

**THE EFFECTS OF AFFECT EXPOSURE IN SHORT-TERM DYNAMIC
PSYCHOTHERAPY AND COGNITIVE THERAPY FOR PATIENTS
WITH CLUSTER C PERSONALITY DISORDERS: A RANDOMIZED
CONTROLLED PROCESS STUDY**

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Forord

Utgangspunktet og hensikten med denne oppgaven har vært å undersøke endringsmekanismer i terapiprosess som omhandler affekteksponering innen korttids dynamisk psykoterapi og kognitiv terapi. Studiet er empirisk, og har bygd på og brukt resultatene fra Svartberg et als randomiserte kontrollerte studie, publisert i 2004, som undersøkte effektiviteten av korttids dynamisk psykoterapi og kognitiv terapi for pasienter med Cluster C personlighetsforstyrrelser. Denne oppgaven innebærer derfor en videreføring av forskning som er gjort på bakgrunn av Svartberg-studiet, og har derfor også brukt det samme opprinnelige utvalget pasienter som grunnlag. Hovedproblemstillingen har vært: *«I hvilken grad kan økt affekteksponering for spesifikke underliggende affekter predikere behandlingsutfall for de spesifikke Cluster C personlighetsforstyrrelsene, uavhengig av terapi?»*. Fordi pasienter med Cluster C personlighetsforstyrrelser representerer en stor andel av pasienter som kommer til klinisk behandling, og fordi pasienter med personlighetsforstyrrelser er forbundet med dårligere behandlingsutfall, vil funnene fra dette studiet kunne få både klinisk og teoretisk relevans, samt gi noen retningslinjer for fremtidig forskning.

Jeg vil først og fremst rette en stor takk til min veileder Tore C. Stiles, som har bidratt med konstruktive tilbakemeldinger og nyttige tips hele veien, samt hjulpet til med å analysere og diskutere resultatane. I tillegg vil jeg takke min bi-veileder, Truls Ryum, som har utført resultatane. Dette har vært en lærerik prosess, og jeg er veldig takknemlig for all den hjelp jeg har fått.

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Abstract

Objective: This study examined if the amount of exposure to anger/assertiveness, grief, positive feelings for self or closeness in the early stages of treatment could predict treatment outcome in the different Cluster C personality disorders (PDs) independently of treatment modality. **Method:** The sample consisted of patients who met the criteria for one or more Cluster C PDs (N=50), and was taken from a randomized controlled trial comparing 40 sessions of either short-term dynamic psychotherapy (STDP) or cognitive therapy (CT). 31 had an Avoidant personality disorder (AVPD), 17 had an Obsessive-Compulsive personality disorder (OCPD) and 10 had a Dependent personality disorder (DPD). Some patients met criteria for more than one Cluster C PD. All sessions were videotaped and rated using the Achievement of Therapeutic Scale (ATOS), and ATOS ratings from an early session (mainly session six) were used as process measures. Outcome variables included measures of psychiatric symptoms, interpersonal problems and personality pathology. **Results:** Amount of exposure to anger/assertiveness in early stages of treatment predicted lower personality pathology in all Cluster C PDs, but seems to be especially beneficial for patients with AVPD. **Conclusion:** Anger/assertiveness seem to be the most important activating affect to focus on in the treatment of Cluster C patients, and our results show that the more time spent experiencing anger/assertiveness in treatment, the better treatment outcome. This is contrary to an earlier trial that found a differentiated affect focus to be beneficial to different Cluster C patients.

Keywords: Short-Term Dynamic Psychotherapy, Affect Phobia Therapy, Cognitive Therapy, Cluster C Personality Disorders, Affect Exposure.

The Cluster C personality disorders (PDs) include Avoidant, Dependent and Obsessive-Compulsive PDs, and individuals with these disorders often appear anxious or fearful (American Psychiatric Association, 2013). A Norwegian study showed that the prevalence of Cluster C PDs in the common population was 9,2 – 9,4 %, which makes the Cluster C disorders the most prevalent personality disorders in the general population. The study showed that 5% had an Avoidant PD, 1,9-2,0% had an Obsessive-Compulsive PD, and 1,5% had a Dependent PD (Torgersen, Kringlen, & Cramer, 2001). In addition, another study showed that more than one of two patients in an outpatient clinic population met criteria for a Cluster C PD (Alnæs & Torgersen, 1988). The fact that this is a highly prevalent patient group in the clinical setting means that knowledge of what kind of therapy is effective, including what factors in therapy is effective for this group, is important.

Meta-analyses and meta-analytic reviews have shown both cognitive-behavioral therapy (CBT) and psychodynamic psychotherapy to be equally effective treatments for personality disorders, including Cluster C PDs (Duggan, Huband, Smailagic, Ferriter, & Adams, 2007; Gabbard, 2000; Leichsenring & Leibing, 2003; Perry, Banon, & Ianni, 1999; Simon, 2009; Svartberg, Stiles, & Seltzer, 2004). One randomized controlled trial also demonstrated additional improvement in this group during a 2-year follow-up period (Svartberg et al., 2004). Using the Inventory of Therapeutic Strategies, Svartberg et al. (2004) found that short-term dynamic psychotherapy (STDP) and cognitive therapy (CT) differ in their emphasis on supportive strategies, work with defences, transference work, agenda setting and homework assignments. The fact that two treatments that are empirically documented to be different can be equally effective, points to an interesting question; how can they produce the same patient outcomes when the contents and focus of the treatments are dissimilar?

Lambert (1992) estimated that 30% of improvement in psychotherapy patients is a result of common factors, whereas therapeutic techniques only account for 15%. Findings like this have led to speculations whether different therapy modalities rely on the same underlying psychological changes, and means that common change factors may play a crucial part in treatment and the patient outcome (Lambert & Ogles, 2004). More knowledge about common factors and change mechanisms in the different therapies that lead to a successful and/or poor outcome in patients with a Cluster C PD is thus important, in order to design more effective and adapted treatments for this patient population in the future.

According to Lambert and Ogles (2004), both affective re-experiencing, corrective emotional experiences, and “facing fears” are common factors in therapy that facilitates therapeutic change. Clinical experience and several studies have given support for focusing more intensively on patients’ experience of affect, and the importance of change through facilitating deeper in-session emotional experiences is increasingly recognized (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Castonguay, Reid, Halperin, & Goldfried, 2003; Diener, Hilsenroth, & Weinberger, 2007; Greenberg, 2002; Greenberg & Pascual-Leone, 2006; Samoilov & Goldfried, 2000).

This implies that ‘affect exposure’ is a change mechanism worth examining. The term ‘affect exposure’ is derived from McCullough’s affect phobia therapy (APT), which is an integrative model of STDP that assimilates interventions from a variety of therapy orientations to facilitate patient improvement. APT follows the fundamental structure of psychodynamic psychotherapy, and is based on Malan’s ‘triangle of conflict’ (e.g., defenses and anxieties block the expression of feelings; See Figure 1) and ‘triangle of person’ (e.g., work with conflicts in relation to the therapist and current/past persons; See Figure 2) (Malan, 1979). These conflicts about feelings, or ‘affect phobias’, are suggested to be the fundamental issues underlying many Axis I and Axis II disorders (McCullough & Andrews, 2001). According to APT, “neurotic” psychopathology, like cluster C PDs, is developed as a result of fear and avoidance of adaptive affective responses (McCullough et al., 2003a). These avoided adaptive affects are also called ‘activating affects’, because they are designed to motivate approach behavior (e.g. grief, anger/self-assertion or closeness). The affect phobia occur when there is a conflict between these activating affects, and inhibitory affects designed to motivate avoidance behavior, such as guilt, shame, pain or anxiety. Different types of defences (e.g. intellectualization, devaluating judgements, self-destructive actions, or avoidant behavior) that the individual is using to avoid the triggering of inhibitory affects are thus hindering patients with cluster C PD from experiencing adaptive activating affects such as grief, anger and closeness (McCullough Vaillant, 1997). This kind of experiential avoidance is assumed to protect the individual from re-experiencing past threats, such as rejection or reprisals (Elliot & Church, 2002), but eventually the extensive use of such strategies may come at considerable costs, like the lack of intimacy, loneliness and in general inflexible behavior patterns. These behavior patterns can over time be rigidly established, and are often presented as personality dysfunctions and interpersonal problems (Berggraf, Ulvenes, Hoffart, McCullough, & Wampold, 2013).

Insert Figure 1 and 2 here.

The goals of APT has been broken down into specific behavioral objectives that permit scientific examination; ‘Defence Restructuring’ (defence recognition and defence relinquishing), ‘Affect Restructuring’ (affect experiencing and affect expression), and ‘Self-Other Restructuring’ (alteration of the inner representations of self and others). While ‘Defense Restructuring’ is a “tool” to access the patient’s affect experiencing and expression, and ‘Self-Other Restructuring’ is a result or outcome of the patients affect experiencing, ‘Affect restructuring’, with affect experiencing in particular, is the most important and central treatment objective in McCullough’s model. To rate the degree to which the patient achieves each of these objectives, the Achievement of Therapeutic Objectives Scale (ATOS) is used (McCullough Vaillant, 1997).

In APT, affect exposure serves as the key intervention in the treatment of the patients’ affect phobias. The model uses learning theory principles of desensitization (exposure and response prevention) to achieve the psychodynamic goals of resolution of conflicts about feelings, and involves exposure to “internal phobic stimuli” rather than external stimuli. The exposure to the phobic affect involves gestalt and experiential techniques (e.g., guided imagery) to encourage the bodily experience of emotions so that the patient can experience, and not just talk about, the adaptive emotion. The systematic desensitization, or stepwise exposure to feelings and defence response prevention, is thus hypothesized to be the fundamental agent of therapeutic change (McCullough & Andrews, 2001).

A study by Schanche, Stiles, McCullough, Svartberg, and Nielsen (2011), using the same data as Svartberg et al. (2004), found that an increase in the experiencing of previously avoided affects is a predictor of improved self-compassion, and suggested that this supports the inclusion of affect exposure as a therapeutic intervention when working with patients with cluster C PDs. The increased levels of previously avoided (activating) affects as a predictor of increased self-compassion were equally strong predictors in STDP and CT. The increased

experience of activating affects and regulation of inhibitory affects is by Schanche et al. (2011) suggested to be common processes of change in both CT and STDP when aiming to change patients' personality characteristics. Findings by Berggraf et al. (2014) are suggesting that a particular focus on interventions aimed at increasing Cluster C patients' experience of activating affects can be more efficient than a particular focus on reducing patients' levels of inhibitory affects in therapy sessions.

In clinical practice, the vast majority of affect phobias center around a few basic feeling categories, for example grief, anger (including healthy assertion), closeness, and positive feelings toward the self (McCullough et al., 2003a). However, only one study (Eliasson, 2012) have investigated specifically which avoided affects should be in focus early in the treatment of the different Cluster C personality disorders in order to predict a better outcome. This study found focus on closeness to predict a better outcome for patients with an avoidant PD, while also indicating the importance of focusing on anger. Focus on positive feelings for self was found to predict a better outcome in patients with an obsessive-compulsive PD, while focus on grief predicted a better outcome in patients with a dependent PD.

However, what has not yet been explored is how the amount and intensity of exposure to each specific emotion can predict outcome in the treatment of patients with a cluster C PD. The knowledge of how much time, and how intensively the Cluster C patients should experience or be exposed to their different avoided emotions in early treatment sessions in order to have a better outcome has a potential high value to both the therapist and the patient. Knowing both what specific emotions to focus upon, and how much each patient would benefit from affect exposure makes it easier to adapt therapy sessions to each individual, and to make therapy more efficient. This knowledge could have important implications not just for clinical practice, but also for theory development and future research.

This study thus aims to explore both the amount of time and how intensively the patients with a Cluster C PD should experience or be exposed to their avoided affects in order to have a better outcome at treatment termination, utilizing data from the Svartberg et al. (2004) trial. We will also explore whether there is a difference between the affects found to be related to more positive outcomes in the different Cluster C disorders (Eliasson, 2012), and how high the amount of affect experiencing/exposure should be in each of them in order to predict a positive outcome. The videotape analyses of early treatment sessions in both STDP and CT

for Cluster C personality disorders, with the following ATOS ratings, are used to see if and how the amount of affect experiencing in early treatment sessions can predict patient outcome. Our hypotheses are:

- a) A higher amount of the experience of closeness in treatment will predict a better outcome in patients with an Avoidant PD.
- b) A higher amount of the experience of anger in treatment will predict a better outcome in patients with an Avoidant PD.
- c) A higher amount of the experience of positive feelings for self in treatment will predict a better outcome in patients with an Obsessive-Compulsive PD.
- d) A higher amount of the experience of grief in treatment will predict a better outcome in patients with a Dependent PD.

Method

The data used in this study comes from the randomized, controlled trial by Svartberg et al. (2004), comparing the effectiveness of STDP and CT in the treatment of patients with cluster C personality disorders. Fifty patients were randomly assigned to 40 sessions of either STDP or CT, with 25 patients in each condition. All the 40 treatment sessions were videotaped, and in this study videotapes with ATOS ratings from an early treatment session (mainly session six) were used for analysis. See Svartberg et al. (2004) for details.

Participants

To be included in the trial, patients had to meet criteria for one or more Cluster C personality disorders given by the Diagnostic and Statistical Manual of Mental Disorders-III-R (American Psychiatric Association, 1987). Most of the 50 patients met the diagnostic criteria for Avoidant PD (n=31) and Obsessive-Compulsive PD (n=17), while fewer were diagnosed with a Dependent PD (n=10). In addition patients with Self-defeating PD (n=3) and Passive-aggressive PD (n=3) were included. Patients meeting criteria for other personality disorders were excluded. Within the total sample, 11 patients met the criteria for more than one personality disorder. The patients were aged from 18-65, and there were no significant differences between the participants in the two treatment conditions (STDP and CT). All patients completed treatment in accord with the planned schedule, except for one, who terminated after childbirth.

Therapists

The CT therapists were six clinical psychologists with a mean of 11.2 years of clinical experience ($SD=4,3$). All but one were full-time clinicians. They were all trained in the CT model and received supervision and seminars from CT experts (e.g., J. Beck, A. Freeman, J. Young). The STDP therapists included three psychiatrists and five clinical psychologists with a mean of 9,2 years of clinical experience ($SD=3,6$). All but one were in full-time clinical practice. All of them received supervision and seminars from Dr. McCullough Vaillant. Treatment integrity and adherence to the manual was closely monitored during weekly supervision activities in both treatments, and all therapists treated at least one patient as a training exercise before treating the patients enrolled in the study.

Treatments

The treatment consisted of 40 sessions. In both treatments, sessions were 50 minutes long, videotaped, and held once weekly. Half of the patients received CT and the other half STDP. *Short-Term Dynamic Psychotherapy*. McCullough's STDP model (APT; Affect Phobia Treatment) follows the fundamental structure of psychodynamic psychotherapy, and is based on Malan's 'triangle of conflict' (e.g., defenses and anxieties block the expression of feelings) and 'triangle of person' (e.g., work with conflicts in relation to the therapist and current/past persons) (See figure 1 and 2 in appendix). Specifically, the therapist 1) clarifies rather than confront defenses, 2) empathizes with and exposes the underlying, conflicted affect, and 3) helps to regulate rather than to provoke anxiety. Three main treatment objectives represent the hypothesized change mechanisms: Defense restructuring, Affect restructuring and Self/other restructuring. The overall goal of this model is for previously avoided affects such as grief, anger, or tenderness to be experienced and expressed adaptively by the patient (McCullough Vaillant, 1997).

Cognitive Therapy. The CT treatment was based on Beck & Freeman's CT for personality disorders, which conceptualizes personality disorders as originating from pathological core beliefs. The therapist initially focus on treating the presenting Axis I pathology, while also focusing on the identification and evaluation of key negative automatic thoughts. Other elements of importance in the treatment is the recognition, understanding and evaluation of core beliefs, identification and alteration of compensatory strategies, the development of adaptive problem-solving, and the development of a collaborative and trusting relationship with the patient. The sessions are structured, and the therapists applies specific cognitive, behavioral, and emotion-focused schema restructuring techniques to dispute core beliefs and

to develop new and more adaptive beliefs and behaviors. The two main treatment objectives that represent the hypothesized change mechanisms are: 1) Help the patient develop new and more adaptive core beliefs; 2) help the patient develop more adaptive problem-solving interpersonal behaviors (Beck & Freeman, 1990).

Raters

The raters were recruited from a student population in a clinical psychology program at the Norwegian University of Science and Technology (NTNU) that participated in a 16-hour rater-training course. At the end of the course, each student had to complete a reliability test of 10-minute segments from 25 therapies. Students who had an inter-rater reliability score (ICC level) (Shrout & Fleiss, 1979) equal to or above .70 were asked to rate in the trial (n=7). Four students who did not reach the required ICC level were given more training until they reached this level. In addition, three reliable and licenced psychologists were rating. Valen, Ryum, Svartberg, Stiles, and McCullough (2011) found all measures of ATOS to be reliably observed and rated.

Process Measures

Achievement of Therapeutic Objectives Scale (ATOS). Videotaped treatment sessions in the Svartberg et al. (2004) trial were analysed and rated using ATOS. The treatment objective relevant to this study is “Affect restructuring”, with the subscale “Affect experiencing”, that measure the degree of the patient’s arousal. ATOS ratings from an early treatment session (mainly session six) were used as process measures in the analyses of the patients’ amount of affect experiencing in treatment. The affects that were shown to be the most common and therefore tested were anger/assertiveness, grief, closeness and positive feelings for self. Each treatment session consisted of five ten minutes segments, and each segment was rated using ATOS, where the patient’s degree of affect experiencing was scored from 1-99. In this trial we measured affect exposure as the average intensity of affect experiencing multiplied with the time spent experiencing this affect, measured in number of segments per treatment session.

ATOS is an observer-based assessment instrument and research tool that has grown directly out of clinical work to evaluate the extent of beneficial or therapeutic effects of therapy that the patient is achieving (McCullough et al., 2003c). To do this evaluation, the degree to which the patient achieves each of the treatment objectives in McCullough’s STDP (Affect

Restructuring, Defense Restructuring and Self/Other Restructuring) is rated (McCullough Vaillant, 1997). Originally, ATOS was developed within a psychodynamic framework; however, later developments of the operational definitions of the scales have led to a more behaviorally grounded and theoretically neutral assessment device. This makes it applicable to other treatment modalities as well, including CT (Valen et al., 2011). Cumulative empirical evidence has shown this assessment device to be valid, reliable, and useful as a research tool measuring therapeutic treatment objectives common to both STDP and CT (Berggraf, Ulvenes, Wampold, Hoffart, & McCullough, 2012; McCullough et al., 2003b; Ryum, Støre-Valen, Svartberg, Stiles, & McCullough, 2014; Valen et al., 2011).

Outcome Measures

To assess patient outcome the Symptom Checklist-90-Revised (SCL-90-R), the Inventory of Interpersonal Problems (IIP), and the Millon Clinical Multiaxial Inventory (MCMI) were used. A measure of psychiatric symptoms was provided by the Global Severity Index of the SCL-90-R. This scale consists of 90 questions divided into nine symptom subscales; somatization, obsessive-compulsiveness, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism. The measure is based on self-reporting, and the patient has to choose a number from 0-4 on a Likert scale to answer the questions. The SCL-90-R is a frequently used assessment instrument and has high test-retest reliability and high internal consistency (Derogatis, Rickels, & Rock, 1976).

The IIP is an easily administered self-report inventory that was used in order to measure the types of interpersonal problems that the patients were experiencing, including the level of distress associated with them, before, during and after psychotherapy. It consists of 127 items that assess patients' problems with assertiveness, intimacy, sociability, submissiveness, control and responsibility for others. The patients are asked to rate how distressing each problem has been on a Likert-scale ranging from 0-4. This instrument is also frequently used, and has high internal consistency and high test-retest reliability (Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988).

The MCMI is a 175-item, true-false self-report inventory, intended to be used with psychiatric patients. It has 22 clinical scales that are clustered into three groups: Personality Scales, Severe Personality Patterns and Clinical Syndromes (Millon, 1984). In this study, MCMI was

used to assess personality pathology as reflected by the Cluster C personality disorder scales of avoidant, dependent-submissive, compulsive-conforming, and passive-aggressive. These measures were administered both pre-treatment, during treatment and at treatment termination. The MCMI have proved diagnostically efficient and congruent with DSM-III personality disorder diagnoses (Millon, 1984; Svartberg et al., 2004).

Statistical Analysis

The statistical analyses were conducted by using the Statistical Program for Social Sciences, version 20 (SPSS, 20). Hierarchical multiple regression analyses were made for each Cluster C PD in order to find correlations between the amount of affect experiencing/exposure in an early treatment session and the outcome at treatment termination. Several main variables were entered in the regression analysis as covariates. In step one the difference between treatments (STDP and CT) were tested. These were coded as 1 and -1. In step two each Cluster C personality disorder (AVPD, OCPD and DPD) was compared to the rest of the Cluster C sample in three separate analyses. This because some patients met criteria for more than one Cluster C personality disorder. In step three the amount of exposure to specific activating affects (anger/assertiveness, grief, positive feelings for self, and closeness) were entered. (In this trial we calculated amount of exposure to specific activating affects as the average intensity of an affect multiplied by the duration of the affect experiencing as measured by number of segments in one treatment session). In step four our hypotheses were tested by entering the interaction between specific Cluster C PD (vs. Other) and amount of exposure to a specific activating affect. P-values below $p < 0.05$ were considered statistically significant. These analyses were conducted the same way in all three outcome measures (IIP, MCMI and SCL-90). Type of therapy and pretreatment scores on SCL-90, IIP and MCMI were used as control variables.

Results

Preliminary analyses

The results of the two first steps of the various hierarchical regression analyses were: Neither treatment type (STDP vs. CT), nor specific Cluster C PD (vs. Other) predicted outcome on any of the three outcome measures at treatment termination. The results of the third step of the hierarchical regression analyses indicated that among the various activating affects, only the amount of exposure to anger/assertiveness predicted lower levels of personality pathology at

treatment termination ($\beta = -2.10$, $t = -2.66$, $p < 0.05$). No activating affects predicted a reduction in psychiatric symptoms or interpersonal problems at treatment termination, but the amount of exposure to anger/assertiveness was nearly significant in predicting improvement in interpersonal problems ($p < 0.056$).

Closeness and Anger/Assertiveness and AVPD

The results of the fourth step of the hierarchical regression analyses indicated that a significant interaction effect between specific AVPD (vs. Other) and amount of exposure to anger/assertiveness ($\beta = -2.97$, $t = -4.66$, $p < 0.0001$), but not between specific AVPD (vs. Other) and exposure to closeness ($\beta = 0.77$, $t = 0.52$, $p > 0.05$) predicted reduction in personality pathology at treatment termination. The interaction effects between specific AVPD (vs. Other) and anger/assertiveness and closeness, respectively, did not predict a reduction in psychiatric symptoms ($\beta = -0.01$, $t = -1.45$, $p > 0.05$ and $\beta = 0.00$, $t = 0.05$, $p > 0.05$, respectively), or interpersonal problems ($\beta = -0.1$, $t = -1.41$, $p > 0.05$ and $\beta = 0.04$, $t = 0.52$, $p > 0.05$, respectively) at treatment termination.

Positive Feelings for Self and OCPD

The results of the fourth step of the hierarchical regression analysis indicated that a significant interaction effect between specific OCPD (vs. Other) and amount of exposure to positive feelings for self, neither predicted a reduction in personality pathology ($\beta = -0.15$, $t = -0.20$, $p > 0.05$), interpersonal problems ($\beta = -0.01$, $t = -0.81$, $p > 0.05$), nor psychiatric symptoms ($\beta = 0.01$, $t = -0.62$, $p > 0.05$) at treatment termination.

Grief and DPD

The results of the fourth step of the hierarchical regression analysis indicated no significant interaction effects between specific DPD (vs. Other) and amount of exposure to grief, did not predict a reduction in personality pathology ($\beta = -0.29$, $t = -0.21$, $p > 0.05$), interpersonal problems ($\beta = 0.02$, $t = 1.26$, $p > 0.05$), or psychiatric symptoms ($\beta = 0.00$, $t = 0.26$, $p > 0.05$) at treatment termination.

Discussion

The results show that the amount of anger/assertiveness exposure early in the treatment of Cluster C patients is especially important for reducing personality pathology at treatment termination, while the other affects tested in this trial failed to predict a better outcome at any outcome measure in this patient group. The results suggest that anger/assertiveness exposure is especially beneficial in reducing personality pathology in patients with AVPD. Thus, only the second of the study's four hypotheses (hypothesis b) was supported. Neither a higher amount of exposure to closeness (hypothesis a), positive feelings for self (hypothesis c), nor the amount of exposure to grief (hypothesis d) predicted a better outcome in patients with AVPD, OCPD or DPD, respectively.

Anger and assertiveness are affects that are adaptive in the sense that they enable us to establish boundaries, and that they provide us with power and protection (McCullough Vaillant, 1997). Being able to experience and express these feelings adaptively thus protect us from being exploited, denigrated or disrespected. However, according to McCullough Vaillant (1997), many patients have affect phobic conflicts around the experience and expression of anger, and in most cases they are unaware of this. These affect phobic conflicts include typical maladaptive beliefs regarding anger, which in turn lead to inhibitory affects such as anxiety (I'll lose control and hurt someone; I'll be rejected by the people I need), shame-guilt (I'll feel like a terrible person; I was taught never to be angry; I don't know if I'm justified in getting angry), and pain (I can't bear to make someone else feel bad) (pp.243).

Our results suggest that anger/assertiveness indeed are affects that Cluster C patients tend to avoid, and that exposure to these emotions in therapy has a significant therapeutic effect.

The results show that the amount of anger/assertiveness exposure early in treatment especially predicts a better outcome in patients with AVPD at treatment termination than the amount of any of the other affects tested, and that this group will have the largest advantage from anger exposure compared to the other Cluster C disorders. This implies that patients in this group are avoiding anger/assertiveness more than patients with other Cluster C disorders. The therapeutic effect was only found to influence their personality pathology scores at treatment termination, and not scores on psychiatric symptoms or interpersonal problems.

At the core of AVPD, as defined by the Diagnostic and Statistical Manual of Mental Disorders-V (American Psychiatric Association, 2013), is a pervasive pattern of social

inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, present in a variety of contexts. Patients with AVPD often avoid activities that involve significant interpersonal contact because of fears of criticism, disapproval or rejection. Being angry with someone (and showing it) would thus surely seem like a certain way to be rejected or humiliated to a patient with AVPD. Their constant avoidance is in turn increasing chances that their maladaptive beliefs never become disconfirmed. When exposed to feel and show anger or assertiveness in a safe and accepting therapeutic environment, the AVPD patients get a chance to realize that their concerns of being e.g. rejected or humiliated are not happening. This can be compared to ‘corrective emotional experiences’, which was first defined by Alexander and French (1946) as “re-experiencing the old, unsettled conflict, but with a new ending”. Emotional corrective experiences like this may in turn help build their self-esteem and sense of self-respect, which eventually may empower them to feel and show more anger/assertiveness. Studies, using the same data as this trial, have shown that an increase in previously avoided affects is a predictor of improved self-compassion toward the end of treatment (Berggraf et al., 2014; Schanche et al., 2011). Increased self-compassion did in turn predict a decrease in psychiatric symptoms, interpersonal problems, and personality pathology (Schanche et al., 2011). This implies that anger/assertiveness exposure early in treatment may lead to increased self-compassion, which eventually leads to better outcome scores. It could possibly be the other way around as well; that increased self-esteem, self-compassion and self-respect in treatment could lead to the acceptance of experiencing and expressing more anger/assertiveness.

The results also show that anger/assertiveness exposure is beneficial for OCPD patients, and that a higher amount of exposure to anger/assertiveness predicts a reduction in personality pathology, but not in interpersonal problems and psychiatric symptoms at treatment termination. This is interesting, since Eliasson (2012) found that a focus on anger/assertiveness exposure did not seem to be relevant for OCPD patients. One explanation for this was, among other, that anger seems to be the most experienced feeling in this patient group, and hence not an avoided/feared affect. However, it has been suggested that the characteristics of OCPD (e.g. rigidity, perfectionism, emotional control) might be an attempt for impulsive aggressive people to compensate for an underlying problem with behavioral disinhibition (Villemarette-Pittman, Stanford, Greve, Houston, & Mathias, 2004), and that they are clinging to a life in restriction to protect themselves from their own angry impulses (Millon, 1999). This sounds much like an affect phobia of adaptive anger, especially when

considering the OCPD patients' common fear of losing control. Many OCPD patients show a lot of frustration and aggressiveness both toward others and toward themselves, especially when not in control, or when other people fail to meet their standards (Greve & Adams, 2002). However, this anger and frustration may in many cases be defensive or maladaptive. Defensive anger differs from adaptive anger in that it is destructive rather than constructive; it is often louder, involves more frustration, and results in interpersonal closure rather than resolution (McCullough Vaillant, 1997). With this in mind, it is obvious that many patients with OCPD may need anger/assertiveness exposure in order to be able to experience and express more adaptive anger. They need 'emotional corrective experiences' where they realize that anger/assertiveness can be felt and expressed without losing control. Eliasson (2012) suggested that the OCPD patients struggle with not feeling good enough, and that the OCPD characteristics are compensatory strategies against their lack of positive feelings for self. They found exposure to 'positive feelings for self' to predict a better outcome in OCPD patients. It is thus possible that initially exposing the OCPD patient to adaptive anger and self-assertion could lead to higher self-respect and self-assertiveness, and eventually to more positive feelings towards themselves. Because this is a diverse group of patients, where some are more aggressive than others when frustrated, while others become more socially withdrawn, it is hard to come up with only one answer to why anger exposure is important in the treatment of patients in this group.

Amount of exposure to anger/assertiveness did also predict a reduction in personality pathology at treatment termination in patients with DPD, but not a reduction in interpersonal problems or psychiatric symptoms. Patients with DPD have, according to cognitive theory, beliefs such as "I am helpless" or "I need others to survive" (Emmelkamp & Kamphuis, 2007). Their uncertainty about own capabilities and a feeling of being incompetent makes them constantly afraid of being abandoned (Davey, 2008). McCullough et al. (2003a) have suggested that fear of anger and assertiveness is the primary affect phobia in this group. This avoidance of experiencing and expressing anger/assertiveness is suggested to be a way to secure safety in form of an attachment, and studies show that patients in this group are extremely self-sacrificing in order to maintain attachments (McCullough Vaillant, 1997). Eliasson (2012) did not find anger/assertiveness to be the preferred affect to focus on in the treatment of patients with DPD; instead, they found grief to predict a better outcome in this group. One reason for this may be that initial focus on anger or assertiveness in treatment, i.e. having the patient acknowledge and feel avoided anger towards a past attachment figure,

could open up for a more adaptive grief process as well. As McCullough Vaillant (1997) suggests, the opposite may also be possible; “After patients experience deep grief, they often awaken a sense of compassion for themselves, and a self-protective anger bubbles up within them naturally” (pp. 242-243). Either way, having the patients feel and express anger in a safe therapeutic environment would probably work the same way as for patients with AVPD; that they will learn that the therapist (who often symbolizes an ‘attachment figure’) will not abandon them even if they show anger or assertiveness. This ‘emotional corrective experience’ (Alexsander & French, 1946) may then eventually help the DPD patient to become more independent and less self-sacrificing, and also more able to “let go” of past attachment figures.

The fact that the amount of anger/assertiveness exposure only predicts a reduction in personality pathology at treatment termination in the three Cluster C PDs, and not a reduction in interpersonal problems or psychiatric symptoms, is interesting. It is hard to determine why, but one simple explanation could be that the avoidance of anger/assertiveness is more important for the maintenance of personality pathology than the maintenance of psychiatric symptoms and interpersonal problems in Cluster C patients. A study by Galgerud (2012) found that the effect of anger/assertiveness exposure was moderated by the patients’ pretreatment scores on personality pathology, in which high pretreatment scores on personality pathology was associated with an increased benefit from anger/assertiveness exposure. Regardless of reason, this is positive in the sense that personality pathology is viewed as the hardest, but most important issue to work with in treatment.

None of the other affects tested in this trial predicted a better outcome in the Cluster C patients at treatment termination. This differs from the findings by Eliasson (2012), who found different specific affect foci to be predictive of a better outcome in the different specific Cluster C PDs. Since the three Cluster C PDs differ from each other, it may also be intuitive that they should have a differentiated affect focus. However, the fact that they are in the same cluster, also means that they share some similarities. According to the DSM-V, one unifying similarity is that patients with Cluster C are described as fearful and inhibited, with high levels of anxiety (American Psychiatric Association, 2013). It is possible that the different Cluster C disorders also share other similar underlying issues; e.g. maybe there is a lack of self-compassion and self-respect in all of them, which in turn is related to affect phobic conflicts about anger/assertiveness.

There are probably a few reasons why we gained different results from Eliasson (2012). First of all, their trial only investigated the predictive value of early affect focus in the treatment of Cluster C patients, while we included both the amount of affect exposure and the average intensity of affect experiencing in one session as a predictor of treatment outcome. Our results indicates that it is not enough to just have much focus on anger/assertiveness, but that it is also important that the patients reach a certain intensity of anger/assertiveness experiencing in order to have a reduction in personality pathology at treatment termination. This does not mean that it is not important to focus on other activating affects as well in the treatment of Cluster C patients, it could simply mean that the intensity of experiencing these other affects is not as important for reducing personality pathology as anger/assertiveness. Thus, it could be that it is enough just to become aware of other previously avoided activating affects.

Another reason may be that the experience and expression of anger/assertiveness probably are connected to the experience of the other affects one way or another, as mentioned earlier in the discussion. It is for instance possible that exposure to, and acceptance of one affect may open up for other affects as well. Eliasson (2012) found all affect foci to be significantly intercorrelated ($r = .30-.50$), except the correlation between closeness and grief. In addition, many of the patients in this trial had more than one PD at the same time, and/or more than one affect phobia (Svartberg et al., 2004), which means that several affects probably have been addressed in their treatment. A bigger sample of patients may have shown the amount of exposure to other affects than anger/assertiveness as important for outcome in the different Cluster C PDs. Nevertheless, there is some support for anger/assertiveness as an important affect in the treatment of this patient group (Galgerud, 2012).

In this trial we investigated the role of exposure to activating affects in the treatment of Cluster C patients. This is only one of the interventions in a more holistic and complex therapy process when considering the ‘triangle of conflict’(Figure 1) and ‘triangle of person’(Figure 2), which makes the basis for McCullough’s APT. Even though the treatment objective ‘Affect Restructuring’ (including affect experiencing) that we investigated represent a very important change mechanism in the treatment of Cluster C patients, it hold little therapeutic value when viewed independently from the other two treatment objectives (‘Defense Restructuring’ and ‘Self-Other Restructuring’).

The role of inhibitory affects and defenses in the ‘triangle of conflict’ are also parts of the patients’ affect phobic conflicts that is important to take into account when investigating change mechanisms. According to theory and clinical observations, the more the patients’ defenses are explored/pointed out, the more inhibitory affects (anxiety, shame, guilt, pain) are activated (McCullough Vaillant, 1997). Schanche et al. (2011) found a reduction of inhibitory affects as predictive of higher self-compassion following treatment, which suggests that a focus on regulating the patients’ inhibitory affects also is important. It is thus important that the therapist carefully attend to a balance between provoking and regulating inhibitory affects. As McCullough and Magill (2009) points out, attuned and graded emotional exposure seems to be a more sensitive and effective curing mechanism; not the insistent emphasis on “the more the better”. The dual focus on increasing adaptive affect experiences and regulating discomfort can be conceived of as gradually increasing patients’ tolerance of their affects. Although anger/assertiveness seems to be an underlying avoided emotion in all three Cluster C disorders, it is also important to take into account that the inhibitory affects and defenses that the patients have can be very dissimilar. This means that the affect exposure and treatment process not necessarily should be carried out the same way with all patients.

Given the strong discomfort that many Cluster C patients feel when exposed to their feared affects, we suggest that also other factors, such as the alliance between the patient and the therapist, is important for treatment outcome in this group. If the therapeutic alliance is bad, the exposure and anxiety regulation may become ineffective, or it could even make things worse. As described earlier, it is important that the patient experience a safe and accepting therapeutic environment in order to have the ‘emotional corrective experience’ necessary for therapeutic change. At the same time, it is important that the therapist is able to withstand resistance and anger from the patients, and be able to repair ruptures in the alliance.

In fact, a recent systematic review of potential mechanisms of change in psychotherapy interventions for personality disorders found evidence for the therapeutic alliance as one of the most important change mechanisms regardless of treatment and type of PD (Forster, Berthollier, & Rawlinson, 2014).

Clinical implications

Knowing that anger/assertiveness are the preferred affects to focus upon in the treatment of Cluster C patients has a potential high value to both STDP and CT therapists in clinical practice. It also have important implications for the development of theories and treatments

that emphasize research and knowledge of common change factors in the treatment of patients with personality disorders. Our results suggest that the intensity of anger/assertiveness exposure, in addition to the time spent experiencing and expressing anger/assertiveness in treatment sessions, is important to the treatment outcome. This implies that therapists should devote more time, not just focusing on this affect in treatment sessions, but also emphasizing that the exposure to anger/assertiveness reach a certain intensity. This knowledge also makes it possible to start the exposure earlier in the therapy process, making the treatment more effective. As CT therapists not necessarily have an explicit focus on affect exposure per se in treatment, knowing that anger and assertiveness are important affects to focus on when treating Cluster C patients is probably beneficial to them.

Methodological strengths and limitations

One main strength of this study is that the data was collected from a randomized controlled trial with manualized treatments. The inter-rater reliability scores were computed, and all raters achieved good reliability, ICC $<.70$, after training. In addition, all raters were uninformed about the research hypotheses being tested, and they were blind to treatment outcome. The patients were also randomly assigned to each treatment condition, and all the therapists got supervision during the whole treatment period.

Another possible strength in this study is that the ATOS ratings and the outcome variables are based on direct observations of patient behavior and self-descriptions over time, as affective experiences are psychological phenomena that patients are not always able to give an actual account of.

A major limitation of the study is that the independent variables (amount of affect experiencing) were measured only at one early treatment session (mainly session six). With the current set of data, we cannot identify with certainty what caused the treatment outcome. We can only draw conclusions about the predictive value of the amount of affective experiencing, since the design is correlational in nature and thus open to several causal interpretations. Another limitation in data collection is the fact that the same individual rated the various subscales of the ATOS within one session – there is a risk that scores may have been influenced by a halo-effect, with an overall impression of the patient influencing the rating of each subscale. Lastly, the study is based on a small sample, and need to be replicated in larger samples of patients with Cluster C personality disorders, and eventually also in other patient populations. Patients with DPD are especially less well represented in this sample, and

it is thus uncertain to what extent the results may generalize to other patient populations and treatment orientations.

Future directions

This study needs replication. Since this trial only used ATOS ratings from an early treatment session of the whole treatment course, it would be interesting to see if the results become the same using ratings of affect exposure from a later session as well. In addition, it would be interesting to test if the amount of anger/assertiveness exposure also can predict a better long-term outcome in patients with Cluster C disorders, as measured by follow-up studies. In general, very little research have been conducted on the Cluster C PDs as a group. In order to generalize our findings, more research is needed on this topic and in this patient group, including a bigger sample of Cluster C patients, especially patients with DPD.

We know that approximately one out of two patients in outpatient clinic populations have a Cluster C PD (Alnæs & Torgersen, 1988), and that patients with personality disorders have proven to be more difficult to treat and have more relapses after ending therapy than patients with Axis I disorders only (Perry et al., 1999). Still, we also know that treatment is effective for this group (Duggan et al., 2007; Gabbard, 2000; Leichsenring & Leibing, 2003; Perry et al., 1999; Simon, 2009; Svartberg et al., 2004). This means that it is important to gain more knowledge of what change mechanisms in treatment is beneficial for patients with Cluster C PDs, independent of treatment type. Knowledge of this is important not just for clinical practice, but also for theory development and future research.

As described earlier, research have found both STDP and CT to be equally effective in the treatment of patients with Cluster C PD, and that affect exposure thus is an important change mechanism in both treatments (Svartberg et al., 2004). Following this, there are two things that would be interesting to know, and hopefully investigated in future research: 1) Why is affect exposure/experiencing an important change mechanism in CT as well, when there is no explicit focus on it? 2) Is affect exposure/experiencing also an important change mechanism in the ‘new wave behavior therapies’ that involve interventions based on concepts such as acceptance and mindfulness, e.g. Dialectical-Behavior Therapy (Linehan, 1993), Acceptance and Commitment Therapy (Hayes, Follette, & Linehan, 2004; Hayes, Strosahl, & Wilson, 1999), Mindfulness-Based Cognitive Therapy (Teasdale et al., 2000), or Meta-Cognitive Therapy (Wells, 2002)?

Conclusion

The amount of anger/assertiveness exposure measured in early stages of treatment seems to be important for change when treating patients with Cluster C PDs, especially patients with AVPD. The amount of anger/assertiveness exposure in an early treatment session predicted a lower level of personality pathology at treatment termination in all of the three Cluster C PDs. The finding that both the amount and the intensity of anger/assertiveness exposure are important change mechanisms in Cluster C patients, especially in patients with AVPD, and regardless of treatment type, has implications for clinical practice, theory development and future research.

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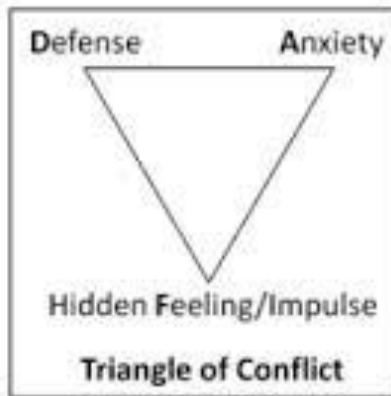


Figure 1: Malan's Triangle of Conflict

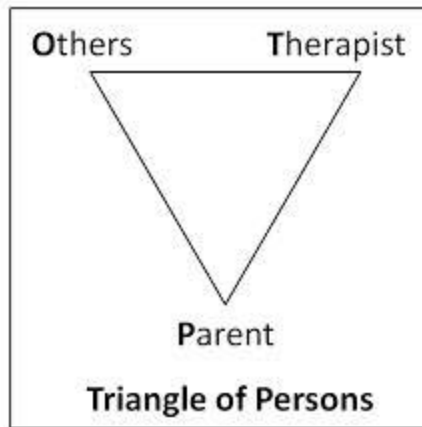


Figure 2: Malan's Triangle of Persons