A clinically useful assessment of patients' (and therapists') mental functioning:

M-Axis implications for the therapeutic alliance

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Abstract

Among its several changes and innovations, the second edition of the *Psychodynamic Diagnostic Manual* (PDM-2) strongly emphasizes the importance of the therapeutic relationship. The manual helps clinicians to understand better their behaviors in therapy with different patient groups, to guide therapeutic interventions, to track in-session processes, to deal with ruptures in the therapeutic alliance, and to achieve a better therapy outcome. In this article, we examine the clinical implications of the PDM-2 Adult M Axis (i.e., the Profile of Mental Functioning). We begin by describing the structure and main features of the M-Axis. We then outline how a psychodynamically informed assessment of the mental capacities involved in a patient's overall psychological health or pathology can provide therapists with useful insight into the development of the therapeutic alliance. We discuss two items of a clinical measure developed by our research group (the Collaborative Interactions Scale – Revised), to illustrate their interplay with specific M-Axis mental capacities and the role of this interplay in determining both patients' and therapists' contributions to the therapeutic alliance. Finally, we provide a clinical illustration and commented excerpt, along with the patient and therapist assessments of M-Axis capacities.

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A growing body of evidence suggests that the *raison d'etre* of any diagnostic system is its usefulness in clinical settings (e.g., First et al., 2004; Keeley et al., 2016; Spitzer, First, Shedler, Westen, & Skodol, 2008). The second edition of the *Psychodynamic Diagnostic Manual* (PDM-2; Lingiardi & McWilliams, 2017) adds a much needed, clinically useful perspective on the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; APA, 2013) and other diagnostic systems, enabling clinicians to achieve a deep understanding of "individuals" (rather than "disorders") to facilitate treatment planning and implementation. More specifically, the PDM-2 aims at: (a) providing a clinically relevant diagnostic system that encompasses the broad spectrum of personality and psychiatric pathology seen in everyday clinical practice; (b) being user-friendly in real-world use; (c) promoting communication between clinicians of different theoretical orientations; (d) accounting for subjective experiences of both patients and therapists; and (e) facilitating identification of effective psychotherapeutic interventions in different patient groups (i.e., the "what works for whom" of Roth & Fonagy, 2004). As McWilliams (2011) has noted, the DSM-5 was not designed to orient therapists toward the *type of relationship* that may be healing to a particular kind of client. In contrast to the DSM, the PDM-2 strongly emphasizes the importance of interlocking elements in the therapeutic relationship (i.e., the therapeutic alliance, transference and countertransference phenomena, and the structural characteristics of both patient and therapist) (Betan, Heim, Zittel Conklin, & Westen, 2005; Colli, Tanzilli, Dimaggio, & Lingiardi, 2014; Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012). Thus, the manual may be considered a resource that helps clinicians better understand their behaviors in therapy, guide their therapeutic

interventions, track in-session processes with patients, deal with ruptures in the therapeutic alliance, and achieve better therapy outcomes.

This paper focuses on the features and main innovations of the PDM-2 Adult M-Axis (i.e., the Profile of Mental Functioning), which provides a detailed description of individuals' mental functioning. In particular, we emphasize the clinical importance of developing patient–therapist agreement about the nature of the patient's suffering (a concept we could define as the "diagnostic alliance"), the subsequent development of an active collaboration built on mutual understanding of therapeutic goals and the tasks that will constitute therapy, and the fostering of a patient–therapist bond (the "therapeutic alliance," Bordin, 1979). We outline how a psychodynamically informed assessment of mental capacities, including both healthy and pathological aspects of individual functioning, can provide useful insight into the development of the therapeutic alliance—one of the most robust predictors of treatment success (Horvath, Del Re, Flückiger, & Symonds, 2011).

Although the PDM-2 was designed to assess patients' psychological and personality functioning, in this paper we apply the M-Axis diagnostic approach to the psychotherapist as well as the patient. There is growing evidence that so-called "therapist effects" account for 5–9% of outcome variance in psychotherapy (Baldwin & Imel, 2013), and that therapists' subjective and therapy-non-specific characteristics (e.g., coping patterns, emotional well-being, values, and interpersonal attitudes) can influence their patients' response to treatment (for a review, see Lingiardi, Muzi, Tanzilli, & Carone, 2017). These considerations seem particularly relevant when applied to the therapeutic alliance research field, in which therapists' attitudes and techniques— not tied to any particular psychotherapy orientation—have been found to influence, positively or negatively, the development or maintenance of the working alliance (Ackerman & Hilsenroth, 2001, 2003).

To address these aims, we need a clinical tool that will define and operationalize the components of the therapeutic alliance in a reliable, clinically useful way. The Collaborative Interactions Scale (CIS; Colli & Lingiardi, 2009), and its revised version (CIS-R; Colli, Gentile,

Condino, & Lingiardi, 2017), are the results of 10 years of ongoing transcript-based research into the ways in which patients and therapists collaboratively construct the therapeutic relationship. Both the CIS and the CIS-R have been found to be reliable rating systems for empirical research and clinical assessments. Thus, we regard these measures as the most suitable for explaining and highlighting how the M-Axis approach has essential therapeutic implications.

The Profile of Mental Functioning in the PDM-2: An Overview

The Profile of Mental Functioning (M-Axis) provides a detailed description of a person's overall mental functioning. By systematizing and operationalizing numerous separate dimensions of mental functioning, it assists clinicians in capturing the complexity and individuality of their patients. The M-Axis assesses 12 crucial areas: capacity for regulation, attention and learning; capacity for affective range, communication and understanding; capacity for mentalization and reflective functioning; capacity for differentiation and integration; capacity for relationships and intimacy; capacity for self-esteem regulation and quality of internal experience; capacity for impulse control and regulation; capacity for defensive functioning; capacity for adaptation, resiliency and strength; self-observing capacities (psychological mindedness); capacity to construct and use internal standards and ideals; and capacity for meaning and purpose. (For a brief description of each, see Table 1.) Each capacity represents a wealth of concepts built on a wide range of psychodynamic, cognitive, and developmental theory and research. To take a deep psychological approach to personality functioning and the psychotherapy process, it is critical that clinicians reflect on these capacities in their patients.

To facilitate clinically useful assessment of M-Axis capacities, the PDM-2 outlines a rating procedure whereby clinicians indicate on a 5-point Likert scale the level at which each mental function is evident in a given patient (or psychotherapist). They then add up the 1-to-5-point ratings assigned to each capacity, yielding a single numerical index of overall mental functioning (with totals ranging from 12 to 60). This score permits the clinician to assign the individual provisionally

to one of seven levels of mental functioning (ranging from "healthy/optimal mental functioning" to "major/severe defects in basic mental functions," corresponding to a psychotic level of personality organization). For each M-Axis capacity, the manual lists several well-validated measures that can further aid in the assessment process, such as the Defense Mechanism Rating Scale (Perry, 1990), the Shedler-Westen Assessment Procedure-200 (Westen & Shedler, 1999a, 1999b), and the Social Cognition and Object Relations Scale (Stein, Hilsenroth, Slavin-Mulford, & Pinsker, 2011).

How Mental Capacities Can Shape the Therapeutic Process: An Empirical and Clinical Approach Using the Collaborative Interaction Scale – Revised

The CIS–R is an observer-rated measure of therapeutic alliance ruptures and collaboration/resolution processes in psychotherapy which can be applied to verbatim transcripts of audio or video recordings of a therapeutic session. The CIS–R is divided into two scales: one used to evaluate therapeutic alliance ruptures and the collaborative processes of the patient (CIS–P) and the other used to evaluate therapeutic alliance ruptures and the collaborative processes of the therapist (CIS–T). The CIS–P includes four subscales: Direct Rupture Markers (DRMs), wherein the patient explicitly and confrontationally ruptures communications; Indirect Rupture Markers (IRMs), wherein the patient implicitly communicates discomfort about the therapeutic relationship and/or the therapy in general; Direct Collaborative Processes (DCPs), wherein the patient explicitly refers to the therapeutic relationship, the therapy itself, or the therapeutic process in a manner that indicates positive collaboration; and Indirect Collaborative Processes (ICPs), wherein the patient indicates an active, although not explicitly stated, collaboration with the therapist.

The CIS–T comprises four subscales: Direct Collaborative Interventions (DCIs), wherein the therapist's collaborative interventions explicitly focus on the relationship with the patient or some aspect of the therapy; Indirect Collaborative Interventions (ICIs), wherein the therapist's interventions are not explicitly directed toward the therapeutic relationship or the therapy in general but may contribute positively to the relationship; Rupture Interventions (RIs), wherein the

therapist's interventions negatively affect the therapeutic process; and Form of Therapist Intervention, which identifies which of the four types of therapist interventions is shown. Both the CIS and the CIS-R have been found to be valid and reliable rating systems (Colli et al., 2017).

In this article, we select one CIS-P item and one CIS-T item that we identify as most significant for illustrating the interplay with specific M-Axis mental capacities that determines both the patient's and the therapist's contributions to the therapeutic alliance. Given space constraints, we discuss only two markers; we note, however, that all capacities of the M-Axis may have relevant implications for the degree of collaboration over the tasks and goals of therapy, the quality of the personal bond between the patient and therapist, and the process of "intersubjective negotiation" (Safran & Muran, 2000) within the therapeutic dyad. For example, patients' maladaptive defense mechanisms (the eighth category of the M-Axis) have frequently been shown to predict a poorer alliance (Bond & Perry, 2004; Kramer et al., 2009) and to influence alliance rupture and resolution processes (Gerostathos, de Roten, Berney, Despland, & Ambresin, 2014). Similarly, therapists' higher reflective and introspective abilities (such as reflective functioning, mindfulness, and self-awareness, which fall into the third and tenth categories of the M-Axis) have been found to be related to more positive alliances and outcomes (Cologon, Schweitzer, King, & Nolte, 2017; Ryan, Safran, Doran, & Moran, 2012; Williams & Fauth, 2005).

1. The patient talks about the meaning of an event that has occurred in the therapeutic relationship, connects something that happened with the therapist to other episodes that occurred outside psychotherapy, or recognizes schemas and recurring models (CIS-P item DCP3 – Meaning of events)

This item is included in the Direct Collaborative Processes (DCP) subscale of the CIS-P. It is rated when a patient is able to talk in a collaborative way about his/her negative feelings about the therapeutic relationship and can recognize a pattern of behavior in the relationship with the therapist or other significant relationships (of the present or the past). This marker, which assesses a patient's

ability to work in a collaborative manner (over the course of therapy), may be related to certain mental capacities described in the M-Axis. In particular, it may relate to the capacity for mentalization and reflective functioning and self-observing capacities (psychological mindedness). Indeed, in order to produce this sophisticated form of collaboration, the patient should be able to infer and reflect on his/her own and others' mental states, to symbolize affectively meaningful experience, to use this experience effectively in self-regulation and interpersonal interactions (this describes the concept of "mentalization," which has been operationalized for research purposes as "reflective functioning," or RF; Fonagy, Target, Steele, & Steele, 1998), and to be introspective— showing an inherent interest in better self-understanding (i.e., the concept of "psychological mindedness," which in turn is related to self-consciousness and self-awareness).

Here, because of their greater relevance for this marker, we focus on the impact of patients' mentalizing abilities on the therapeutic process and outcome. When this collaborative process is shown by a patient, it can be considered an expression of the patient's well-functioning M-Axis capacity for mentalization and reflective functioning, as the highest score for this capacity is given when a patient "can comprehend and reflect on internal mental states (e.g., emotions, thoughts, desires, and needs) and understand, even when challenged or distressed, internal experiences that underlie others' actions and reactions" (Lingiardi & McWilliams, 2017, p. 89).

In recent years, the concept of mentalization has been found to play a central role in patient diagnosis, therapy outcome, and therapy process. Generally speaking, difficulties in mentalizing abilities have been reported in patients with borderline personality disorder (Sharp & Kalpakci, 2015) and other personality disorders (Bateman & Fonagy, 2016; Nazzaro et al., 2017), as well in patients with other psychiatric conditions (Fisher-Kern, Fonagy, Kapusta, & Luyten, 2013; Skårderud, 2007).

Surprisingly, only a few studies have investigated mentalization as a moderator/mediator of the psychotherapy outcome and/or process. The results of these studies have been mixed but promising (Katznelson, 2014; Rudden, 2017). In a small pilot study, RF was found to be

significantly related to improvement in overall mental condition after treatment (Müller, Kaufhold, Overbeck, & Grabhorn, 2006). Taubner, Kessler, Buchheim, Kächele, and Staun (2011) found that RF predicted a change in overall mental condition in chronically depressed patients after 8 months of long-term psychoanalytic treatment. However, mentalization has also been proposed as a mechanism of change in psychotherapy. In a large-scale clinical trial, Levy et al. (2006) compared transference-focused psychotherapy (TFP), dialectical behavior therapy, and modified psychodynamic supportive psychotherapy with patients with borderline personality disorder. Results showed a significant increase in RF in patients in the TFP treatment group relative to patients in the other treatment conditions, suggesting that this variable can be considered an index of structural improvement in psychological functioning in this group of patients. Moreover, Rudden, Milrod, Target, Ackerman, and Graf's (2006) randomized controlled trial with patients suffering from panic disorder showed that psychoanalytic psychotherapy enhanced patients' ability to understand and reflect upon their mental states (albeit in the specific study this was assessed in relation to their symptoms).

Specific empirical findings about the associations between RF and the psychotherapy process (including the therapeutic alliance) are lacking. Taubner et al. (2011) reported a moderate association between pre-treatment RF and early patient ratings of the therapeutic alliance, as well as a trend for high RF to predict improvement in the alliance during treatment. These findings are in line with those of another study, which found positive correlations between RF and the therapeutic alliance in the first 8 months of treatment, suggesting that higher RF might be helpful in forming a positive alliance early in treatment (Antonsen, Johansen, Rø, Kvarstein, & Wilberg, 2015). Furthermore, a recent investigation by Ekeblad, Falkenström, and Holmqvist (2015) showed that lower pre-treatment RF in depressed patients predicted significantly lower therapist-rated working alliance levels during interpersonal psychotherapy and cognitive behavioral therapy. No significant relation was found between RF ratings and patient-rated levels of alliance. The authors hypothesized that patients with less capacity to mentalize about their symptoms may have felt

frustrated with their therapist's attempts to understand the psychological causes of their depression. This lower alliance might relate to symptom-specific mentalization, regardless of the patients' general reflective capacity.

Finally, the M-Axis capacity for mentalization and reflective functioning points to another relevant topic, as it posits that patients should be able to mentalize even when "challenged or distressed" (Lingiardi & McWilliams, 2017, p. 89). This suggests that the assessment of mentalization should take into account patient arousal level, because in challenging or stressful interpersonal situations (i.e., those with intense arousal activation), the capacity for mentalization is likely to decrease (Bateman & Fonagy, 2016). With respect to the therapeutic alliance, patient-therapist collaborative interactions in the here-and-now—described by the DCP3 marker—can be considered moments in which the patient's arousal is very high, due to the activation of the attachment system (Fonagy, Bateman, & Luyten, 2012). In other words, the ways in which the patient and therapist "process the therapeutic relationship" (Hill & Knox, 2009) under stressful conditions (e.g., during an alliance rupture and the subsequent resolution process) might be particularly informative about the patient's capacity for mentalization.

Another relevant area assessed by this CIS-P marker is the patient's capacity for self-understanding and the achievement of meaningful insight over the course of therapy. Fonagy, Steele, Steele, Moran, and Higgitt (1991) defined insight as an increasing awareness of one's (and others') mental states. Castonguay and Hill (2007) outlined the importance of the patient's capacity to reach an understanding of the connection between past and present experiences or between thoughts, feelings, desires, and behaviors. Empirical findings suggest that this variable may be related to patient personality characteristics and that it could affect therapist techniques in psychotherapy. Lehmann and Hilsenroth (2011), who developed the SWAP Insight Scale (SIS) from six items on the Shedler-Westen Assessment Procedure-200, found that higher levels of insight may facilitate growth in patient-therapist interaction by allowing more clear and open dialogue about what happens during the therapeutic session. They also found that greater insight

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can promote the process of working through difficult therapeutic experiences, and thus potentially contribute to rupture resolution. Moreover, SIS was related to therapist techniques in early treatment sessions, such as the identification of similar relationships over time and an association of recurring patterns of actions/feelings/experiences (Lehmann et al., 2015).

2. The therapist is focused on feelings and/or thoughts and helps the patient clarify the intensity and/or the quality of feelings; the therapist is focused on the attitude of the patient toward therapy and/or on desires/affects of the patient toward the therapy and/or the therapist (CIS-T item DCI2 – Affects)

This item is included in the Direct Collaborative Interventions (DCI) subscale of the CIS-T, and it is rated when the therapist focuses on a patient's affective experience and some aspects of the person's experience in the therapeutic relationship. The therapist may reflect on or communicate this experience to the patient in an effort to analyze what the patient feels or to discuss emotional experiences, desires, or thoughts about the therapeutic relationship.

Shifting to the perspective of the PDM-2 and exploring the application of the M-Axis to assessing the therapist's mental functioning, we note that the capacity for affective range, communication, and understanding seems potentially relevant for this CIS-T marker. This mental capacity pertains to the therapist's ability to experience, comprehend, and express affects in a situationally appropriate manner. More specifically, the third component of this capacity, "affective understanding," is the ability to recognize one's own emotions and to read and interpret others' emotional communications (verbal and non-verbal) in adaptive, empathic, responsive, and relationship-facilitating ways. This ability is also related to social cognition, insofar as it allows one to understand, act on, and benefit from interpersonal interactions.

Starting from this definition, the relevance of therapists' ability to use, express, communicate, and understand a wide range of subtle emotions and feelings effectively in therapy is supported by both the clinical and the empirical literature. Several studies suggest that therapists' emotional and

affective functioning have an impact on therapy sessions and outcomes. Gurman (1972) showed that therapists' pre-session emotional well-being influenced their ability to provide facilitative conditions (i.e., empathy, warmth, and genuineness) in sessions, and Hill et al. (1994) found that therapists' pre-session negative affect was related to lower therapist-reported helpfulness and session depth. A more recent study by Chui, Hill, Kline, Kuo, and Mohr (2016) showed that therapists' pre-session positive affect predicted higher session quality and a better working alliance, as rated by both patients and therapists, whereas therapists' pre-session negative affect had detrimental effects. Furthermore, Duan and Kivlighan (2002) demonstrated that therapists' pre-session affect influenced their understanding of client emotions, which in turn related to client-rated session depth.

This latter result is in line with the findings of Kaplowitz, Safran, and Muran's (2011) investigation, in which therapists' emotional intelligence quotient (EIQ) (i.e., their capacity to use emotional information to understand and interact with others) was found to be moderately associated with therapist ratings of patients' interpersonal and presenting problems. This effect was significant even when single EIQ dimensions (i.e., the ability to integrate emotions into thought, manage affects, and understand the interpersonal meaning of emotions) were considered. Other research suggests that helpful therapists are more able to understand, manage, and use difficult emotions effectively (Dalenberg, 2004; Hill et al., 2003). An extensive meta-analysis showed a statistically significant relationship between the therapist's facilitation of patient affective experience or expression and the outcome of short-term psychodynamic psychotherapy (Diener, Hilsenroth, & Weinberger, 2007). Recent research on cognitive behavioral therapies also suggests the importance of the therapist's facilitation of affective experience (Aafjes-van Doorn & Barber, 2017).

Another M-Axis mental function relevant to this CIS-T item is therapists' capacity for relationships and intimacy; that is, their ability to develop and sustain relationships by engaging in a

wide array of relationship-promoting behaviors. More specifically, this capacity reflects two key areas. First, it captures the depth, range, and consistency of one's (here, the therapist's) interpersonal relationships, as well as the quality of one's internalized object relations (i.e., mental representations of one's self, other people, and self–other interactions). Second, it pertains to one's ability to adjust interpersonal distance and closeness in response to situational demands, on the basis of the qualities of specific relationships.

These characteristics may have a critical influence on the patient–therapist relationship, particularly with respect to the way in which psychotherapists work with, refer to, wonder about, or explain patients' experiences of the ongoing therapeutic interaction and relationship (i.e., transference work; Høglend, 2014). Several studies show that clinicians' characteristics inevitably influence patients' reactions to and perceptions of them (Andersen & Przybylinski, 2012; Gelso, 2011), as well as therapists' ability to deliver transference interpretations that are empathically attuned, open, and curious reflections of both here-and-now emotions triggered within the therapy relationship and their connection with patients' early significant relationships.

These reflections are supported by studies in which therapists who showed a more affiliative interpersonal stance—characterized by nurturing, helping, warmth, and protecting behaviors—and involving and engaging attitudes were found to be more effective in achieving a positive therapeutic outcome (Lingiardi et al., 2017). Furthermore, Schut et al. (2005) found that therapists who demonstrated fewer affiliative and more hostile interpersonal behaviors (i.e., belittling, blaming, attacking, and rejecting) were associated with more interpretations in therapy; these, in turn, were connected to fewer favorable changes in patients' personality and overall functioning. Similarly, Ackerman and Hilsenroth (2001, 2003) showed that therapists' interpersonal attributes were related to the development and maintenance of the therapeutic alliance, both early on and late in treatment. More specifically, the authors found significant positive relationships between the alliance and therapists' attributes, such as a conveyed sense of being flexible, interested, relaxed, confident,

warm, and empathic. On the other hand, perceived rigid, self-focused, critical, cold, disconnected, or indifferent interpersonal attitudes in therapists had a negative impact on the working alliance.

Clinical Illustration

The following is a transcript excerpt from a wider and ongoing research project on therapist personal characteristics and the therapeutic relationship in psychodynamic therapies (see Lingiardi et al., 2017; Muzi, Talia, & Lingiardi, 2017). We include this clinical material with the informed consent of both the patient, a 31-year-old woman, Lisa, and her therapist, Susanna, a 42-year-old female psychotherapist in private practice. The portion of the text coded with the CIS-R markers is underlined. Along with the annotated excerpts, we provide information on both the patient and the therapist M-Axis capacities. (For a full evaluation of the mental functioning of both parties, see Table 2.)

Lisa sought individual therapy to overcome severe anxiety and interpersonal difficulties. At the beginning of the treatment, she tended to feel inferior and inadequate, indecisive, and socially inhibited, and had difficulty recognizing and describing her feelings (especially her feelings of fear and shame). She had trouble reflecting on the influence of her difficult relationship with her mother, who saw her role in her daughter's life as one of providing economic support, without truly connecting emotionally with Lisa's needs and feelings. Lisa seemed to view other persons as potential sources of unimagined perils that she must somehow elude, both behaviorally and affectively. She showed an anxious–avoidant and phobic personality, according to the PDM-2 P-Axis, as well as mild impairments in some domains of mental functioning, such as M-Axis capacities of relationships and intimacy, self-esteem regulation and quality of internal experience, mentalization and reflective functioning, and affective communication and understanding.

In responding to a semi-structured clinical interview on her childhood relationship with her parents and to broad questions on her characteristic ways of thinking, feeling, relating, regulating emotions, and representing herself and others, Lisa's therapist (Susanna) reported good

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relationships with her parents, despite emotional struggles during her infancy and adolescence that were related to a younger brother with moderate intellectual disability. Susanna stated she always felt devoted to protecting and defending other people in need. She believed that her best quality, as a person and as a psychotherapist, was her emotional availability and empathic nature; however, she acknowledged some difficulties in maintaining the therapeutic frame (with a tendency, for example, to give in to some patients' excessive requests or to disclose some aspects of her personal life). According to the PDM-2 P-Axis, Susanna showed an overall healthy level of personality organization with a depressive personality style. Her functioning was good and appropriate in almost all mental capacities, though she showed mild difficulties in a few areas (such as affective regulation and defensive functioning during stressful events and situations; see Table 2).

Susanna often experienced protective and parental countertransference feelings toward Lisa, but sometimes felt detached and "pushed away" by her. The excerpt below was taken from the session before the winter holidays after 1 year of psychodynamic therapy. It follows an interval in which Lisa had been silent for a long time:

Therapist: <u>Lisa, I would like to understand your silence today. It seems to me that when we have to deal with some break in our relationship, you often seem to answer in… a cold way.</u> For example, before, it looked as if you were trying to exit from this room, looking out of the window and absently checking the clock near the door. You missed some sessions before the holidays. <u>I am wondering if there is something that worries you in these situations, and if we can try to understand that together.</u> [*In this passage, the therapist gives the patient a meta-communication and shifts the focus to the here and now (CIS-T, DCI4), helping the patient to clarify the intensity and/or the quality of her feelings (CIS-T, DCI2). Considering the M-Axis capacity for affective range, communication, and understanding, Susan seems able to decipher and reflect on Lisa's subtle emotional signals flexibly and accurately,*

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communicating her thoughts in a way that seems appropriate in quality and intensity to the situation at hand.]

Lisa: Maybe I have nothing to say today. I am simply looking at the rain outside. [Silence] I've never been the kind of person who cares about being alone during festivities. I never have this type of thought. It would be… sad. Other people would think that I am a loser, or stupid. Or they would make fun of me. [*In this passage, Lisa denies and minimizes an affective state (CIS-P, IRM2).*]

Therapist: And then what would happen?

Lisa: I would feel humiliated. It would be sad for me. [*In this passage, Lisa begins to collaborate with Susan, clarifying the quality of her feelings (CIS-P, IRM2).*]

Therapist: <u>Is it possible that this is happening here too? And that you are afraid our relationship will become so important to you that you run the risk of suffering if you were to be rejected or disregarded?</u> [*In this passage, the therapist focuses her intervention on feelings and/or thoughts, helping Lisa to clarify the intensity and/or the quality of feelings toward therapy (CIS-T, DCI2). Considering the M-Axis capacity for relationships and intimacy, Susan seems to show an emotionally rich capacity for intimacy, caring, and empathy, even if Lisa's feelings are intense and painful.*]

Lisa: Sometimes I think that you could be like everyone else. [Silence] You might make fun of me with your husband, the patient who whines before the holidays… No, I prefer to avoid this thought.

Therapist: <u>This difficulty, this fear to be open about your feelings within relationships is quite understandable given all that you have gone through emotionally in your relationships. Perhaps even in our relationship there is the fear that expressing these emotions could lead to a painful rejection or humiliation. So you try to avoid this fear, looking for "a way out."</u> [*In this passage, the therapist connects something that happened in other relationships with something happening in the psychotherapy (CIS-T, DCI3). Considering the M-Axis capacities*

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mentioned previously, Susan seems able to provide support to Lisa and, at the same time, to understand and link her painful feelings to her characteristic ways of relating at an interpersonal level.]

Lisa: [Silence] <u>Sometimes I remember that when I was a child, my mom often chuckled while I cried when she left me. Just like… I was a weak baby unable to stay 5 minutes alone. I remember when she joked about that with our neighbors, and they laughed too… It was terrible. So when I grew up, I realized that it was worthless… I mean, we have known each other for 1 year, and a part of me knows that you would never do something like that to me, but then there is the other part, and I think that maybe with you something similar could happen again</u>. And… I'm scared. Yes, I'm scared. [*In this passage, Lisa connects something that happened with the therapist to other episodes that occurred outside psychotherapy (CIS-P, DCP3). In terms of the M-Axis capacity for mentalization and reflective functioning, Lisa seems able to reflect on her mental states even when challenged, generating psychological insight into her motives and emotions in the context of behavioral patterns.*]

Therapist: Of course I understand this fear, but… you must know that I won't blame you for it. Conversely, this feeling is very touching for both of us.

Conclusions

The main aim of this paper was to demonstrate how an empirical assessment of ruptures in the therapeutic alliance and collaborative/resolution processes in psychotherapy (the CIS-R) can be supported and enhanced by idiographic assessment (the M-Axis) focusing on the complex and unique characteristics of an individual's mental functioning. Clinical utility demands that both intrapsychic and relational variables be taken into account in order for therapists to plan the most effective and well-rounded therapeutic interventions, anticipate challenges that may arise in treatment, delineate therapeutic goals, and evaluate treatment progress.

Moreover, in recent years we have observed, in both clinical and research contexts, shifts in the conceptualization of the therapeutic alliance from a more static conceptualization to one that describes an ongoing process of intersubjective negotiation (Safran & Muran, 2000) wherein therapist and patient characteristics reciprocally influence each other (Hilsenroth, Cromer, & Ackerman, 2012). In this contribution, we have suggested the importance of certain PDM-2 M-Axis capacities, such as: (a) the therapist's capacity for affective range, communication, and understanding and his/her capacity for relationships and intimacy (Ackerman & Hilsenroth, 2003; Lingiardi et al., 2017); and (b) the patient's capacity for mentalization and reflective functioning and the related ability to achieve meaningful insight over the course of therapy. As shown in the clinical illustration, ruptures and collaborative/resolution processes in therapy are likely influenced by the dynamic interplay of the therapist's subjective variables and/or techniques and the patient's specific mental functions that contribute to the patient's personality organization.

Although this brief contribution cannot do justice to the richness and complexity of the topic, we believe that this summary of findings can provide a useful resource for future studies, training initiatives, and the development of clinical practices that show a careful appreciation of the patient and therapist contributions to the therapeutic alliance. In sum, while the PDM-2 is a diagnostic manual that aims at evaluating different groups of patients in treatment, it also enables clinicians to reflect on their own psychological functioning and on their mental and relational capacities.

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Table 1

Profile of Mental Functioning – M-Axis capacities

Mental capacities	Definitions
1. Capacity for regulation, attention, and learning	Ability to attend to and process information, regulate attentional focus, filter extraneous information from consciousness, and learn from experience.
2. Capacity for affective range, communication, and understanding	Ability to experience, express, and comprehend the full range of pre-representational and representational patterns of affects; to symbolize affectively meaningful experience; and to verbalize affect states appropriately.
3. Capacity for mentalization and reflective functioning	Ability to infer and reflect on one's own mental states as well as those of others, and to use this capacity in personal and social interactions.
4. Capacity for differentiation and integration (identity)	Ability to distinguish one's self from others, fantasy from reality, internal representations from external objects, and present from past and future.
5. Capacity for relationships and intimacy	Depth, range, and consistency (i.e., stability) of one's relationships; ability to adjust interpersonal distance–closeness; sexuality.
6. Capacity for self-esteem regulation and quality of internal experience	Level of confidence and self-regard that characterizes relationships with one's self, others, and the larger world; degree of internal control, self-efficacy, and agency.
7. Capacity for impulse control and regulation	Ability to modulate impulses and express them in adaptive, culturally appropriate ways.
8. Capacity for defensive functioning	Degree of maturity of coping and defense mechanisms and degree of distortion in reality testing.
9. Capacity for adaptation, resiliency, and strength	Ability to adjust to unexpected events and changing circumstances and to cope effectively when confronted with uncertainty, loss, stress, and challenge.
10. Self-observing capacities (psychological mindedness)	Ability to observe one's own internal life mindfully and realistically and to use this information adaptively; degree of interest in better self-understanding.
11. Capacity to construct and use internal standards and ideals	Ability to formulate internal values and ideals and to make mindful decisions based on a set of coherent, flexible, and internally consistent underlying moral principles.

12. Capacity for meaning and purpose	Ability to construct a personal narrative that gives coherence and meaning to personal choices, as well as a sense of directedness and purpose, a concern for succeeding generations, and a sense of spirituality.

Table 2

Summary of Basic Mental Functioning: M-Axis total score and levels of mental functioning

Lisa		Susanna	
Capacity for regulation, attention, and learning	5	Capacity for regulation, attention, and learning	5
Capacity for affective range, communication, and understanding	3	Capacity for affective range, communication, and understanding	4
Capacity for mentalization and reflective functioning	3	Capacity for mentalization and reflective functioning	5
Capacity for differentiation and integration (identity)	4	Capacity for differentiation and integration (identity)	5
Capacity for relationships and intimacy	2	Capacity for relationships and intimacy	5
Capacity for self-esteem regulation and quality of internal experience	3	Capacity for self-esteem regulation and quality of internal experience	4
Capacity for impulse control and regulation	4	Capacity for impulse control and regulation	5
Capacity for defensive functioning	3	Capacity for defensive functioning	4
Capacity for adaptation, resiliency, and strength	3	Capacity for adaptation, resiliency, and strength	5
Self-observing capacities (psychological mindedness)	3	Self-observing capacities (psychological mindedness)	4
Capacity to construct and use internal standards and ideals	4	Capacity to construct and use internal standards and ideals	5
Capacity for meaning and purpose	3	Capacity for meaning and purpose	4
Overall mental functioning:	*40*	*Overall mental functioning:*	*55*
[M03 40–46: Mild impairments in mental functioning, showing mild constrictions and areas of inflexibility in some domains of mental functioning, implying certain rigidities and impairments.]		[M01 54–60: Healthy/optimal mental functioning, showing optimal or very good functioning in all or most mental capacities, with modest, expectable variations in flexibility and adaptation across contexts.]	

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