

# Affective Activation but not Insight Predicts Sense of Self in Short-Term Dynamic Psychotherapy: A Single-case Study

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**Affective Activation but not Insight Predicts Sense of Self in  
Short-Term Dynamic psychotherapy: A Single-case Study**

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# Abstract

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Title: Affective Activation but not Insight Predicts Sense of Self in Short-Term Dynamic Psychotherapy: A Single-case Study.

Supervisors: Asle Hoffart (research psychologist, Modum Bad, Vikersund, and Professor II, Department of Psychology, University of Oslo) and Postdoctoral Research Fellow Pål Gunnar Ulvenes.

**Objective:** This study investigates the entire course of an Affect Phobia Therapy (APT; McCullough, 1997) treatment. APT postulates that affective activation, insight into maladaptive patterns and an increased sense of Self are essential for positive treatment outcome. The present study investigates the change of three process variables: Insight (into defensive patterns; D), Activating affects (F[eeeling]) and Sense of Self (SoS), both within and across sessions. The thesis studies D and F as process predictors, SoS as intermediate outcome variable, and overall outcome. Further, it also inquires into whether there are sequential relationships between these four variables. We test three hypotheses: I. More than expected F in a session will predict higher SoS in the following session(s). II. More than expected F in a session will predict higher D in (the) subsequent session(s). III. More than expected D in a session will predict higher SoS in the subsequent session(s). **Method:** Data from a single subject based on the previously published Randomized Control Trial of Brief Cognitive and Dynamic Therapy (Svartberg, Stiles & Seltzer, 2004) were scored with the Achievement of Therapeutic Objectives Scale (ATOS). ATOS ratings were based on video-recorded therapy. The patient met the criteria for a Cluster C personality disorder (dependent personality disorder). Time series modeling of process variables was performed to test our hypotheses. Outcome measures were SCL-90, MCMI-C, BDI and IIP, in addition to qualitative observation and SoS. The entire treatment was transcribed. **Analysis:** The data were analyzed by a two-way Analysis of Variance design, linear regression, ARIMA and a Cross Lagged Correlation design. Variance, trends and the sequential relationships between the process variables were investigated. Qualitative analysis was done based on verbatim transcripts of the entire treatment. **Results:** The results indicated a significant clinical change, overall high ATOS-scores and very good/excellent alliance. Between therapy sessions we found three small trends (nonsignificant) of sequential relationships: 1. More than expected F

in a session predicted more than expected SoS; 2. More than expected D predicted less than expected F; 3. More than expected D predicted less than expected SoS. **Conclusion:** The overall results indicated significant positive clinical change, which signals that this was a successful treatment course. Increased SoS and F can to a certain extent predict this outcome, but the vague indication that D negatively predicts SoS and F is puzzling. All results from the lagged crosscorrelations were nonsignificant. This single case study offers small effect size, and results cannot be easily generalized. However, even though results must be interpreted as change mechanisms in this unique case, they also seem to confirm some central tenets in APT. Our findings may also largely be due to diverse methodological weaknesses/challenges, and the properties of the outcome and/or process measures.



# Acknowledgments

First and foremost we warmly thank our supervisors, Asle Hoffart and Pål Gunnar Ulvenes, for their patience with us, for generously sharing their knowledge, and for spending valuable time on our project.

Our first supervisor and guide, Leigh McCullough, was tragically diagnosed with amyotrophic lateral sclerosis (ALS) in 2010 and died on June 7, 2012. In contrast, our daughter, Sigrid, was born in July 2012, and as we have read too much Margaret Mahler to “risk” kindergarten, we have been rather occupied lately. Espen has also worked in parallel with his studies as an MBT rater and therapist at The Norwegian Resource Centre for Personality Psychiatry since January 2013. We wish to thank Sigmund Karterud for being an inspiring and brilliant executive. In relation to this thesis he has, among other things, taught us that research should be theoretically driven. We also acknowledge Geir Pedersen, who has generously aided us in interpreting and analyzing the outcome measures.

This thesis has been on its way since April 2009, and we hope this latency has not damaged our late term fetus,<sup>1</sup> in terms of making it less original, current or relevant. During the initial period, we rated hundreds of therapy-sessions in STDP and CT at Modum Bad Research Institute. During this task, we came across a therapist who displayed noteworthy excellence. We therefore transcribed the entire course of this therapy.

We would also like to thank Jon Monsen and Dag-Erik Eilertsen for inspiring conversations, and for generously sharing their deep knowledge, e.g., Jon has kindly permitted Espen to study one of his own complete therapy courses on video, and Dag-Erik has shared his knowledge about Durbin-Watson and time series analysis. It is a privilege to be surrounded by such competent faculty.

The world we perceive is a dream we learn  
to have from a script we have not written.  
— Silvan Tomkins (1992).

*Dedicated to Leigh McCullough, Martin Svartberg & The Girl with Gold Medals.*

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<sup>1</sup> The Department of Psychology writes: “Det kan være hensiktsmessig å begynne planleggingen av hovedoppgaven tidlig i studiet” (<http://www.uio.no/studier/emner/sv/psykologi/PSYC6100/krav.html>).





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# 1 Introduction

This thesis will initially present an introduction to the field of psychotherapy research, and subsequently outlay our motivation for undertaking this single-case study. After reporting methods and results, our findings will be discussed.

There is a great puzzle in the field of psychotherapy research concerning the effective components of psychotherapy. Although it is well established that individual psychotherapy is effective (Abbass, 2006; Ablon, Levy & Katzenstein, 2006; Anderson & Lambert, 1995; Bergin & Lambert, 1978; Garfield, Prager & Bergin, 1971; Grissom, 1996; Lambert, 2013; Leichsenring, Rabung, & Leibing, 2004; Luborsky, Singer & Luborsky, 1975; Smith & Glass 1977), dozens of meta-analyses of psychotherapy, with widely varying hypotheses about change, have not shown one type of therapy to be more effective than another (Budd & Hughes, 2009; Messer & Wampold, 2002; Shapiro & Shapiro, 1982; Wampold, 2001). Furthermore, with the exception of the alliance,<sup>2</sup> no robust mechanisms of change have been identified (Ahn & Wampold, 2001; Kazdin, 2007; Lambert, 2013; Orlinsky, Rønnestad, & Willutzki, 2004; Norcross & Wampold, 2011; Wampold et al., 1997; Wampold, 2013).

## 1.1 The state of psychotherapy research

Half a century ago, Hans Eysenck (1952, 1965, 1966) interpreted the results of six controlled studies and concluded that three-quarters of neurotics got better regardless of whether or not they were in therapy, i.e., spontaneous remission. He also stated (1952, p. 322) that there “appears to be a negative correlation between recovery and psychotherapy; the more psychotherapy, the smaller the recovery“. Since then, it has been demonstrated that the average effect size of psychotherapy is about 0.8 (Wampold, 2001; Wampold, Imel, & Minami, 2007), which means that nearly three-quarters of patients who receive psychotherapy are better off than those left to recover by themselves (Roth & Fonagy, 2006; Fonagy, 2010). However, there continues to be a lively debate about why this is so, and whether Rosenzweig's (1936) supposition that the common factors are so pervasive that there would be minor differences between diverse forms of psychotherapy, or if the occasional significant differences in treatment outcomes should be taken seriously, as Lambert and

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<sup>2</sup> Some theorists have referred to the alliance as the “quintessential integrative variable” (Wolfe & Goldfried, 1988, p. 449) of therapy.

Bergin (1994) tentatively suggest. Some authors argue that “the Dodo Bird Verdict is alive and well – mostly” (Luborsky et al., 2002, p. 2), others suggest that “the dodo bird is extinct” (Beutler, 2002, p. 30).

### **1.1.1 Clinical significance and treatment efficacy**

The clinical significance of a treatment refers to its ability to meet standards of efficacy set by the government, consumers, clinicians, and researchers (Jacobson & Truax, 1991). In contrast to criteria based on statistical significance, judgments concerning clinical significance are based on external standards specified by interested parties in the society. Jacobson & Truax (1991) criticized Smith, Glass and Miller (1980) for confusing statistical effect or effect size with efficacy. There have been launched numerous suggestions of criteria for operationalizing clinical significance, e.g., Kazdin (1978) proposed that behavior changes should be viewed as clinically important, if the intervention brought the client's performance within the range of socially acceptable levels, as evidenced by the client's peer group, or if the client's behavior is judged by others as reflecting a qualitative improvement on global ratings. Today, within the clinical population, a return to normal functioning (40–60% of patients typically return to normal functioning; Lambert & Ogles, 2004) is a consensus standard for treatment efficacy, but as mentioned above, there are considerable methodological problems concerning outcome measures (Fonagy, 2010).

Observing that approximately half the patients recover implies that a relatively large proportion of patients do not benefit from the treatments they are provided with (often classified as non-responders). Unfortunately, there has been limited research on patients who do not respond to psychotherapy (15–20% show no significant change, while 5–10% reliably deteriorate during the course of treatment; Lambert & Ogles, 2004), but there are indications that the likelihood of non-response or negative response increases “with more severe symptoms, with more profound functional impairment, with more problems in interpersonal relatedness, and with the presence of personality disorder[s]” (Solbakken & Abbass, 2014, p. 2).

Although there today remains no doubt that Eysenck's argument has been falsified by evidence through randomized clinical trial (RCT) designs, these studies explain surprisingly little comparative outcome variance (Rønnestad, von der Lippe, Axelsen, Wampold &

Greenberg, 2006; Wampold, 2013; Wampold & Brown, 2005). An RCT design typically accounts for about 1% (Cohen's  $d$  of 0.20) of the outcome variance for differences among treatments (Messer & Wampold, 2002) and predicts about 5% of the variance in outcomes due to the alliance (Martin, Garske & Davis, 2000). Variability in outcome explained by specific ingredients account for roughly 0%. Further, some studies indicate no therapist effects in RCT trials (Elkin, Falconnier, Martinovich, & Mahoney, 2006), while others present rather substantial therapist effects, explaining a range from 5% (Wampold & Brown, 2005) to 12% of the variance in outcomes (Baldwin, Wampold, & Imel, 2007; Blatt, Zuroff, Quinlan, & Pilkonis, 1996; Dinger, Strack, Leichenring, Wilmers & Schauenburg, 2008; Wampold & Bolt, 2006; Lambert, 1989; Lutz, Leon, Martinovich, Lyons, & Stiles, 2007; Orlinsky & Howard, 1980; Wampold, 2010; Zuroff, Kelly, Leybman, Blatt & Wampold, 2010).

Further discrepancies stem from statistical controversies, methodological challenges, multiple variables to measure outcome, and even biased reporting of results (Elliot, 2002; Fonagy 2010; Luborsky, et al., 1999), e.g., as Wampold and Bolt (2006) write: "We demonstrate that Elkin et al. [2006] chose a model and performed various operations that increased the likelihood that therapist effects will be absent". Still, knowing that the therapist explains a robust portion of the variance in outcome (Wampold, 2010) is not an explanation of the factors separating successful from less successful therapists (Beutler et al., 2004). However, in studies examining the effectiveness of different therapy methods, one finds more variation within each method than between them, due to the differences among therapists. Nissen-Lie, Monsen & Rønnestad (2010) state, "[a]ccordingly, a more justified, alternative conception to 'the dodo bird verdict' [...] could be that some therapists win and some do not, independent of the therapeutic method they use." This can be seen as an argument for the appropriateness of studying the technique of expert therapists (Lambert & Ogles, 2004).

Another puzzling issue raised by Messer and Wampold (2002) is that researcher allegiance has been found to account for 70% of the variance (Luborsky et al., 1999) in effect sizes of treatment comparisons: "How odd it is, then, that we continue to examine the effect of different treatments (accounting for less than 1% of the variance) when a factor such as the allegiance of the researcher accounts for nearly 70% of the variance!" (p. 23).

The authors, therefore, emphasize the common factors and therapist effects and recommend the following for psychotherapy research and practice (ibid., p. 23–24): 1) "Limit clinical



trials comparing bonafide therapies because such trials have largely run their course. We know what the outcomes will be”; 2) ”focus on aspects of treatment that can explain the general effects or the unexplained variance in outcomes”; 3) ”cease the unwarranted emphasis on ESTs [empirically supported treatments]. They are based on the medical model, which has been found wanting and wrongly leads to the discrediting of experiential, dynamic, family, and other such treatments”.

### **1.1.2 Talented therapists provide “magic potions”**

In terms of the therapeutic relationship, correlation studies show that alliance (Bordin, 1979, 1983, 1994; Gaston, 1990; Luborsky, 1976) at the beginning of treatment predicts improvement in symptoms at the end (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Cloitre, Chase Stovall-McClough, Miranda & Chemtob, 2004; Martin et al., 2000; Klein et al., 2003). But as we all know, demonstrating correlation is but an illusion of explanation, and even though a meta-analysis from 2011 (Horvath, Del Re, Flückiger & Symmonds) reported an aggregate correlation between alliance and outcome of .275 (typically described in the range of .20 to .30), there continues to be a lively debate about the therapeutic role of the alliance, predominantly in treatments that are examined using RCT designs (Flückiger, Del Re, Wampold, Symonds & Horvath, 2012; Ulvenes, Berggraf, Hoffart, Stiles, Svartberg, McCullough, & Wampold, 2012). Lemma, Target and Fonagy (2011) write: “So the ability to form an alliance does mark out our more talented therapists, but what it is that they do more or less of that makes them more or less effective still remains a mystery”.

Meta-analyses demonstrating equivalence (Luborsky et al., 2002) compared active treatments and found a non-significant effect size of 0.20 based on 17 meta-analyses, which shrank further to 0.12 when corrected for researcher allegiance of different treatments (Grissom, 1996; Wampold et al., 1997), cast doubt on the power of the medical model of psychotherapy. The evidence-based movement emphasizes the empirical demonstration (RCT designs) of specific therapies’ effectiveness in the treatment of particular disorders (Budd & Hughes, 2009; Messer & Wampold, 2002; Norcross & Goldfried, 2005; Stiles, Shapiro, & Elliott, 1986). The goal is to establish a causal relationship between treatment and outcome (Fonagy, 2010). In this whole arena, the perhaps most striking absence of empirical knowledge concerns the treatment of personality disorders (PDs; Castonguay & Beutler,

2006, p. 365–366). In fact, only one of the variables presented by the Division 29 Task Force as effective factors has received an acceptable level of attention for this clinical population (ibid.).

Even though there is converging evidence for a non-significant difference between bonafide psychotherapies (Grissom, 1996, meta-analyzed 32 meta-analyses of comparative treatments and found an average effect size of 0.23, while Wampold et al. (1997) found an effect size identical to that of Luborsky et al. (2002), namely, 0.20), this does not mean that there are no significant differences in these treatments and that their “magic potions” (Fonagy, 2010) contain specific ingredients that are, for instance, moderated by common factors: E.g., Ulvenes et al. (2012)<sup>3</sup> analyzed 46 psychotherapy sessions from a previously conducted RCT (Svartberg, Stiles & Seltzer, 2004), and argue in line with other recent studies (Wampold & Budge, 2012; Hoffart, Borge, Sexton, Clark & Wampold, 2012) that alliance has an indirect effect, in that it is necessary for other factors such as specific ingredients, to work.

Wampold (2013) simply states that the most important common curative factor is treatment itself, while others call for efforts to study how psychotherapy leads to change (e.g., Elliot, 2011; Kazdin, 2009). Elliot (2011) claims that in spite of many theories about what brings about change, we know little of how change actually occurs. Kazdin (2009) writes that “[a]fter decades of psychotherapy research and thousands of studies, there is no evidence-based explanation of how or why even the most well-studied interventions produce change, that is, the mechanisms through which treatments operate”. The major enigma today is the last of the four questions Klaus Grawe articulated in 1997: How does psychotherapy work?

Simultaneously, it would also be exciting to examine how talented therapists obtained their potion recipes (Fonagy, 2010) and administering skills, as existing literature also seems to exclude major effects of therapist training (Beutler et al., 2004; Miller & Binder, 2002; Rønnestad & Ladany, 2006): “Overall, these findings tend to cast doubt on the validity of the suggestions that specific training in psychotherapy, even when unconfounded with general experience, may be related to therapeutic success or skill” (Beutler et al., 2004, p. 239). This is indicated as true for training in manualized short-term psychodynamic treatment (Bein et al., 2000). However, there are some indications for further research, e.g., Crits-Christoph et

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<sup>3</sup> The patients rated the alliance after session 4 on the Helping Alliance Questionnaire (HAQ; Luborsky, Crits-Christoph, Alexander, Margoli & Cohen, 1983).

al. (2006) reported non-significant, but promising, results from training therapists in alliance fostering techniques.

## **1.2 Single-case observational design**

Psychotherapy researchers have necessitated methods that can shed light on what actually accounts for therapeutic change (Elliot, 2002, 2010; Kazdin, 2005, 2009; Lemma et al., 2011), and this might be taken as an argument for the appropriateness of qualitative methods. Single-case experimental designs have been proposed as one way to introduce systematic assessment and evaluation in clinical practice (e.g., Barlow & Hersen, 1984; Kazdin & Tuma, 1982). Indeed, there has been an increasing interest in the study of individual cases (e.g., Busse, Kratochwill & Elliot, 1995; Elliot, 2002; 2010; Hilliard, 1993; Iwakabe & Gazzola, 2009). Stiles (2005, 2007, 2009) argues that case studies offer an important supplement to group-level statistical hypothesis testing, where unique features often are considered as error (Rosenwald, 1988) and can point out where theories need to grow: “If you restrict yourself to the themes that are common across cases, you will overlook the most interesting parts. Each case tells us something new, and new observations are always valuable, whether they confirm previous theory or add something unexpected” (Stiles, 2007, p.123). An adequate theory, then, has to encompass the unique qualities of each case, as well as the common features (Elliot, 2002).

Even when a therapy has been shown to be responsible for change in general (RCT), other factors than therapy may cause apparent reported changes. RCTs have been criticized for having poor statistical power, poor generalizability (as a result of restricted sample sizes), and for being “causally empty” (Cook, Campbell & Day, 1979; Elliot, 2002; Haaga & Stiles, 2000; Kazdin, 1998). For this reason it has been argued, e.g., Haynes and O’Brien (2000), that inferring a causal relation requires another condition: the provision of a logical mechanism or the possible causal relation, i.e., science should be driven by theory. Elliot (2010), therefore, advances change process research (CPR) as a necessary complement to RCT, and argues that single-case student research projects is a good alternative to qualitative interview research in professional training programs: “By staying close to clinical practice, significant events studies can appeal to practice-oriented students in many of the same ways that qualitative interview studies do, while actually being more grounded in practice by virtue

of exposing students to actual therapeutic practice as opposed to talk about practice” (ibid., p. 131).

This thesis closely examines the therapeutic process of one patient (single-case design), diagnosed with cluster C PD, receiving forty sessions of Affect Phobia Therapy (APT; McCullough et al., 2003) from a psychiatrist McCullough (psychotherapist, researcher and founder of APT, who reformulated psychodynamic conflicts in behavioral terms) considered to be one of the best psychotherapists she knew of (Leigh McCullough, personal communication, September 9, 2009). Videotapes of the therapy are arduously examined by the use of a quantitative observer-rated assessment instrument, the Achievement of Therapeutic Objectives Scale (ATOS; McCullough et al., 2004). The ATOS measures change in ten objectives assumed to be central in psychological treatment, and will be elaborated further below (p. 23). The quantitative measures are accompanied by qualitative descriptions describing the micro-processes (all the 33 available sessions were transcribed), and also giving general information about the psychotherapeutic practice. The purpose of this study is to elucidate the processes and effects of what McCullough et al. (2003) have termed affective restructuring, a dimension of change proposed to be central for treatment outcome in APT.

### **1.3 Affect-focus in psychotherapy**

While Silvan Tomkins distinguished and defined the terms affect (“sets of muscle and glandular responses located in the face and also widely distributed through the body, which generate sensory feedback which is either inherently ‘acceptable’ or ‘unacceptable’”; Tomkins, 1962a, p. 243), feelings<sup>4</sup> (“some level of awareness that an affect has been triggered”; Tomkins, 2008, p. xiv) and emotions (“whereas affect is biology, emotion is biography”, ibid.), there is no unison definition of these terms today (Cole, Martin & Dennis, 2004). There is, however, general consensus that affect is a multidimensional phenomenon (Burum & Goldfried, 2007; Ekman, 1992; Ekman et al., 1987; Mennin & Farach, 2007, Sloan & Kring, 2007; Suveg, Southam-Gerow, Goodman & Kendall, 2007; Zeman, Klimes-Dougan, Cassano & Adrian, 2007), including “biologically prepared capabilities evolved and endured in human beings because of their extraordinary value for survival” (Cole, et al., 2004, p. 319). This can be understood as a continuance of Darwin (1998) and James’ (1918;

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<sup>4</sup> Disagreements among theorists persist today over Tomkins’ firm insistence in his affect theory that there are nine and only nine affects, biologically based.

Lang, 1994) theories, which suggest that emotions are response predispositions stemming from significant evolutionary situations. While many personality theorists favor emotions as the most important source of personality differences, e.g., Zuckerman (2007), others take a dimensional view (Clark, 2005), the five-factor model of personality being one example. Affect has also been viewed as exercising a central influence on the organization of self-experience (Fonagy, Gergely, Jurist & Target, 2002; Monsen & Monsen, 1999; Stolorow, Atwood & Brandshaft, 1987).

### **1.3.1 Tomkins' affect theory**

According to Tomkins, optimal mental health requires the maximization of positive affect and the minimization of negative affect (Tomkins, 1962a; 1962b). In Tomkins' words, affects make good things better and bad things worse (amplifying) and make certain experiences urgent:

Although mathematics and sexuality are different, the excitement that amplifies either cognitive activity or drive is identical. Sexuality without the affective amplification of excitement, however, makes a paper tiger of the penis. The id is not very imperious or pushy without affect. The affect amplifies by increasing the urgency of anything with which it is co-assembled. (Tomkins, 1995, p.53.)

In Tomkins' theory of affect, human emotional experience is organized into scripts, which in turn consist of individual scenes. Tomkins (1992, p. 239) put it, "the world we perceive is a dream we learn to have from a script we have not written". When a scene is experienced repeatedly with necessary similarity, its content will elicit a parallel response pattern for each time it is activated. "Human life is dramatic; human affect produces drama; our scripts direct the dramatic scenes" (Mosher & Tomkins, 1988, p. 79). In a nuclear scene (any magnified negative affect scene) a good experience turns bad. A nuclear script (comparable to Young's (1994) concept of "early maladaptive schema") attempts to reverse the nuclear scene, but does never achieve this lastingly, resulting in a perpetuation of the nuclear scene (Tomkins, 1995). This is somewhat similar to several theories, e.g., affect integration (Solbakken, Hansen, Havik & Monsen, 2011a; 2012; Solbakken, Hansen & Monsen, 2011b), cyclical psychodynamics (Wachtel, Kruk & McKinney, 2005) and object relations theory (e.g., Winnicott, 1956; Mitchell, 1983). These scripts (Monsen & Monsen, 1999; Tomkins, 1995), maladaptive schemas (Hoffart et al., 2005; Young, 1994), prementalistic representations of internal states (Bateman & Fonagy, 2004), or maladaptive behavior patterns (McCullough et al., 2003) would be a natural focus in most psychotherapy.

Tomkins' theory might address why emotional suffering is tantamount in bringing people to therapy (Whelton, 2004). All personality disorders and more than half of the non-substance abuse Axis I disorders have been found to involve some form of emotional dysregulation (Gross & Levenson, 1997). Affect consciousness (AC; Monsen, Eilertsen, Melgård & Ødegård, 1996; Monsen & Monsen, 1999) was operationalized as degrees of awareness, tolerance, nonverbal expression, and conceptual expression of eleven specific affects. A semistructured interview (ACI; Monsen, Monsen, Solbakken & Hansen, 2008) and separate scales were developed to assess these aspects of affect integration (the functional and fluent integration of affect in cognition, motivation, and behavior). A low AC was associated with interpersonal problems and low self-esteem (Normann-Eide, Johansen, Normann-Eide, Egeland & Wilberg, 2013) and strongly correlated with all the relevant measures of psychological dysfunction (Solbakken et al., 2011a; 2012). The theory of primary emotional systems (Panksepp, 1982; 1998; 2005; Panksepp & Biven, 2011) as operationalized in the Affective Neuroscience Personality Scales (ANPS), explained 20 and 19 % of the variance in borderline and avoidant criteria, respectively, in 546 patients with different degrees and qualities of personality pathology (Karterud et al., in press).

As expected, more healthy people are reported to recruit assertive emotional resources such as pride and anger to combat depression and negative cognitions (Whelton & Greenberg, 2005). Further, extraversion and gregariousness are among the best predictors of subjective well-being, positive affectivity, better health outcomes and longevity (Fredrickson, 2004; Seligman & Csikszentmihalyi, 2000; Burgdorf & Panksepp, 2006). Positive affects have also been found to “undo” lingering negative emotions (Frederickson, 2001; Fredrickson & Levenson, 1998). This process is one of “changing emotion with emotion” (Greenberg, 2008), as opposed to altering emotions with thoughts (e.g., Beck, 1974; 1976).

### **1.3.2 Affect-focus and the Dodo bird**

Diverse theorists have proposed that “emotional work”, or affect-focus, is therapeutic (Balint, 1991; Bowlby, 1980; Davanloo, 1978, 1995, 2001; Fairbairn, 1954; Fonagy et al., 2002; Fosha, 2000; Freud, 1961; Greenberg & Watson, 1998; Greenberg & Pascual-Leone, 2006; Guntrip, 1992; Izard, 1977, 1991, 1992; Kernberg, 1992; Kohut, 1977, 1984; Malan, 1976, 1979; McCullough et al., 2003; Monsen & Monsen, 1999; Perls, 1969; Rogers, 1951; Teasdale, 1993; Tomkins, 1962a, 1962b, 1991, 1995; Wachtel, 2010; Watson, 1996,

Winnicott, 1956) and the affect consciousness model (Monsen et al., 1996; Monsen & Monsen, 1999), mentalization-based treatment (MBT, Bateman & Fonagy, 2004), accelerated experiential dynamic therapy (AEDP; Fosha, 2000), intensive short-term dynamic therapy (ISTDP; Abbass, Town & Driessen, 2012), short-term dynamic psychotherapy (STDP; McCullough-Vaillant, 1997) or emotion-focused therapy (EFT; Greenberg, 2008) are but a few contemporary treatments accentuating affect. Abundant research and theory now support the basic motivational force of affect in driving behavior (e.g., Panksepp, 1998; Damasio, 1994), as well as the role of dysfunctional affects in pathology (e.g., Gross, & Muñoz, 1995; Schore, 2003; Southam-Gerow & Kendall, 2002), and the exploration of emotions is one of the most speedily growing study-areas in psychology (Cacioppo et al., 2007).

The significance of emotions is underscored in their role not only as intrapsychic phenomena, but as communicators of information about the self in relation to others, and they are essential in forming and maintaining trusting, open and intimate relationships (Bowers, Metts & Duncanson, 1985; Buck, 1989; Finkenauer and Rimé, 1998a, 1998b; Fosha, 2001; Greenberg & Johnson, 1988; Greenberg and Pascual-Leone, 2006; Neborsky, 2003). Clarke, Bradshaw, Field, Hampson and Rose (2005) comprehended emotions as dynamic relational processes between the individual and the environment, rather than intrapsychic states. As Fridja (1986) states, emotions are both the means and the measure of a person's engagement with the world. Indeed, affective change has been associated with improvement in humanistic-, psychodynamic-, and cognitive therapy (e.g., Castonguay, Goldfried, Wiser, Raue & Hayes, 1996; Coombs, Coleman & Jones, 2002; Goldfried, Raue & Castonguay, 1998; Orlinsky & Howard, 1986). One would therefore anticipate that affect-focused therapies should demonstrate better outcomes than therapies not focused on affect.

Some correlations between affect focus and outcome have been identified across therapies (Orlinsky et al., 2004; Ulvenes et al., 2012; in press). Diener, Hilsenroth and Weinberger (2007) report an association between therapists' affect facilitation and outcome in psychodynamic therapy. On comparable grounds, Coombs et al. (2002) denoted a significant relation between emotional exploration and benign outcome. Analogously, Coady (1991), Jones, Parke and Pulos (1992), Hilsenroth, Ackerman, Blagys, Baity and Mooney (2003) and McCullough et al. (1991) recorded that therapists who focused on affect displayed better outcome. Town, Hardy, McCullough and Stride (2012) further found that specific interventions, e.g., clarification and support, were connected to patients experiencing affect.

Process research, therefore, confirms experiencing of affect as a change factor (e.g., Diener & Hilsenroth, 2009; Diener, et al., 2007; Orlinsky et al., 2004; Orlinsky, Grawe & Parks, 1994; Shedler, 2010), but clinical trials with therapies that are affect-focused do not display better outcomes than those *not* affect-focused (e.g., meta-analysis by Leichsenring et al., 2004). Affects may simply be so prevalent that all therapies work with them – whether they intend to or not. In fact, there is research to suggest that the change agent in cognitive therapy is not the change in beliefs, but the change in affects (Ablon et al., 2006; Kazdin, 2008; Weersing & Weisz, 2002; Weisz, Weiss, Han, Granger & Morton, 1995; Whelton, 2004).

This argument is supported by the recognition that emotional processes have been studied across different therapy modalities and received support as a central mechanism of change in for instance cognitive therapy (Samoilov & Goldfried, 2000; Strosahl, Hayes, Bergan & Romano, 1999; Teasdale, 1993), experiential–humanistic therapy (Elliott, Watson, Goldman & Greenberg, 2004; Greenberg, 2008; Greenberg & Safran, 1989), interpersonal therapy (Watson, 1996), psychodynamic therapy (Davanloo, 1978; Kernberg, 1992; McCullough et al., 2003; Monsen et al., 1996), and behavior therapy (Foa & Kozak, 1986). Consequently, we would expect some therapists to do better than others in working with affects (“experiencing distressing and negative emotions [...] has strong effects that can be for good or ill depending on how effectively therapists deal with them”; Orlinsky et al., 2004, p. 345), but there is no available monopoly on emotional psychotherapy interventions, and this ability might not correlate with therapy orientation.

## **1.4 Insight in psychotherapy**

Since Freud's heyday insight has been considered the foundation of the psychoanalytic theory of structural change (Crits-Christoph, Barber, Miller, & Beebe, 1993, p. 408; Messer & McWilliams, 2007). Insight is generally regarded as fundamental for therapeutic change and usually “follows a slow, gradual accretion of self-knowledge” (Moore & Fine, 1990, p. 99). Client insight is theorized to (i) increase across psychological treatment and (ii) decrease symptoms as insight increases. O'Conner, Edelstein, Berry and Weiss (1994), however, found a different pattern of insight development in five brief psychotherapies. They reported higher levels of insight at the beginning and end of counseling, and lower levels of insight during the



middle of treatment. They also found that the higher the average level of insight across therapy, the better the outcome.

Wallerstein and Robbins (1956) suggested that client insight might be (i) a precondition of symptom change, (ii) a direct result of symptom change, (iii) a cause of symptom change, or (iv) a correlate of symptom change. Some psychoanalytic theorists (Munroe, 1957; Sundberg & Tyler, 1962; White, 1956) have proposed a distinction between intellectual (becoming aware) and emotional insight (feeling change). Zajonc (1980, 1984) and Lazarus (1982, 1984) later debated the primacy of cognition and emotion, and stalemated the discrepancy as it was primarily rooted in semantics. Today there is no clear consent on how best to identify and construe insight or how to operationalize it (Kivlighan, Dennis, Multon & Patton, 2000), and “empirical research has provided little information about the measurement or development of insight or the relationship between insight and symptom change” (ibid., p. 50). However, most authors agree that insight involves a conscious awareness of some of the wishes, defenses, and compromises (Brenner, 1982; Wallerstein & Robbins, 1956) that have interacted to produce emotional conflict or deficits in psychological development.

Hobbs (1962, p. 742) stated: “The best definition I have been able to come up with is this: Insight is manifested when a client makes a statement about himself that agrees with the therapist notions of what is the matter with him.” A few years earlier, Rosenbaum, Friedlander and Kaplan (1956) asked psychiatric residents to rate patient pretreatment insight, which they defined as the degree to which the patient demonstrated awareness of the factors influencing his or her illness. Results showed no significant relationship between improvement and insight at pretreatment. Gelso, Kivlighan, Wine, Jones & Friedman (1997) asked ten counselors to complete post session scores of the patient’s extent of emotional and intellectual insight in a session. There are methodological issues with such an approach, for example that gathered data remain global, and obtained from only one, possibly biased, observer (Kivlighan et al., 2000). Contrary to this, some early researchers operationalized insight as the observed match or congruence between the client's descriptions of self and other, following client-centered therapy (e.g., Dymond, 1948).

At the affected end of the novel *Harry Potter and the Goblet of Fire*, Professor Albus Dumbledore enlightens Minerva McGonagall: "He will stay, Minerva, because he needs to understand. Understanding is the first step to acceptance, and only with acceptance can there

be recovery. He needs to know who has put him through the ordeal he has suffered tonight, and why” (Rowling, 2000, p. 680). Apparently, even wizards have no potion against emotional suffering. Dumbledore’s words could be inspired by Wilfred Bion (1962, 1977), who argued that emotional experience is either avoided (evasion), or elaborated through thought (transformation). The instinctive response of most humans experiencing pain or anguish is likely to be evasion (as conceptualized in “the pleasure principle”; Freud, 1966; Freud, 1961, 1964, 1977; 2011; or “opposing motivational forces”; James, 1918; Skinner, 1953); psychoanalysis asks us to contain, endure, work and “play” with the emotion (Godbout, 2004, p. 1124).

Such affect avoidance can be understood as the foundation for developing what McCullough et al. (2003) conceptualizes as an affect phobia. In APT, insight is seen as a facilitator of behavioral change and is the first step in defense restructuring, usually termed defense recognition (D; McCullough et al., 2003). When conceptualizing defenses as basically unconscious responses patients use to avoid conflicted affects (F), insight is the first step in making exposure and response prevention possible. Also discerning the origin of defensive patterns from their maintaining factors is a way of preparing the patient for change (McCullough-Vaillant, 1997).

McCullough was initially trained in behavior therapy, and later in Davanloo’s Intensive Short Term Dynamic Psychotherapy (1995, 2001; ISTDP). Davanloo emphasizes unconscious alliance and a strong confrontation of D (“unlocking of the unconscious”) to bring unacceptable Fs to the surface. ISTDP has later been verified as effective psychotherapy for a number of diagnoses, including PDs (Solbakken & Abbass, 2014; Town, Abbass, Bernier, 2013), but McCullough felt that the style was too harsh, and started synthesizing APT. This choice was also informed by several studies demonstrating that defenses were more greatly transformed by supportive, empathetic and clarifying methods than by confrontative means (Foote, 1989; Joseph, 1988; Makynen, 1992; Salerno, Farber, McCullough, Winston and Trujilo, 1992; Winston et al., 1994). Patients seemed more able to digest the painful information contained in a therapist’s confrontation or interpretation when it was paired with a statement that reflected consideration or care. Further, in harmony with Ulvenes et al. (2012; in press), it was detected that confrontations made along with a supportive or empathic statement by the therapist (Foote, 1989) resulted in a greater probability of affective activation.

### **1.4.1 Mentalization and affect consciousness**

This playful exploration of reality (“playing with reality”; Fonagy & Target, 2000) encouraged by psychoanalysis (as mentioned above) is echoed in mentalization-based treatment, which focuses on “minding minds” (Bateman & Fonagy, 2004). The interpersonal process pursuing on an open exchange of minds in an attachment relation to the therapist is assumed to be an effective potion to increase mentalization (in borderline patients). Mentalization is thus believed facilitated by the quality of the attachment relationship (Fonagy et al., 2002; Bateman & Fonagy 2004; 2005). The ability to reflect about own and other minds will not develop unless being minded by another human. Low reflective functioning (RF; Fonagy, Target, Steele & Steele, 1998) or mentalizing abilities handicap the capacity to engage in the ordinary “intersubjective dance” with other persons and one resorts to prementalistic modes of thinking (teleology, psychic equivalence, pretend mode) when under stress (Morken, Karterud & Arefjord, 2014). Mentalization is conceptualized within the following dimensions: self–other, internal–external, cognitive–affective and automatic–controlled (Fonagy et al., 2002).

Mentalization is a term that has been claimed to partly overlap with Monsen’s affect consciousness (AC) (Lech, Andersson & Holmqvist, 2012; Mohaupt, Holgersen, Binder, Nielsen, 2006). Inspired by Tomkins, Monsen et al. (1999) also introduces a strong cognitive element (affect integration views emotions as being organized by cognition) in the AC therapeutic approach (Mohaupt et al., 2006, p. 238). Further, the concept of metacognition is also fundamental to therapeutic insight, and it is often differentiated into three essential stages of development: Comprehension of action intentionality, comprehension of pretending, and comprehension of the beliefs on which behavior is based (Semerari, Carcione, Dimaggio, Nicolò & Procacci, 2007).

### **1.4.2 Insight as process variable**

As we by now probably expect, it proves difficult to distinguish cognitively from affectively oriented therapy approaches, and the results can often seem equally paradoxical. (Connolly Gibbons et al. (2009) found that patient insight increased significantly more in the dynamic psychotherapies than in cognitive therapies) as when it comes to those mentioned regarding affect-focus in psychotherapy (Johansson et al., 2010). One study analyzing the material by

Svartberg et al. (2004) reported that insight was a central factor to change in short-term dynamic psychotherapy (STDP), but not in cognitive therapy (CT; Kallestad, Valen, McCullough, Svartberg, Høglend & Stiles, 2010): “Within CT, gain of insight did not predict long-term improvement”. Another recent study has found insight to be associated with change in dynamic psychotherapy but not in cognitive behavioral therapy (CBT; Connolly Gibbons, Crits-Christoph, Barber & Schamberger, 2007). Grosse Holforth et al. (2007) concluded that there is empirical support for insight occurring in CBT, but to a lesser degree than in dynamic and interpersonal therapy. A central integrative finding, perhaps supporting the fictional Dumbledore’s statement, is that when emotions are sufficiently regulated to facilitate and process it, the combination of their affective arousal and a more cognitive reflection on their meaning produces the deepest therapeutic transformation (Whelton, 2004, p. 58–59).

Connolly, Crits-Christoph, Shappell, Barber and Luborsky (1998) found that 4% of therapist statements were interpretative. Such interpretations of maladaptive patterns are often the key to fostering insight (Castonguay & Hill, 2007, p. 155). von der Lippe, Monsen, Rønnestad and Eilertsen (2008) studied 14 positive-change (PC) and 14 negative-change or nonchange (NC) therapies, and reported that rejection of therapists’ interventions predicted negative outcome most strongly, and that this also escalated with time. Noteworthy, in NC therapies, this pattern was apparent from session 3 and on (ibid., p. 430). Typically, sessions in the PC treatments started with client disclosure and therapist affirmation and later in the hour efforts to understand and construct meaning. Even if McCullough, and others, have felt that Davanloo was focusing too much on opposing D, therapists do need to challenge maladaptive behavior, misperceptions, character and dynamic resistance (ibid., p. 430). However, if this well-meant potion is inedible, attempting to serve it (which s/he has to; Ulvenes et al., 2012) might lead to hostility and ruptures in the alliance. And hence, unless dealt with (Safran & Muran, 2000), the chance of NC increases (von der Lippe et al., 2008).

As we have seen, D (defense recognition) is usually the first step in APT. Congruent with this, Grosse Holforth et al. (2007) formulated insight as “newly acquired recognition or awareness of maladaptive cognitive schemas or maladaptive automatic thoughts” or simply as “the acquisition of new understanding” (p. 57). Closely related to the concept of learning, insight has also been defined as a form of corrective experience (Castonguay & Hill, 2007, p. 67). As we have seen, insight, or the acquisition of a new understanding, is recognized as an

important vehicle of change across a variety of theoretical approaches in psychotherapy. Kivlighan et al. (2000) also found that when patients were rated to have less insight in a session, they had more distress in the following session.

### **1.4.3 Insight and treatment outcome**

Studying emotional and cognitive insight separately, Gelso et al. (1997) found that neither correlated significantly with outcome. However, they reported that high levels of transference and high levels of emotional insight predicted better outcome. Another such interaction was found by Høglend, Engelstad, Sørbye, Heyerdahl and Amlo (1994): Insight was significantly correlated with outcome in interaction with treatment length. Luborsky, Crits-Christoph, Mintz & Auerbach (1988) used independent raters of insight, and were able to show that patients' average level of self-understanding significantly predicted better outcome, correcting for initial level. Kelman and Parloff (1957) also demonstrated some<sup>5</sup> correlation between self-awareness ("the extent to which a patient sees himself as others see him", p. 283) and the symptom checklist; self-awareness predicted lower symptom level.

Connolly et al. (1999) defined self-understanding as "the understanding of maladaptive interpersonal patterns" (p. 473), but in their study, self-understanding across psychotherapy was not significantly associated with outcome. Kivlighan et al. (2000) reported that a linear increase in insight across treatment was related to a decrease in symptom distress. Grande, Rudolf, Oberbracht & Pauli-Magnus (2003) found that patients who gained definitive insight into their problems managed life better after treatment. Hoffart, Versland & Sexton (2002) reported that greater patient understanding early in treatment was associated with a reduction in schema belief and emotional distress. Luborsky (1962) on the other hand, found no correlation between pretreatment insight ("awareness, ability to compare actual state of functioning with desired state of functioning, and concerns about the discrepancy") and health measure scores across treatment.

Hill et al. (2007, p. 444) write: "Many psychoanalytic therapists consider insight a desirable outcome of therapy, whereas a large number of behavioral therapists consider the attainment of new understanding to be important only if it leads to other outcomes, such as behavioral change". Along these lines one might also wonder how well the secondary gains from

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<sup>5</sup> Authors noted this correlation might be due to chance.

recognizing one's maladaptive patterns (insight) are captured in outcome measures (e.g., symptom relief). Bion (1977, p. ii) wrote: "All helpful endeavors have a foundation which is, like most foundations, unobserved – the belief that things can be improved. Even psychoanalysis is tainted with ideas of cure that imply a better state. I think it is 'better' to know the truth about one's self and the universe in which I exist. But I do not wish to imply that it is 'nicer,' or 'pleasanter.' Whether it is 'better' is a matter of opinion which each individual has to arrive at for himself: his opinion and only his." In a study based on the RCT by Svartberg et al. (2004), increased levels of D (i.e., insight measured by ATOS) did not predict higher self-compassion when changes in inhibitory and activating affects were statistically controlled for (Schanche, Stiles, McCullough, Svartberg & Nielsen, 2011). Within the paradigm of the medical model of psychotherapy, Bion's statement might perhaps best serve as a reminder that "[c]onventional statistical comparisons between groups tell us very little about the efficacy of psychotherapy" (Jacobson & Truax, 1991, p. 12).

Notwithstanding it being a major theme in psychotherapy, a 2007 review (Connolly Gibbons, Crits-Christoph, Barber, & Schamberger, 2007) found only eight studies conducted between 1954 and 2007 on the correlation between insight gained during therapy and outcome. The results in these studies were mixed and had several methodological problems (Kallestad et al., 2010), e.g., insight had been defined differently in the various studies, making it difficult to compare the results. It is also unclear whether a reverse causality could be the case, i.e., whether it is symptom change that gives rise to insight and not vice versa.<sup>6</sup> As Hobbs (1962, p. 742) states it: "I suggest that insight is not a cause of change but a possible result of change. It is not a source of therapeutic gain but one among a number of possible consequences of gain." Similarly, Cautela (1965) reasoned that insight shadowed affective activation (desensitization), and wrote: "The criterion of real emotional insight is a feeling of change accompanied by removal or alleviation of symptoms" (ibid. p. 60).

## **1.5 Sense of self in psychotherapy**

According to interpersonal theory and object relations theory, a person's self-image originates from early relationships and is maintained as a relatively stable psychological structure in conjunction with the establishment of mental representations of self and others.

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<sup>6</sup> Togstad and Kolstad (2010) in their single-case study on another patient from the Svartberg et al. (2004) material, found indications that affective activation predicted insight.

These early internalized objects form a postulated personality structure denoted introject, which consists of a relatively stable potpourri of strategies for treating oneself (Henry, Schacht, & Strupp, 1990).

Psychologically healthy individuals are thought to have introjects that are relatively friendly and self-accepting (most of the time). Persons with emotional problems, in contrast, tend to have hostile introjects that are self-critical or self-negligent (Halvorsen & Monsen, 2007; Henry, 1996). Negative self-representation and self-criticism are also found to be central factors in a variety of psychological disorders, including personality disorders (Gilbert & Irons, 2005). Positive changes in an individual's attitudes toward self are generally assumed to be vital components of fruitful psychotherapy (Arnold, Farber & Geller, 2000; Gibbons et al., 2009). In restructuring images of self and other, the therapist attempts to provide these internal images with more positive valences (Diener & Hilsenroth, 2009, p. 230). In the APT model, the maturity of sense of self (SoS) and sense of others (SoO) is vital for healthy mental functioning (McCullough-Vaillant, 1997; McCullough & Stuart, 2001).

McCullough has incorporated the interpersonal theory that people learn to treat themselves as they were treated by others (Sullivan, 1953) in the APT model. Therefore, a person's development of internalized SoS and SoO, is to a large extent established in early attachment relations (McCullough-Vaillant, 1997). SoS comprises aspects of self-image (self-perception, self-esteem and self-compassion), including ability to feel positive feelings toward the self, to know and care about one's own wants and needs, and to function autonomously in a healthy manner (McCullough et al., 2003, p. 238). In APT it is assumed that increase in D, decrease in inhibitory affects (A; e.g., anxiety, shame, guilt), and increase in F are related to enhanced SoS across therapeutic approaches (Schanche et al., 2011).

Connolly and Strupp (1996) argued for the importance of including a measure of changes in self-concept in psychotherapy research. Several studies derived from the Svartberg et al. (2004) sample have also utilized SoS (as operationalized in the ATOS) as a measure of change. A recent analysis of the material from Svartberg et al. (2004) found that SoS increased as the therapies progressed, lending further support to its use as a valid outcome measure (Aronsen, 2013, p. 21). Similarly, in the original study by Svartberg et al. (2004), the average level of positive SoS at session 6 in the STDP group was 34.7 ( $SD = 12.9$ ; range: 29–40). But at session 36 the level of SoS had increased with 13.2 points to 48.0 ( $SD = 21.4$ ;

range: 38–58). When the two groups were combined, the level of SoS was linked to the composite outcome ( $p = .009$ ) and captured 8% of the variance (McCullough & Magill, 2009). Halvorsen and Monsen (2007) studied 233 complete therapies (mean number of sessions was 34; theoretical orientations included psychodynamic, 67%; cognitive, 16%; humanistic, 5%; and unspecified, 10%; outcome measure was IIP-C) and found that, "patients with a hostile self-image showed larger changes than those with less pathological self-images".

Recent results by Berggraf et al. (2012) showed that increases in SoS and SoO were significant for improvement of interpersonal problems for cluster C patients only within the APT treatment group (i.e., not the cognitive therapy group). Patients' relationships to their own affects are critical for SoS and SoO (McCullough-Vaillant, 1997) and Berggraf et al. (2013) further found that F above baseline predicted increased levels of both SoS and SoO the next session. Ulvenes et al. (2012; 2013; in press) have indicated affect focus to be positively related to outcome, and that affect focus is connected to sense of self. Aronsen (2013, p. 23) writes, "[a]ffects are a fundamental aspect of a person's sense of self (McCullough et al., 2003), and orienting the patient to affect parallel to ensuring a sound alliance could benefit the process of strengthening the patient's sense of self, thereby making the patient more prone to affect orienting interventions." However, D does not seem to enhance SoS for cluster C patients (Schanche et al., 2011).

### **1.5.1 Affect-focus and alliance**

Nissen-Lie et al. (2010) report, "[a] substantial portion (almost 17%) of variability in patient early alliance ratings was due to differences between therapists. That is, some therapists generally formed better alliances, whereas others generally formed poorer alliances, as rated by the patients". It is also indicated that the therapist being warm is important to facilitate feelings, which is again linked back to alliance by some researchers, e.g., Ackerman and Hilsenroth (2003) found facilitation of affect expression to positively influence the development and maintenance of the alliance. Yet, this result seems somewhat controverted by research indicating that the alliance in STDP<sup>7</sup> needs to form "despite the therapist focusing on affect" (Ulvenes et al., 2012, p. 298). This again suggests that orienting the

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<sup>7</sup> Both Webb et al., (2011, p. 279; "bond between therapist and patient may be more of a consequence than a cause of symptom change in CT") and Ulvenes et al., (2012, p. 291; "avoidance of affect was positively related to both the formation of the bond and to symptom reduction"), indicate that the process in CT and STDP differ.



patient to affect should be done in parallel to ensuring a sound alliance (Aronsen, 2013), but also that a therapist needs to focus on what is important: “[T]he therapist might participate in actions that the patient finds agreeable but leads to an avoidance of real work in psychotherapy” (Ulvenes et al., 2012, p. 292).

Psychotherapists’ technical activity has usually been linked to psychotherapy outcome rather than to alliance formation (Bedi, Davis & Williams, 2005). Arguably, orienting to affect is a technical activity within APT, and in some studies (ibid.; Bachelor, 1995; Mohr & Woodhouse, 2001) clinical interventions were understood by the patients as having relational consequences for the formation and strengthening of the alliance above and beyond their direct impact on outcome. Methods, it seems, cannot be dissociated from the context of the relationship (Bedi et al., 2005; Mohr and Woodhouse, 2001). Lending further support to this idea is Luborsky's (1976) finding that bewitching psychodynamic interpretations led to improved alliances, while less fitting interpretations decreased the strength of the alliance. Similarly, Kivlighan and Schmitz (1992) reported that technical activity accounted for 32% of the variation of patients’ ratings of the alliance. For this reason, Bachelor, Laverdière, Gamache and Bordeleau (2007) argue that therapists may need to explicitly address how the therapeutic work is helpful and conducive to desired changes.

## **1.6 Affect Phobia Therapy (APT)**

Short-term dynamic psychotherapy (STDP) theory theorizes that most patients’ problems can be traced to conflicts or fears regarding feelings (Alexander, 1963; Davanloo, 1978; 1980; 1988; Fosha, 2000; Malan, 1979; Mann, 1991; McCullough et al., 2003; Sifneos, 1978, 1980, 1987, Wolberg, 1980). The central premise is that psychodynamic conflict can be thought of as a fear about feeling, or “Affect Phobia”, and fears of feeling (both conscious and unconscious) underlie most, if not all problems that patients present (McCullough et al., 2003). In contrast to maladaptive responses (such as acting out, loss of control, impulsivity or catharsis), activating affects are defined by their adaptive function; i.e., well-regulated balance of inner experience, leading to adaptive action. However, some level of “negative” affects like shame and guilt are also necessary and adaptive in order for optimal functioning. Whether a feeling is termed defense, activating or inhibiting is determined by its function: A feeling can be defensive (crying when angry), activating (grieving when experiencing a loss) or inhibitory (anxiety over anger).

Some possible misunderstandings exist about the dichotomies of “positive and negative affects”, “activating versus inhibitory categories of affects”, and “adaptive versus maladaptive or defensive affects”. The perspective in APT is that there is no “positive” or “negative” affects per se, but that they can be adaptive or not, e.g., anger can be both destructive and adaptive depending on the ability to contain, on adequate expression and the situation. For instance, appropriate communication of anger may even strengthen the relationship between the angry person and the person who is the target of the anger (Izard, 1991). Different researchers often have their own understanding of this. As an example, Monsen’s main research focus has been on specific affects rather than affect groups, which means that he, like Greenberg, does not label affects into activating and inhibitory categories. Nonetheless, residuals of “activation” and “inhibition” can also be found throughout his model. One example of Monsen’s patient affect script was described thus:

*Interest/excitement ⇒ guilt ⇒ loss of self (confusion) ⇒ shame ⇒ withdrawal*

APT would say that this patient has a phobia against interest/excitement, and the model is based on the proposition that psychodynamic conflict results from opposition between activating and inhibitory affects that underlie behavioral motivation and inhibition. Phobias can occur in response to external stimuli, or to internal phenomena such as affects.

McCullough synthesized learning theory with the psychodynamic model. Consequently, in an “affect phobia”, anxieties are the inhibitory feelings that block the expression of true or activating feelings. When these two systems are in conflict, defenses emerge as a “compromise response” (psychodynamic) or as a “phobic avoidance response” (learning theory). Change is therefore an expected result of desensitization to warded-off feelings (Barlow, 1988). Desensitization does not occur in response to exposure to thoughts about feelings, words about feelings, or general fantasies or images about feelings (McCullough & Magill, 2009). So, it is essential that the affect be experienced in the body for desensitization to occur. This process is twofold: (i) Exposure to activating affective experience (bodily experience of anger, care for self, grief, compassion, etc.), and (ii) reduction of associated anxiety, guilt, shame or pain, and related maladaptive defenses. Thus, APT states that psychodynamic conflict results from conflicts surrounding feelings. Frequent examples of Affect Phobias are guilt over anger, shame or embarrassment about crying, pain over closeness, or shame about oneself.

APT emphasizes four main areas of intervention (McCullough et al, 2003):

- *Gaining Insight (defense recognition; D)* – Restructuring of defenses by identifying patterns of avoidance of unconscious conflicted affects, how they emerged in early life, and their present day costs and benefits.
- *Exposure to and Expression of Feeling (Activating affect; F)* – Restructuring activating affects by exposure until inhibition is reduced and affects can be endured and expressed to others in an adaptive way.
- *Regulation of Inhibitory Affects (Anxiety; A)* – Anxiety, guilt, shame, and emotional pain are brought within normal limits to allow more flexible experience and expression of activating feelings.
- *Restructuring the sense of self and others (SoS; SoO)* – Maladaptive inner images of self and others are improved by decreasing shame attached to self-image and exposure to positive self-feelings, as well as suitable feelings toward others.

Simply put, in the APT model people have problems (maladaptive defenses) that exist due to phobic inhibitions (conflicts) about natural adaptive affective responses (feelings). These patterns of conflicted or neurotic behavior originated with past persons,<sup>8</sup> and can be observed with the therapist. This model grew out of two triangles conceptually developed by Malan (1979).

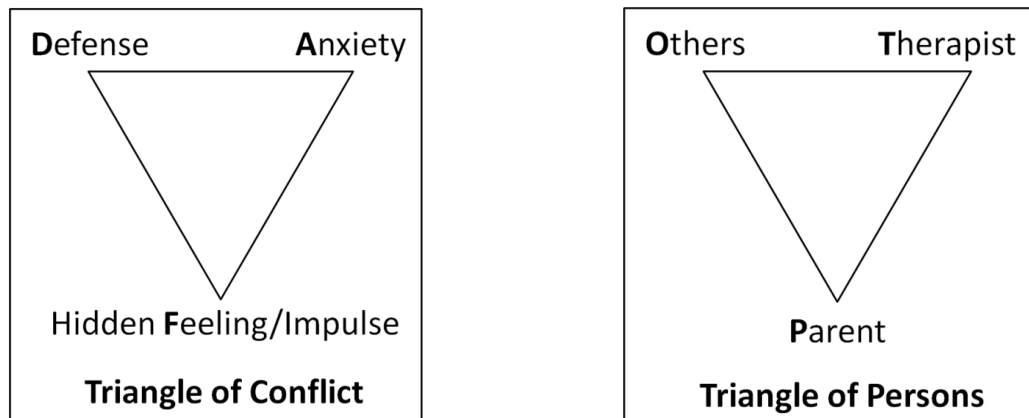
### **1.6.1 Malan's triangles – the six-cornered hat of APT**

The first step in the APT model is recognition of defense (insight), which is congruent to Malan's (1979) rationale for interpreting the defense before the hidden feeling (impulse): "The whole process is unconscious, and if you simply interpret the impulse without also showing the patient how he is defending against it, he will often respond to you as if you were offering a *non sequitur*" (p. 78). Thus, the natural progression is from the defense (which is usually what the patient's complaint is about) through anxiety to the hidden feeling (ibid., p. 92). Malan represented an outline of this movement by adopting Menninger's (1958) "triangle of insight", which he renamed "Triangle of Persons" and Ezriel's (1952) triangle of conflict. McCullough (2003) has further incorporated these figures in APT in order to facilitate the therapist's understanding of the steps in affect exposure. McCullough writes: "The schema of the two triangles has guided my clinical and research work for the past two decades—and with each passing year, I become more and more thankful to David

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<sup>8</sup> "The most significant tension in the history of psychoanalytic ideas has been the dialectic between the original Freudian model, which takes as its starting point the instinctual drives, and an alternative comprehensive model initiated in the work of Fairbairn and Sullivan, which evolves structure solely from the individual's relations with other people" (Mitchell, 1983, p. 20).

Malan for his elegant simplification of an enormously complex process” (Solomon et al., 2001, p. 59).



*Figure 1 and 2: Triangle of Conflict (Ezriel, 1952) and Triangle of Persons (Menninger, 1958). The bold styles indicate the abbreviation for the six corners: Defense (D), Anxiety (A), Hidden Feeling/Impulse (F), Others (O), Therapist (T) and Parent (P).*

Both triangles (figure 1) stand on its apex. In the Triangle of Conflict this epitomizes that the hidden feeling/impulse (F) resides under the defence (D) and the anxiety (A), while in the Triangle of Persons it “personifies” that what happened in the relation to the Parent<sup>9</sup> (P) lies under and is prior to what happens in relationship to Others or to the Therapist (transference). Malan related both triangles: The hidden feeling is related to one or more categories of the Triangle of Persons. In the models launched by Malan (1979, p. 80) and McCullough, nearly every intervention of the therapist is reflected in these triangles. The therapist needs to realise at every moment in the therapy which area of which triangle is most salient. The aim of APT is thus i) to give the patient insight into his behavior pattern by working through the defence, ii) welcoming the hidden feeling into consciousness (facilitate adaptive expression), iii) making clear how his maladaptive pattern affects current relationship with others, and iv) with his parents in the past. The relation to the therapist (transference) is the here-and-now (Malan, 1979), often qualifying a transposition of the triangle of persons into a “triangle of time”: O is current or recent past, T (usually) here and now and P the distant past.

This task might perhaps sound artless, but is not so. One major challenge is for the therapist to correctly identify which experiences the patient needs to be exposed to (e.g., not to confuse F, D and A):

<sup>9</sup> As for instance Davanloo's Trial Therapy (1980, p. 99–128) captures, the original psychic conflict is forged within multiple relationships, involving mostly the mother, the father, siblings and sometimes others as well. P, then, is of course an oversimplification.

The occurrence of defenses that obscure what it is that is being avoided makes it difficult to identify just what the target of the exposure should be, as does the inherent ambiguity of most emotional and interpersonal experiences. [...] Moreover, even where the therapist does have a pretty good idea what it is that the patient needs to be exposed to, it is not so easy to bring that exposure about. (Wachtel, 2010, p. 205.)

APT is a manualized treatment focusing on the principles of exposure to adaptive affect, but also with a strong focus on freedom and the possibility for eclecticism (Messer & Warren, 1995). The manual operationalizes the most important factors for training and research. McCullough's philosophy has been that good therapists adapt their strategy intuitively (McCullough-Vaillant, 1997; McCullough & Andrews, 2001). ATP also strongly emphasizes the common factors in psychotherapy, such being in line with Messer & Wampold (2002) and with Norcross and Goldfried (2005). The model has been empirically validated (Svartberg et al., 2004), and shown to produce significant change in cluster C patients.<sup>10</sup> In the same key signature as McCullough, Diener and Hilsenroth (2009) remark: "Porter found that patients had better outcomes when interpretations were followed by experienced affect in contrast to a defensive response" (p. 232). However, psychotherapy process has demonstrated that treatments may promote change in ways other than their underlying theories claim (Ablon & Marci, 2004), circling the focal point back to the common potion ingredients, e.g., alliance and therapist effects. Importantly, original research (Ulvenes, 2012; in press) illuminates the role of the alliance and patient's SoS for effective affect focus in therapy, and thus brings more color to the picture of skills needed for being a talented therapist within this model.

## **1.7 Publications from the Svartberg et al. (2004) data set**

To the best of our knowledge, this is the sixth graduate thesis (Aronsen, 2013; Bremer, 2010; Holmboe, 2011; Togstad & Kolstad, 2010; Tveit-Winther, 2010) applying data from the cluster C sample by Svartberg et al. (2004). Ulvenes (2013) and Berggraf (2013) both defended their doctoral thesis, presenting research on this material, at the University of Oslo. By now, reputable researchers such as Ulvenes, Berggraf, Kallestad, Town, Nielsen, Ryum, Shanche, Hoffart, Svartberg, Hardy, Stiles, Stride, Kallestad, Valen, Høglend, McCullough

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<sup>10</sup> Patients, in general, should not have any Cluster A or B diagnosis and have a GAF (Global Assessment of Functioning Scale) score above 50 to benefit most from APT (McCullough, 2003, p. 305).

and Wampold have published 14 studies derived from this cauldron, and further articles are in press (e.g., Ulvenes et al., in press).

The Ulvenes et al. (2012) study found that therapist focus on feelings proved helpful for the alliance and outcome in APT treatment of cluster C patients. Analyzing the same data set, Ryum, Stiles, Svartberg and McCullough (2010) found no statistical significant effects of the therapeutic alliance. Kallestad et al. (2010) found that D near the end of therapy predicted improvement of symptom severity and interpersonal functioning during a 2-year follow-up period. These results support the theoretical assumption in APT that D is a factor in the change process. However, Schanche et al. (2011) analyzed sessions 6 and 36 from the Svartberg et al. (2004) sample. All 50 patients' D, inhibitory affects (A), F, and self-compassion (SoS) were rated with ATOS. Results revealed no link between D and SoS.

Schanche et al. (2011) additionally reported that an increase in F was significantly associated with higher self-compassion towards the end of treatment. Town et al. (2012) reported that confronting interventions that attempted to direct attention towards either F or D led to the highest levels of immediate affect experiencing. Ulvenes et al. (in press) state that orienting the patient to affect while securing a sound alliance benefits the process of strengthening the patient's SoS, which again makes the patient more receptive for focus on F. So, the therapist should purportedly interpret F when SoS is relatively high, and facilitating F stimulates change in SoS (higher SoS in next session; Berggraf et al., 2013) when there is an adequate alliance (Ulvenes, in press).

## **1.8 The aim of the present study**

APT is empirically supported to be as effective as other therapies in the treatment of cluster C PDs (Svartberg et al. 2004; Winston et al., 1991; Winston et al., 1994), a finding in harmony with the concert pitch of present-day psychotherapy research. Analyzing data from the Svartberg et al. (2004) sample further has revealed intriguing relations between alliance, A, D, F, SoS and outcome. Still, the processes and change-mechanisms within dynamic therapy-models in general, and APT specifically, are not well investigated. Strupp (1998) recommended intensive studies of single cases selected from such well-organized studies. von der Lippe et al. (2008, p. 430) propound: "It seems advisable that such studies, highlighting positive and negative processes, also should be incorporated in therapist

training.” Nevertheless, not exemplifying such high ideals, our goal with this single-case exploration is to excogitate and explicate some of the mechanisms associated with change educed by process research.

Elliot (2002, p. 1) identifies three critical questions for a single-case design: (i) Has this client actually changed; (ii) is psychotherapy generally responsible for change; and (iii) what specific factors (within therapy or outside it) are responsible for change? Answering Elliot’s first call, this thesis will study the patient’s changes during the course of therapy and the outcome measures. Adressing his second question, we cannot give a confident answer, but will rather discuss (“guesstimate”) whether observed changes in therapy can be associated with outcome (overall modifications in symptoms, interpersonal problems and unhealthy personality functioning during the course of therapy and the follow-up period). In response to Elliot’s final query, the ratings and statistical analysis of the process variables are qualified and contextualized by qualitative renderings and transcripts from the course of therapy. This makes it possible to relate ATOS scores and detailed observations to both measured outcome and inferred change.

The aim of the present study is to use ATOS to examine D and F as process predictors, SoS as intermediate outcome variable, and overall outcome. This study investigates potential change in these three variables and their interrelationships within a single-case observational design.

### **1.8.1 Hypotheses**

This thesis will test three hypotheses:

- I. More than expected F (affective activation) in a session predicts increased SoS (sense of self) in (the) subsequent session(s).
- II. More than expected F (affective activation) in a session will predict higher D (defense recognition) in (the) subsequent session(s).
- III. More than expected D in a session (defense recognition) predicts increased SoS (sense of self) in (the) subsequent session(s).

## **2 Methods and procedures**

### **2.1 Dataset and sample**

This case material, consisting of videotapes of a complete Affect Phobia Therapy treatment (40 sessions), was part of a randomised controlled trial, comparing STDP (APT;  $N = 25$ ) with cognitive therapy (CT;  $N = 25$ ) at the Norwegian University of Science and Technology, Trondheim, Norway (Svartberg et al., 2004). The Norwegian Institute of Science and Technology Review Board approved the research protocol. All participants provided written informed consent before participating in the study. The present case has requested that her file is deleted when the research project is finished. The patient was randomly assigned to the APT condition. To be included, referred patients had to meet the criteria for one or more of the DSM–III–R Cluster C PDs or self-defeating PD. Exclusion criteria were current or past psychotic disorder, present-day substance abuse or dependence, current eating disorder, organic brain disorder and other serious physical illness, active suicidal behavior, denial to discontinue other treatments, and unwillingness to have therapy sessions videotaped. The treatment was conducted in Norwegian. The patient was randomly assigned to this study.

#### **2.1.1 Video sample**

Due to poor video or audio quality or missing videotapes, 7 of the 40 sessions could not be used in the study (excluded sessions: 6, 11, 15, 23, 31, 36 and 40). In total, 177 ten-minute segments were rated with ATOS and transcribed. Mean duration of sessions was 53.5 minutes ( $SD = 11.4$ ).

#### **2.1.2 The patient – The Girl with the Gold Medals**

The patient, whom we have called “The Girl with the Gold Medals” (GG), was a married woman in her early thirties with three children, the youngest daughter being six months when the treatment started. The patient was selected for the present thesis because she seemed highly motivated and apt for the treatment (e.g., in line with Sifneos’ [1968; 1975] criteria for Short-Term Anxiety-Provoking Psychotherapy; STAPP), displayed high D (insight) and F (affective activation), and from initial observations indicated good alliance and an overall positive change in SoS (sense of self). The noted change in observed functioning (and variance in outcome measures) is expected to indicate variance in process variables. This



variance can be assumed to make it more probable to uncover significant correlations in our process variables and between process variables and outcome.

### **Brief case description**

GG was motivated for therapy, but at some points doubted whether she deserved the treatment, as she did not experience her own distress unusually salient compared to others. However, she had difficulties working, and felt she needed to be a “world champion” in everyday life. She had serious difficulty in displaying her weaknesses and vulnerability. At the beginning she was preoccupied with others’ image of her accomplishments and was constantly trying to get narcissistic mirroring, love and confirmation from significant others. Her strategy was mainly trying to be a champion without needs of her own, but also that of being an indispensable helper.

Her hurt self-esteem was what she accurately understood as her most central challenge. Adamantine perfectionism combined with a strong sensitivity to others’ demands kept her exhaustingly busy. At the beginning of therapy she idealized her husband, whom she called a “world star”. He had an important job position and worked a lot. At some points it was difficult for GG to make it to sessions because she did not get much help with the children. During the course of therapy this changed, and she saw significant others more realistically and was able to express own wants and needs more clearly. Halfway in the treatment GG idealized the therapist, and also tried referring her friends to therapy. One early formative experience was that she came home with four gold medals from a national sports event. She hoped for recognition and love, but her mother and father were too drunk to notice neither GG nor her accomplishment.

Both her mother and father had problems with alcohol (especially the mother), and her father divorced her mother early in the patient’s life. Her father started a new life with other children. This was very painful for the patient, who strongly wished for her father to see her and love her. At the beginning of therapy she idealized him, and was very hurt when he for instance did not remember that he had recently seen her newborn daughter. During the course of therapy she represented her father more realistically, and began setting boundaries for herself in relation to him. GG was uneasy about the videotaping, and pondered who might see the sessions, and what impression they would have of her. For this reason, GG and the therapist watched an early session together (in session 36). GG was surprised about the

difference between her present state and where she was at the beginning of treatment. At the end she felt she had gained a lot from the therapy, and that it was time to quit therapy and start working again.

### **Diagnosis**

GG was diagnosed with dependent PD (DPD; SCID-II; Spitzer, Williams, Gibbon & First, 1990a; DSM-III-R, American Psychiatric Association, 1987) and agoraphobia (SCID-I; Spitzer, Williams, Gibbon & First, 1990a; 1990b) at pretreatment (Svartberg et al., 2004).

## **2.2 APT treatment**

Treatments were carried out in accordance with the APT treatment manual (McCullough, 2003). Therapy was systematically reviewed for its adherence to the treatment protocols. APT, as we have seen above, conceptualizes that psychologically based disorders result from affect phobias. In the APT model the therapist is free to employ a range of techniques from various therapeutic traditions in order to accomplish the objectives, e.g., the use of guided imagery to experience F, but the main trajectory (McCullough-Vaillant, 1997) follows the basic structure of psychodynamic psychotherapy outlined by Malan's (1979) two triangles.

All therapists in the original study were trained in the STDP model and received supervision and seminars from McCullough (Svartberg et al., 2004). Treatment adherence and competence was monitored using video-based group supervision (two hours weekly). The clinical supervisor gave adequate feedback on how to improve the treatment in accordance with the treatment manual. The APT therapists were three psychiatrists and five clinical psychologists with a mean of 9.2 years of clinical experience ( $SD = 3.6$ ). The therapists treated at least one patient as a training exercise before treating patients who were enrolled in the study (ibid.). All sessions lasted about 50 minutes and were videotaped.

### **2.2.1 Therapist**

The therapist was an experienced 46 years old male who worked as a full-time psychiatrist and researcher. Experts in the therapy modality supervised him.

## **2.3 Process Assessment**

### **2.3.1 Collection of data**

Rating and transcription was completed at the Modum Bad Research Institute in the period from 13.05.09 to 14.03.11 as part of The Psychotherapy Process Mapping Network (PROCMAP) program.

### **2.3.2 Transcripts**

All 33 available therapy sessions, summing up to 29.5 hours of video data, were transcribed into about 240.000 Norwegian words. The file was kept on a memory stick with Windows' BitLocker Drive Encryption. Pin code was securely selected on <http://strongpasswordgenerator.com/> and not written down or shared. Personal data was altered and anonymized (i.e., names of friends and relatives, workplaces, toponymes). The transcriptions were meticulous, and would allow an unacquainted reader to apprehend the following:

- i. Which session and segment the transcript was from
- ii. Who spoke ("P" or "T")
- iii. Significant tones of voice (e.g., soft and warm)
- iv. In verbatim what was said (including communicative sounds, laughter, mumbling and whispering)
- v. Descriptions of communicative gestures and facial expressions were recorded in parentheses (e.g., crying, sitting posture, gaze)
- vi. Silent pauses with duration of less than five seconds were indicated with an ellipsis after the last uttered word, and longer pauses were written out in seconds
- vii. Interruptions and overlapping speech were put in parenthesis inside the interrupted sentence

### **2.3.3 Achievement of Therapeutic Objectives Scale**

ATOS is a psychotherapy rating system for training therapists and for research, and it assesses the patient's behavior during therapy. On a scale of 1—100 it rates the degree to which each of the treatment objectives has been met in the patient, e.g., it is the degree of the patient's activating affect that is rated, not the therapist's affect focus. In other words, ATOS scores the in-session quantity of observed patient behavior related to objectives in therapy. The ATOS contains seven subscales: insight, motivation, activating affect, inhibiting affects,

new learning, sense of self, and sense of others. These subscales were written in a theory-neutral language and represent generally accepted common factors, and have been used to rate diverse therapy orientations (Valen, Ryum, Svartberg, Stiles & McCullough, 2011). ATOS has also been confirmed to have adequate psychometric properties (Berggraf, Ulvenes, Wampold, Hoffart & McCullough, 2012; Carley, 2006; McCullough et al., 2003b; Valen et al., 2011). The ratings are of videotaped sessions, and four of the scales are rated (insight, motivation, activating affects, and inhibiting affects) every ten minutes in the session. The three remaining scales (new learning, sense of self, and sense of others) are only rated once, at the end of every session. For the purpose of this study three scales from the ATOS were used.

#### **2.3.4 Raters**

Reliable raters of the instrument performed the ATOS ratings (intraclass correlations; ICC > .80,  $p < .0001$ , on all scales).<sup>11</sup> The raters in this study were assigned all sessions in this course of therapy, which functioned as a motivating factor allowing the raters to follow the natural flow of therapy as it presented itself in the clinical context (Berggraf et al., 2012; Hill & Lambert, 2004, p. 98). Two raters rated all scales, and a consensus rating was subsequently established. Raters were controlled for drift as other rater pairs also scored six sessions in this therapy course. Raters were blind to outcome, treatment modality, and they did not know the scores from former ratings (i.e., The Trondheim Psychotherapy Research Program; TPRP), or parallel quantifications, of the same sample.

#### **2.3.5 The three process variables**

Measures of patients' level of defense recognition, activating affects and sense of self were provided by three of the seven ATOS subscales: Defense recognition, Experience of activating affects and Sense of self. Each rating was based on a 0–100 scale, which was divided into ten-point levels. Each level contained operational definitions that guide categorization of observable behaviors (see the Appendix).

#### **Insight – Defense recognition (D)**

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<sup>11</sup> The internal consistency between raters (ICC; Shrout and Fleiss, 1979) was calculated by the two-way random effects model using average measures across raters.

The ATOS defines insight (D) as “level and awareness of maladaptive patterns” including i) degree of clarity and completeness of verbal descriptions of maladaptive patterns of thoughts, feelings and/or behaviors, with explicit examples, and ii) degree of ability to state why and how maladaptive/defensive patterns began and are maintained. Further, there are certain cut-off points in the scale; e.g., to achieve a score  $\geq 61$ , the patient needs to connect past with present.

### **Activation – Activating affect (F)**

Activation rates the level of “in-session intensity/depth/fullness of bodily arousal phobic or conflicted affects” (F). This scale does not measure inappropriate or regressive affective arousal, which is rated A. The scores are based on (i) the intensity of arousal of adaptive affect (intensity of inner affective arousal as shown in vocal tone, facial expression, non-verbal behavior or charged verbal statements), (ii) the duration of the affective arousal (a few seconds to many minutes) and (iii) the degree of relief in the experience of the feeling. When rating Activation, the raters also score core conflict every segment (i.e., anger, grief/sorrow, closeness, positive feelings for self, sexual desire, joy, interest, healthy fear, unclear, or other).

### **Sense of Self (SoS)**

This subscale captures the individuals’ degree of self-compassion and self-acceptance (SoS), and hence the focal points of this scale are: (i) degree of experience of self-compassion, self-care, or value as a human being, (ii) degree of adaptive pride in positive qualities (not defensive pridefulness or grandiosity), and (iii) degree of ability to compassionately acknowledge and accept one’s limitations or realistic negative qualities of the self. Ratings are based on patients’ ability to hold both positive and negative aspects of self in balance and recognize their wants and needs.

## **2.4 Measure of therapeutic alliance**

Patients rated the therapeutic alliance at the closing of session 4 and 20 applying the Helping Alliance Questionnaire (HAQ; Luborsky et al., 1983). The HAQ was intended to be a pantheoretical measure of the therapeutic alliance, and has been demonstrated both reliable and moderately related to outcome (Horvath & Symonds, 1991; Martin et al., 2000). The HAQ consists of 11 questions each rated on a Likert scale proper with the following levels:

–3 (strongly disagree), –2 (disagree), –1 (slightly disagree), 1 (slightly agree), 2 (agree), and 3 (strongly agree). All items are considered parallel instruments and the distances on each item are assumed equal. A total score can therefore be calculated, in which a higher score signals better alliance. However, because the HAQ has been found to contain items that reflect early symptom improvement, rather than the alliance, it has later been revised excluding these items (Luborsky et al., 1996). A central feature of the therapeutic alliance concept is that of the bond between a therapist and a patient. Employing HAQ-items that address the nature of the therapeutic bond (6, 7, 8, 9, and 10), the measure used in this study therefore consists only of items considered to represent the therapeutic bond.

## 2.5 Outcome assessment instruments

In the present thesis, the SoS-scale is also used as a measure of outcome. The psychometric properties of the ATOS have been suggested adequate (Berggraf et al., 2012; McCullough et al., 2003; Valen et al., 2011) and change in SoS is a major objective in APT treatment.

In addition to the ATOS ratings, outcome was assessed by a standard outcome battery of self-report measures used in Svartberg et al., (2004). This battery was scored by the patient at pretreatment, end of treatment and at a 2-year follow-up. A measure of symptom distress was provided by the Global Severity Index (mean score of the 90 items) of the SCL-90–R (Derogatis, 1983). The total mean score of the full version (127 items) of the IIP (Horowitz, Rosenberg, Baer, Ureño & Villaseñor, 1988) was used to assess patients' average interpersonal distress based on the scores for all subscales. Beck Depression Inventory for Primary Care (BDI-PC) was used to screen for depression, and the MCMI-III (Millon, 1984) was used as a measure for personality disorders, and for cluster C pathology.

### Clinical significant change

Outcome measures were checked for clinical significant change by utilizing the method proposed by Jacobson-Truax, which is the common method of calculating clinical significance. It involves calculating a Reliability Change Index (RCI), which equals the difference between a participant's pre-test and post-test scores, divided by the standard error of the difference (Jacobson & Truax, 1991;  $RC = \frac{X_2 - X_1}{\sqrt{2(\sqrt{(S_1 - r_{xx})^2})}}$ ), where  $r_{xx}$  is the test–retest

reliability of the measure, and  $S_1$  represents the standard deviation of “control group, normal population and pretreatment experimental group” (p. 14).

## **2.6 Analysis**

### **2.6.1 Statistical analysis**

Crosslagged correlations of residuals (after ARIMA correction) were used to check our three temporal hypotheses. Linear regression was employed to study the changes in the three process variables, and a two-way ANOVA analysis was conducted to sort out the main sources of variance. In order to investigate comparative trends (e.g., possible ceiling effects) GG’s ATOS scores in session 6 and 36 were also expressed in units of standard deviations (z-scores) based on previous ratings of the same sample (Svartberg et al., 2004; including GG’s case).

#### **Two-way ANOVA**

ATOS ratings are done for every ten-minute segment (values for segment and session are again identical for SoS). Hence, it is possible to examine the variance of change during therapy on both session (mean ATOS subscale value per session) and segment level. This implied a segment by session two-way ANOVA design, with one observation in each cell. The total variance in observations was decomposed in three possible sources: Main effects of segment and session, and an interaction between segment and session (Ses\*Seg).

#### **Linear regression**

Change in process variables during the course of therapy for the three examined ATOS variables was analyzed by fitting linear regression models to the data, modeling each process measure as a function of “time”, which was examined both at the Ses\*Seg level and at the session level. Linear regression was also employed in exploring time-lagged relations between the process variables (Darlington, 1968; Darlington & Smulders, 2001). The Durbin–Watson statistic (D–W-test; Durbin & Watson, 1950; 1951) was used to control for first order autocorrelation.

#### **Crosslagged correlation**

In order to test our hypothesis, that F and D will increase SoS (but F more so than D), and that F will predict D, we need to check if there is a sequential relationship between our process variables. In other words, we predicted that (i) higher F will forerun improved SoS; (ii) that higher D will precede increased SoS; and (iii) that higher F will precede increased D. Therefore, we conducted an analysis of concomitance in time-series to inspect the time lagged (sequential) correlation between the process variables at both segment and session level (Jones, Ghannam, Nigg & Dyer, 1993).

For the purpose of describing the procedure applied in time series analyses, session level can function as an example. Our ATOS ratings are averaged for each session, such that we obtain 33 values for each subscale ( $\bar{D}$ ,  $\bar{F}$  and  $\bar{SoS}$ ). Because these observations are connected by time (i.e., session 1 comes before session 2, etc.), we have three simple time series ( $D$ ,  $F$ ,  $SoS$ ;  $D_1, D_2, D_3, \dots, D_{33}$ ;  $F_1, F_2, F_3, \dots, F_{33}$ ;  $SoS_1, SoS_2, SoS_3, \dots, SoS_{33}$ ), each consisting of 33 data points. This yields 3 different cross-correlations of interest (D-series with F-series, D-series with SoS-series, and F-series with SoS-series). We can now crisscross whether the series generate significant cross-correlations when they are lagged, e.g., if  $F_1$  indicates  $SoS_2$ , or  $F_1$  signals  $D_2$  or if  $D_1$  indicates  $SoS_2$ , etc. The temporal relationship between two series is called the cross-correlation function (CCF). “Lag x” is the term for the number (x) of timepoints between the two series (Lag 0 is therefore a normal correlation between the two

series, e.g.,  $CCF_0 = \frac{\sum_{i=1}^{33} (D_i - \bar{D})(SoS_i - \bar{SoS})}{\sqrt{\sum_{i=1}^{33} (D_i - \bar{D})^2} \sqrt{\sum_{i=1}^{33} (SoS_i - \bar{SoS})^2}}$ . Pairing  $D_1$  with  $SoS_2$  derives a Lag 1

cross-correlation function for D and SoS. This pairwise matching will produce  $N = 32$  ( $33-1$ ) data points for a Lag 1 correlation.  $\propto$  Lag 2 will produce 31 data pairs, and so on.

Before the CCF can determine if predicaments correlate with data, our series must first be checked and corrected for any systematic cross-correlations (at any Lag) within the single time series itself, as this may cause misleading results (e.g., Tsay & Tiao 1984).

Autocorrelation is the cross-correlation of a signal with itself. In regression analysis using time series data, autocorrelation of the errors is a problem. Autocorrelation of the errors, which themselves are unobserved, can generally be detected because it produces autocorrelation in the observable residuals. As variations in the residuals should be uncorrelated with time, the necessary assumption is that the residuals are not correlated serially from one observation to the next. The traditional test for the presence of first-order



autocorrelation is the Durbin–Watson-test. The A D–W-test, and SPSS’s autocorrelation function (ACF) indicated autocorrelation in one of our series, and we did an Auto–Regressive Integrated Moving Average (ARIMA)<sup>12</sup> correction of the series in order to explore if the residuals from the corrected data display any predictive power (significant cross-correlations not due to autocorrelation).

Because the Box–Ljung tests in SPSS indicated that current observations of the process variables in the series were correlated with themselves at Lag 0, it was necessary to transform our series to reduce autocorrelation. Established models (Box, Jenkins & Reinsel, 1994) indicated that an ARIMA (0,0,1) model would produce uncorrelated residuals in all process variables. This process significantly and satisfactorily removed autocorrelation and correlated error, and new variables of uncorrelated residuals were derived. Finally, the residuals of the process variables were cross-correlated to examine the predicted sequential relationships. As our predicted sequential relationships included all process variables, all potential relationships between all process variables were examined by exploratory ARIMA analyses.

The SPSS 21.0.0.0 program (IBM) was used for all Auto-regressive Integrated Moving Average (ARIMA) modeling, analyses and plots. It was also used for the ANOVA-analyses and initial crosslagged correlations. Windows’ Excel was used for simple computations (e.g., averages, sums and standarddeviations) and making plots, tables and figures. We also used SPSS for a simple univariate analysis of variance.

### **2.6.2 Qualitative analysis**

After completing the ATOS ratings and conducting the quantitative analyzes, the complete transcripts were searched for relevant excerpts to describe, exemplify and illuminate the macro- and micro-processes in the course of therapy. These are presented in the results- and discussion section of the thesis.

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<sup>12</sup> One limitation with ARIMA is that it only tests for  $AR(1)$ , i.e., first order autocorrelation.

### 3 Results

Our postulates were that more than expected F would predict both increased SoS and D in the subsequent session(s), and that D should predict increased SoS. Before presenting results informing these assumptions, we will first outline some descriptives of the ATOS scores.

#### 3.1 Descriptive statistics of ATOS scores

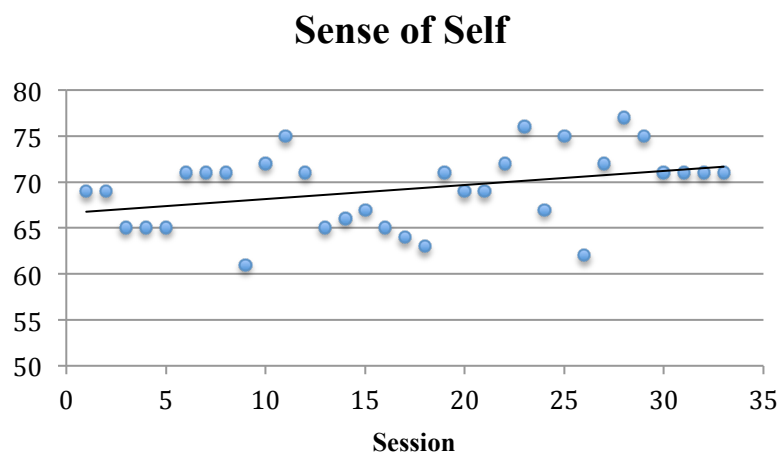
The results indicate that GG had high levels of D and SoS from the onset and throughout treatment. There is a slight temporal increase in F and SoS, and a minor increase in D. In line with the results displayed above, a univariate analysis of total variance also reveals that segment level explains 10.2% of observed variance, while session level accounts for 21.8% of the observed changes in the process variables. Therefore, we will mostly present results at session level.

*Table 1:* Mean values of the ATOS scores in the rated sessions

<i>ATOS variable</i>	<i>Mean</i>	<i>SD</i>	<i>N</i>
Sense of Self	69.21	4.16	33
Activation	49.55	10.01	33
Insight	64.97	6.97	33

##### Sense of Self

GG's SoS scores ranged from 61 to 77 ( $SD = 4.16$ ), and showed a significant increase over the course of therapy ( $R^2 = .098$ ,  $p = .042$ ).

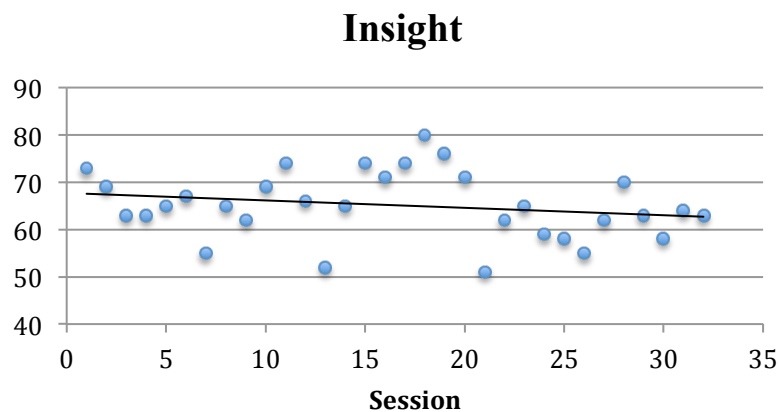


*Figure 3:* Outlines ratings of SoS through the course of therapy (best fit regression line for

the relationship between SoS and session).

### Insight

Insight on session level was rated from 51 to 80 ( $SD = 6.97$ ), while fluctuating from 44 to 92 on segment level ( $N = 177$ ;  $M = 66.18$ ;  $SD = 9.72$ ). On session level, there was a non-significant ( $p = .186$ ) decrease in D during therapy. On segment level this diminution was significant ( $p = .008$ ), but explained only 3.4% of the fluctuations in ATOS ratings.



*Figure 4:* Illustrates ratings of D throughout the therapy sessions (best fit regression line for the relationship between D and session).

### Affective activation

The scores on F ranged from 29 to 71 ( $SD = 10.01$ ) on session level, and observed changes represent a significant increase ( $R^2 = .181$ ,  $p = .008$  on session level;  $R^2 = .121$ ,  $p < .000$  on segment level). On segment level, the oscillation was between 25 and 81 ( $N = 177$ ;  $M = 49.88$ ;  $SD = 12.03$ ).

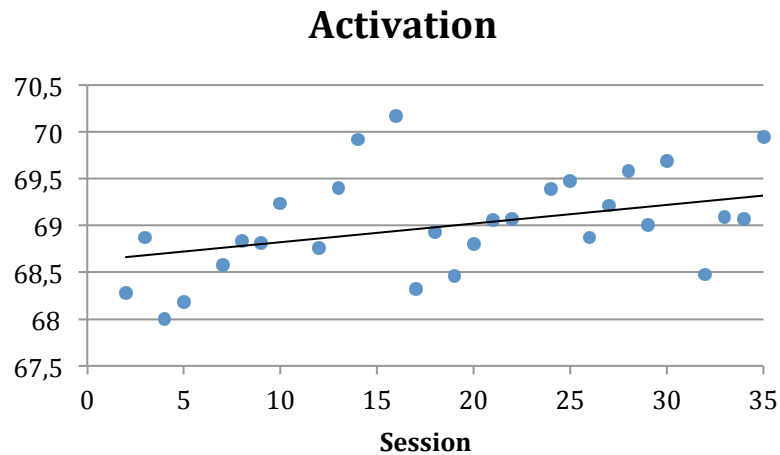


Figure 5: Shows ratings of F through the treatment (best fit regression line for the relationship between F and session).

### 3.1.1 GG's standard scores in session 6 and 36

None of the about 20 publications from the PROCMAP program have reported mean ATOS scores for the total Svartberg et al. (2004) sample, which would be of interest in order to calculate GG's z-scores. McCullough and Magill (2009) have published some data from TPRP, which was the preceding project involving video-based ATOS rating of the same sample. In the TPRP, the patients were studied early (session 6) and late (session 36) during the course of therapy,<sup>13</sup> and were assessed by 14 reliable ATOS raters. However, because the TPRP study used raters with dissimilar training from this study (PROCMAP), it is reasonable to report and calculate GG's z-scores based on both the TPRP and the PROCMAP data. Further, McCullough and Magill (2009) looked into the differences between the CT- and STDP group in the Svartberg et al. (2004) sample, but as the differences between these groups were relatively small (e.g., SoS in session 36 for STDP was 48.0;  $SD = 21.4$ ; while 48.5 in CT;  $SD = 16.7$ ), table 2 displays ATOS scores without discriminating between CT and STDP.

Table 2: GG's standard scores in session 6 and 36 calculated on ATOS ratings (TPRP) of the Svartberg et al. (2004) sample.

ATOS variable	Overall scores in session 6*			GG's ATOS scores in session 6		Overall scores in session 36*			GG's ATOS scores in session 36	
	Mean	SD	N	Score	Z-score	Mean	SD	N	Score	Z-score

<sup>13</sup> When videotapes from Session 6 or 36 were not available, the closest available sessions were analyzed.

Sense of Self	35.51	13.0	47	71 <sup>p</sup>	2.73 <sup>p</sup>	48.23	18.8	46	71 <sup>p</sup>	1.21 <sup>p</sup>
				58*	1.73*				86*	2.00*
Activation	28.72	12.0	49	45 <sup>p</sup>	1.36 <sup>p</sup>	42.49	20.2	45	54 <sup>p</sup>	0.57 <sup>p</sup>
				51.9*	1.93*				65*	1.11*
Insight	42.89	13.3	49	67 <sup>p</sup>	1.81 <sup>p</sup>	52.99	15.4	48	64 <sup>p</sup>	0.71 <sup>p</sup>
				59.7*	1.26*				74.8*	1.42*

\* ATOS scores from TPRP (unpublished data). <sup>p</sup> Data from PROCMAP.

## 3.2 Analysis of variance in the process variables

To assess the variance components in the process variables, a two-way ANOVA design was employed (univariate for each variable). The dependent variables were the three process variables (segment and session as independent variables). The analysis was conducted to examine the relationship between each of the process variables with respect to segment, session, and segment by session interactions (residuals in first Lag were not significantly correlated;  $r \approx .0$ ,  $p < .05$ ).

Table 3: Total variance ( $R^2$ ) in observed measures decomposed in session, segment, and session by segment interaction effects.

	<i>Session</i>	<i>Segment</i>	<i>Ses*Seg</i>
INSIGHT	0.41	0.19	0.37
ACTIVATION	0.65	0.11	0.23

The  $R^2$  ( $\eta^2$ ) values suggest that variation in the process variables is largely due to session-effects, while segment-effects are minor. This signals that most of the variation in ATOS scores is between sessions, and that there is less variance on segment level. The interaction of segment by session signifies that the specific change patterns observed across segments in a session vary somewhat across sessions (over the course of treatment).

Table 4: Parameter estimates from linear regression analyses (segments).

	Insight			Activation		
	<i>Coeff</i>	<i>t</i>	<i>p</i>	<i>Coeff</i>	<i>t</i>	<i>p</i>
Constant	69.542	48.23	0.00	42.47	24.93	0.00
Time	-0.038	-2.69	0.08	0.083	5.01	0.00
Adjusted $R^2$	0.034			0.121		
$N$	177					

Table 5: Parameter estimates from linear regression analyses (sessions).

	Insight			Activation			Sense of Self		
	<i>Coeff</i>	<i>t</i>	<i>p</i>	<i>Coeff</i>	<i>T</i>	<i>p</i>	<i>Coeff</i>	<i>t</i>	<i>p</i>
Constant	67.86	27.68	0.00	41.55	12.88	0.00	66.61	47.35	0.00

Time	-0.17	-1.35	0.186	0.47	2.84	0.008	0.153	2.12	0.042
Adjusted $R^2$	0.025			0.181			0.098		
$N$	33								

The results presented in table 4 and 5 demonstrate that both F ( $N = 177$ ,  $R^2 = .12$ ,  $p < .00$ ;  $N = 33$ ,  $R^2 = .18$ ,  $p = .008$ ) and SoS ( $N = 33$ ,  $R^2 = .098$ ,  $p = .042$ )<sup>14</sup> display significant temporal linear increase. F and SoS shows a significant increase both on session (across sessions) and segment level (within-sessions), while the decrease in rated D is significant on segment level only.

### 3.3 Time series modeling of ATOS scores

The ACF indicated that the only process measure that was displaying temporal cross-correlations with itself was D. This series was therefore corrected with an ARIMA (0,0,1) model. After this adjustment, several crosscorrelations were performed. No significant predictors were identified, but the analyses sketched out several trends at an “almost significant” level and some significant predictions, but with low power (effect size) due to  $N = 33$ .

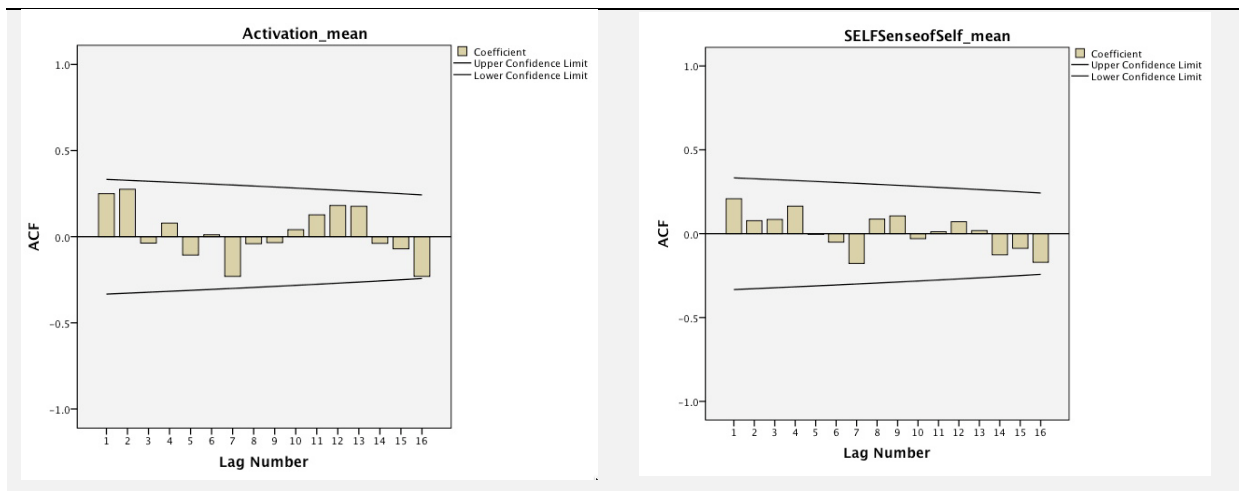


Figure 6 and 7: The autocorrelation function in SPSS unveils no significant correlations at any lag for F or SoS.

<sup>14</sup> Since SoS is measured only once a session, segment level ( $N = 177$ ,  $R^2 = .169$ ,  $p < .00$ ) is redundant and/or misleading information.

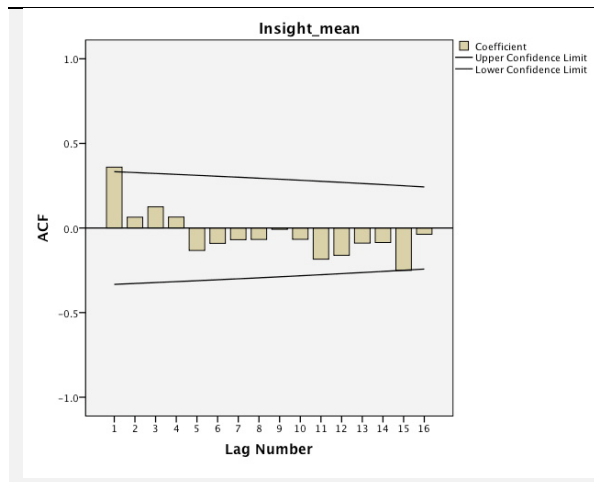


Figure 8: ACF indicates a significant autocorrelation at Lag 1.

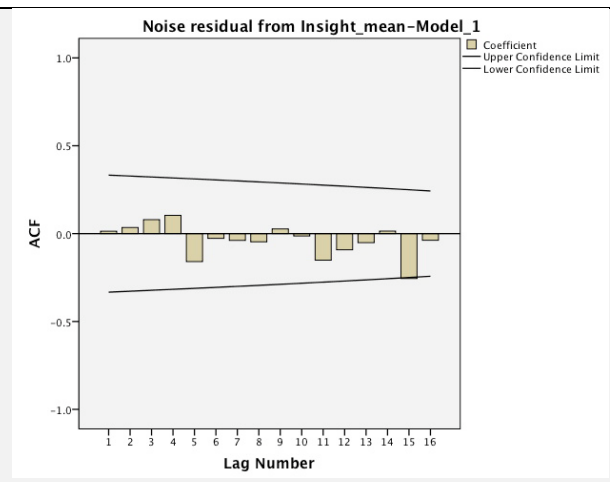


Figure 9: Demonstrates no significant autocorrelation in the residuals after the ARIMA (0,0,1) correction.

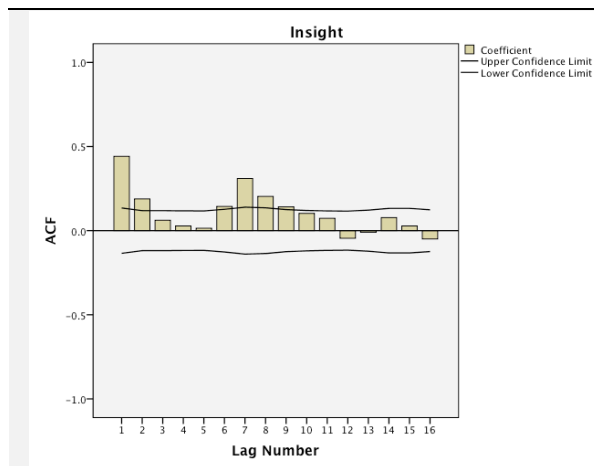


Figure 10: ACF shows significant autocorrelation in D at segment level.

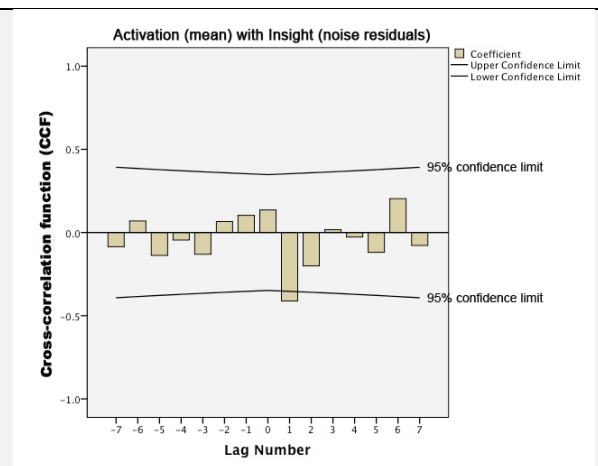


Figure 11: Indicates the trend that low D predicts high F (high D predicts low F) in the two next sessions.

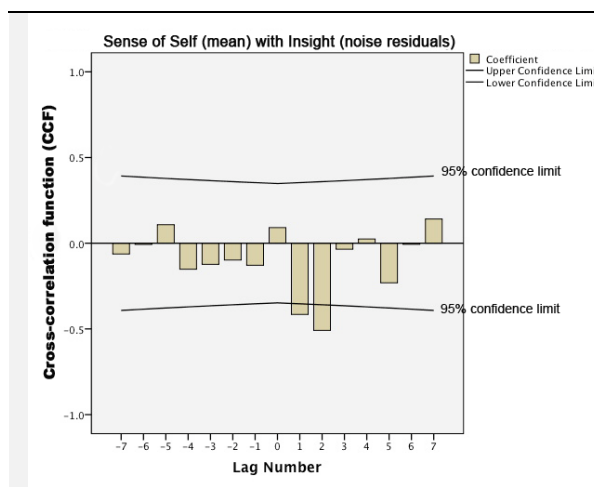


Figure 12: SoS predicts low D (high D

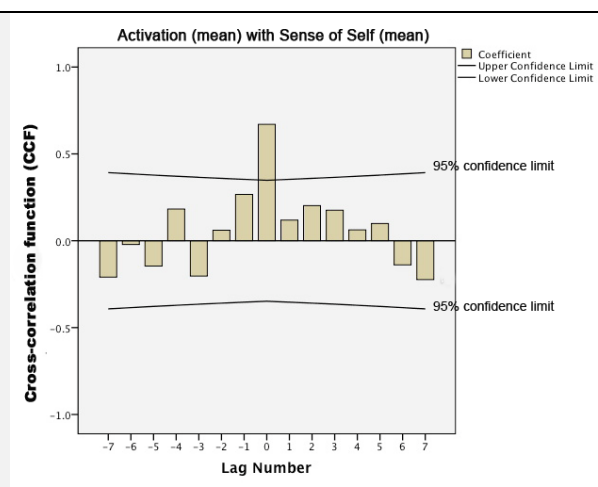


Figure 13: Illustrates that F predicts SoS in

predicts low SoS) in the two next sessions.      same session.

*Table 6: Cross Lagged Correlation (CLC) of noise residuals after ARIMA (0,0,1) correction (session).*

	INSIGHT <sub>0</sub>	ACTIVATION <sub>0</sub>	SENSE OF SELF <sub>0</sub>
INSIGHT <sub>0</sub>	1	0.136	0.091
ACTIVATION <sub>0</sub>	0.136	1	<b>0.67*</b>
SENSE OF SELF <sub>0</sub>	0.091	0.67	1

\*  $p < .05$ , but low power. Bold fonts indicate interesting trend.

*Table 7: Cross Lagged Correlation (CLC) of noise residuals after ARIMA (0,0,1) correction (session).*

	INSIGHT <sub>1</sub>	ACTIVATION <sub>1</sub>	SENSE OF SELF <sub>1</sub>
INSIGHT <sub>0</sub>	0.014	<b>-0.411<sup>a</sup></b>	<b>-0.416<sup>a</sup></b>
ACTIVATION <sub>0</sub>	0.103	0.25	0.266*
SENSE OF SELF <sub>0</sub>	-0.129	0.119	0.208

\*  $p < .05$ , but low power. <sup>a</sup>  $p = .064$ . Bold fonts indicate interesting trend.

*Table 8: Cross Lagged Correlation (CLC) of Noise residuals after ARIMA (0,0,1) correction (session).*

	INSIGHT <sub>2</sub>	ACTIVATION <sub>2</sub>	SENSE OF SELF <sub>2</sub>
INSIGHT <sub>0</sub>	0.035	-0.2	<b>-0.508<sup>b</sup></b>
ACTIVATION <sub>0</sub>	0.066	<b>0.276<sup>c</sup></b>	0.061
SENSE OF SELF <sub>0</sub>	-0.098	0.202	0.036

<sup>b</sup>  $p = .051$ . <sup>c</sup>  $p = .079$ . Bold fonts indicate interesting trend.

*Table 9: Cross Lagged Correlation (CLC) of Noise residuals after ARIMA (1,0,0) correction (segment).*

	INSIGHT <sub>0</sub>	ACTIVATION <sub>0</sub>	SENSE OF SELF <sub>0</sub>
INSIGHT <sub>0</sub>	1	<b>0.455<sup>b</sup></b>	0.079
ACTIVATION <sub>0</sub>	0.136	1	<b>0.67*</b>
SENSE OF SELF <sub>0</sub>	0.079	<b>0.67*</b>	1

\*  $p < .05$ , but low power. <sup>b</sup>  $p = .051$ . Bold fonts indicate interesting trend.

*Table 10: Cross Lagged Correlation (CLC) of Noise residuals after ARIMA (1,0,0) correction (segment).*

	INSIGHT <sub>1</sub>	ACTIVATION <sub>1</sub>	SENSE OF SELF <sub>1</sub>
INSIGHT <sub>0</sub>	0.014	0.008	0.006
ACTIVATION <sub>0</sub>	-0.09	-0.01	<b>0.446*</b>
SENSE OF SELF <sub>0</sub>	0.05	0.5	0.042

\*  $p < .05$ , but low power. Bold fonts indicate interesting trend.



The CCF analysis (figures 6 to 13 and tables 6 to 10) identifies three trends:

1. F predicts SoS.
2. High D predicts low F, and high F predicts low D in next session ( $p = .064$ ).
2. High D predicts low SoS.

*Table 11:* Summary of temporal trends in the process variables (session; not significant).

	Lag 0	Lag 1	Lag 2
F predicts SoS	<b>0.67*</b>	<b>0.266<sup>c</sup></b>	0.061
High D predicts F (negatively)	0.136	<b>-0.411<sup>a</sup></b>	-0.2
D predicts SoS (negatively)	0.091	<b>-0.416<sup>a</sup></b>	<b>-0.508<sup>b</sup></b>

\*  $p < .05$ , but low power. <sup>a</sup>  $p = .064$ . <sup>b</sup>  $p = .051$ . <sup>c</sup>  $p = .079$ . Bold fonts: interesting trend.

### 3.3.1 Times series modeling by regression

Regression indicated, as did the CCF, a trend that F predicts D negatively at Lag 2 ( $p = .051$ ,  $R^2 = .125$ ).

### 3.3.2 Observed ATOS scores in two subsequent sessions

As both alliance and clinical change during the first sessions have been indicated to predict outcome (Lambert, Hansen & Finch, 2001), e.g., Haas, Hill, Lambert & Morrell (2002) reports that such “rapid responders” positive response to therapy during the first three sessions were associated with fewer psychological problems at termination and follow-up ( $N = 147$ ), we will, for the purpose of later discussion, choose transcripts from session 2 and 3 in order to trail and illustrate temporal variation in ATOS scores (tables 13, 14 and 15).

*Table 12:* Mean ATOS scores in session 1, 2 and 3, and mean value in treatment.

	<i>D</i>	<i>F</i>	<i>SoS</i>	<i>Core affect/conflict</i>
Session 1	73	35	69	Positive feelings for self
Session 2	69	46	69	
Session 3	63	29 <sup>d</sup>	65	
Mean ( $N = 33$ )	64.97	49.55	69.21	

<sup>d</sup> Lowest observed F value in the treatment (session level).

Table 12 indicates all trends unveiled by CCF at Lag 1 of the residuals (table 11): Less than expected F (46) predicts less than predicted SoS (65) in the next session, while more than expected D (69) predicts both lower F (29) and lower SoS (65) in the succeeding session. The same trends are apparent at Lag 2 (D = 73 predicts SoS = 65 and F = 29, and F = 35 predicts SoS = 65).

*Table 13: Transcript from session 2 with comments and indications of ATOS ratings.*

	<i>Verbatim material</i>	<i>Comments and ATOS ratings</i>
Patient	And then I felt that my world fell apart, because then she had triggered that stuff of mine about being an assistant and not the director of the department in that situation, and that is something I find hard. My role should have been different, and she knows why it isn't. Because I have spoken to her about it. So she knows I'm afraid. I worked with her the first year, yes two–three years earlier. So she knows how vulnerable I am around that. And afterwards I went into the department and was able to convey this to my leader, and just had to go straight out because then I was really crying.	Core conflict about positive feelings for self. GG was used to being a high achiever.
Therapist	You were really crying.	Mirrors back
Patient	Yes, I went into the smoking shack and sat there about ten minutes crying. I cried enormously.	and exposes for affect.
Therapist	What did she hit in you?	Going for D.
Patient	She hit exactly what it is that I don't handle. "And you mustn't come here demanding anything, when you're not willing to do your part," kind of. I felt that it was that a lot, that I came there thinking I was better than I was. That is what I felt she insinuated, and then the world fell apart.	D $\cong$ 60, due to no past–present link, but she recognizes pattern.
Therapist	Hm, is that what is painful for you to hear? (yes) Things like that? (yes) Don't believe that you are better than... (yes). Or is there something else too?	This D might be linked to session 3 (see table 15).
Patient	No, it is that. Being hurt like that.	D
Therapist	Yes, what is hurting you?	Recognizes maladaptive pattern, and elaborates: D > 50.
Patient	I take it so personally, you know. That is what is. I take it in so violently instead of saying "OK, they are principles..." But I think it is very bad, and it is. I think it is very rigid (Hm), because I do think that. I think it is rigid and that it would be possible to do it differently. I call that "riding the principles", I completely disagree with it, and I said that, in that decision. That is perfectly ok, and I stick to that. And then leave there and leave it be.	
Therapist	Yes, but you take it very personally.	Mirrors back D.
Patient	Yes I did, yes.	
Therapist	It seems like you break completely? (Yes) It seems like you have an open wound, or... (Yes)... which is easy to open?	Linking D to history.
Patient	Yes. That is what I am so scared of. Also in relation to the	D > 41

	parent's meetings, that someone should come and pick at that. (Hm.) Because I can't allow that when I'm standing there, right, with 18–20 parents and the staff. (No...) So it can't happen, and I am so afraid that it will happen.	Ratings of D depend on how much insight is accumulated in the segment.
Therapist	I am not quite clear on what this is about yet? About what the painful is in this? (Hm?) What is the really painful?	
Patient	Well, no, the big hurdle in my working situation has been to hold these parents' meetings.	
Therapist	I understand that, but in what she said exactly? (Yes...) What is the really painful there? That makes it so very hurting?	Prodding for defense recognition.
Patient	(Thinking.) Mmmmm.	SoS
Therapist	It is something to do with competence, isn't it? (Yes.) Being good enough...	
Patient	Yes. And I do know that I am that. But it is about having faith in that I am. That is really some weird stuff. Because it is not about the remarks made on my skills as a professional, because I receive so much positive. And from school, too. I was the one in my year with the best grades. And good feedback here and there, from the teachers when I left, not only about grades, but about socially and... this and that. Yes.	High academic achiever, in line with Sifneos' (1975) intelligence criteria for STAPP.
Therapist	It doesn't seem like it is enough?	D.
Patient	No.	
Therapist	It is almost like water on a goose? (Yes.) Hm? (Yes.) It seems like there is something fundamental which...	We called this patient "The Girl with the Gold Medals" because she was used to bringing home the gold medals, but was afraid of feeling pride or to fail in her task.
Patient	Yes. At work too – the leader which is here now, when I was on leave, she has asked me two–three times if I could come working there, they wanted me there. (Mmmm.) I participate, it is not about that, the parents came up to me and said "can't you take that job?" They were lacking department leaders at that department. "Can't you take that job?" I was a fill-in for about a month before they had her in there. So the trust is there...	
Therapist	So what is it about? (Sigh) When someone.... Don't appreciate (Mmm) you and your competence? ... Is that it?	
Patient	Yes.	
Therapist	Contrary, do the opposite? (Yes.) Then the world falls apart.	
Patient	Yes. I become insignificant, yes.	
Therapist	Insignificant?	Vulnerable
Patient	Insignificant, and that is completely awful.	SoS.
Therapist	Aha... Mmmm...	
Patient	That I shouldn't mean anything, in a context like that.	
Therapist	Isn't that the way you can feel about Father too?	D
Patient	Yes. It is the same.	
Therapist	So there is a connection there?	Asking for past–present link.
Patient	Yes.	
Therapist	You think it is a connection? (Yes.) Between Father and work? (Yes.) When you came here today, you mentioned two themes. (Yes.) One was work (Yes) and the other was Father.	
Patient	Yes. I have thought it and seen it before too, kind of, but how clearly they are connected. Because it is about performing. I have to perform in relation to my father and I shall perform in	D ≥ 61

	relation to my job.	
Therapist	Yes... And you can feel insignificant...	Validates.
Patient	Yes. I have thought so many times that I should change style, that I should make myself less vulnerable, and then I will talk less, I will be a bit more relaxed and listen a bit more. I have done that because it has been necessary and because it has been positive. And because it is about that I have become calmer and have obtained more of a fundament in myself the latest years. But also because I won't be as easy a target then. Because if I'm active and partaking and exposing myself, I am easier to take down.	A  Some D and SoS.
Therapist	Mmm... But with Father you chose a different path. (Yes.) You showed some of your vulnerability then. (Yes.) If I may call it that. You were quite open?	Exposing for affect.
Patient	That vulnerability, if I choose to show it, if I begin to analyze and say it – they don't yet know that I am going here. (Aha.) But that is because it hasn't been natural to say, because I have said earlier that I should start this and be part of a project, so they know there were possibilities that I should be part of a thing like this. But that I rather go directly at what I feel in those situations where he is saying this and that, and hope that he can take it more easily.	GG has shared with her friends and colleagues that she was about to begin in therapy, and thus made herself vulnerable.
Therapist	If you can make it...	GG
Patient	Yes, rather than becoming kind of business-like when I express it, that I struggle with performance anxiety and when I express it, that it is hard. Which means that I talk in that way, because then I feel that I don't really make myself vulnerable (No) because then I just speak about it like that.	understands her defense, and a willingness to change is implicit.

*Table 14: Transcript from later in session 2 with comments and indications of ATOS ratings.*

	<i>Verbatim material</i>	<i>Comments and ATOS ratings</i>
Patient	And she is the one I think is most like my father in her way of being. (Aha... Way of being...) It is probably something about her getting on her high horse and making herself better than me in a way. And I don't think she is, and I don't think Father is... Because there is something about how I have never felt that I am as good as him.	GG has picked up therapist's comment about father in table 13. D ≥ 61
Therapist	You have not felt that?	
Patient	No. Have never felt that I am as good as him. (Hm.) In that teenage time. (Hm.) Always my friends were better than me. (All right?) And no matter if I was equally good in sports, and no matter if I won everything there was, every single bit, for two years when I was doing sports, I was so afraid that someone would be better than me.	D ≥ 71  (IIP 122)
Therapist	That someone should be better than you...	
Patient	Mmm. They weren't. I did beat them. I was only beaten once.	SoS and grief.
Therapist	How is it thinking about it?	Exposing for affect.
Patient	It all seems so meaningless...	

Therapist	What do you feel when you think about it?	Focusing on
Patient	Well, Mom and Dad! But they were always caught up in their own stuff. And I remember once when we were heading for a swimming competition, at the time when Mom and Dad separated, both of them were at that competition... and I break down and can't compete, you know, my brother doesn't manage either (ok). He doesn't manage to take part in the competition, he was all... As strong signals as that prove that something is wrong. Someone 12–13 years old isn't in that kind of state, you know. Dad and I took the car and drove around. My mother and my brother went for the competition. And Dad and I were driving around. I remember we did that. (Yees?) And then Dad told me about how hopeless Mom is, why he is leaving her. She couldn't defend herself, you know. And so it was him it was supposed to be all about. I was completely down and broken, and then I was supposed to sit there and understand him... I understand, yes of course, and that was hard...	grief for what was yearned for, but not received (McCullough et al., 2003).
		D ≥ 60
		Reversal of roles.
		Compassion for self, and grief.
Therapist	It wasn't that which you missed?	Therapist is
Patient	No, it wasn't that I missed.	attuned and
Therapist	What would you have needed then?	empathic.
Patient	Well, I would have needed him to take some responsibility.	Keeps exposing
Therapist	What does that mean? How should he have been towards you? In the car?	for affect.
Patient	Be closer, he should have told me that he loved me, could have been nearer.	GG's voice is very soft.
Therapist	Could have held you and... (yes) stroke your hair and (yes) be good to you? (Mmmm) ... Not having to listen to him and...	Exposing for affect (SoS).
Patient	Mmm. How I must have felt, sitting there...	Therapist
Therapist	Hmm. How much you have been through?	affectively
Patient	(Sighing, whispering) Yes, I...	involved and
Therapist	Because they had so much (Mmmm) They didn't see you?	responsive.
Patient	So we were supposed to look after them, then?	SoS
Therapist	Look after them.	
Patient	Yes, that is how it turned out. (Yes.) Or look after Mom, then.	
Therapist	So the roles were swapped here?	Mirrors back D.
Patient	Dad disappeared and we just had to be there for her.	
Therapist	How strong you must have been? (Mmm.) You must have used so much of your strength? (Yes – sighs.) You haven't gotten what you should have got? (No – whispering.) Disappointed with you father? (Sighing, crying.) Hm... that is so heavy... How did you feel in the car, then?	Mirrors back, and exposes for self-care and grief.
Patient	(Crying) Scared all the time. (Hmmm.) That everything should fall apart again (Mmm). There was not one thing to hold on to (Hmmm) And when you do that to – we were little – 11 and 12 years old (Yes) – then you can't love someone. (No.) That is how I think.	F > 60
Therapist	How do you think?	In general,
Patient	Well, they couldn't love me – Dad couldn't love me when he does that kind of stuff.	much information is lost in transcription.

Therapist	That he didn't love you...	
Patient	I would never have been able to do something like that to my children (Hm). Imagine I did something like that to my children! (Hm.) That is ...tragic, really. I will never do that! (Hm.) At the same time I have in the back of my mind that I am going to hurt them. I am afraid that I am going to hurt them, you know, that I won't be good enough in their lives (Yes) so they will have a life like that. But you know, I could never do something like that.	Positive feelings for self.  A (anxiety, defense).
Therapist	No... You must have felt so unsafe? (Mmm.) Exactly the feeling you might have today too? (Has to repeat.) (Mmm.) That you wish Father there as a safety factor? (Mmm.) Maybe he was the one with the greatest potential in that area?	Therapist is attuned and empathic. Continues to expose for affect.
Patient	It was actually, because he was the most present in himself.	Assertiveness.
Therapist	Mmm. He was the one taking you for a drive... (Yes.)	
Patient	Yes. But at the same time, Mom is the one with the insight, she says, right, that I know I have done things that have been bloody awful for you. I have talked to her, don't have a problem with it, and I have been going at her a bit about – “What do you think I felt when you said such and such, what do you think I felt then.” So I have been going at her about quite a few things. And she has the ability to understand that now, kind of (Yes). And very interested in this [therapy]. Asks: How did it go, have you been to a session... Damn it, you know. Kind of gets hysterically concerned about my wellbeing.	Some self-compassion.  Assertiveness.
Therapist	Aha, do you think she goes too far?	
Patient	Yes, I say that, that this I am not interested in talking to you about. And I might well say that.	Sets limits; good for DPD.
Therapist	You might well say that?	
Patient	Yes, that is not hard. What is really hard in relation to her is the problem with alcohol.	D Vulnerability and SoS
Therapist	Yes.	gradually becomes main focus:
Patient	All the crap that gets in the wake of it, kind of. Everything that happened that time in connection to alcohol, which I feel is coming back now when she is drinking.	Malan (1963, p. 210): “This preliminary mutual offering can often be seen quite clearly in the initial interview and one or two subsequent sessions, resulting in the crystallization of a focus on which most of
Therapist	Yes, I see. But one thing we see from what you have been saying (Hm?) is that you are quite strong/resourceful (Mmm) and competent (Mmm). You have been there (Mmm). Been there for Father, and been there for Mother.	
Patient	Yes, my aunt too has said that I turned self-reliant very soon when I was little (Yes). I was 4 the first time I travelled alone by plane to [a city] (aha...) ... and then I hadn't even turned around to wave, I had just boarded the plane and gone along and traveled down there on holiday alone. You are not big when you are four years old (No). I did the same thing when I was seven, too. (Yes.) My brother came down the year after me. And Mom and Dad had a hard time then too. Mom had planned to divorce then, but then she didn't do it, because her mother and father were separating then, and it was hard, and then she took me and my brother – my brother was born here in	

Therapist	[town] too, but then we moved North to [town]. And it was hard there too. So I didn't have a good life there either, really.	the rest of therapy is based".
Patient	No. (Hm?) No, I still have that. My brother came along one year after me, and I have understood that I grew up very quickly.	
Therapist	Hm.	
Patient	And my aunt told me that when I was ten, I was standing in the kitchen when they were sending up the fireworks at New Year's Eve. And I hadn't thought I had such a hard time then.	Grief and SoS.
Therapist	No.	
Patient	I didn't remember that I had such a painful time when I was ten years old. But I must have had when I was standing on my own in the kitchen at my Grandmother and Grandfather's – who are the people that have made me survive, I'm sure of it. (Hm.) But anyway I am standing there, and Aunt asks: Are you standing here all by yourself? And I had said that I didn't wish for a new year to come. (All right.) Because I didn't wish for a new year because I didn't find pleasure in it. (Hm.) Fireworks zooming into the air, and Happy new year and hooray, and I didn't find any pleasure in that. (No.) Aunt asked me what it was, and I said that there was so much fighting at home and that Mom was drinking a lot (Mmm), so I obviously had a consciousness about Mom drinking so much... But if I had noticed, or if it was because Dad had commented on it... Things weren't easy and safe then either. (No.)	GG explores history. This session (and the course of treatment in general) is characterized by the therapist being attuned, empathic, affectively involved and responsive.
Therapist	We have to round off now, but I have to ask you whether you have felt vulnerable in this session?	Building alliance for future focus on affect.
Patient	No, not vulnerable, or I haven't been afraid of being vulnerable. Not unpleasant being so vulnerable, no.	
Therapist	Not that, no.	
Patient	Not at all.	
Therapist	Good. So it wasn't that painful to come into contact with your feelings?	Connecting D with F.
Patient	No. That is actually quite good, to... try to see myself the way I was, how I looked, how I was and how I must have felt it.	Self-compassion.
Therapist	That is very important, very important. It almost always is.	Alliance.
Patient	Yes. And it was good to feel that I was the little girl, in a way (Yes). <i>Being held</i> (Yes).	Positive feeling for self.
Therapist	How two children were off? (Yes.) As children? (Sighing. Yes.) Mmm. I think this is our first step.	Crystallization of focus.

Table 15: Transcript from start of session 3 with comments and indications of ATOS ratings.

	Verbatim material	Comments and ATOS ratings
Patient	(Smiles a little, whispers) Yes.	
Therapist	Yes. What do you wish to talk about?	
Patient	I don't know. I have thought a little about... in relation to getting something I see as negative reactions, that make my	Core conflict 4 (positive)

	self-esteem falling apart, I have felt what is happening later, after it has happened, that I pick up everything that I find to be negative about myself, and feed it to myself, it leads to things going downhill a bit, then.	feelings for self). D
Therapist	Yes.	
Patient	There are two little episodes the last week that scrambles things completely. The first thing was when I was writing Christmas letters, and [husband] comes home and had printed them at work, and he had cut a few lines that I had written. When I read it through, I... Now I don't want to read anymore. Because then I was annoyed that he had deleted something I had written, it was something to do with him, not more than a couple of sentences. That was kind of ok. But then he said I had to read on, and he had added something about me, which I saw as praise and I couldn't carry it. When he read that out, I ran over to him and tore everything apart. Have to write new letters. All this stuff can't be on there. And then I was on the verge of crying afterwards.	It was very difficult for GG to accept own pride in self at beginning of treatment.
Therapist	Hm.	
Patient	And then I feel... But it...	
Therapist	What did it say?	
Patient	Well, it said – it was only 3–4 lines, where I had written that I was at home, a kind of administrator, I was to be at home now, then, coordinating it all (Yes) and then I wrote that I had made some earrings and pictures in the past year, and that I had sold quite a lot of it. That is what I wrote, and he had added on... something about me getting to... use my creative skills in making pictures and earrings that were put up for sale, and that the response had been very good. (Yes.) He had written that. And my world fell apart then, because I felt that was bragging, I can't be in on that, and no one will believe that I think it is so good, and this and that and that.	In session 2 GG had high D related to her anxiety about feeling (being seen as) superior. In line with our findings from the CCF: F and SoS are lower than expected in this session.
Therapist	All right... You can't say things like that about yourself?	D
Patient	No. Nooo... I can... I can actually say that I am good too. To say that I did this and that in a good way, that it was good, I can say that. (Mmmm.) – But it is something about that there is always something better, and when you realize that, this is very much a hobby, and it's... I can see that I have sold quite a bit, which is good... I see that and I think so too. But at the same time it looked rather over the top. That I had a self-image that made me look like... Then it got a bit like that.	GG often said that she had to be "world champion", but without pride. IIP 88
Therapist	Was that what made you tear apart... (Yes) That exactly? (Yes.) Many would have thought that it is a compliment.	Defense recognition.
Patient	Yes, it was...	
Therapist	When your husband writes that kind of thing.	
Patient	Yes, and I said that straight afterwards, to him, and I thanked him a lot for what he had written, and that it was a compliment, and that it was very good what he had written, and I think so, and I was able to say that to him afterwards.	Somewhat defensive.
Therapist	But it was too much for you? (Yes.) It wasn't a compliment to	Challenges.



	you... deep down.	
Patient	Yes, if it was something that he had written to me, but this is something we should send out as a Christmas letter, and that is–	A (shame/guilt).
Therapist	That is something else?	
Patient	Yes.	
Therapist	Aha. That is more like bragging?	D
Patient	Yes, I felt it was much like bragging. (Hm.) And in its wake, in a way, there were quite a few episodes from 10, 15, 20 years back when I have said something that was a little bad – and we all do through a long life – but I can't see that. But what I see is that I have done this and that and that throughout, and to... goodness... no, that is completely (Mmm), and I am simply more evil than people think, I get that over me then.	D > 50 A (shame). Some D. A

### 3.4 Alliance

GG presented identical HAQ-scores in session 4 and 20, namely 18. In the overall Svartberg et al. (2004) material ( $N = 50$ ), the HAQ-scores measured in session 4 ranged from -13 to 18 and the 99% confidence interval was bound between 7.58 and 12.9. In session 20, the range was from -6 to 18, with the 99% confidence interval spanning from 10.72 to 14.36. GG's rating of the alliance was therefore stable, and significantly above sample mean in both session 4 and 20. This is even more noticeable when GG is compared with the STDP treatment group (where the SD was smaller), as we can read from table 16.

Table 16: HAQ-scores measured by Svartberg et al. (2004) in session 4 and 20.

Session	Mean/SD	STDP ( $N = 25$ )	CT and STDP ( $N = 50$ )
4	Mean	9.28	10.24
	SD	6.89	7.03
20	Mean	12.8	12.54
	SD	3.44	4.8

This therapist also had another patient in the study by Svartberg et al. (2004). This patient was a 19 years old girl diagnosed with avoidant PD and social phobia. Over the course of therapy, this shy girl mostly whispered and looked down over the treatment course, and also displayed low overall ATOS scores in the 38 rated sessions ( $\bar{D} = 36.4$ ,  $SD = 6.4$ ;  $\bar{F} = 34.5$ ,  $SD = 5.9$ ;  $\bar{SoS} = 40.1$ ,  $SD = 6.9$ ). Yet, this patient produced HAQ scores on 12 (session 4;  $M = 10.24$ ) and 15 (session 20;  $M = 12.54$ ). This vaguely suggests this therapist being able to produce good alliances with different patients.

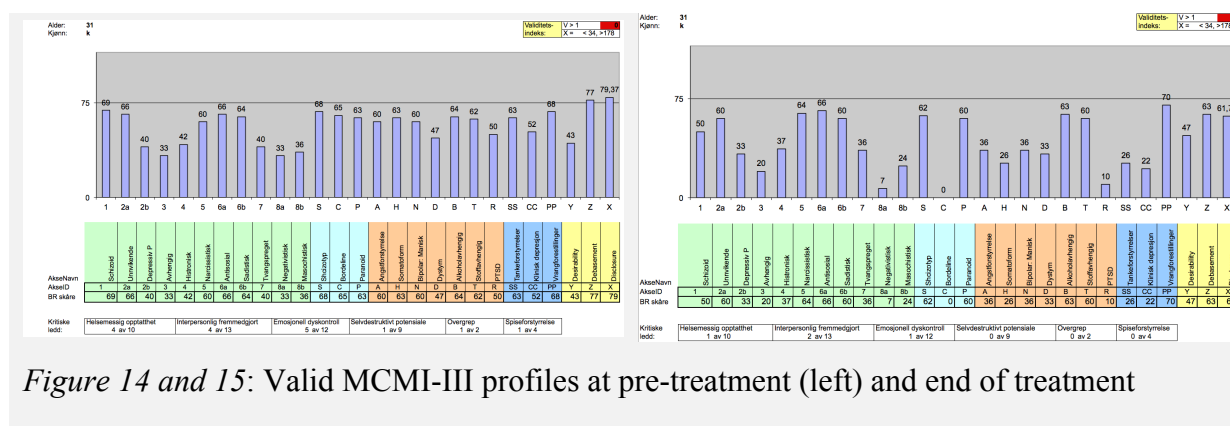
## 3.5 Outcome

The scores of SCL- 90-R and MCMI-III were never in the clinical range during therapy, while IIP scores were in the clinical range initially but fell within the normal range by session 20 and improved further at end of treatment and 1-year follow-up (table 17).

Table 17: Pre-, post and follow-up scores on the four outcome measures.

Measures	Pre treatment	Mid treatment	End treatment	6-months follow-up	1-year follow-up	2-year follow-up	Cut-off scores
SCL- 90-R	0.26	0.34	0.07	0.19	0.09	0.14	1
IIP	1.14	0.76	0.31	0.43	0.13	0.42	0.88
IIP-64	0.94	0.63	0.28	0.20	0.08	0.33	0.8
MCMI-III	55.5	-	33.75	-	30.5	-	74
BDI	0		0	5	0	2	4

GG comes in with a prescore on SCL-90-R below cut-off (mean scores in normal samples are typically around 0.30;  $SD \approx 30$ ; Pedersen, personal communication, March 11, 2014).<sup>15</sup> It can therefore be disputed whether the term significant clinical change can be applied to GG's case. Shedler, Mayman and Manis write, "[f]or patients with a prescore below 'c', a clinically significant improvement is not possible. For these pseudohealthy patients a statistically significant change requires  $RCI = 0.16$ " (1993, p. 202–203). If we apply this reasoning to our case, both SCL- 90-R and IIP scores imply a significant change both at the end of treatment and at 1-year follow-up (for IIP the  $RCI = 3.85$  at end of treatment, and 4.69 at 1-year follow up, which is above the  $p = .05$  value of 1.96). MCMI-III is not suited for RCI-calculations, but GG's scores pre- and post-treatment do indicate some clinical change (figure 14 and 15).



<sup>15</sup> The only items GG scored "2" was 76 and 89, while she reported "3" on items 8 and 75.

(right).

At session 20 GG's GSI was measured to 0.34 (while IIP was rated 0.76), and this was also the only time she had a score ("1") on item 79 ("feeling worthless"). The mean GSI (mean value of all SCL- 90-R scores) at pre-treatment in the original study by Svartberg et al. (2004) was 1.25 ( $N = 50$ ;  $SD = 0.64$ ; range: 0.26–2.82). Mean GSI fell to 0.81 ( $N = 50$ ;  $SD = 0.52$ ; range: 0.07–2.28) at the end of treatment and to 0.73 ( $N = 50$ ;  $SD = 0.53$ ; range: 0.03–2.16) at 1-year follow-up. Mean IIP (mean value of all 127 IIP-items) at pre-treatment was 1.64 ( $N = 50$ ;  $SD = 0.48$ ; range: 0.71–2.79), which fell to 1.27 ( $N = 50$ ;  $SD = 0.56$ ; range: 0.31–2.54) at the end of treatment, and further to 1.12 ( $N = 50$ ;  $SD = 0.64$ ; range: 0–2.80) at 1-year follow-up. The CIP (Pedersen, 2002) sum score has been demonstrated to correlate .99 with the sum score of the circumplex version of IIP (IIP-C; Wilberg, Karterud, Pedersen & Urnes, 2009; Alden, Wiggins & Pincus, 1990), and therefore a recalculation of the IIP scores to CIP scores could possibly illustrate GG's change.

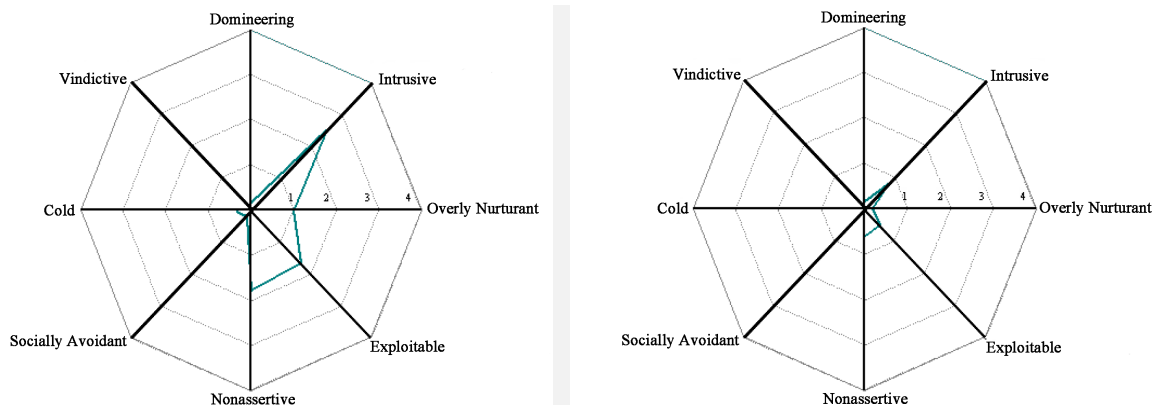


Figure 16 and 17: GG's pre- (left) and end treatment (right) scores on CIP.

Because IIP and CIP are multidimensional instruments, the sum score must be interpreted with care, as the patient might be left with specific problem areas even though the mean score has decreased. Figure 16 and 17 denote that GG leaves therapy without reporting any significant interpersonal problems in any dimension. This trend is also evident at the 2-year follow-up.

Table 18: Scores on CIP at pre treatment, end treatment and 2-year follow-up.

CIP Subscale	Pre treatment	End treatment	2-year follow-up
--------------	---------------	---------------	------------------

Intrusive	2.50	0.83	0.33
Overly Nurturant	1.00	0.17	0.17
Exploitable	1.67	0.50	0.83
Nonassertive	1.80	0.60	0.80
Cold	0.33	0.00	0.00

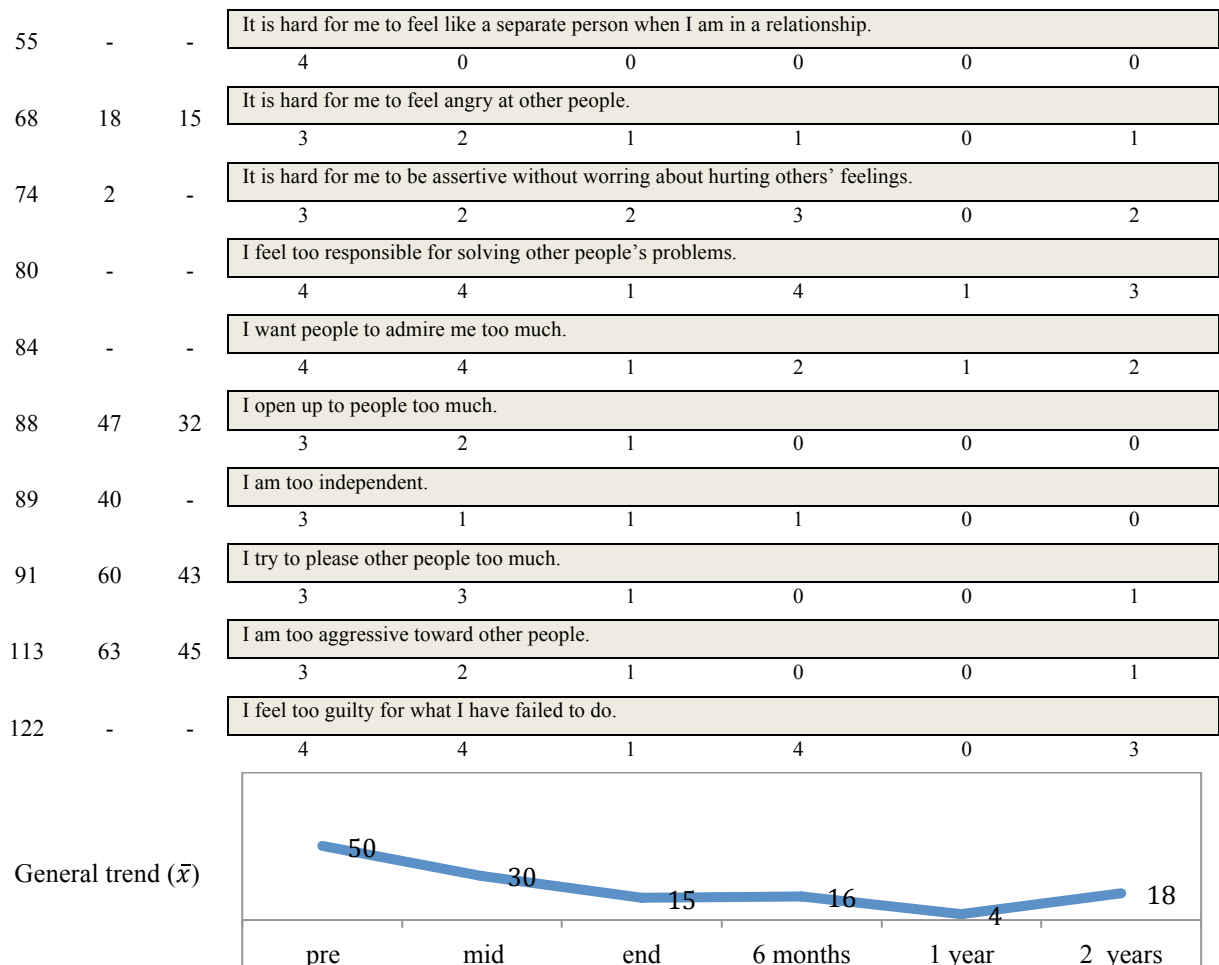
The IIP scores seem to imply a clinical significant change when GG reports some problems at the starts of therapy, but in sum almost none at termination. The BDI score of 5 at 6-months follow-up seems to be connected to some external event (loss, physical illness or worries) and falls back to 0 at the 1-year follow-up. This seems not to be connected to this treatment. However, at two-years follow-up, GG's BDI score is 2, and she also reported more problems in regulating alcohol consumption in the MCMI. Further, GG might be underreporting on GSI, as for instance a score on 0.07 is quite infrequent even in normal samples. In general, measures of outcome are difficult to interpret on an individual level, and a deep knowledge about the case is necessary to judge data correctly. Cut-off scores are also often debated, but Derogatis' (1992) suggestion of a T-score of 63 indicating significant problems seems at least mathematically tenable. This would for instance imply a cut-off for SCL-90-R at about 0.8 instead of 1.

### 3.5.1 Inventory of Interpersonal Problems

The most salient scores in IIP might serve as markers of change and problem areas in our subsequent discussion of GG's clinical change, and it seems arguable to focus on pre-treatment scores  $\geq 3$  on IIP-C.

Table 19: Scores  $\geq 3$  on IIP-C and CIP, and/or scores = 4 on IIP.

<i>Item</i>	<i>Pre</i>	<i>Mid</i>	<i>End</i>	<i>6-months</i>	<i>1-year</i>	<i>2-year</i>	
<i>IIP</i>	<i>IIP-C</i>	<i>CIP</i>	<i>treatment</i>	<i>treatment</i>	<i>treatment</i>	<i>follow-up</i>	<i>follow-up</i>
2	31	23	It is hard for me to say 'no' to other people.				
			3	1	1	0	0
4	-	-	It is hard for me to keep things private from other people.				
			4	1	1	0	1
20	33	24	It is hard for me to be aggressive toward someone when the situation calls for it.				
			3	1	1	1	1
36	15	13	It is hard for me to set limits for other people.				
			3	1	1	0	0
41	10	8	It is hard for me to argue with another person.				
			3	2	1	0	0



The IIP-C scores additionally seem consistent with her diagnosis (DPD; see discussion below, p. 56–57), which signal that they are acceptable measures in trying to decipher and depict alterations in GG's interpersonal problems.

### 3.5.2 Sense of self and clinical change

81% of the segments (143 of 177) were rated as core-conflict being “positive feelings for self” (ATOS). As reported above, GG's sense of self showed a significant increase ( $R^2 = .098, p = .042$ ). Such change in SoS is also indicative of positive clinical change.

### 3.5.3 Sense of Self: Autonomy versus relying on others

The primary affect phobia in patients with DPD is anger/assertion (e.g., GG's IIP scores on items 2, 20, 36, 41, 68 and 74; the response on item 113 probably also reflects her shame and guilt for being assertive) and confidence in one's sense of self or sense of autonomy (McCullough et al., 2003). Other people are needed to provide the missing capacities these patients have not developed themselves, like decision making, caretaking, initiative, etc. An

average DPD patient becomes desperate when left alone with such responsibilities. Primary gains of defenses are thus the avoidance of inhibitory feelings involved in autonomy, independence or simply being alone. In such patients, defensive behaviours include seeking reassurance, indecisiveness, helplessness, or childlike behavior. Secondary gain is conceptualized as the safety and comfort of relying on others, or the freedom from taking responsibility for one's own life (McCullough et al., 2003). The missing capacity for DPD patients is a sense of mastery and competence about the self (e.g., GG's IIP scores on items 4, 55, 88, 80, 84, 89, 91 and 122), and having comfort rather than pain when alone (feeling comfortable with autonomy). Observing this pattern, it makes sense why the therapist exposed for positive feelings for self in 143 of the 177 rated segments. GG's pattern of dependence was particularly salient in relation to her husband, whom she idealized at the beginning (e.g., IIP 55). The therapist challenged this position, and exposed for assertiveness and self-care. One example of this was seen in session 14 (table 20).

*Table 20: Transcript from session 14, first segment (D: 58; F: 65; SoS: 71).*

	<i>Verbatim material</i>	<i>Comments and ATOS ratings</i>
Therapist	But you feel let down.	Core conflict 4 (positive feelings for self).
Patient	Yes, I do a little bit too, because...	
Therapist	How has he [husband] let you down?	
Patient	Because he has so many things that are important. This is important to me... What is important, that is. This is important to me, and it is very important that he understands (Yes...) So he can manage to be there for me. Because it is very important that he does that now.	F > 55 D ≈ 50
Therapist	Yes, right	Some D, > 40
Patient	But I probably allow things to go so far that I am quite down before I might signalize it...	
Therapist	So you can feel it, that he... prioritizes other things than... than you? (Yes) ... And your wellbeing? (Mmm) ... Hm... All things are so important. (Hm?) All things are so important.	Pointing out costs.
Patient	Yes, but I don't feel that the reason he does so, is that what I do isn't quite so important. I can get that feeling, I can. But I can also... Because he understands, but he doesn't act on it, because he plans two months ahead with a program that is just inhuman for me to manage.	Defense, rationalization: Low insight. Some care for self.
Therapist	You defend him a lot?	Challenges.
Patient	Yes I do defend him, I do. But I let myself be heard too!	A
Therapist	I hear that right here and now.	
Patient	Yes I do now, because I don't want you to believe that he is like this or like that, because he is a world star actually (laughs	

	a little).	
Therapist	He is a world star...	
Patient	Yes he is, yes.	
Therapist	Is he?	
Patient	(Still smiling) Yes, and he will remain so. Because I don't want you to believe that I don't love, for example. It is very important for me that you know that I love him.	A. Defense in line with DPD. D ≤ 30
Therapist	Hm	
Patient	More than anything in the world. It must... It...	
Therapist	It is important for you to love him, is it not?	
Patient	Yes. Yes. But there is something about the way I am, too. I can be completely on rock bottom, you know, but I can also be on top of a mountain. And when I have a man I love him above everything else in the whole world, really. And I will continue to do so my whole life. Because we are so happy together. This is not something I play with. It is intense what I feel now. Both for good and bad. I can feel things in an intensely painful way too.	IIP 55  Core conflict could be love/closeness, but overall theme is SoS.
Therapist	But you have said yourself that you need him to be a world star.	Points out defense.
Patient	Yes. But I can well handle that he is mistaken, you know, so it isn't that...	
Therapist	But maybe not too much...	Challenges.
Patient	(Laughs.) Yes, but he isn't, so...	A

Advised by the APT manual, the therapist persisted in his focus on exposing fears about autonomy in the relationship (McCullough et al., 2003). Consequently, this maladaptive pattern in relation to her husband gradually changed over the next sessions, and in session 22, she started recognizing her dysfunctional defense and its costs.

*Table 21: Transcript from the first segment of session 22.*

	<i>Verbatim material</i>	<i>Comments and ATOS ratings</i>
Therapist	What would you like to use today's session for?	
Patient	I have thought about independence in relation to my husband.	
	GG tells how starting work again is showing up for herself. Such that she is more autonomous in relation to others. Says this means a lot to her confidence, and that she does not have enough confidence to only do what she is doing now (being at home with children). Envy her husband, the possibilities he has and uses. She sees that is basing her happiness on him. Becomes dependent on him to have that safety and confidence. Now she is building more comfort and confidence in herself.	
Therapist	So that might make you stronger, getting back to work? Colleagues, a lot of praise?	D
Patient	In a way I am pleased with what I do now too, but it isn't enough. Why isn't it enough? Can't stand nagging at him for having so much to do. Can't stand feeling that she is the one in	Positive feelings for self. Image of

	the background, who is at home with the responsibility for the children.	husband has changed since session 14.
Therapist	You can't stand it?	$D \geq 60$
Patient	No. What I can't stand is that it doesn't necessarily strengthen me. I am reducing myself a little by not making that job important enough. In order to strengthen my self-esteem, I need to get out and work. I have been dependent on others all the time. Not be so dependent upon that the husband's happiness is my happiness.	SoS. IIP item 89.
Therapist	Has that been safe?	Important insight. IIP 55 & 89.
Patient	Yes, have said "can't you just look after me financially the rest of my life?" That is kind of fooling oneself.	$D > 55$ . Central for DPD.

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### 3.5.4 Overall observations and outcome

GG's perfectionism and obsessive self-criticism in the early sessions stand in stark contrast to observed behavior in the later sessions. In session 32 one major theme was the patient reporting being able to be ambitious within normal boundaries. She also started working again between session 27 and 28, something she seemingly managed rather well. Therefore, if clinical change is primarily a return to normal functioning (Svartberg et al., 2004), then GG displayed significant change during the treatment period. In relation to mother, the patient gradually managed to set limits in terms of not allowing her mother to get drunk while visiting her grandchildren and daughter. The restructuring of her image of father took a long while, and went from him being unattainable to becoming more unimportant. Session 1 began with the patient talking about her father forgetting about seeing her daughter, this was very painful for her, and she longed for her father's love. Later in therapy she saw him more realistically, and separated from her idealization of him. In session 36 (one of the excluded sessions) the therapist and GG watched a videotape of an early session. In session 36 and 37 she reported how surprised she was by how much she had changed over the course of treatment, as if the person she was watching "was another person". In session 32 she felt she had already gained what she wanted from therapy, and wondered whether she should terminate treatment. Due to the treatment being part of a study, the therapist suggested five normal sessions in addition to one session to watch an early session together. Session 39 was therefore the last session, and the patient expressed much gratitude for the treatment and was ready to engage fully in life. The therapist confirmed GG's positive change, and encouraged her to continue working with self-acceptance as her own therapist (in line with many short term dynamic psychotherapies, e.g., Monsen, 1990).



## 4 Discussion

The objective of the present study was to examine the temporal fluctuations in, and interaction between, three selected ATOS variables seen as essential in psychological treatment by the APT model. Our first aim in this concluding discussion is to contrast presented results with the initial hypothesis. Secondly, prior to outlining limitations and directions for further inquiry, we also debate possible mechanisms for clinical change.

### 4.1 Presumptions and postsumptions

Our precluded position was that (i) more than expected F per session would predict increased SoS in the subsequent session(s), (ii) more than anticipated F per session should predict higher D in the next session(s) and that (iii) more than expected D per session should predict higher SoS. Table 22 summarizes our results and hypotheses.

*Table 22: Our hypotheses compared to the trends (nonsignificant) in our findings.*

	<i>Proposition</i>	<i>Trend in our results</i>	<i>Presumption vs trend</i>	
I	F will predict increased SoS.	F predicts increased SoS.	Congruent	=
II	F will predict higher D.	High D predicts low F, and high F predicts low D.	Opposite	≠
III	D will predict higher SoS.	D predicts low SoS.	Opposite	≠

Rønnestad and Skovholt (2003) nominated “awareness of complexity” a central characteristic of a psychotherapist’s development. This also includes being open to the contributions which different theoretical approaches have brought to the field of psychotherapy, and not erroneously assume any of them having the copyright on truth (Monsen, 1990). Presented findings (nonsignificant trends) are multifaceted, especially when seen in perspective of previous studies from the Svartberg et al. (2004) study, and the literature on affect, insight and self-representations in general. The potential complexity of affect processes reaches for infinity (Solbakken et al., 2011a) and can be highly idiosyncratic. Furthermore, the organization of these affect processes into scripts (Tomkins, 2008) is thought to develop into the formation of the individual’s representations of self and others.

#### 4.1.1 Affect restructuring and affect consciousness

The therapist maintained focus on affect throughout the treatment (F showed a significant temporal increase  $\beta = 0.47$ ;  $p = .008$ ), and such focus seems accurate, recognizing that GG had an overall high SoS ( $M = 69.21$ ; Ulvenes et al., in press) and that the alliance was  $\geq$  adequate ( $\overline{HAQ} = 18$ ). GG's F-scores ranged from 29 to 71 at session level (25 to 81 on segment level), and  $\bar{F} = 49.55$ , and  $F \geq 60$  in 6 of the 33 rated sessions. According to Davanloo (1995) it is important for patients to become aware of and experience feelings to enable the “working through” of unresolved feelings related to broken attachments in the past and other trauma. It seems likely that F enabled facilitation of essential emotional restructuring (desensitization), leading to changes in the patient. Emotion-focused theorists have suggested that there are aspects of the therapeutic process, other than emotional activation and arousal that are essential to emotional restructuring. “Personal reflection” (Monsen & Monsen, 1999) and “emotional processing” (Greenberg, 2008), including reorganization of affective scripts and connecting cognitive-affective experiences respectively, have been proposed as an essential part of the therapeutic healing process. This fits well with GG, who had an overall high score on both D and SoS. Monsen and Monsen (1999) stress the aspect of reflecting on affective material to facilitate AC. The theory predicts that increased affect consciousness, through emotional integration and reorganization of maladaptive affective scripts, enables patients to make use of the affects as signals and motivating agents in new and more adaptive ways (Monsen & Monsen, 1999). In line with MBT, Greenberg (2008) also notes that in addition to facilitating emotional activation, integration of affective experience with cognitive elaboration is important for positive therapeutic effects. Both Greenberg and MBT emphasize that this emotional processing is most efficient when affects are at an “optimal level” (not too much, not too little) and that moderate amounts of emotional arousal best predict good outcome (Bateman & Fonagy, 2004; Carryer & Greenberg, 2010). In GG's case F and SoS are closely related (see below), and much of the reflection in the treatment was about positive feelings for self, which McCullough thought essential for psychotherapy: “[W]ith self compassion...well, trust me here for some moments....it has to be 100% or there is something dangerous lurking about” (McCullough, personal communication June 25, 2009).

#### **4.1.2 Relation between F and SoS**

One immediate challenge here is that 81% of the segments were rated as exposing for “positive feelings for self”. Observed F is therefore closely related to SoS (table 11 indicates

that the correlation at Lag 0 is .67), and a large portion of the suggested trend that more than predicted F per session predicted higher SoS in the next session (correlation is .27;  $p = .79$ ; at Lag 1) might thus simply be due to the trend that more than expected F predicted higher F in the next session. There might be somewhat similar factors beneath the trends that (quite opposite to our assumptions) more than expected D predicted lower F (Lag 1 correlation at -.41;  $p = .064$ ) and SoS (correlation at Lag 1 was -.42;  $p = .064$  and -.51 at Lag 2;  $p = .051$ ) in the next session(s). Hence, as F and SoS are temporarily connected, it is not surprising that D correlated negatively with both variables. Because GG was indeed very self-critical (perfectionism) and a high achiever, it might further make sense that more than expected D would prime lower SoS, as higher D indicates that she explored the many ways in which she had a weak and dependent self-representation (at least in segments scored with F being positive feelings for self). Another factor not unlikely to influence the results is that therapy (incorrectly) could be found inadequate to enhance D (ceiling effect), as the mean values were rather high from the onset of treatment ( $D = 73$  in session 1, and  $\bar{D} = 65$ ).

#### **4.1.3 Temporal variation in D**

Insight would be anticipated to increase linearly (Grenyer & Luborsky, 1996; Kallestad et al., 2010) or curvilinearly (O'Connor et al., 1994) over the course of therapy. Kivlighan et al. (2000) found that insight increased in time on global measures. One possible reason why the  $\beta = -.17$  ( $p = .186$ ) is that the ATOS subscale for D has a cut-off score at 61 for past–present link, such that established knowledge between therapist and patient about the historic cause of maladaptive patterns is no longer languaged (and increasingly so as time progresses). Another similar trend could be that the focus gradually shifts from history and childhood, towards GG's present situation. She started working again before session 28, and this shift in her life was an important focal point. When D decreases temporarily while SoS increases ( $\beta = 0.153$ ;  $p = .042$ ), it might also give some indications to why GG's D proved an inadequate predictor of SoS in this design (as the variables move in opposite directions there is less chance for correlation). Further, other variables, for instance F, might be a moderator for D in affecting SoS, such that the synergic effects between the six corners of APT are more sophisticated than expected.

APT and ATOS define D as a process measure and do not perceive insight as a goal in itself. Thus, unlike some other traditions, e.g., psychoanalysis (Messer & McWilliams, 2007) and

some psychodynamically oriented psychotherapies of a certain length, which aim at enhancing insight and integrate split off mental states (Katznelson, 2014), APT does not focus on explicitly accumulated insight. Consequently, because ATOS ratings are based on D displayed within ten-minute segments only; the ATOS scores do not intentionally capture such amassed gains in insight. Expecting a temporal increase in D is therefore perhaps mostly a conceptual confusion. Further, GG's case is most likely quite unique in many ways, as she showed high D from onset, and also had a style of self-judgment (perfectionism) likely to influence the relation between D, F and SoS. However, in the process of understanding mechanisms of change from the vantage point of ATOS, one could posit that the maximum values of peaks in D, for instance, might be most important, or alternatively that the amplitude would be less important than the average scores over the treatment course; e.g., Monsen and Solbakken theorize that process learning and affect integrations happen through many repetitions of small steps (Monsen & Monsen, 1999; Solbakken et al., 2011a).

#### 4.1.4 High D nebulously predicts low F – and vice versa

Parallel to Cautela (1965), Fosha (2000), Hill et al. (1992), Hobbs (1962) and Wachtel (2010) we assumed that increased D would result from more than expected F, even though this would be opposing the cornerstone of D being the first step in APT. However, D and F might be somewhat overlapping, and the operationalization of D in the ATOS further makes no distinction between cognitive and emotional insight, something several theoreticians lend support to (e.g., Crits-Christoph et al., 1993; Gelso & Harbin, 2007; Gelso et al., 1997). In MBT, pseudomentalization is seen as a prementalistic mode; pretend mode. The concept of such a nonproductive state could arguably lead to an erroneously high D and low F on the ATOS (that high F also predicts low D would not exclude this explanation, as pretend mode would be absent when F is present). Our transcripts seem to support the post hoc interpretation that D predicts low F simply because the present therapist tends not to focus on D when F is present, and when F is not present, he targets D. This maneuvering is in line with the APT model, and can be illustrated by segment 100, which had the highest ATOS score on D (D: 92; F: 63; SoS: 71) in the treatment course.

*Table 24: Transcript of segment 6 in session 22 (segment number 100).*

<i>Verbatim material</i>		<i>Comments and ATOS ratings</i>
Patient	What I have had, with my low self-esteem and all of that, he	Core conflict 4

	[father] has felt is a bit disgusting, like nerves, you know. I think I have been afraid that he would see how small I have felt. If I have had long hair, been thin/slim, I have tried to hide it.	(positive feelings for self).
Therapist	I think there is weight in what you say now. That you have felt that he couldn't accept you when you were little or didn't have self-esteem or not being too well. Elevate the other side in you, the active, competent, action-oriented.	Confirms D about positive feelings for self.
Patient	That feeling, the weak image, it is in my teens that I feel it very strongly, and not further back. He says: "You are so lucky to have met your husband. Terrific guy." Why have I been so lucky with those things all the time? It means that he doesn't think I am good enough to deserve having a good life, meaning I have been lucky. No given that I should find such a good man.	D ≥ 61 because of past-present link.
Therapist	Could it also be that he thinks you have found a salvation?	Challenges D.
Patient	Yes, a salvation for me, it could just as well have gone straight to hell a few years back. But it is a salvation for Dad too. Because then he walks free.	D ≥ 60
Therapist	Yes, I see, his conscience is good now that you are in good hands?	Important in light of IIP scores 55 and 89 (see table 19).
Patient	Yes, he says so, how good my husband is. He sees that the weakness I have needs the strength my husband possesses. And that is the strength I don't want from the outside anymore now.	Central for DPD.
Therapist	You started the session talking about independence, not leaning too much on others.	D ≥ 80. In order to reach D ≥ 81, there needs to be sustained high levels of D.
Patient	Yes, that thing about my father in my teens has created a strong fear in me for not being accepted for my weak sides. That fear was bigger before, but now I am ready, because I am more confident about the strong. The strong – 70% strength and 30% weakness. It is not so dangerous to show weakness then. But before, when 80% was weakness and 20% hiding [the weakness], it was frightening to show it.	Confirms.
Therapist	So now it's the other way around.	F > 61; SoS > 61 <sup>d</sup>
Patient	Yes, now it's the other way around, but this is in my thoughts, it is still a challenge to go out into the world and practice this, but I feel that I have the strength for it now. ...	

<sup>d</sup> ATOS scores are done on basis of observations on video, and a lot of nuances are lost in transposing to verbatim data. Some ratings might therefore seem unsupported in the text.

Observing that D predicts low F might indicate one reason why D failed to predict SoS (having seen the possible connection between F and SoS), as has been demonstrated on group level analysis of the TPRP data; e.g., Tveit-Winther (2010, p. 32) reports a "significant positive association between the increase on Insight and treatment outcome, defined as change on Sense of self".

#### **4.1.5 Relation between D, F and outcome**

Wampold, Imel, Bhati and Johnson-Jennings (2007, p. 119) propose, “that insight is a beneficial common factor present in and critical to all psychotherapeutic orientations”, and it is important to note that even though D did not predict SoS (which may have diverse idiosyncratic and/or methodological reasons as seen above), GG’s high D is most likely to have been central for her observed clinical change. Hoffart et al. (2002) reported that greater patient understanding early in treatment was associated to a reduction in schema belief and emotional distress. GG’s mean D score in the first 6 sessions was 67. This also links well with Sifneos’ (1975) first selection criterion (“[t]hey must be of above average intelligence”) for successful STAPP, and with Flegenheimer’s (1985) observation that the probability for a patient succeeding in short term psychotherapy increases if s/he has done well earlier in personal and social life. GG was intelligent (academic results; Sifneos, 1975) and had done well in personal and social life, and was gaining insight in her own tendency to perfectionism and low self-compassion, and it seems likely that this knowledge would benefit GG long after termination of therapy.

The fundamental idea that clients build a capacity to reflect on their own affective and lived experience, including maintaining connections with that experience, and thus evolving insights on their own, is often recognized as an effective ingredient in therapy and has been indicated to linger long after termination (Schottenbauer, Glass & Arnkoff, 2007). E.g., self-reflexivity (Aron, 2000), AC (Monsen & Monsen, 1999), mentalization or RF (e.g., Fonagy et al., 2002), potential space (Bram & Gabbard, 2001) and self-analysis, have all been shown to have positive associations with outcome after treatment and predict adjustment on a day-to-day level and to be retained by patients for a prolonged time after end of therapy (e.g., Kantrowitz, Katz & Paolitto, 1990). However, an increased understanding of a problem does not necessarily imply that the patient takes the required steps for adaptive change.

## **4.2 Therapeutic change and processes**

As we have seen, psychotherapy is often effective, with most effect sizes of differences in outcome vacillating between 0.75 and 0.85 (Wampold, 2001). However, gifted therapists do provide better potions (e.g., Crits-Cristoph et al., 1991; Henry & Strupp, 1994; Lambert, 1989; Luborsky et al., 1986, Orlinsky & Howard, 1980; Ricks, 1974), despite causal

explanations for this phenomenon being casuistical. The therapist demonstrated high expertise in APT, without being rigid to the treatment manual. Such inflexibility has been related to a negative outcome (e.g., Castonguay et al., 1996; Høglend, 1996), in that the therapist may try to fit the patient into a model, instead of adjusting the model to the patient (Roth & Fonagy, 2006). We have also argued that GG was well suited for APT. In terms of summing up GG's case we return to Elliot's (2002) three questions:

i) *Has this client actually changed?* To interpret outcome measures (which are only reliable on group level) on an individual level one needs deep knowledge about the subject. It is also important to remember that denoting change is different from understanding the basis of change (question ii). However, as both outcome measures and observations point in the same direction, we think there is enough evidence to answer this question positively.

(ii) *Is psychotherapy generally responsible for change?* We have insufficient information to answer this question adequately. Other studies reporting an answer to this demanding question often present test results, transcripts from the therapy sessions, verbal reports from the therapist(s), reports from other helpers (e.g., social counselor), verbal reports from her friends and family and our their own video observations (e.g., Morken et al., 2014). However, it seems likely that observed changes in therapy is associated with outcome.

iii) *What specific factors (within therapy or outside it) are responsible for change?* GG's suitedness for APT therapy, the therapist being an expert, her overall high ATOS scores and that her HAQ-scores indicated excellent alliance already in session 4, despite the therapist focusing on affect (Ulvenes et al., 2012), all seem plausible factors in GG's change.

## 4.3 Limitations

The most obvious limitation of this study is the lack of statistical power (presented findings from the CCF are all nonsignificant). Further, the internal validity of a single-case observational design is threatened by many factors, and outcome of treatment may very well be affected by other uncontrolled variables. Further, our design has a number of possible methodological weaknesses (some of which have already been mentioned above). We will first address a few limitations connected to the ATOS before mentioning more general reasons for interpretive caution.

### 4.3.1 Possible ceiling effect due to the tradition of the ATOS

As the ATOS training and reliability testing (RT) was done in line with McCullough's (and colleagues) Gold Standards of selected sessions, her way of scoring ATOS might also add some limits on the use of the scale. In the RT the highest score on F was 90. This was a segment where the patient cried unrestrictedly and loudly for several minutes, such that his shirt got wet and he started bleeding from his nose (table 23).

Table 23: Partial transcript from a session used in the reliability testing at PROCMAP.<sup>16</sup>

<i>Verbatim material</i>	
Patient	[Really starts sobbing]
Therapist	mmm, [comforting sounds]
Patient	[Continues sobbing louder, more intensely] I think some of the crying has to do with like... (my ex-wife) using (my daughter) as a punishment. You know, not letting me... [Loud crying. Shirt getting wet of tears. But patient does not cover face.]
Therapist	Is that a nosebleed? [Patient's nose has apparently started bleeding] Therapist takes care of the nosebleed.
Therapist	Uh-huh. How much do you think you poured off? What percent of the pain there did you let go of right now?
Patient	About ninety percent. Oh I feel so much better.

In her explaining the reasoning behind the ATOS rating of this segment, McCullough writes (personal communication May 28, 2009):

Affect Experiencing Score: 90 – This is an example of full and vivid feeling sustained over several minutes. Some anger is integrated with the grief. Note that he did not hide his face in his hands. He was unashamed to cry in front of the therapist. (6:06-6:08) He sustained crying and sobbing for 2 minutes. The only reason he doesn't get 99 or 100 is that when he gets a bloody nose, (6:08) he stops crying and begins talking about the feeling. This may be practical to do, but nevertheless, the grief is cut off at that point – rather than just reduced. He said he had poured out about 90% of what he was feeling – and in this case we think this is about right for a rating as well.

This rather stringent criterion (perhaps due to cultural differences between the US and Scandinavia) for gaining scores  $\geq 90$  puts restraints of the full use of the ATOS scale, such that most ratings fall between 30 and 70. This could reduce measured variance, and might also be one reason why GG's F scores only ranged from 29 to 71 at session level, and why the complete ATOS ratings of GG's case (all three variables) ranged from 29 to 80 in sessions.

### Limitations in rating feelings

The ATOS captures only the predominant F per segment, and ratings are based on observation of arousal, which can be a deficient measure of the patient's actual inner felt

<sup>16</sup> Reliability testing was conducted on videotapes of several sessions with Leigh McCullough as therapist.



emotion (Sparks & Greene, 1992). As the different affects have different physiological and behavioral manifestations (Ekman, 1992), some might be more difficult to rate. Rating positive feelings for self, for instance, often depends more on subtle changes in qualities of the patient's voice and on the expressed content, and it could be much harder to find high levels of positive feelings for self than high levels of sadness (as in table 23), joy or anger.

### **4.3.2 Possible ceiling effect due to overall high ATOS scores**

The data from the TPRP (table 2) indicate that GG's ATOS scores on D, F and SoS were between one and two SD above mean in both session 6 and 36. ATOS scores from PROCMAP also indicate that GG's mean ATOS scores were high ( $\bar{D} = 64.97$ ,  $SD = 6.97$ ;  $\bar{F} = 49.55$ ,  $SD = 10.01$ ;  $\bar{SoS} = 69.21$ ,  $SD = 4.16$ ), e.g., defined by the ATOS (see Appendix), SoS averaged on "[v]ery adaptive sense of self; much compassion and acceptance, but some self-blame or shame present". D averaged on "[g]ood recognition of problem patterns. Some description of origins in past, linked to present. Good awareness/insight". In terms of what change could be expected in for instance D, it might be useful importing some findings from research on Reflective Functioning. An ordinary population is expected to be capable of mentalizing at a mean level of RF 5 (Karlsson & Kermott, 2006). As GG appeared both intelligent and curious, and presented a mean D on 65, changes of RF within a normal population might be most informative. Studying RF in mental health professionals, Trowell, Davids, Miles, Shmueli, and Paton (2008) found that RF increased (from  $M = 3.56$  to  $M = 4.81$ ,  $N = 56$ ) after a two-year training program tailored to cope with the emotional stressors of professional life. In the clinical population, Levy et al. (2006) compared transference-focused psychotherapy (TFP), dialectical behavior therapy (DBT) and a modified psychodynamic supportive psychotherapy for patients with borderline PD ( $N = 90$ ). Results indicated a significant increase in RF for patients in the TFP treatment group ( $M = 2.68$  pre-treatment to  $M = 4.11$  post treatment). We see that the RF increased by 1.43 points (16%) for the BPD group and 1.25 points for health professionals (14%). Both groups were below RF 5 at the start, and neither group scored  $> 5$  at the end. Even though insight and RF are only partially related (Karlsson & Kermott, 2006), these data might suggest that significantly elevating GG's D would be somewhat challenging (if at all a reasonable focal point in this APT treatment).

### **4.3.3 Other limitations with the process measures**

Despite efforts in defining ATOS in a behaviorally grounded and theory-neutral way (Siefert, Defife & Baity, 2009), its construct validity might be questioned for several reasons. As mentioned above, one limitation with the ATOS is the cut-off score for D at 61. ATOS is also rated by external observers only, and self-report measures would enhance the understanding of how much of the D presented by the therapist is absorbed by the patient. This is particularly true if the patient has a  $\bar{D}$  around 40, because the patient can achieve a score  $\leq 40$  by simply agreeing with the therapist. As discussed above, D is also narrowed down to defense recognition, and is thus possibly not congruent with definitions of insight proposed by other researchers (e.g., Hill et al., 2007). Furthermore, although the raters did not know which treatment modality they were rating (i.e., STPD or CT), it is reasonable to assume that they could figure this out. This could potentially bias their scores (e.g., raters may have preferred one treatment approach to the other). Raters may also be biased by their personal opinion of the therapist and/or patient. In terms of statistical power, it is a challenge that all ATOS subscales are rated every ten-minute segment, except for SoS (and SoO).

#### **4.3.4 Limitations in other applied methods**

In calculating GG's z-scores we would prefer to have the mean ATOS scores from PROCMAP. Having the data from TPRP is an acceptable compensation, but was limited to data from session 6 and 36. Further, the transcripts were selected based on their ability to portray typical themes in the treatment and illuminate higher than expected ATOS ratings. The reported verbatim material is therefore not a complete picture of the course of therapy, and the potential of biased selections cannot be excluded. Another limitation is the lack of observer-rated measures for outcome (Perry, Banon & Ianni, 1999).

#### **Limitations in the statistical analyzes**

First, as in all correlational designs, there is a possibility that unknown variables are responsible for this correlation (e.g., a third variable). ARIMA is an established method for estimating the temporal relationship between variables in time series analysis (Darlington & Smulders, 2001), but other analyses might yield different results. ARIMA is often an attempt to find a model that explains variance in the data, and consequently the results can be hard to interpret (Dag-Erik Eilertsen, personal communication, March 14, 2014).

## **4.4 Conclusion**

The results from this single-case observational study report only small linear trends over the course of therapy, and some weak (nonsignificant) sequential relationship of the process variables between sessions (crosslagged correlations). However, because this is a single-case design, high statistical power from sophisticated analyses was not to be expected. Mixing the quantitative with the qualitative methods seems fruitful, and the qualitative measures and the quantitative impression from this study are also highly congruent. This might indeed imply that the change during therapy is somewhat captured by the three ATOS variables, and also that the quantitative measures could be applied to highlight trends in the qualitative material.

The trends thus uncovered in this treatment was that more than expected F in a session somewhat predicted higher SoS in the next session, and that more than expected D in a session predicted lower F and SoS (high F also predicted low D) in the next sessions. These correlational findings must be interpreted with caution, as they may be largely due to properties of the process measure (ATOS), but seen in relation to GG's case, the scores and these findings make some sense. The therapist did not target D when F was present, and when F was absent he aimed for D (in line with the APT model). Further, SoS and F in this case were highly related, such that D would have similar effect on SoS as on F.

The long-term effect of repeated process learning with a sustained focus on affects and their associated meaning may have induced essential experiences in the patient's self-understanding (SoS) and subsequent character change. In terms of observed significant clinical change (return to normal functioning), it seems plausible that overall high ATOS scores and the treatment in general were beneficial for GG.

Single-case studies may add important knowledge about the mechanisms of change in psychotherapy and give basis to refine, extend, modify and qualify established theories. On the other hand, such studies cannot make predictions about psychotherapeutic processes common across patients. Further investigations of the relation between affect, insight and sense of self, and the assumed underlying processes of change, would also require systematic exploration in studies of larger samples, but with as much focus on micro-processes as possible. It would be of particular interest to have a large sample of detailed ratings of both therapist and patient (ideally at intervention level), with observer-rated and self-report measures for the therapeutic process as well as for outcome.

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# Appendices

**ATOS – 1 Page Brief Overview**  
**ACHIEVEMENT OF THERAPEUTIC OBJECTIVES SCALE- 20 Point Brief Rating Guides** 18MAR09  
**The Psychotherapy Research Program at HMS**  
**Leigh McCullough Ph.D., Director**

**CORE AFFECTIVE CONFLICT:** 1) Anger/Assertion \_\_\_\_\_ 2) Sorrow/Grief \_\_\_\_\_ 3) Closeness/Tenderness/Love \_\_\_\_\_  
 4) Positive Feelings for Self \_\_\_\_\_ 4.1) Self Compassion \_\_\_\_\_ 4.2) Self Interest \_\_\_\_\_ 4.3) Self Respect \_\_\_\_\_ 4.4) Self Confidence/Mastery \_\_\_\_\_ 4.5) Self Worth \_\_\_\_\_ 4.6) Self Entitlement/Deserving \_\_\_\_\_ 4.7) Other \_\_\_\_\_  
 5) Sexual Feelings \_\_\_\_\_ 6) Enjoyment \_\_\_\_\_ 7) Interest/Excitement \_\_\_\_\_ 8) Healthy Fear \_\_\_\_\_ 9) Other \_\_\_\_\_ 10) Unclear \_\_\_\_\_

**INSIGHT OR AWARENESS INTO MALADAPTIVE PATTERNS OF THOUGHTS, FEELINGS, AND/OR BEHAVIORS**

**81-100--Excellent recognition** of problem patterns. Excellent links to past origin of behaviors. Excellent awareness/insight.  
**61-80--Good recognition** of problem patterns. Some description of origins in past, linked to present. Good awareness/insight.  
**41-60--Moderately clear recognition.** On own describes occurrence of maladaptive patterns. No references to past. Moderate awareness/insight.  
**21-40--Low recognition.** Can see problem pattern **only** when pointed out by therapist. Little/no elaboration. Minimal awareness/insight.  
**1-20--No recognition** of maladaptive behavior patterns, or unsure when pointed out. May mention anxiety without reference to pattern. No awareness/insight or resists awareness/insight.

**MOTIVATION TO GIVE UP MALADAPTIVE PATTERNS OF THOUGHTS, FEELINGS, AND/OR BEHAVIORS**

**81-100--Excellent motivation** to give up maladaptive patterns. Very strong discomfort, sorrow, openness to change. Little/no resistance.  
**61-80--Strong motivation** to give up maladaptive patterns. Strong discomfort, sorrow, openness to change. Low resistance.  
**41-60--Moderate motivation** to give up maladaptive patterns. Moderate discomfort, sorrow, openness to change. Moderate resistance.  
**21-40--Low motivation** to give up maladaptive patterns. Low discomfort, sorrow, openness to change. Much resistance.  
**1-20--No motivation** to give up maladaptive patterns. Ego-syntonic/desirable. "This is who I am." Almost total resistance.

**ACTIVATING AFFECTS (VERBAL OR NONVERBAL BODILY SIGNS OF AROUSAL OF MAIN CONFLICTED/ PHOBIC AFFECTS)**

**81-100--Full experience** of emotion, well-integrated. Full grief, full openness/tenderness/trust, full justifiable outrage, full joy, etc.  
**61-80--Strong experience** of emotion. Strong affect quickly cut off or sustained but a little held back.  
**41-60--Moderate experience** of emotion. Some grief, some anger, some openness/tenderness/trust/care, etc. Some holding back.  
**21-40--Low experience** of emotion. Beginning indications of grief, anger, openness/tenderness/trust/care/joy, etc. Much holding back.  
**1-20--Little/no physiological experience** of emotion in facial expression, verbal report, tone of voice, body movement. Flat, dull, bland presentation.

**INHIBITORY AFFECTS: (VERBAL OR NONVERBAL BODILY SIGNS OF ANXIETY, GUILT, SHAME, OR PAIN)**

**81-100--Extreme inhibitory affect:** e.g., extreme shakiness, hesitancy, vigilance, trembling, anxiety or shame. Extreme uneasiness.  
**61-80--High inhibitory affect:** e.g., high levels of shakiness, hesitancy, vigilance, trembling, anxiety or shame. Great uneasiness.  
**41-60--Moderate inhibitory affect:** e.g., moderate shakiness, hesitancy, vigilance, trembling, anxiety or shame. Moderate uneasiness.  
**21-40--Low inhibitory affect:** e.g., low shakiness, hesitancy, vigilance, trembling, anxiety or shame. Low level of uneasiness.  
**1-20--Little or no inhibitory affect.** Little or no shakiness, guardedness, hesitancy, vigilance, trembling, anxiety, etc. Comfortable, at ease.

**NEW EMOTIONAL LEARNING: ABILITY TO EXPRESS THOUGHTS, FEELINGS, WISHES, OR NEEDS**

**81-100--Excellent expression** of thoughts/feelings; sense of completeness, balance and excellent results. Great relief and satisfaction experienced.  
**61-80--Good expression** of thoughts/feelings; slight holding back. Not all expressed, but good sense of relief in speaking up. Good satisfaction.  
**41-60--Moderate expression** of thoughts or feelings; moderate holding back, but moderate effectiveness. Moderate relief. Moderate satisfaction.  
**21-40--Beginning attempt to express** thoughts or feelings. Much holding back. A little relief in expression. A little satisfaction.  
**1-20--No expression** of adaptive thoughts or feelings. Total holding back. No relief. No satisfaction. High end of this rating level: can begin to imagine expressing adaptive thoughts or feelings, wants and needs, but is as yet unable put it into action.

**SENSE OF SELF**

**81-100--Highly adaptive** sense of self; compassionate and accepting of strengths and vulnerabilities.  
**61-80--Very adaptive** sense of self; much compassion and acceptance, but some self-blame or shame present.  
**41-60--Moderately adaptive/maladaptive** aspects of self-image in approximately equal amounts.  
**21-40--Very maladaptive** sense of self, but a little compassion, and a little ability for acceptance.  
**1-20--Highly maladaptive** sense of self; little or no compassion, awareness, or self acceptance—or excessive grandiosity.

## SENSE OF OTHERS

**81-100--Highly adaptive** sense of others. Very much compassion/acceptance/trust in others; little or no idealization or devaluation.

**61-80--Very adaptive** sense of others. Much compassion/acceptance/trust, but some devaluation or idealization.

**41-60--Moderately adaptive** as well as maladaptive aspects; moderate compassion/acceptance/trust, moderate devaluation/idealization.

**21-40--Very maladaptive** sense of others, but some compassion, empathy or ability for acceptance; much devaluation or idealization.

**1-20--Highly maladaptive** sense of others; Little or no compassion, empathy or acceptance. Very much devaluation, idealization or splitting.

## INSIGHT

### Level of Insight, Understanding, or Awareness of Maladaptive Patterns 18MAR09

*STDP: Defense Recognition (Noting Patterns of Maladaptive Defenses, Anxieties, and Feelings)*

*CBT: Recognition of Maladaptive Cognitions or Maladaptive Cognitive Schemas*

*DBT: Mindfulness of self-destructive pattern. Degree of dialectical thinking/ behavior observation.*

#### MAIN COMPONENTS:

1. Degree of clarity and fullness of **verbal** descriptions of maladaptive patterns of thoughts, feelings, and/or behaviors, with explicit examples.
2. Degree of ability to state why and how maladaptive/defensive patterns began and are maintained (secondary gain, meanings, causes, and with whom.).

NOTE: Rate higher within each 10-point category for multiple examples, and lower for fewer examples.

#### BRIEF OVERVIEW OF LEVEL OF INSIGHT or AWARENESS ABOUT MALADAPTIVE PATTERNS of THOUGHTS, FEELINGS and/or BEHAVIORS

**81-100--Excellent recognition** of problem patterns. Excellent links to past origin of behaviors. Excellent awareness/insight.

**61-80--Good recognition** of problem patterns. Some description of origins in past, linked to present. Good awareness/insight.

**41-60--Moderately clear recognition.** **On own** describes occurrence of maladaptive patterns. No references to past. Moderate awareness/insight.

**21-40--Low recognition.** Can see problem pattern **only** when pointed out by therapist. Little/no elaboration. Minimal awareness/insight.

**1-20--No recognition** of maladaptive behavior patterns, or unsure when pointed out. May mention anxiety without reference to pattern. No awareness/insight or resists awareness/insight.

**91-100** **Excellent recognition of maladaptive behavior patterns.** Clear, comprehensive descriptions of maladaptive patterns. Describes clearly and fully how pattern is transferred from past to present. (e.g.; learning history or T-C-P links). Also, excellent descriptions of reasons for maladaptive responses, including meanings and secondary gain. Excellent and full awareness/insight.

**81-90** **Very good recognition of maladaptive behavior patterns.** Clear, somewhat detailed descriptions of maladaptive patterns. Very good description of origins in past, linked to present. Very good understanding of reasons for maladaptive responses, meanings and secondary gain—but not all aspects mentioned. Very good awareness/insight.

**71-80** **Good recognition of maladaptive behavior patterns.** Good but not detailed descriptions of maladaptive patterns. Some description of origins in past, linked to present. Good understanding of reason for maladaptive responses or secondary gain. Good awareness/insight.

**61-70** **High-moderate recognition of maladaptive behavior patterns.** Fairly good, general descriptions of maladaptive patterns. Minimal description of origins in past, or links to present. Some understanding of reasons for maladaptive responses or secondary gain. Fairly good awareness/insight.

**51-60** **Moderate recognition of maladaptive behavior patterns.** Partial descriptions of maladaptive patterns. No past-present links. No mention why maladaptive behaviors occur or secondary gain. Moderate awareness/insight.

**41-50** **Low-moderate recognition of maladaptive behavior patterns.** **On own** begins to describe maladaptive patterns but only vague or general description without clear examples. No past-present links. No mention of why maladaptive behaviors occur nor understanding of secondary gain. Some awareness/insight.

**31-40** **Low recognition of maladaptive behavior patterns.** Can acknowledge maladaptive patterns **only** when pointed out, but readily agrees when pointed out by therapist—with little elaboration. Lower level: Agrees without reluctance but does not elaborate further. Beginning awareness/insight.

**21-30** **Minimal recognition of maladaptive behavior patterns.** Can acknowledge maladaptive behavior **only** when pointed out, but reluctantly agrees and does not elaborate further. Upper level: Agrees with a little reluctance.

Lower level: Agrees with much reluctance/or unclear whether the patient agrees or not. The barest evidence of beginning awareness/insight.

**11-20 No recognition of maladaptive behavior patterns.** Does not recognize maladaptive patterns and questions, doubts or does not agree when pointed out by therapist. Seems to lack interest in identifying maladaptive patterns. No awareness/insight.

Mention of anxiety or inhibition without understanding of maladaptive pattern is rated here.

**1-10 No awareness of maladaptive behavior patterns, anxieties or feelings.** Does not see maladaptive patterns on own nor when therapist points it out. Upper level: No apparent interest in recognizing maladaptive responses. Lower level: Disagrees or becomes angry/belligerent when maladaptive responses are pointed out. No awareness/insight or resists awareness/insight. No mention of anxiety or inhibition.

## ACTIVATING AFFECTS

### Level of In-Session Intensity/Depth/Fullness of Bodily Arousal to Phobic or Conflicted Affects 18MAR09

*STDP: Affect Experiencing: Degree of Bodily Arousal of Adaptive Affects (to desensitize Affect Phobias)*

*CBT: Affect arousal is not a primary focus – and may or may not be present*

*DBT: Mindfulness and management of internal reactions. Emotional modulation vs reactivity. Affect tolerance.*

#### MAIN COMPONENTS:

1. Intensity of arousal of **adaptive affect** (rate **peak** degree of arousal for anger, grief, or excitement and the **deepest** arousal for joy, closeness, or self feelings).  
Base the rating on intensity of inner affective arousal as shown in vocal tone, facial expression, non-verbal behavior/movement or charged verbal statements. This is not a rating of intensity of interpersonal expression, which would be rated as Affect Expression/New Learning.
2. Duration of the affective arousal (a few seconds to many minutes).
3. Relief in the experience of the feeling.

NOTE: This scale does **not** a measure **inappropriate** or regressive affective arousal, which is defensive.

#### BRIEF OVERVIEW OF LEVEL OF INTENSITY OF ACTIVATING AFFECTS: IN-SESSION BODILY AROUSAL OF CONFLICTED/PHOBIC AFFECTS

**81-100--Full experience** of emotion, well-integrated. Full grief, full openness/tenderness/trust, full justifiable outrage, full joy, etc.

**61-80--Strong experience** of emotion. Strong affect quickly cut off **or** sustained but a little held back.

**41-60--Moderate experience** of emotion. Some grief, some anger, some openness/tenderness/trust/care, etc. Some holding back.

**21-40--Low experience** of emotion. Beginning indications of grief, anger, openness/tenderness/trust/care/joy, etc. Much holding back.

**1-20--Little/no physiological experience** of emotion in facial expression, verbal report, tone of voice, body movement. Flat, dull, bland presentation.

**91-100 Full and complete affective arousal.** Full and vivid feeling, imagery, and memories sustained over several minutes (ebbing and flowing); e.g., full sobbing, with other affects, e.g., murderous but justifiable outrage, openness/care/tenderness/joy/trust deeply felt as shown in face, vocal tone or body. Excellent ability to modulate or control affect, and integrate it with other affects that balance and enrich the experience, e.g., rage with compassion, tenderness with limit-setting. Full relief and resolution.

**81-90 Very strong affective arousal.** Very strong feeling, imagery, and memories, well sustained (ebbing and flowing) just slightly inhibited or interrupted by other affects as shown in face, vocal tone or body. The affect is partially integrated with other affects, e.g., rage with some compassion; care/trust with limits. Very strong but not full relief.

**71-80 Strong affective arousal.** Strong feeling either sustained (ebbing and flowing) with a little holding back **or** strong feeling that slowly diminishes or is interrupted by another affect; e.g., strong bursts of sobs or anger, strong expressions of caring/tenderness as shown in face, vocal tone or body. Minimal integration with other feelings. Imagery or memories with strong emotional content. Strong relief

**61-70 High-moderate affective arousal.** Much feeling, somewhat sustained (ebbing and flowing) with some holding back **or** quickly cut off. e.g., bursts of crying or anger, much caring/tenderness/warmth/trust as shown in face, vocal tone or body. Only beginning indications of integration with other affects. Imagery or memories with much emotional content. Much relief.

**51-60 Moderate affective arousal.** Moderate feeling; moderate duration/moderate holding back, e.g., tearing up, moderate anger, some tender feelings as shown in face/vocal tone/body. Imagery or memories with moderate emotional content. Moderate relief.



- 41-50 Low-moderate affective arousal.** Mild feeling with much holding back shown in face, vocal tone or body, e.g., briefly tears up, raises voice a little in anger, or says a few tender words for short duration, speaks openly. Imagery or memories with some emotional content. Some relief.
- 31-40 Low affective arousal.** Low, quickly passing experience of feeling shown in face, vocal tone or body; e.g., clenching fist, sighs, grimaces, choking up, slight sadness/anger/care for self but quickly stopped. Imagery or memories with low emotional content but appears very restrained/held back/constricted. Very little relief.
- 21-30 Very low affective arousal.** Minimal or barely visible/audible signs of feeling of short duration shown in face, vocal tone or body. May report slight change in internal bodily state. Imagery/memories have very low expression of feeling. Almost no relief.
- 11-20 No affective arousal, but bland verbal report of feeling.** Almost no expression on face. Flat/dull/bland tone of voice, stiff or barely moving body. Patient may sense a change in internal bodily state, but is unsure whether it is a feeling or not. Only bland, unfeeling report of images or memories with emotional content. No relief.
- 1-10 No affective arousal. No report of feeling.** No observable experience of feeling on face. Flat/dull/bland tone of voice. Stiff, unmoving body. No imagery or memories with emotional content. Emotionally numb and/or tense. Self hate/negation. No relief.

### LEVEL OF SENSE OF SELF 18MAR09

*STDP: Restructuring of the Sense of Self*

*CBT: Improvement in self-esteem and positive self talk*

*DBT: Degree of self-validation vs self-invalidation.*

**MAIN COMPONENTS:** The patient's inner experience or verbal report of adaptive self image, in terms of the following:

1. Degree of experience of self compassion, self care, or value as a human being.
2. Degree of adaptive pride in positive qualities (not defensive pridefulness or grandiosity); e.g., self worth, self esteem, competence, etc.
3. Degree of ability to compassionately acknowledge and accept one's limitations or realistic negative qualities of the self.

NOTE: Both grandiosity and devaluation of self should be considered maladaptive.

#### BRIEF OVERVIEW OF LEVELS OF SENSE OF SELF

**81-100--Highly adaptive** sense of self; compassionate and accepting of strengths and vulnerabilities.

**61-80--Very adaptive** sense of self; much compassion and acceptance, but some self-blame or shame present.

**41-60--Moderately adaptive/maladaptive** aspects of self-image in approximately equal amounts.

**21-40--Very maladaptive** sense of self, but a little compassion, and a little ability for acceptance.

**1-20--Highly maladaptive** sense of self; little or no compassion, awareness, or self acceptance—or excessive grandiosity

- 91-100 Highly adaptive sense of self.** Great but healthy pride in own strengths (not grandiose), and highly affirming of own wants and needs, but not demanding. Very realistic but highly compassionate about own weaknesses. Great sense of self-compassion and self-acceptance, with almost no self-blame or shame.
- 81-90 Mostly adaptive sense of self.** Very much pride in own strengths and very much affirming of own wants and needs. Very much ability to acknowledge and accept limitations. Very much compassion and self-acceptance, but a little self-blame or shame.
- 71-80 Very adaptive sense of self.** Much pride in own strengths, and quite affirming of own wants and needs in relation to others. Much ability to acknowledge and accept limitations. Much compassion and self-acceptance, but some self-blame or shame.
- 61-70 Somewhat adaptive sense of self.** Some pride in own strengths, and some affirming of own wants and needs. Some ability to acknowledge and accept limitations. Some compassion and self acceptance, but moderate self-blame or shame present.
- 51-60 Mixed adaptive/maladaptive view of self.** Slightly more adaptive than maladaptive view of self. Slightly more pride than shame in self. Compassion and self-acceptance slightly greater than devaluation or grandiosity. Only moderately affirming of own wants and needs. Only a little more compassion and self-acceptance than self-blame or shame.
- 41-50 Mixed maladaptive/adaptive view of self.** Slightly more maladaptive than adaptive view of self. Slightly more shame than pride in self. Devaluation or grandiosity is slightly stronger than self-compassion or acceptance of limitations. Only moderately affirming of own wants and needs. Slightly more self-blame and shame than compassion for self.

- 31-40 Somewhat maladaptive sense of self.** Some shame in self. Minimal pride in own strengths. Somewhat affirming of own wants and needs in relation to others. Somewhat able to acknowledge and accept limitations. Some compassion and self-acceptance of self regarding limitations, but more self-blame or shame.
- 21-30 Very maladaptive sense of self.** Much shame in self. Little pride/some grandiosity. Almost no affirming of wants and needs. Minimal ability to acknowledge and accept limitations and minimal ability to control impulses. Minimal compassion and self acceptance of self regarding limitations. Much self-blame or shame.
- 11-20 Mostly maladaptive sense of self.** Very much shame and very little pride/or much grandiosity. Devaluation of self or wants and needs. Very little ability to acknowledge and accept limitations. Very little ability to control impulses. Very little compassion and self-acceptance, but very much and very destructive self-blame or shame.
- 1-10 Highly maladaptive sense of self.** Extremely maladaptive view of self, with little or no pride/or extreme grandiosity. Denying or ignoring wants and needs. Little or no ability to acknowledge and accept limitations or control impulses. Almost no compassion or self-acceptance, but extremely destructive self-blame or shame.