordered patients receiving psychodynamic treatment (with a mean duration of 33 weeks), both dependency and SCP decreased significantly from the start to termination of treatment (with effect sizes of Cohen's d = 0.31 for dependency and d= 0.70 for SCP, representing small and large effect sizes respectively). Multilevel analyses showed that there was no association between changes in dependency and symptomatic improvement. In contrast, there was a highly significant association between changes in SCP and symptomatic improvement. In addition, patients who had a stronger linear decrease in SCP during treatment also showed a stronger linear decrease in symptoms during treatment, as evidenced in a highly significant correlation between subject-specific slopes for SCP and symptoms. Together, these findings suggest that changes in SCP may mediate changes in symptomatic improvement in patients with personality disorders, as it does in patients with symptom disorders. This in turn may make these patients more open to positive influences in their environment (i.e., salutogenesis). Studies that investigate these assumptions more directly are needed, but findings to date suggest that we might be one step closer to unraveling the mechanisms of change in psychotherapy with personality disordered patients. So far, studies appear to have identified an important personality factor that may seriously constrain the effectiveness of various forms of psychotherapy for various disorders—that is, SCP—because it renders individuals closed to environmental input, including that offered by psychosocial interventions.

Conclusions

This paper shows that research concerning the moderators and mediators of therapeutic change rooted in psychoanalytic thinking is highly relevant for both clinicians and researchers, regardless of their theoretical orientation. Specifically, this paper demonstrates that personality-related vulnerability for both symptom and personality disorders, particularly SCP, may be a major factor influencing treatment outcome across different types of psychotherapy. Features characteristic of SCP typically disrupt therapeutic progress because patients with high levels of SCP want to be in control and are highly critical of themselves, the therapist, and their therapeutic progress. In light of recently proposed views on the nature of therapeutic change, we would also like to add that these patients also typically lack epistemic trust, which prevents them from benefitting from positive environmental (and particularly interpersonal) influences. The extent to which the therapist is able to engender feelings of validation and understanding in patients with these features—a process which may often take considerable time—seems to be an important factor in determining therapeutic outcome, as this seems to be directly related to the patient's *constructive participation* in the therapeutic process. With patients who predominantly show anaclitic features, feelings of validation and understanding may be more easily stimulated, and the constructive participation of the patient, leading to a process of change being set in motion both within and outside the treatment, may be, on average, easier. Yet, this may be an overly optimistic view, as the possibility of negative iatrogenic impact is perhaps as likely in these patients as it is in highly introjective patients. Treatments that are overly focused on insight and provide too

little structure, support, and validation seem likely to lead to a negative treatment outcome in highly anaclitic/dependent patients.

As we have discussed, these findings and speculations may lead to the conclusion that ruptures in the therapeutic alliance are inevitable with all patients, and that it is the extent to which both therapist and patient manage these disruptions that is related to therapeutic outcome—much as in normal development, in which experiences of interpersonal relatedness (mutuality and understanding) and self-definition (separateness) synergistically interact in a mutual facilitating process.

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