

Reflective and High Functioning in preliminary assessment

Raffaella Perrella¹, Luigi Alessandro Russolillo¹, Michele Tammaro¹, Giorgio Caviglia¹

¹ University of Campania “Luigi Vanvitelli”, Department of Psychology

Email Corresponding author: raffaella.perrella@unicampania.it

Abstract

Objectives: In this work we tried to infer some important information in psychotherapeutic process from different measures. The primary aim was to obtain a better assessment of strengths and weaknesses of two patients during the first evaluation sessions and generally in psychotherapy.

Methods: We used two main measures, the Adult Attachment Interview and the SWAP-200. The first assessed adult mental representations regarding relationships, while the latter assessed personality disorders and traits. We also measured reflective functioning through the Reflective Functioning scale applied on the AAI. As for the SWAP-200, the Personality Health Index and the RADIO were calculated.

Results: We tried to explain in descriptive terms some unusual results from the measurements, comparing the data. Discordances in the different levels of reflective functioning of the two patients were explicated through the in-

depth analysis of the SWAP indices, showing different ways to deal with personal and relational difficulties.

Conclusions: Comparing two different patients that share similar scores in the assessment can be confusing. In order to better envision strengths and weaknesses of the patients it is sometimes necessary to go in depth of the different indices. Also, we tried to stress some of these results in order to better orient the therapeutic program.

Key words: Assessment, Outcome, Mentalization, Attachment, Case Study

Introduction

This work stems from a longitudinal study in progress with a sample of 10 units recruited at the Asl of Caserta (District 13 of Maddaloni). The sample is composed mainly by people with Eating Disorders from 16 to 60 years of age and its aim is to evaluate, through the Shedler-Westen Assessment Procedure (Shedler, Westen, 1998) and the Adult Attachment Interview (George, Kaplan, Main, 1985), the change in psychotherapy by repeated measures at one-year intervals.

Personality diagnosis is a great challenge in clinical practice (Shedler, Westen, 2007), as in most cases patients exhibit a complex pattern of different “features” or traits, as well as other clinically meaningful problems. In this possibly confusing scenario, a good and (hopefully) repeated in time assessment is a key factor to diminish clinician confusion, ultimately leading to a better outcome for the patient. In addition, another issue regarding personality assessment is the tendency to rely on measures that evaluate the general severity of pathology as it manifests in observable signs and symptoms (see Josephs et al., 2004; Waldron et al., 2011): through the SWAP, the clinician evaluates with his/her judgement in assessing personality patterns. Lastly, many therapeutic outcome measures lack to highlight health indices, focusing mainly on the reduction of symptoms (Jahoda, 1958).

For these reasons, the dimensional assessment tools that a clinician can use to support his global assessment are a fundamental added value, although a simplistic reading of their results may, unfortunately, increase rather than diminish confusion.

To meaningfully assess the main features that could intervene in the therapeutic process blocking, slowing down or conversely helping and supporting the process itself, we chose to measure personality traits and reflective functioning, taking into account also adult attachment representations of two patients, Norah and Donna.

The concept of mentalization, popularized in the last years by Fonagy and colleagues (Fonagy, 1991; Fonagy et al., 2002), describes the way by which humans make sense of their social world by imagining mental states (beliefs, motives, emotions, desires, and needs) that underpin their own and others' behaviors in interpersonal interactions (see also Choi-Kain, Gunderson, 2008). Reflective functioning (RF) refers to the processes that underlie the capacity to mentalize, and involves both a self-reflective and interpersonal component (Fonagy et al., 1998): many works have highlighted that an increase in RF is a positive index of therapy outcome, especially in borderline patients (Levy et al., 2006; Rudden et al., 2006), although some studies do not support this thesis (for a systematic review, see Katznelson, 2014).

Like reflective functioning, also attachment models have been used to assess change in psychotherapy (Ammaniti, Dazzi, Muscetta, 2008; Steele, Steele, Murphy, 2009; Dazzi, Speranza, 2014). Also, many authors agree in considering it as a useful aid in the whole clinical practice (Di Carlo, Schimmenti, Caretti, 2011), thus including the assessment of the patients' psychological strengths and difficulties (Steele, Steele, 2008). This is especially true with children, not only because of the significant nature of attachment in early age, but also for all the implications in other (seemingly) distant areas of functioning (Zarrella et al., 2016). For adult psychotherapy, studies (e.g. Dozier, Cue, Barnett, 1994) have shown that the clinician's responses to the patient varies in respect of adult attachment

representations, both of the client and the therapist as well: in this sense, knowing in advance the clients'/patients' attachment representation may be very useful to know, in advance and to a certain extent, the possible reactions to them.

Objectives

The main goal of our evaluation was to better focus the psychotherapists' attention on critical areas of functioning of the two patients, both in terms of good functioning (e.g., a particularly good reflective functioning, or a good coherence in discussing past trauma or loss) and in terms of weaknesses (e.g., insecure/disorganized attachment representations, or particularly low High functioning score). Moreover, our evaluation, if repeated in time, can possibly measure process and outcome of the therapies; many studies, in fact, have used similar tools to assess and monitor change in psychotherapy using these tools (Lingiardi, Shedler, Gazzillo, 2005; Levy et al., 2006; Steele, Steele, Murphy, 2009; Waldron et al., 2011). Furthermore, we tried to explain and make sense of some inconsistencies in the measurements.

Measures

Shedler-Westen Assessment Procedure (SWAP-200). The SWAP (Shedler, Westen, 1998) is an Q-sort, clinician report assessment instrument designed to provide clinicians of all theoretical orientations with a standard "vocabulary" for case description. The vocabulary consists of 200 statements, each of which may describe a given patient very well, somewhat, or not at all. The clinician describes a patient by ranking or ordering the statements into eight categories, from those that are most descriptive (assigned a value of 7) to those that are not descriptive at all or don't apply (assigned a value of 0). Thus, the SWAP yields a score from 0 to 7 for each of 200 personality-descriptive variables. Studies (e.g., Lingiardi, Shedler, Gazzillo, 2005) have shown that the 30 items assigned to the top three salient categories provide a useful summary of patient functioning. The Q-sort creates a fixed distribution of SWAP-200 items that resembles the right half of a normal distribution.

This distribution requires the rater to assign a specified number of items to each score category (8 in pile 7; 10 in pile 6; 12 in pile 5, etc.). This process is to avoid measurement error and heteroscedasticity because of that fact that all clinicians must use each value the same number of times (Shedler, Westen, 1998).

Personality Health Index (PHI) and RADIO. The PHI (Waldron et al., 2011) offers an assessment of personality functioning that may be applied to the study of outcome in any treatment that aims to affect overall psychological health. Its calculation is based on the 200 SWAP statements and their assigned value, and the meaning of it is comparable to Luborsky's Health-Sickness Rating Scale (1962). The RADIO (Waldron et al., 2011) is the decomposition of the whole set of the SWAP items into five historically very explored areas of mental functioning: Reality testing, Affect regulation, Defensive operations, Identity integration and Object relations. Both the PHI and RADIO return a percentile score. Adult Attachment Interview (AAI). The AAI (George, Kaplan, Main, 1985) is a semi-structured interview that is audio recorded and subsequently transcribed verbatim (Main, 1994), and explores adult mental representations and childhood memories regarding attachment. After a precise work of coding (Main, Goldwyn, Hesse, 2002), the interviewee is assigned to a broad category reflecting the main style that the subject uses to deal with attachment relationships. The categories are secure/autonomous (F), dismissing (Ds), preoccupied (E), unresolved/disorganized (D).

Reflective Functioning (RF). In its application to the AAI, the Reflective Functioning scale (Fonagy et al., 1998) allows the measurement of the level of mentalization, through the analysis of the answers to the so-called "demand questions" in the AAI protocol. In these, the interviewee is demanded to use his/her ability to mentalize in order to answer, whereas in the others ("permit questions") reflective functioning can be shown but is not directly sought by the interview itself. The scale returns a score that goes from -1, indicating a complete refusal (or a bizarre mode) of

reflective functioning, to 9, indicating an exceptional reflective functioning.

Methods

The study was approved by the ethics committee of the University of Campania “Luigi Vanvitelli” in 2016. After signing an informed consent, the we administered the Adult Attachment Interview and the Clinical Diagnostic Interview (CDI; Westen, 2002) to the two patients separately. The CDI explores all the topics addressed by the SWAP, allowing the clinician to complete the assessment without necessarily conducting at least four sessions, the minimum to acquire all the information needed to complete the SWAP (Shedler, Westen, Lingiardi, 2003). The AAI was transcribed and coded, as for the Reflective Functioning, by an experienced and reliable coder (L.A.R.). Two reliable coders (L.A.R. and I.Z.) rated the RF from the transcripts.

Participants

N. and D. have quite different life experiences. Norah is in her forties, has a dramatic history of severe nervous anorexia, that led her to various hospitalizations and electroconvulsive therapy (ECT). She reports having no intimate relations nor a permanent job, and still lives with her parents and aunts. At the moment of the interview, she had had over 8 years of psychoanalytic psychotherapy. As for D. case, she too is in her forties, and in the sessions (both with the psychiatrist and afterwards with the interviewer) shows strong and invalidating depressive and anxiety symptoms. She reports living an unfortunate wedding, from which two daughters were born, and has a stable (although unsatisfactory) job. She attempted many brief (and seemingly ruinous) psychotherapies in the last decade, often being prescribed antidepressants and anxiolytic drugs. She followed these cures for a brief period, but later on abandoned them without consulting the various medical figures following her case; the patient reports that she substituted the prescribed medications with homeopathic treatments.

Results

All the scores are summarized in Table 1 and 2. In particular, we took into account the High functioning score, the PHI and the RADIO from the SWAP results, the final classification from the AAI and the final RF score.

Patient	Diagnosis	Personality Health Index	High Functioning	Reflective Functioning	AAI classification
N. case	Severe schizotypal, schizoid, avoidant and dependent traits	1%	41.47	1	U/E
D. case	Borderline, avoidant and dependent personality disorders	1%	43.52	4	U/E

Table 1. SWAP and AAI data.

The two patients show very different diagnoses (expressed in PD factors, coherent with the DSM-IV nosography; see APA, 1994; Shedler, Westen, 1998; Shedler, Westen, 2007) and levels of mentalizing abilities, yet they

share a similar value of High functioning and the same PHI. Also, their final classification regarding mental representations of attachment are the same, primarily unresolved and preoccupied. Comparing the scores of the two patients, we can see that, in the face of a substantial concordance of high-functioning and PHI (and attachment) and a major difference in diagnosis, Reflective functioning is very different: a score of 1 represents in fact a substantial adherence to a distorted RF or even a lack of mentalization, albeit not bizarre, while a 4 (average score between 3 and 5, supported by both judges) represents an almost ordinary – although low - reflective functioning (Fonagy et al., 1998). We would have expected to observe a lower score in the presence of three personality disorders, given also an unresolved/preoccupied attachment.

We tried to explain these results with an in depth analysis of the RADIO (Table 2).

Patient	R Reality testing	A Affect regulation	D Defensive operations	I Identity integration	O Object relations
N. case	1%	11%	2%	13%	11%
D. case	2%	1%	25%	14%	7%

Table 2. RADIO areas.

The interpretation of such low PHI and RADIO scores should not alarm us: comparing the patients' scores with a sample of patients in psychoanalytic therapy (therefore with a medium to high functioning, see Cogan, Porcerelli, 2004, 2005; Waldron et al., 2011), these indices will not distinguish very clearly different "low" levels.

Decomposing the SWAP and PHI data into the 5 areas of the RADIO, we can see how the two patients, although sharing the same PHI and similar High functioning values, show quite different scores from one another in some areas: in particular, the style and effectiveness of defenses and of affect regulation. Probably this significant difference, D. case substantially higher value in defensive operations than N., justifies and substantiates a more effective, though not exceptional, reflective functioning. D. case great disadvantage is, in fact, in the management of her affectivity, an area where such an RF might be of great help in a therapeutic work. At the same time, N. case better affect regulation and quality of object relations could possibly enhance her developing of a reflective stance. Both patients show a particularly low level in reality testing, that could possibly be a limit to any therapeutic intervention.

Conclusions and limitations

Focusing on the representations of attachment, both patients show a problematic constellation of disorganization and insecurity. In terms of a preliminary assessment, this information prepares the clinician to the fact that the patient will have some trouble in discussing attachment-related themes, a core area in most, if not every, psychotherapy (Caviglia et al., 2010). The discourse of preoccupied individuals (the adult analog of anxious/ambivalent attachment) tends to be verbose, vague, and digressive (Main, Goldwyn, Hesse, 2002; Westen et. al., 2006).

The discourse is often interrupted with irrelevancies; “psychobabble”, nonsense words, childlike speech are used in the interview. Individuals classified as unresolved with respect to loss and/or trauma - roughly corresponding to the infant classification of disorganized attachment (Main, Hesse, 1992) – on the other hand, show narratives with great incoherencies. Theory and research suggest that these individuals have often suffered significant childhood separation, loss, or trauma that has not been adequately grieved or elaborated so that derivatives of these experiences remain emotionally disruptive or prone to expression in dissociative or quasi-dissociative experiences in every-day life (Main, Goldwyn, Hesse, 2002; Westen et al., 2006; Liotti, Farina, 2011; Zarrella et al., 2017). These features can negatively intervene in the whole

therapeutic process, but knowing them in the initial assessment phases can prepare the clinician to a more specifically oriented work on the dissociated parts of past experiences (Steele, Steele, 2008; Perrella, Del Villano, Caviglia, 2016).

The aim of the work was primarily to obtain relevant data (possible outcomes, strengths and weaknesses, anamnesis and relational history) for the therapists in few sessions. This was possible in just two sessions of about two hours each. Using two (relatively) simple tools such as the SWAP and the RF (applied to the AAI), we can gather a lot of information on the patient and his/her changes in time. The additional SWAP indices, the PHI and RADIO, are particularly suitable for making ipsative comparisons, more than they are between different individuals, therefore highlighting the areas where the patient (still) has difficulties or, on the contrary, is particularly well-suited. In addition, the High functioning score too is a good summary of how, generally, the patient functions in everyday life, although it may not be enough to express the real complexity of a patient. Overall, this means that it is possible to monitor different areas of personality and other relevant psychological changes over time with just two solid instruments, analyzing in depth their scores, if necessary.

Another aim of this study was to explore and try to explain inconsistencies between measurements. To do this, we went further in the analysis of the scores by displaying the SWAP data breakdown (Waldron et al., 2011). If we don't analyze the RADIO in particular we may not be able to explain two fairly different reflexive styles: in essence, a single value (such as the PHI or the RF) may not provide enough information and potentially confuse clinicians.

Another point that could make the reason for the inconsistency between low high functioning, presence of personality disorders and an RF with a value of 4 is that the scale, as it is composed, lacks of a Mastery

component (that roughly answers to a question like "what do I do with my reflective stance?"), present in procedures that measure similar constructs,

like the MAS (Semerari et al., 2003; see also Perrella, Semerari, Caviglia, 2013).

As to the limits, it is very difficult to extend our conclusions on patients different than the ones assessed, because of the descriptive nature of the work, specifically built to aid clinicians. Also, the sample is very limited, and is being increased in number in another work currently in progress. The assessment method we present could possibly be of limited use for other types of samples. Furthermore, another limit is the validity of the measured scores because of the presence of one judge and interviewer for coding the AAI and the SWAP. Although certified as reliable, the golden standard would have been two, as it has been for the RF. In this sense, the discussion of our conclusions should be precautionary.

Acknowledgements

We kindly thank all the therapists and the director of the ASL of Caserta, District 13 of Maddaloni for their useful collaboration.

References

1. Ammaniti, M., Dazzi, N. & Muscetta, S. (2008). L'AAI in un contesto clinico. Esperienze ed esempi. In H. Steele & M. Steele (Eds) (2008), *Adult Attachment Interview: Applicazioni Cliniche*. Tr. it. Milano: Raffaello Cortina, 2010.
2. APA – American Psychiatric Association (1994). *Manuale Diagnostico e Statistico dei Disturbi Mentali (DSM-IV-TR)*. Tr. it. Milano: Masson, 1996.
3. Caviglia, G., Perrella, R., Sapuppo, W. e Del Villano, N. (2010). La ricerca in psicoterapia: il contributo del Gruppo di lavoro della Cattedra di Psicologia Dinamica (base) della Seconda Università di Napoli. *Research in Psychotherapy: Psychopathology, Process and Outcome*, 2 (13), 32-52.

4. Choi-Kain, L. W. & Gunderson, J. G. (2008). Mentalization: Ontogeny, Assessment, and Application in the Treatment of Borderline Personality Disorder. *American Journal of Psychiatry*, 165, 1127–1135.
5. Cogan, R. & Porcerelli, J. H. (2004). Personality pathology, adaptive functioning, and strengths at the beginning and end of psychoanalysis. *Journal of the American Psychoanalytic Association*, 52, 1229–1230.
6. Cogan, R. & Porcerelli, J. H. (2005). Clinician reports of personality pathology of patients beginning and patients ending psychoanalysis. *Psychology and Psychotherapy: Theory, Research and Practice*, 78, 235–248.
7. Dazzi, N. & Speranza, A. M. (2014). Apporti della teoria dell'attaccamento allo studio del cambiamento. *Giornale Italiano di Psicologia*, 4, 703-714.
8. Di Carlo, G., Schimmenti, A. & Caretti, V. (2011). Uso clinico dell'Adult Attachment Interview: un approfondimento. *Psichiatria e Psicoterapia*, 30 (3), 181-197.
9. Dozier, M., Cue, K. L. & Barnett, L. (1994). Clinicians as Caregivers: Role of Attachment Organization in Treatment. *Journal of Consulting and Clinical Psychology*, 62 (4), 793-800.
10. George, C., Kaplan, N. & Main, M. (1985). Adult Attachment Interview protocol, 2nd edition, unpublished manuscript. Berkeley (CA): Department of Psychology, University of California.
11. Fonagy, P. (1991). Thinking about thinking: some clinical and theoretical considerations in the treatment of a borderline patient. *International Journal of Psychoanalysis*, 72, 1-18.
12. Fonagy, P., Gergely, G., Jurist, E. J. & Target, M. (2002). *Regolazione affettiva, mentalizzazione e sviluppo del sé*. Tr. it. Milano: Raffaello Cortina, 2005.

13. Fonagy, P., Target, M., Steele, H. & Steele, M. (1998). *Reflective-functioning manual for application to Adult Attachment Interviews (version 5)*, unpublished manuscript. London: University College.

14. Jahoda, M. (1958). *Current concepts of positive mental health*. New York: Basic Books.
15. Josephs, L., Anderson, E., Bernard, A., Fatzer, K. & Streich, J. (2004). Assessing progress in analysis interminable. *Journal of the American Psychoanalytic Association*, 52, 1185–1214.
16. Katznelson, H. (2014). Reflective functioning: A review. *Clinical Psychology Review*, 34, 107–117.
17. Levy, K. N., Kelly, K. M., Meehan, K. B., Reynoso, J. S., Clarkin, J. F., Lenzenweger, M. F. et al. (2006). Change in attachment and reflective function in the treatment of borderline personality disorder with transference focused therapy. *Journal of Consulting and Clinical Psychology*, 74, 1027-1040.
18. Lingiardi, V., Shedler, J. & Gazzillo, F. (2005). Assessing personality change in psychotherapy with the SWAP-200: A case study. *Journal of Personality Assessment*, 86, 23–32.
19. Liotti, G. & Farina, B. (2011). *Sviluppi traumatici. Eziopatogenesi, clinica e terapia della dimensione dissociativa*. Milano: Raffaello Cortina.
20. Luborsky, L. (1962). Clinicians' judgments of mental health: A proposed scale. *Archives of General Psychiatry*, 7, 407–417.
21. Main, M. (1994). Recording and transcribing the Adult Attachment Interview, unpublished manuscript. Berkeley (CA): Department of Psychology, University of California.
22. Main, M., Goldwyn, R. & Hesse, E. (2002). Adult Attachment Scoring and Classification Systems (version 7.1), unpublished manuscript. Berkeley (CA): Department of Psychology, University of California.
23. Main, M. & Hesse, E. (1992). Attaccamento disorganizzato/disorientato nell'infanzia e stati mentali dissociati dei genitori. In M. Ammaniti & D. N. Stern (Eds) (1992), *Attaccamento e psicoanalisi*. Roma-Bari: Laterza.
24. Perrella, R., Del Villano, N. & Caviglia, G. (2016). Referential activity, dissociation, psychopathology and psychotherapy.

- Research in Psychotherapy: Psychopathology, Process and Outcome, 19(2), 165-171.
25. Perrella, R., Semerari, A., Caviglia, G. (2013). Metacognition, borderline pathology and psychotherapeutic change: A single-case study. *Research in Psychotherapy: Psychopathology, Process and Outcome*, 16 (2), 102-108.
 26. Rudden, M., Milrod, B., Target, M., Ackerman, S. & Graf, E. (2006). Reflective functioning in panic disorder patients: A pilot study. *Journal of the American Psychoanalytic Association*, 54, 1339–1343.
 27. Semerari, A., Carcione, A., Dimaggio, G., Falcone, M., Nicolò, G., Procacci, M. & Alleva, G. (2003). How to evaluate Metacognitive Functioning in Psychotherapy? The Metacognition Assessment Scale and its Applications. *Clinical Psychology and Psychotherapy*, 10, 238-261.
 28. Shedler, J. & Westen, D. (1998). Shedler-Westen Assessment Procedure-200 (SWAP-200). Tr. it. Shedler, J., Westen, D. & Lingardi, V., *La valutazione della personalità con la SWAP-200*. Milano: Cortina, 2014.
 29. Shedler, J. & Westen, D. (2007). The Shedler–Westen Assessment Procedure (SWAP): Making Personality Diagnosis Clinically Meaningful. *Journal of Personality Assessment*, 89 (1), 41-55.
 30. Shedler, J., Westen, D. & Lingardi, V. (2003). *La valutazione della personalità con la SWAP-200*. Tr. it. Milano: Raffaello Cortina, 2014.
 31. Steele, H. & Steele, M. (Eds) (2008). *Adult Attachment Interview: Applicazioni Cliniche*. Tr. it. Milano: Raffaello Cortina, 2010.
 32. Steele, H., Steele, M. & Murphy, A. (2009). Use of the adult attachment interview to measure process and change in psychotherapy. *Psychotherapy Research*, 1, 1-11.
 33. Waldron, S., Moscovitz, S., Lundin, J., Helm, F., Jemerin, J. & Gorman, B. (2011). Evaluating the Outcomes of Psychotherapies:

The Personality Health Index. *Psychoanalytic Psychology*, 28, 363-388.

34. Westen, D., Nakash, O., Thomas, C. & Bradley, R. (2006). Clinical Assessment of Attachment Patterns and Personality Disorder in Adolescents and Adults. *Journal of Consulting and Clinical Psychology*, 74 (6), 1065-1085.
35. Zarrella, I., Lonigro, A., Perrella, R., Caviglia, G. & Laghi, F. (2016). Social behaviour, socio-cognitive skills and attachment style in school-aged children: what is the relation with academic outcomes? *Early Child Development and Care*. DOI: 10.1080/03004430.2016.1266486.
36. Zarrella, I., Russolillo, L. A., Caviglia, G. & Perrella, R. (2017). Continuity and discontinuity between psychopathology of childhood and adulthood: a review on retrospective and prospective studies. *Research in Psychotherapy: Psychopathology, Process and Outcome*, 20 (2), 101-110.