CAN DIFFERENT AFFECT FOCUS IN EARLY STAGES OF THERAPY PREDICT OUTCOME FOR DIFFERENT PERSONALITY DISORDERS WITHIN CLUSTER C?

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Hovedoppgave

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Abstract

Objective: The study compared how specific affect focuses in early stages of treatment predict outcome (SCL-90) for specific cluster C personality disorders. Method: The sample consisted of patients with cluster C personality disorders from a randomized controlled trial comparing 40-sessions of short-term dynamic psychotherapy and cognitive psychotherapy. Thirty-one patients had an avoidant personality disorder (AVPD), 17 patients had an obsessive compulsive personality disorder (OCPD) and 10 had a dependent personality disorder (DPD). The Global Severity Index (GSI) of the SCL-90 was used as the outcome measure and the Achievement of Therapeutic Objective Scale (ATOS) was used as a process measure to rate patients affects in an early session (session 1 and 6). Results: The results indicated that focus on closeness and anger predicted outcome for AVPD, focus on positive feelings for self predicted outcome for OCPD and focus on grief predicted outcome for DPD. Conclusion: Specific affect focuses in early stages of treatment is significant for various cluster C personality disorders to predict outcome.

Keywords: Affect Phobia Treatment, affect focus, short-term dynamic psychotherapy, cognitive therapy, cluster C personality disorder

Within the range of personality disorders, cluster C is the most common with a prevalence between 2.6 % (Coid, Yang, Tyrer, Roberts, & Ullrich, 2006) and 10.5 % (Grant et al, 2004) in the general population. 2.3 % (Grant et al., 2004) to 5% (Torgersen, Kringlen, & Cramer, 2001) of this group have an avoidant personality disorder (AVPD), 2.0 % (Torgersen, Kringlen, & Cramer, 2001) to 7.8 % (Grant et al, 2004) have an obsessive compulsive personality disorder (OCPD) and 0.4 % (Grant et al, 2004) to 1, 5% (Torgersen, Kringlen, & Cramer, 2001) have a dependent personality disorder (DPD). In an outpatient population 21.8% to 82% (Alnaes & Torgersen, 1990) meet the criteria for a cluster C personality diagnosis. The high prevalence makes it probable for all psychologists to meet these patients at some point during their career.

We know that psychotherapy is effective for cluster C personality disorders (Perry, Banon & Ianni, 1999), and a meta-analytic review of fifteen studies showed that both cognitive-behavioral and psychodynamic approaches are equally beneficial for this group (Simon, 2009). Common factors that different therapies embody are shown to be effective, and the changes patients achieve during treatment are not associated exclusively to any specific school of therapy (Asay & Lambert, 1999; Stiles, Shapiro & Elliot, 1986). However, treatments are not achieving optimal effects. A randomized controlled study made by Svartberg, Stiles, & Seltzer (2004) on patients with cluster C showed that 60 -71 % of the patients were unchanged or deteriorated at termination. This indicates that treatment needs to become more effective. Therefore it is important to investigate processes in therapy more in detail to form a "designer treatment" for various personality types.

A lot of process research has focused on the relationship between patient and therapist (Safran & Muran, 2000), and therapists behaviour (Hill & Lambert, 2004), but few studies have focused on patient response or change during treatment (Siefert, Defife, & Baity,

2009). This focus becomes important as patients own expression and experience during treatment might influence outcome.

The acknowledgement of emotions in psychopathology, psychotherapy and personality is gaining ground (Carter, 2003). Different forms of psychopathology are suggested to occur as a result of the avoidance of emotions (Hayes, Wilson, Gifford, Follette & Strosahl, 1996; Perls, Hefferline & Goodman, 1951), and it is unanimous among different forms of therapies that focus on emotions in therapy is vital for change (Greenberg & Safran, 1987). Process studies show that the level of affect that patients experience in both cognitive (Castonguay, Goldfried & Heyes, 1996) and psychodynamic therapy (Diner, Hilsenroth & Weinberger, 2007) predict outcome. In general, patients have shown to have more positive changes during therapy if the focus on affect and expression is high (Diner, Hilsenroth, & Weinberger, 2007). However, there is a need to explore for which patients the focus on affect is useful, and under which conditions it is most effective.

A process-measure named Achievement of Therapeutic Objective Scale (ATOS, McCullough et al, 2003b) makes it possible to distinguish patients' accomplishment on different objectives during therapy. Patients' reactions are in focus and not necessarily the therapist´s interventions (McCullough, et al, 2003b). Inhibitory affect is one objective that measures how much anxiety, guilt, shame or emotional pain that is experienced during the session, and activating affect is a measure of the level of bodily arousal of adaptive affects that is experienced in the session. By using the ATOS, Schanche, Stiles, McCullough, Svartberg & Nielsen (2011) found that psychiatric symptoms, interpersonal problems, and personality pathology were reduced from pre to post treatment as there was a decrease in patients inhibitory affects, and increase in activating affects in both CT and STDP for patients with cluster C personality disorders. This indicate that the focus of experience and expression of some affects were essential for change among patients during therapy.

Affect phobia treatment (APT, McCullough, 2001) can be used as a fundament for understanding this discovery. APT assumes that anxiety (inhibitory affects) and defenses are blocking the expression of adaptive feelings (activating affect) and that these feelings have to be expressed by the patient to get healthy. The structure of this treatment originates from Malan's theory of "triangle of conflict" (Malan, 1979), and it is possible to understand the development, maintaining and treatment of psychopathology by using this model (see Figure 1.). Different types of defenses are hindering patients with cluster C personality disorders to experience feelings such as grief, anger, closeness and positive feeling for self (McCullough Vaillant, 1997). Psychopathology assumes to be developed as a result of fear and avoidance for adaptive affective responses. The treatment rationale of these affect phobias is the same as for classic phobias, where patients have to be exposed to feared stimuli to improve (McCullough, et al, 2003a). By using APT the therapist helps the patient to a stepwise exposure to avoided feelings. This solves the emotional conflict and patients obtain the ability to use emotional information to direct behavior (McCullough, et al, 2003a). We suggest that psychopathology within cluster C personality disorders is developed as a result of avoidance of adaptive feelings, and exposure will therefore lead to improvement. ATOS will help us to determine how this exposure appears during treatment.

Insert Figure 1 here.

Differences within cluster C

The three personality disorders comprising cluster C share descriptive similarities. They are described as fearful and inhibited with high levels of anxiety and are therefore related to each other (American Psychiatric Association, 2000). However, the three personality disorders are also different from each other, and are suggested to be based on different core conflicts in accordance with APT. A theory of different core conflicts suggests that different affects have differentiated importance in each disorder. If so, it may be important to find the specific affect focus for optimal treatment.

AVPD is characterized by a feeling of not being good enough, hypersensitivity for criticism and a tendency to avoid social situations (Davey, 2008). This way of being is proposed to be a result of parental criticism, rejection and deprecation (Millon, 1999). An avoidant person has according to cognitive theory beliefs such as "I might get hurt", "I am unlovable" and "I should avoid unpleasant situations at all costs". Compensatory strategies are avoidance and unassertiveness (Emmelkamp, & Kamphuis, 2007). The fear of get confirmation on their assumptions make them avoid school, work and other group contexts, which contributes to a difficulty in forming relationships with others. Distance makes them feel safe (McCullough Vaillant, 1997), and avoidance is a way for them to hide and contain their feelings of weakness and protect themselves from future experience of humiliation and rejection (Millon, 1999). This behavior excludes the possibility of gathering new information that is contrary to their beliefs.

Avoidant personalities are associated with negative thoughts about experiencing emotions in general, and in distinction to non clinical controls, AVPD has been shown to avoid positive emotions as frequently as negative emotions (Tyler, Laposa, & Alden, 2004). It seems like positive feelings are unfamiliar and anxiety provoking in the same manner as novel

events, and are therefore avoided. This is in accord with the fact that AVPD seems to experience few pleasurable events (Millon & Davis, 1996). The high level of inhibitory affect makes it hard for AVPD persons to form an attachment to other people, and McCullough and colleagues, (2003a) suggest that the main affect phobia for AVPD is fear of closeness. The affective flatness is a defense against underlying emotional distress, and the refill of closeness might be satisfied in intellectual occupation or other artistic activities (Millon, 1999). Despite this strategy, the desire for closeness and acceptance is strong for patients with AVPD. Our hypothesis in accordance with this is that people with AVPD would profit from focus on closeness in therapy.

Obsessive-compulsive patients, according to cognitive theory, believe "I must not err" and "I need order to survive" which are followed by strategies such as perfectionism and control (Emmelkamp, & Kamphuis, 2007). The rigidity and aim for perfectionism is protecting them against social criticism and intrapsychic conflicts, and contributing to exclusion from inner feelings and intimate relationships with other. OCPD personalities have an extreme emotional control and you often experience them as tense, joyless and grim (Millon, 1999). Failure, according to OCPD subjects, is a consequence of bad planning and poorly prepared actions, and criticism of themselves and their own actions result in an increase of perfectionist behavior (Arntz, Weertman, & Salet, 2010). Consequently, an acceptance for themselves as incomplete, together with a tolerance of failure in different aspects of life might reduce symptoms of perfectionism. We therefore suggest that an affect focus on positive feelings for self might reduce symptoms for patients with OCPD.

In addition to perfectionism, it is found that OCPD patients have problems with aggressiveness (Hummelen, Wilberg, Pedersen, & Karterud, 2008). Frustration, anger and irritability are the most expressed feelings by a sufferer of OCPD in spite of the fact that they have difficulty expressing personal feelings in general (Bailey, 1998). OCPD patients both

experience anger towards themselves and others as a result of failures to satisfy the high standards they set. We suggest that anger directed to the self might vanish as OCPD patients obtain more self-compassion. In addition to the view of themselves, OCPD patients have schemas of others as irresponsible and incompetent (Bamelis, Renner, Heidkamp & Arntz, 2011). The anger they feel towards others become nonfunctional as they have problems with an adaptive expression of this feeling. This indicates that focus on anger could also be a relevant topic in therapy. So, in addition to an affect focus on positive feelings for self, we hypothesize that it is important to have an affect focus on anger during psychological treatment.

Patients with DPD have a pervasive need to be taken care of (Davey, 2008). According to cognitive theory, they have beliefs such as "I'm helpless" and "I need a strong person to survive", and compensatory strategies used are clinging, help seeking and attachment (Emmelkamp, & Kamphuis, 2007). Passivity and compliance are used to avoid losing the position as a dependent part (McCullough Vaillant, 1997). As a consequence the persons with this personality disorder often end up in a pattern where other decides for them (Davey, 2008). Uncertainty about their own capability and a feeling of being incompetent makes them constantly afraid of being abandoned (Davey, 2008).

McCullough and colleagues, (2003a) suggests that the primary affect phobia for this group is fear of anger/assertiveness. Patients with DPD might turn their angry impulses inward because of the fear of alienation and interpersonal conflicts (Millon, 1999). Avoidance of expressing anger is proposed to be a way for DPD to secure safety in form of an attachment (McCullough Vaillant, 1997). Patients with the disorder use self-sacrificing behaviors and tolerate physical, psychological and sexual assault to achieve security from other people. About 80 % of patients with DPD are victims of violent acts (Cormier, LeFauveau & Loas, 2006). The high rate of abuse that they are exposed to indicates that they have impairment in

asserting themselves. This lead us to a hypothesis that experiencing and anger/assertiveness would be a feeling that is avoided would be a significant affect focus during psychological treatment.

Earlier research on cluster C personality disorders focus on the type of treatment that is most effective, and they only include AVPD and OCPD. As far as we know, nobody has examined whether focuses on specific affects for avoidant, obsessive compulsive and dependent personality disorder predict outcome. The fact that these personality disorders differ and are suggested to be based on different core conflicts makes us believe that treatment should be different as well.

This study looks across different therapies such as STDP and CT. The study addresses the following questions: Is a specific affect focus in early stages of treatment facilitating for avoidant, for obsessive compulsive and for dependent personality disorder? More specifically, the following hypotheses where tested:

1. It is hypothesized that focus on closeness predicts a better outcome for patients with AVPD.
2. It is hypothesized that focus on positive feelings for self and anger/assertiveness predicts a better outcome for patients with OCPD.
3. It is hypothesized that focus on anger/assertiveness predicts a better outcome for patients with DPD.

Method

Data used in this study derive from the study made by Svartberg and colleagues (2004). Fifty patients received either STDP or CT in a randomized controlled trial at the Norwegian University of Science and Technology, Trondheim, Norway. Treatment consisted of 40 sessions and videotapes from session 1 and 6 were used for analysis (Svartberg, et al, 2004). See Svartberg et al (2004) for details.

Participants

To be included in the study patients had to meet criteria for one or more of the DSM-III-R cluster C personality disorders or self-defeating personality disorder. SCID-II was used as assessment tool, with inter-rater reliability. The sample consisted of 50 patients, 31 (62%) with a AVPD, 17 (34%) with an OCPD, 10 (20%) with a DPD, 3 (6%) with a passive-aggressive PD, and 3 (6%) with a self-defeating PD. Eleven (22%) of all patients had more than one PD (Svartberg et al, 2004). Patients were aged between 18 and 65. There were no significant differences between participants in the two groups before treatment (STDP and CT). One patient in the STDP group was excluded due to missing videotapes. Exclusion criteria was current substance abuse or dependence, current eating disorder, organic brain disorder and other physical illness, current or past psychotic disorder, refusal to have therapy sessions videotaped, active suicidal behavior and refusal to discontinue other active treatment.

Treatments

Treatment consisted of 40 sessions and all patients completed in accordance with the preplanned program. Half of the patients received CT and the other half STDP according to manuals (Beck & Freeman, 1990; McCullough Vaillant, 1997).

CT

Beck and Freeman´s (1990) manual for cognitive therapy for personality disorders was used. The main focus in treatment is to change maladaptive beliefs/schemas to more adaptive ones and also assist the patient in building up more adaptive problem-solving abilities and interpersonal behaviors. Therapists had to deal with coexisting axis I problems during initial sessions. The cognitive model of personality disorder also encourages the therapist to build a trusting relationship with patients, structure sessions and teach patients to evaluate and identify negative automatic thoughts. Techniques that are used is guided imagery to understand the meaning of earlier and new experiences, homework assignments for patient specific issues and restructuring of central cognitions, emotions and behaviors to be more adaptive.

STDP

This treatment follows McCullough Valliant's (1997) model of affect phobia. It is based on theories that affect phobias block adaptive emotional and behavioral responses. Affects are motivators to adaptive, healthy behavior but when avoided it can lead to unhealthy, maladaptive behavior. The inability to respond adaptively to emotion is usually unconscious and it is important to help the patient to regulate anxiety connected to the feared emotion. This might be treated by systematic desensitization, were the patients experience higher levels of feared emotion. The main focus in treatment is to restructure defenses (recognizing and relinquishing defenses), affects (exposure to conflicted feelings and desensitization) and self/other (adjustment of conceptions of self/others).

Therapists

The six therapists who used CT were all clinical psychologists, with a mean of 11.2 years of experience (SD = 4.3). They were all trained weekly and got feedback on video-taped sessions. CT experts J. Beck, A. Freeman, and J. Young gave supervision and seminars. The eight therapists who used STPD consisted of three psychiatrists and five clinical psychologists, with a mean of 9.2 years of clinical experience (SD = 3.6). They got weekly training and supervision in STDP from STDP expert L. McCullough. All therapists had one patient for training before treating the patients that was engaged in the study (Svartberg, et al, 2004).

Outcome measures

Outcome assessment consisted of the Global Severity Index (GSI) of the Symptom Checklist-90-Revised (SCL-90-R) which was used to get information about symptoms. This measure is based on self-reporting, where the patient is filling out a Likert scale from 0 to 4. SCL-90 is a frequently used instrument and has good test-retest reliability (.80 and .90) over one week and high inner consistency (.77 to .90) (Derogatis, Rickels & Roch, 1976).

Process measures

All sessions in Svartberg et al's (2004) study were videotaped and analyzed with the Achievement of Therapeutic Objectives Scale (ATOS). This tool was developed by McCullough and collegues (2003b) to identify patients' adaptive changes that come as a consequence of treatment. Objectives are divided into defense recognition (insight), defense relinquishing (motivation), affect experiencing (activating affect), affect expression (new learning), degree of anxiety, guilt, shame (inhibition), and sense of self and sense of others (McCullough, et al, 2003b).

Ratings on the subscales insight, motivation, activating affect, new learning, and inhibition were all related to one specific affect (core conflict). The affects that are shown to be the most common and therefore tested are anger, grief, closeness and positive feelings for self. ATOS were rated for each ten minutes segment. For every segment, five main subscales were scored from 1-99. The affect chosen to be used as focus for the ATOS ratings reflects how each session segment was focused around one affect. Session segments where the raters found no particular affective focus were categorized as no data on affective focus. For better comparison between patients, all ratings of core conflict were summarized for each affect within each quarter of the treatment and divided on total number of core conflict ratings. Each of the four session phases of possibly ten sessions will therefore have a relative and comparable frequency of focus on each affect. Raters take into account the sense of relief observed after experiencing an emotion and duration of the affective arousal.

Raters

Raters were recruited from a student population at NTNU, Trondheim that participated in a 16-hr training course on ATOS. At the end of the training course each student had to complete a reliability test of 10-min segments on 25 therapies. Students who had an inter-rater reliability score (ICC, model (1,1), Shrout & Fleiss, 1979) equal to or above .70 were invited to rate the present study (N=7). Four students didn't reach the required ICC level but still wanted to rate and were therefore given more training until they reached the calibrated level. Three reliable raters and licensed psychologists were also participating. Valen, Ryum, Svartberg, Stiles & McCullough (2011) found that all measures of ATOS are reliably observed and rated.

Statistical analysis

The statistical analyses were conducted using statistical software R 2.14 (Plummer, 2012). R 2.14 was chosen as a statistical program because it has functions to do regressional modelling of subsets of a grouping factor. Correlations between the four affect foci were examined using Pearson correlations. Separate hierarchical multiple regression analyses were made for each personality disorder to find correlations between affect focus in early sessions and outcome at termination of treatment. Several main variables were entered in the regression analysis as covariates. In step 1 levels of psychiatric symptoms at intake were entered. In step 2 the difference between STDP and CT were tested. In step 3 either avoidant, obsessive-compulsive or dependent personality disorder were compared to the rest of the cluster C sample in three separate analyses. Each cluster C personality disorder was compared to the rest of the cluster C sample since some patients met criteria for more than one cluster C personality disorder. In step 4 three different affect foci were entered simultaneously. These were anger/assertion, closeness and positive feelings for self. All three were compared to grief as an affect focus. In step 5 the hypotheses were tested by entering the interactions between treatment type (STDP vs. CT) and each of the three affect foci. P-values below $p < 0.05$ were considered statistically significant.

Results

Table 1 summarizes the correlations between the different affects. All affect foci were significantly intercorrelated (r= .30- .50), except the correlation between closeness and grief. Meaning that grief and closeness was rarely at focus at the same time in therapy but other affect were.

Insert Table 1 here.

Avoidant PD

The results of the hierarchical regression analysis examining the interaction effects between avoidant PD vs. other cluster C PDs and the three affect foci are summarized in Table 2.

Insert Table 2 here.

Higher initial levels of psychiatric symptoms as measured by the SCL-90 were significantly associated with higher levels of psychiatric symptoms at treatment termination. Therapy type did not differ in outcome, but patients with AVPD had a significantly better outcome compared to the other cluster C personality disorders. Moreover, more focus on anger/assertion and positive feelings for self were associated with a better outcome for all cluster C personality disorders. The results of the fifth step , which tested the study`s first hypothesis, indicated that more focus on both anger/assertion and more focus on closeness compared to focus on grief were associated with a significantly better outcome for AVPD compared to the other cluster C personality disorders.

Obsessive compulsive PD

The results of the hierarchical regression analysis examining the interaction effects between obsessive compulsive PD vs. other cluster C PDs and the three affect foci are summarized in Table 3.

Insert Table 3 here.

Higher initial levels of psychiatric symptoms as measured by the SCL-90 were significantly associated with higher levels of psychiatric symptoms at treatment termination. Neither therapy type nor OCPD versus other cluster C personality disorder differed in outcome. Moreover, more focus on anger/assertion and positive feelings for self were associated with a better outcome for all cluster C personality disorders. The results of the fifth step , which tested the study`s second hypothesis, indicated that more focus on positive feelings for self compared to focus on grief were associated with a significantly better outcome for OCPD compared to the other cluster C personality disorders.

Dependent PD

The results of the hierarchical regression analysis examining the interaction effects between dependent PD vs. other cluster C PDs and the three affect foci are summarized in Table 4.

Insert Table 4 here.

Higher initial levels of psychiatric symptoms as measured by the SCL-90 were significantly associated with higher levels of psychiatric symptoms at treatment termination. Therapy type did not differ in outcome, but patients with DPD had a significantly better outcome compared to the other cluster C personality disorders. Moreover, more focus on both anger/assertion, closeness and positive feelings for self were associated with a better outcome for all cluster C personality disorders. The results of the fifth step, which tested the study`s third hypothesis, indicated that more focus on grief compared to focus on both anger, closeness, and positive feeling for self were associated with a significant better outcome for DPD compared to other cluster C personality disorders.

Discussion

This is the first study that examines which role specific affect focuses have on outcome in an early stage of treatment for AVPD, OCPD and DPD, respectively. We found evidence for the hypothesis that focus on closeness predicted improved outcome for AVPD, but analyses also implied that a specific focus on anger/ assertiveness predicted improved outcome for this disorder. We found evidence for the hypothesis that a focus on positive feelings for self predicted improved outcome for OCPD. We found implications for the hypothesis that a focus on grief predicted improved outcome for DPD. Our results put new light new on what affect focus different cluster C personality disorders need during treatment.

Our finding that AVPD patients gain better outcome when focus is on closeness indicate that closeness has indeed been avoided, as supported by studies that suggest that people with AVPD avoid positive emotions (Taylor, Laposa, & Alden, 2004). It makes sense that people keep away from close relations if these lead to situations that cause distress. AVPD patients' history of a negative childhood (Rettew, 2003) with low parental affection (Johnson, Cohen, Chen, Kasen & Brook, 2006) is related to the fear of being rejected. They have learned as a result of earlier experiences that prevention of letting anyone close will obviate them from disappointment.

It has been found that CT is more effective than both interpersonal therapy (IPT) (Barber & Muenz, 1996) and brief dynamic therapy (BDT) (Emmelkamp, Benner, Kuipers, Feiertag, Koster, & van Apeldoorn, 2006) for patients with AVPD. This might be because CT is using exposure consciously where patients get interpersonal experiences with anxiety-provoking situations that they normally do not experience. Patients with AVPD need an experience where social situations are interesting and enjoyable; this is achieved through experiencing and expressing feelings towards other people (McCullough Vaillant, 1997).

Historically, positive feelings haven't been in focus in therapy. However, affect like closeness is one of the most important affects in life (McCullough Vaillant, 1997).

A focus on anger/assertiveness is also related to improved outcome for AVPD patients. Anger is a feeling that people in general don't like to experience and the expression of anger can force other people away. We can assume that the fear people with AVPD have concerning further evidence of not being good enough, makes them avoid anger. Therefore, expressing anger might be relevant confirmation for people with AVPD that they won't be rejected as they express this feeling. This will lead to an experience where these sufferers get a confirmation that other people will not reject them regardless of the feeling that is expressed. This might give them a deeper feeling of self-worth.

As predicted, focus on positive feelings for self improved outcome for patients with OCPD. These people are struggling with a feeling of not being good enough and try to compensate with rigid structure and rules. A way to reduce this perfectionism may be to enable OCPD patients to accept both positive and negative sides of themselves. A new perspective on themselves might increase self-compassion and also contribute to a higher tolerance for affects. Unlike feelings of closeness and anger, positive feelings for self are not an interpersonal affect but an intrapersonal affect.

A focus on experiencing anger does not seem to be relevant for OCPD patients. A phobic affect according to the APT model should be avoided, and as mentioned before, anger is the most experienced feeling for these patients (Bailey, 1998). Villemarette-Pittman, Stanford, Greve, Huston & Mathias (2004) suggested after studying lifetime history of these patients' symptoms, that the impulsive aggressive behavior had a much earlier onset than any OCPD symptoms. This indicates that the characteristics of OCPD might be an attempt for impulsive aggressive people to compensate for an underlying problem with behavioral disinhibition. It has been suggested that they are clinging on to a life in restriction to protect

themselves from their own angry impulses (Millon, 1999). Anger is present in OCPD sufferers life but does not seem to be a relevant affect focus during therapy.

Our results indicate that grief is the preferable affect focus in treatment with DPD. Grief is associated with an acceptance of loss which might lead to resolvement (McCullough, 2003a). One can argue that grief might be relevant as DPD patients have to let go of addictive attachments to become healthier. Losing the one they are dependent upon is ripping away an important structure. It might therefore be important for people with DPD to be able to use and feel grief for the support they are about to lose. No research is done regarding different treatment and effect on people with dependent personality disorders. Some studies have investigated dependency as a trait across diagnosis but couldn't find any treatment superior to another.

Clinical implications

We conclude that specific affect focuses is relevant for the cluster C personality disorders. This is something that a therapist should be aware of during treatment. One other clinical implication is that diagnostics becomes crucial as the diagnosis directs the therapist in choice of affect focus. The different problems that people have in accordance with affect also implicate what kind of interpersonal relations these people have.

This further implies that different themes should be in focus for the different personality disorders. Some patients might have an advantage of talking about the relation they have with other people, while others might benefit from a focus on the view they have of themselves. Our results indicate that treatment for OCPD patients should focus on gaining self-compassion. Compared with the other two disorders, OCPD patients should have focus on how they see themselves, while AVPD and DPD should have focus on affects associated with relations with other people. It is essential for these people to get information through

emotions about the self in relation to and with other people to be able to establish open, intimate and trusting relationships (Fosha, 2001).

Psychopathology can result from non-adaptive interactions with other people; it is therefore helpful for these people to get emotional corrective experiences from the therapist. The therapist's role is to be a new model for attachment, help patients with desensitization of conflicted affects and validate and clarify experiences (McCullough Vaillant, 1997). It is shown that the alliance between therapist and patient is correlated with experience and expression of feelings and therefore essential in this kind of therapy (Wullum, 2008).

Strengths and limitations

The results should be interpreted in light of several strengths and limitations. The first strength is that data is derived from a RCT study. Both STDP and CT were manual based and the therapists got supervision during the treatment period. The personality disorders was diagnosed with SCID-II that had a inter reliability. Another strength of this study is that raters were randomly assigned to rate sessions and all raters were blind to the hypotheses tested. It is also a strength that raters and not the patients themselves rated the affective experience, as this might be hard for them to distinguish. The study is, however, based on a rather small sample and needs to be replicated; particular according to dependent personality disorder as this group contained the smallest sample. In addition, the small sample size is note worth, since some patients met criteria for more than one cluster C personality disorder. According to ratings, we question if all affects were identified correctly, as raters might have missed segments of affect when patients have vague expressions. The rater's impression of the patients might influence evaluation. It is also important to mention that this study does not assess the different intensities of affect that the patient experience. This might be important,

as studies show that emotional processing is most efficient when at an optimal level, and are also shown to predict the best outcome (Carryer & Greenberg, 2010). Power would also have increased if affect focus was measured at more than just two occasions (session 1 and 6).

Future directions

This study needs to be replicated. Further research could be investigating whether a difference in intensity of emotions influence outcome, using subscales on ATOS. As this study only focused on the early sessions in treatment, it would be interesting to see if affect focuses change during treatment (early, middle, late) and what sequences of affect focuses that can predict best outcome for different personality types. The three personality disorders are suggested to be based on different types of core conflicts and would therefore benefit one specific affect in therapy. But it is atypical for patient to have one affect phobia but several of them (McCullough, et al, 2003a). We can therefore expect that the patient benefit in treatment both from a general effect derived from activation of any affect and another specific effect that are caused by focus on a specific affect. It would be interesting to study the impact these effects have on each other, and what consequence that have for our results.

Conclusion

Personality disorders within cluster C need different type of affect focus during treatment to achieve better outcome. Our results indicate that focus on affect should be different in early stages of treatment for the various cluster C personality disorders across treatments such as CT and STDP. Focus on closeness and anger/ assertiveness is beneficial for AVPD, focus on positive feelings for self is beneficial for OCPD and focus on grief is beneficial for DPD. These results might bring more interest to the already growing field of focus on affects in psychological treatment.

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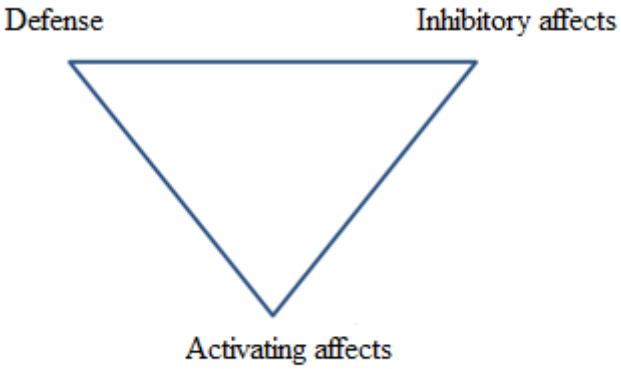

Figur 1. The triangle of conflict

Table 1. Correlations Between the Four Affect Foci.

	Anger/assertion	Closeness	Positiv feelings for self	Grief
Anger/assertion	--	-.50**	-.40**	-.31**
Closeness	-.50**	--	-.40**	.034
Positiv feelings for self	-.40**	-.40**	--	-.30**
Grief	-.31**	.034	-.30**	--

Note: 1. px< 0.05, pxx<0.01

Table 2. Result of step five of the Hierarchical Regression Analysis, Testing the Interaction Between the Presence of an Avoidant Personality Disorder and Affect Focus on Outcome.

Independent	Step	β	SE	ΔR
SCL-90	1	.41	.09***	.33
Therapy type	2	.18	.12	.00
AV vs no AV [1]	3	.74	.37*	.01
Anger/Assertion	4	- .82	.26**	.00
Closeness	4	- .02	.36	
Positive feelings for self	4	- 1.07	.26***	
Anger/assertion x AV vs no AV	5	- 1.04	.41*	.14
Closeness x AV vs no AV	5	- 1.36	.49**	
Positiv feelings for self x AV vs no AV	5	- .60	.41	

Note: 1. AV vs no AV = Avoidant personality disorder vs no avoidant personality disorder. Significant codes:`***' 0.001 `**' 0.01 `*' 0.05

Table 3. Result of step five of the Hierarchical Regression Analysis, Testing the Interaction Between the Presence of an Obsessive Compulsive Personality Disorder and Affect Focus on Outcome.

Independent	Step	β	SE	ΔR
SCL-90	1	.41	.09***	.33
Therapy type	2	.15	.12	.00
OCPD vs no OCPD	3	.58	.36	.00
Anger/Assertion	4	-1.04	.28***	.00
Closeness	4	- .46	.30	
Positive feelings for self	4	- .84	.28**	
Anger/assertion x OCPD vs no OCPD	5	- .32	.41	.15
Closeness x OCPD vs no OCPD	5	-.65	.49	
Positiv feelings for self x OCPD vs no OCPD	5	- .91	.40*	

Note: 1. OCPD vs no OCPD = Obsessive compusive personality disorder vs no obsessive compulsive personality disorder. Significant codes: `***' 0.001 `**' 0.01 `*' 0.05

Table 4. Result of step five of the Hierarchical Regression Analysis, Testing the Interaction Between the Presence of an Dependent Personality Disorder and Affect Focus on Outcome.

Independent	Step	β	SE	ΔR
SCL-90	1	.36	.10***	.33
Therapy type	2	.16	.11	.00
DPD vs no DPD [1]	3	- 1.53	.40***	.00
Anger/Assertion	4	- 1.56	.22***	.00
Closeness	4	- 1.28	.25***	
Positive feelings for self	4	- 1.71	.23***	
Anger/assertion x DPD vs no DPD	5	1.20	.47*	.15
Closeness x DPD vs no DPD	5	2.08	.52***	
Positiv feelings for self x DPD vs no DPD	5	1.87	.46***	

Note: 1. DPD vs no DPD = Dependent personality disorder vs no dependent personality disorder. Significant codes: `***' 0.001 `**' 0.01 `*' 0.05