Graduate thesis

NTNU
Norwegian University of Science and Technology
Faculty of Social and Educational Sciences
Department of Psychology

Hilde Husby Christensen

Anger - Friend or foe?

Anger restructuring in cognitive therapy and short-term dynamic psychotherapy for cluster C personality disorders: A randomised controlled trial

Graduate thesis in Psychology
Supervisor: Tore Charles Stiles and Truls Ryum
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Preface

One of my first patients in my part time job changed the way I view therapy and emotions. Having studied at NTNU, I'd grown accustomed to working with the association between emotions, thoughts, body and action in a cognitive framework. During our fourth session together, she told me about her angry and alcoholic father. It then occurred to me, that the anger she had grown up with from her parents, had made it difficult for her to express her own anger and disappointment towards her parents. This anger, she had thus turned inwards toward herself. The anger seemed to be upholding her depression. After we started working with experiencing and expressing anger, the depression lifted and the creative woman that lived underneath a cloud of darkness was revealed. It was a transformative experience for both of us, and awoke my interest in emotions, and anger particularly, in therapy. My observant employer and supervisor thus suggested this as the topic of my master thesis. During the exhausting task of writing one's master thesis, I have experienced a series of emotions ranging from complete lack of motivation to inexplicable bursts of energy and consolidation of effort. It has been an interesting journey where I've had to face my own proneness to postponing things and my enjoyment of the more relaxing parts of life. The enthusiasm and guidance of my two supervisors has made it all the more enjoyable. I wish to thank Tore Charles Stiles for his continuous availability and rapid feedback, his inexhaustible source of knowledge, and his way of viewing science and methods as the most uncomplicated thing in the world. Truls Ryum, I thank, for his knowledge of SPSS and his positivity. Furthermore, I would like to thank my sister, Ingrid Marie Husby Hollund, for her attention to details and knowledge about research. She has given me important remarks and improvements for my master thesis. When I embarked upon the writing process alone, I realised that I don't particularly like to write alone. Thus, it has been very helpful to have good friends that I could work together with at different venues in the city.

«You will not be punished for your anger, you will be punished by your anger» - Buddha.

Abstract

The aim of the present study was to examine to what extent higher levels of anger restructuring would lead to symptom reduction on SCL-90-R for cluster C personality disorders independent of treatment condition. The two treatments given were cognitive therapy for personality disorders (CT) and short-term dynamic psychotherapy for personality disorders (STDP). Furthermore, higher levels of anger restructuring late in therapy were hypothesised to be significantly more associated with symptom reduction post treatment in the STDP-condition. The aforementioned associations where hypothesised to be independent of level of inhibition late in treatment. Analysis were conducted on 35 patients concerning levels of anger restructuring early and late in the two treatment conditions (STDP: N=16; CT: N=19). A hierarchical regression analysis revealed that all hypotheses were empirically supported in the current study. Clinical implications of the results emphasise the importance of anger restructuring in the treatment of cluster C personality disorder, and furthermore that anxiety provoking treatment of supressed anger can be more effective than a more anxiety regulating approach. Finally, it suggests that anger restructuring can be a common denominator in treatment in both CT and STDP.

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Introduction

Emotions in Therapy

As a species, we are able to become conscious of our emotions, and subjectively this understanding can give us a sense of a core self – a sense of who we are and what we want (Damasio, 1999). Intersubjectively, emotions allow us to know others intimately and adjust to other's needs. And culturally, emotions allow us to share values and connect with humankind. Emotions are, in other words, a fundamental way we make sense of the world. They mobilise us to act on our own behalf to pursue goals (Frederickson, 2013a).

The emphasis on emotions in psychopathology and psychotherapy is gaining ground. Different forms of psychopathology are suggested to occur as a result of the avoidance of emotions, and it is unanimous among different forms of therapies that a focus on emotions is vital for change (Frederickson, 2013a; McCullough, Kuhn, Andrews, Kaplan, et al., 2003; Salters-Pedneault, Tull, & Roemer, 2004; Samoilov & Goldfried, 2000). According to a meta-analysis, the effect of affect restructuring in psychodynamic psychotherapy was positive therapeutic outcomes and improvement in patients distress (Diener, Hilsenroth, & Weinberger, 2007). Specifically, patients obtained more positive changes during therapy when the focus on affect expression was high. Furthermore, affect restructuring in a case study of depressed patients reduced stress and strengthened the therapeutic alliance (Town, Salvadori, Falkenström, Bradley, & Hardy, 2017). In-session affective processing and experiencing has also showed promising effects in dynamic psychotherapy (Lilliengren, Johansson, Lindqvist, Mechler, & Andersson, 2016), and in cognitive behavioural therapy (Aafjes-van Doorn & Barber, 2017).

A variety of emotional expressions guide our actions. There is some agreement around the existence of six basic emotions: Anger, fear, disgust, sadness, surprise, and happiness (Ekman & Cordaro, 2011; Izard, 1994; Tomkins, 1969). In therapy, the aim is to help the patient pay attention to their feelings, label them accurately, experience them in their bodies, and express them adaptively (Frederickson, 2013a). Whilst sadness can allow a patient to grieve over upsetting events of their lives or broken relationships, happiness enables appreciation and warm feelings towards themselves and others. Unprocessed feelings become repressed due to the conflict associated with consciously experiencing the emotion. When current circumstances activate this emotion-laden content, anxiety and defences are activated (Town et al., 2017). Concerning anger, several theorists have underscored avoidance of this adaptive affect as the real culprit in therapy (Davanloo, 1996; McCullough, Kuhn, Andrews, Kaplan, et al., 2003). Furthermore, Frederickson (2013a) estimates that 95% of patient cases involve supressed anger. Hence, there is a need to further explore for which patients and under which conditions such a

focus is effective. Research on affect thus far has not had a differentiated affect-focus, meaning that it is custom to investigate the impact of activating affects in general, but not anger specifically. Accordingly, such a focus is warranted, and thus the aim of the current study.

Anger. Anger is a difficult and strong emotion to experience. It is associated with aggression and threatening behaviours. Nevertheless, some theorist call for that anger is an understudied emotion in relation to its influence in emotional disorders (Cassiello-Robbins & Barlow, 2016). Freud (1957) theorised that depression was upheld by anger turned inwards, and this notion is mirrored by McCullough Vaillant (1997e). The role of internalised anger and dependency in depression is upheld as a negative influencer of the diagnosis (Abi-Habib & Luyten, 2013). Anger and assertiveness are adaptive affects in the sense that they allow us to establish boundaries, and enable us to let others know when they have overstepped our boundaries (Vaillant, 1997a). An adaptive expression of anger involves a rush of energy in the body and an action tendency to lash out. When applied adaptively, it releases a sensation of relief or satisfaction (Vaillant, 1997e). Being able to experience and express this emotion adaptively thus protect us from being exploited, denigrated or disrespected (Tomkins, 1991). Anger is an outwards emotion that is directed towards someone else, and when properly regulated, it is an adaptive way of self-assertion. In victims of traumatic incidents, anger in the form of healthy outrage can replace anguish, and promote constructive action that helps prevent further abuse (Vaillant, 1997b). With the help of imagery patients can allow angry fantasies unfold in therapy and thus to acknowledge such angry feelings. This in turn improves their relationships (Vaillant, 1997e). Adaptive expressions of anger can be constructive self-assertion where the patients are able to set limits and make requests in relationships (Vaillant, 1997d). However, patients that have conscious or unconscious fears of being angry, often have maladaptive beliefs about anger (i.e. “If I’m angry, others will reject me” or “It’s not others that act wrongful towards me, it’s something wrong with me”). This awakens inhibiting affects such as anxiety, shame and guilt when anger arises, and elicits defences that inhibits the person from experiencing the emotion. People who use defences to cover their feelings can thus act upon wrongful information. Feelings no longer guide their actions; anxiety and defences do (Frederickson, 2013a).

Achievement of Therapeutic Objective Scale (ATOS)

The process-measure Achievement of Therapeutic Objective Scale (McCullough, Larsen, et al., 2003) makes it possible to distinguish patients’ accomplishment on different objectives during therapy. The measure was developed with the intention to evaluate treatment and identify the central mechanisms for change within therapy. It is both a treatment guide and

a process-measure in regard to its ability to continuously assess treatment on fundamental measures (McCullough, Kuhn, Andrews, Valen, et al., 2003). Patients' reactions are in focus rather than the therapists' interventions. There are three treatment objectives in ATOS, including defences, affects (activating and inhibiting) and sense of self and others (object relations) (McCullough, Larsen, et al., 2003). Activating affects motivate goal directed behaviour in relations with oneself and others, and relate to the level of anger, sadness, happiness etc. that is experienced in the session. Anger restructuring refers to the level of anger experience and expression that occurs within the session. Inhibitory affects function as a constraint for activating affects, and they relate to the degree of anxiety, guilt, shame, or emotional pain that is experienced during the session.

Originally, ATOS was developed within a psychodynamic framework. However, later developments of the operational definitions of the scales have paved way for a more behaviourally grounded and theoretically neutral direction. This makes it applicable to other treatment modalities as well, including cognitive therapy (Valen, Ryum, Svartberg, Stiles, & McCullough, 2011). In the present study, ATOS is used to determine the intensity of anger restructuring at two different times of treatment, early and late.

Affect Phobia Treatment (APT)

In affect phobia treatment it is assumed that inhibitory affects and defences are blocking the expression of adaptive feelings (activating affects) (McCullough, Kuhn, Andrews, Kaplan, et al., 2003). In order for the patient to improve, these feelings have to be expressed. The structure of this treatment originates from Malan's theory of "triangle of conflict" (Malan, 1995). Thus, it is possible to understand the development, maintaining and treatment of psychopathology by using this model (see appendix). Different types of defences are hindering patients from experiencing feelings such as anger, grief, closeness and positive feelings for the self (Vaillant, 1997a). Psychopathology develops as a result of fear and avoidance of adaptive affective responses. The treatment rationale of these affect phobias is the same as for classic phobias, where patients are exposed to the feared stimuli in order to improve (McCullough, Kuhn, Andrews, Kaplan, et al., 2003). The fear of the emotion releases inhibitory affects such as shame, guilt and anxiety. The inhibitory affects are uncomfortable and by wanting to avoid feelings of shame etc., different defences are activated. The defences and the inhibitory affects disguise the activating affect that is feared, thus clouding the reality of one's own emotions (McCullough, Kuhn, Andrews, Kaplan, et al., 2003). By using APT, the therapist guides the patient in a stepwise exposure to avoided feelings. This resolves the emotional conflict and the patient obtains the ability to use emotional information to direct behaviour.

Cognitive Therapy

Cognitive therapy is based on a continuous collaboration with the patient. Thus, therapist and patient together set goals for the therapy and find ways to solve problems. Guided discovery leads the conversation; questions are asked rather than answers given. An agenda for each session is posed, and the focus is on specific challenges for each session (Berge & Repål, 2016). Within the cognitive framework, there is an understanding that in order to create change within the patient, symptom reduction is a first step (Beck, 1995). To work with symptom reduction, the patient's patterns need to be clarified. Through psychoeducation, the patient can become familiar with the meaning of their symptoms. There is often reason and logic behind a patient's patterns, and by becoming aware of the reason for a maladaptive pattern, it is easier to change course. This can be conceptualised by using a trigger situation to clarify the patient's thoughts, feelings, bodily expressions and actions at the time of the trigger situation. Symptoms are typically reduced when patients become aware of their own thought patterns, their detriment, and are thus motivated to change. An important part of cognitive therapy is exposure to emotions (Samoilov & Goldfried, 2000). The patient can be confronted with and exposed to their own emotions with the aid of a number of techniques. The main purpose is to diminish the fear of adaptive affects and allow the patient to experience the emotions that give them direction.

Personality disorders. Cognitive therapy theorists share with psychoanalysts the concept that it is usually more productive to identify and modify core concepts when treating personality disorders (A. T. Beck & A. Freeman, 1990b). Schemas can be operationalised as specific rules that govern behaviour and information processing. Regarding personality disorders, the schematic work is at the heart of the therapeutic endeavour (A. T. Beck & A. Freeman, 1990b). The difficulty with treating patients with personality disorders arises when the goal is to alter or transform a patient's schemas. Thus, an important treatment consideration is to be aware that therapy will evoke anxiety because the patient is being asked to go far beyond altering a particular behaviour or reframing a schema; they are being asked to reconceptualise who they are and how they define themselves. In order to transform from a personality disorder, the patient has to experience anxiety and successfully cope with this feeling (A. T. Beck & A. Freeman, 1990b). Given the importance of the schematic changes, the therapeutic approach must be tripartite: Both the behavioural, cognitive and affective aspects must be addressed. The emotional mechanisms serve to construct schemas and reinforce behaviours directed toward survival and bonding through the experience of pleasure. Consequently, complementary mechanisms serve to dampen potentially self-defeating actions through arousal of anxiety to

avoid pain. Given the long-term nature of personality disorders, their avoidance of therapy and the continuous pressure from families to seek therapy, they are often a difficult patient group to treat (A. T. Beck & A. Freeman, 1990b). These patients typically seek therapy for the treatment of Axis I disorders, such as depression and anxiety.

The Anxious Personality Disorders

The three personality disorders comprising cluster C share descriptive similarities. They are described as fearful and inhibited. These characteristics are often accompanied by high levels of anxiety, and the subtypes are therefore related to each other (American Psychiatric Association, 1994).

Obsessive-compulsive personality disorder (OCPD). OCPD is characterised by excessive perfectionism, orderliness, and control. Symptoms include preoccupation with rules and details, rigidity, difficulty delegating tasks and over-conscientiousness (American Psychiatric Association, 1994). They see themselves as responsible for themselves and others. Within the cognitive framework it is theorised that they have a core image of themselves as helpless, and their emphasis on systems and order is seen as a compensating defence for this inner belief (A. T. Beck & A. Freeman, 1990a). Although emotional constriction is a hallmark feature, OCPD patients are also found to have problems with anger (Gilbert, Daffern, Talevski, & Ogloff, 2015). OCPD patients can experience frustration and irritability towards themselves and others as a result of failures to satisfy the high standards they set. OCPD patients have schemas of others as irresponsible and incompetent (Skodol, Oldham, & Bender, 2009). The anger they feel towards others become maladaptive as they have problems with the expression of this feeling. This anger can be experienced as an intrusive thought of violence that result in obsessional fears (Whiteside & Abramowitz, 2005). The subsequent suppression of anger draws parallels to affect phobia, shame and defences. Signified by the need that arises to supress anger along with other intrusive thoughts and instigating compulsive actions to abolish the intrusions. This indicates that focus on anger would be a relevant topic in therapy for OCPD-patients.

Dependent personality disorder (DPD). The DPD-patient has a self-perception of being needy, weak and vulnerable. The only way of survival is to attach themselves to a strong and caring individual. This leads to a strategy of subordination to another person and a reliance of their assessments and rules. Within the cognitive framework their core affect is anxiety, as with the other personality disorders within cluster C (A. T. Beck & A. Freeman, 1990a). At the same time, anger is perceived as a threatening affect for this group, because it can lead them to alienate their caretaker. Moreover, this can motivate the acceptance of suppressive and abusive

relationships, and create difficulty in ending them. McCullough, Kuhn, Andrews, Kaplan, et al. (2003) suggest 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. Avoidance of expressing anger is proposed to be a way for DPD to ensure security and safety in form of attachment to others (Vaillant, 1997a). Patients with the disorder use self-sacrificing behaviours as defences and thus tolerate physical, psychological and sexual assault with the means to achieve security from others. Their seeming tolerance of abuse indicate that they have an impairment in asserting themselves.

Avoidant personality disorder (APD). Patients with APD would avoid significant interpersonal relationships due to fear of rejection and criticism. The key conflict within the cognitive framework is the desire to be close to others and assert their needs and preferences, but a subsequent fear of being hurt and rejected. Thus, they avoid getting involved. Emotionally they have a low tolerance for negative affect and fear of rejection, and solve this conflict by lowering their expectations to others and steers clear of emotional involvement (A. T. Beck & A. Freeman, 1990a). This form of distancing themselves from others, can create bitterness and anger towards others for managing close relationships, and towards themselves for being unable to create close bonds with others. Their low tolerance for negative affect will continuously motivate to avoid affects such as anger. A type of avoidance promptly named “cognitive avoidance”. In a psychodynamic framework an avoidance of closeness to others can impose bitterness and anger upon the patient for others being able to live their lives in close relationships (McCullough, Kuhn, Andrews, Kaplan, et al., 2003).

Anger phobia within the cluster. Regarding the anxious personality disorders, it can be theorised that they have an underlying affect phobia of anger in common. The dependent personality disorders tolerance for abuse, can lead to a theory that restructuring of anger/assertiveness in psychological treatment would represent an improvement in symptom distress in the sense that they improve their ability to set boundaries for themselves. When the internal anger and the avoidance of negative emotions that is found in avoidant personality disorder is addressed and experienced, one could think that their symptom distress consequently would be reduced. For the OCPD patients one could theorise that anger restructuring could influence the concept of anger as an intrusive thought and allow anger to become an adaptively expressed emotion. Furthermore, this suggest that anger directed to the self, for the anxious personality disorders, will diminish as a result of the patients experiencing and expressing more anger outwards in therapy.

Anger Phobia

A question concerning cluster C personality disorders is whether or not there is an underlying core conflict that influence symptom severity and that a focus on anger can be pertinent. There is generally a lack of focus on activating affects in cognitive therapy research. Regarding psychodynamic research, a differentiated affect focus has thus far also not been custom. In the meta-analysis by Diener et al. (2007), the affect focus of the studies was activating affects in general, not specific affects. It is warranted to investigate whether a differentiated affect focus can issue new results regarding treatment efficiency. Anger is a difficult and conflicted emotion that is as such avoided and supressed by many, emphasising the importance of the current study to further investigate its effect on treatment outcome for cluster C personality disorder.

An earlier thesis on the same sample found that an early affect-specific focus in treatment reduced symptom severity on SCL-90-R for various cluster C personality disorders, and that anger positively predicted the outcome for APD (Eliasson, 2012). Another study on the same sample, found that anger/assertiveness indeed are avoided by patients with APD, and the author suggests that early affect restructuring has significant therapeutic effects (Nyjordet, 2014). Furthermore, Nyjordet (2014) poses that anger restructuring or assertiveness would be beneficial to the entire group of cluster C personality disorders. An unresolved question is thus whether anger restructuring is an underlying activating affect that is inhibited in this group as a whole. Furthermore, this is regardless of early exposure, as in the two earlier thesis' (Eliasson, 2012; Nyjordet, 2014). The emphasis in the present study is on total degree of anger restructuring throughout therapy.

Svartberg, Stiles, and Seltzer (2004) found that psychiatric symptoms, interpersonal problems, and personality pathology were reduced from pre- to post treatment for cluster C personality disorders, after 40 sessions of either cognitive therapy or short-term dynamic psychotherapy. The results indicated that the significant treatment outcomes were independent of treatment modality. Hence, the authors posed the question regarding what factors, other than treatment modality, that may discriminate better between successful and poor outcomes for this patient group. The present study poses that one of these factors is the emotion anger. Furthermore, Schanche, Stiles, McCullough, Svartberg, and Nielsen (2011) found that there was a decrease in patients' inhibitory affects and an increase in activating affects in both treatment conditions for the cluster C personality disorders. A remaining question is whether these mechanisms can be effective independently of each other. Meaning that treatment can include affect exposure without emphasising reduction of inhibitory affects, or if they represent

a two-step process, where inhibitory affects need to be reduced in order to access and expose for activating affects.

Aim of the Thesis

We hypothesise that higher levels of anger restructuring, both early and late in treatment, will lead to symptom reduction on SCL-90-R for cluster C personality disorders independent of treatment condition. Secondly, we hypothesise that higher levels of anger restructuring late in treatment will be significantly more associated with symptom reduction post treatment in the STDP-condition. Finally, we hypothesise that the former associations remain significant when statistically controlling for the effect of levels of inhibition late in treatment.

Methods

The methods of the present study are based on data from a study by Svartberg et al. (2004) comparing the effectiveness of Short-term dynamic psychotherapy and Cognitive therapy for cluster C personality disorders. For a more comprehensive overview of the methods used in the present study, it is referred to the original study by Svartberg et al. (2004).

Patients

During the 5-year recruitment period, a total of 127 patients were screened by an intake evaluator. Patients were included if they were between ages 18 and 65 years and if they met the criteria for one or more DSM- III-R cluster C personality disorders. All diagnostic evaluations were audio- or videotaped and performed by the intake evaluator with the Structured Clinical Interview for DSM-III-R (SCID-II) (Friis, Havik, Monsen, & Torgersen, 1995; Spitzer, First, Gibbon, & Williams, 1990). Patients who met the inclusion criteria returned within a week for a second diagnostic interview with the intake evaluator. The SCID-I interview was used to obtain DSM- III-R axis I diagnoses (Spitzer, Williams, Gibbon, & First, 1990). Exclusion criteria were cluster A or B personality disorder, current or past psychotic disorder, current substance dependence or abuse, current eating disorder, organic brain disorder and other serious physical illness, active suicidal behaviour, refusal to have the therapy sessions videotaped, and refusal to discontinue other active treatments. A total of 51 patients were included. Patients were presented with a full description of the study's procedures, gave their written consent to participate, and were subsequently randomly assigned to receive 40 weekly sessions of either dynamic or cognitive therapy. Except for one patient who, in agreement with the therapist, terminated after childbirth mid treatment; all patients completed treatment of 40 sessions. The current study included 35 patients in its analysis, as only patients with data on anger restructuring was included. Sixteen patients were excluded as they did not experience or express anger during the sessions that were analysed (N=35).

Treatments and Therapists

In both treatments, sessions were 50 minutes long, and held once weekly. All therapists treated at least one patient as a training exercise before treating the patients who were enrolled in the study.

Short-term dynamic psychotherapy. Leigh McCullough Vaillant (1997a) short-term dynamic psychotherapy model follows the fundamental structure of psychodynamic psychotherapy as outlined by Malan's triangle of conflict (i.e., defences and anxieties block the

expression of feelings) and triangle of person (i.e., work with conflicts in relation to the therapist and current and past persons). Specifically, the therapist 1) gently clarifies rather than confronts defences, 2) empathises with, and exposes the underlying conflicted affect, and 3) helps to regulate rather than to provoke anxiety. Three main treatment objectives represent the hypothesised change mechanisms: defence restructuring (recognising and relinquishing defences), affect restructuring (desensitisation of affects through exposure to conflicted feeling), and self/other restructuring (alteration of maladaptive conceptions of self/others). The overall goal of this model of short-term dynamic psychotherapy is for previously avoided affects such as sadness/grief, anger, or tenderness, to be experienced and expressed adaptively by the patient.

The short-term dynamic psychotherapy therapist team consisted of three psychiatrists and five clinical psychologists. All, but one, were in full-time clinical practice. Their general clinical experience ranged in length from 2 to 14.5 years (mean=9.2, SD=3.6), their experience with short-term dynamic psychotherapy in general ranged from 1.2 to 10.5 years (mean=6.0, SD=2.8), and their experience with this model of short-term dynamic psychotherapy for personality disorders ranged from 1.2 to 7.2 years (mean=4.7, SD=1.9). The therapist training program for short-term dynamic psychotherapy encompassed weekly 2-hour video-based peer supervision meetings and 2-day supervision seminars with Dr. McCullough Vaillant twice annually. Treatment integrity and adherence to the treatment manual, including the achievement of the treatment objectives, were carefully monitored during these supervision activities, which included the active use of rating scales by Dr. McCullough Vaillant (1997a). Each therapist treated an average of three patients (range=2–4).

Cognitive therapy. Equipped with the cognitive model of personality disorders (A. T. Beck & A. M. Freeman, 1990), the therapist specifically 1) deals during initial sessions with any coexisting axis I problems, 2) teaches the patient to identify and evaluate key negative automatic thoughts, 3) structures the sessions carefully and builds a collaborative and trusting relationship with the patient, 4) employs guided imagery to unravel the meaning of new and earlier experiences, 5) in collaboration with the patient prepares homework assignments tailored to the patient's specific issues, and 6) applies specific cognitive, behavioural, and emotion-focused schema restructuring techniques to dispute core beliefs and to develop new and more adaptive beliefs and behaviours (A. T. Beck & A. Freeman, 1990b). Two main treatment objectives represent the hypothesised change mechanisms: First, to help the patient develop new and more adaptive core beliefs, and second, to help the patient develop more adaptive problem-solving interpersonal behaviours.

The cognitive therapy therapist team consisted of six clinical psychologists, whereof five were full-time clinicians. Their general clinical experience ranged in length from 6 to 21 years (mean=11.2, SD=4.3), their experience with cognitive therapy in general ranged from 1.2 to 9.8 years (mean=5.9, SD=2.4), and their experience with cognitive therapy for personality disorders ranged from 1.2 to 7.5 years (mean=4.1, SD=1.8). The training program for the therapists who provided cognitive therapy encompassed weekly 2-hour video-based peer supervision meetings and, twice annually, supervision seminars with visiting cognitive therapy experts (e.g., J. Beck, A. Freeman, J. Young). Treatment integrity and adherence to the manual were closely monitored during the weekly supervision activities. Each therapist treated an average of four patients (range=1–5).

Process Measures

Achievement of therapeutic objectives scale (ATOS). As a means of process measure, some of the sessions were videotaped to be assessed by independent reviewers and rated with ATOS. ATOS in an observer-based assessment instrument and research tool (McCullough, Larsen, et al., 2003). The psychometric properties of ATOS have been found to be sensitive to differences among patients. Cumulative empirical evidence has shown this assessment device to be valid, reliable, and useful as a research tool measuring therapeutic treatment objectives common in both Short-term dynamic psychotherapy (STDP) and Cognitive therapy (CT) (Berggraf, Ulvenes, Wampold, Hoffart, & McCullough, 2012; McCullough, Kuhn, Andrews, Valen, et al., 2003; McCullough, Larsen, et al., 2003; Ryum, Støre-Valen, Svartberg, Stiles, & McCullough, 2014; Valen et al., 2011). In addition, there was little variability due to raters, indicating that adequately trained raters are able to apply ATOS without contributing to measurement error (Berggraf et al., 2012).

The treatment objective relevant to this study is “Affect restructuring”, with the subscale “Affect experiencing” and “Affect expression”. It measures the degree of the patient’s arousal on the targeted affect. ATOS ratings from an early treatment session (session six) and a late treatment session (session 36) were used. Each treatment session consisted of five ten minutes segments, and each segment was rated using ATOS, where the patient’s degree of anger experience and expression was scored on a scale of 1-99. In this trial the affect restructuring was measured as the average intensity of affect experiencing multiplied with the time spent experiencing this affect, measured in number of segments per treatment session. In this sense, anger expression and experiencing were combined measures for total anger restructuring.

Outcome Measures

A measure of symptom distress was provided by the Global Severity Index of the SCL-90-R (Derogatis, 1983; Nilsen & Vassend, 1991). The Norwegian version of the questionnaire is found to adequately measure psychiatric symptoms and changes in level of symptom severity over time (Siqveland, Moum, & Leiknes, 2016). The measure was administered repeatedly before treatment and at treatment termination.

Statistical Analysis

Chi squares were used to examine dichotomous variables and t-tests were used to examine continuous variables. Independent t-tests were used to assess group differences both at pre-test and post-test. Dependent t-tests were used to assess within group temporal changes from pre-test to post-test. To test the study's hypotheses a step-wise hierarchical regression analysis was conducted. Levels of psychiatric symptoms at post-test were used as the dependent variable. In the first step levels of psychiatric symptoms at pre-test were entered. In the second step treatment condition (CT vs. STDP) was entered. In the third step levels of anger restructuring early in treatment were entered. In the fourth step the interaction between treatment condition and anger restructuring early in treatment was entered. In step five levels of anger restructuring late in treatment was entered. In step six the interaction between treatment condition and anger restructuring late in treatment was entered. Finally, in the last step levels of inhibition late were entered. The first hypothesis was that higher levels of anger restructuring, both early and late in treatment, would lead to symptom reduction on SCL-90-R independent of treatment condition. Secondly, it was hypothesised that higher levels of anger restructuring late in treatment would be significantly more associated with symptom reduction post treatment in the STDP-condition. These two hypotheses were tested in the first 6 steps of the hierarchical regression analysis. Finally, it was hypothesised that the associations remain significant when statistically controlling for the effect of levels of inhibition late in treatment. This was tested in the last step of the analysis. P-values below 0.05 were considered statistically significant.

Results

Descriptive and Preliminary Analysis

Final sample. The original sample was N=50 patients. Due to missing values for the statistical analysis, the final sample for the current study was N=35. An examination of the data revealed that there where 15 patients without any anger data. In order to get a score on anger restructuring, the focus in the session has to be on anger and not on other affects. In the case of the 15 patients, other affects than anger could be the topic of the sessions, and the patients was subsequently not included in the analysis. There were no significant differences between excluded patients (N=16) and the final sample (N=35) used in the present study. Furthermore, excluded patients did not affect the homogeneity of the groups. Independent t-tests and chi-square tests revealed that there were no significant differences between the final sample and the excluded patients concerning age, sex or SCL-90-R pre-treatment (all $p > .05$).

Preliminary analysis. There were no significant differences between treatment groups (STDP vs CT) at pre-treatment (SCL90R: $t(35) = -.70$, $p = .49$; Age: $t(35) = .49$, $p = .63$; Gender: $\chi 2(2) = .47$, $p = .49$). Demographic and clinical variables between treatment groups at pre-test are shown in Table 1.

Insert Table 1 about here

Hypothesis Testing

Means and standard deviations. Table 2 describes means and standard deviations for anger restructuring early and late for both treatment groups.

Insert Table 2 about here

An independent t-test indicated borderline significant results in favour of higher levels of anger restructuring for patients receiving CT compared to patients receiving STDP early in treatment ($t(35) = 1.91$, $p = .06$). An independent t-test showed that there are borderline significantly higher levels of anger restructuring in STDP compared to CT late in treatment (t

(35) = -1.53, p = .14.). Furthermore, the STDP-condition had a significant increase in anger restructuring from early to late in treatment. A dependent t-test indicated a significant increase in levels of anger restructuring from early to late in treatment for patients receiving STDP (t (16) = -3.77, p < . 01), but no significant increase from early to late in treatment for receiving CT (t (19) = .85, p = .41).

Hierarchical regression. A hierarchical regression analysis was used to test the hypotheses of the current study. The results are summarised in Table 3.

Insert Table 3 about here

Higher levels of psychiatric symptoms at pre-test as measured by SCL-90-R, were significantly associated with higher levels of psychiatric symptoms at treatment termination when entered in step 1. Treatment condition was not associated with higher levels of psychiatric symptoms at treatment termination when entered at step 2. Higher levels of anger restructuring early in treatment were associated with lower levels of psychiatric symptoms at treatment termination entered at step 3. The results from step 4 of the hierarchical regression analysis indicated no treatment outcome specific effect of higher levels of anger restructuring measured early in treatment. The results of step 5 indicated that higher levels of anger restructuring late in treatment were associated with significantly lower levels of psychiatric symptoms at treatment termination. The results of the step 6 of the regression analysis showed a treatment outcome specific effect indicating that higher levels of anger restructuring were associated with lower levels of psychiatric symptoms in STDP compared to CT late in treatment. The results of step 7 indicated that lower levels of inhibition late in treatment were uniquely associated with lower levels of psychiatric symptoms at treatment termination. It is worth mentioning that higher levels of anger restructuring late in treatment were still significantly associated with a more positive outcome when levels of inhibition late in treatment were statistically controlled for (t = -2.62, p = .01, (*b* = -32)).

Discussion

The aim of the present study was to examine to what extent higher levels of anger restructuring would lead to symptom reduction on SCL-90-R for cluster C personality disorders independent of treatment condition. Furthermore, higher levels of anger restructuring late in treatment was hypothesised to be significantly more associated with symptom reduction at post treatment in the STDP-condition. All the aforementioned associations were hypothesised to be independent of level of inhibition late in treatment. All hypotheses were empirically supported in the current study. The first hypothesis included the effects of levels of anger restructuring both early and late in treatment. The results indicated that level of anger restructuring early in treatment were associated with more symptom reduction at treatment termination. In addition, increased levels of anger restructuring late in treatment were also uniquely associated with more symptom reduction at treatment termination. These results were independent of treatment condition, signifying that there is an underlying common denominator in both treatment modalities that makes the treatments efficient. As demonstrated by Town et al. (2017) in depressed patients, affect experiencing is an important treatment process that contributes to alliance formation and therapeutic improvement.

Thirdly, a treatment-specific outcome effect was demonstrated in that higher levels of anger restructuring late in treatment were associated with significantly more symptom reduction at treatment termination in STDP compared to CT, representing an additive and unique treatment effect. In addition, there was a significant increase in anger restructuring from early to late in treatment only in the STDP-condition. These results raise the question of what treatment techniques that promotes even higher levels of anger restructuring in STDP compared to CT. Svartberg et al. (2004) included treatment integrity and treatment differentiability in their analysis of the two treatments. The STDP-therapists outperformed the CT-therapist on measures of work with defences and transference. Improved cognitive insight and affect awareness are change mechanisms of long-term transference work in dynamic psychotherapy (P Høglend & Hagtvet, 2019). On measures on work enhancing strategies both treatments had an equal emphasis (Svartberg et al., 2004). The STDP-treatments explicit focus on defences and transference could be assumed to promote more effective anger restructuring during treatment. This is in line with the treatment's framework of the triangle of conflict; where emotions, anxiety and defences are interchangeably linked (Malan, 1995). Furthermore, it is supported by the findings of Town, Hardy, McCullough, and Stride (2012) examining patients affective experience following therapist interventions in STDP-treatment. The results indicated that higher levels of affective experiencing followed the therapist's use of confrontation, clarification and support. Therapist's confrontation of patient's affective experience or defences

led to the highest level of affect experience (Town et al., 2012). The CT-treatment had significantly more use of supportive strategies compared to STDP. In line with the results from Town et al. (2012), this could be an effective strategy to promote higher levels of anger restructuring. In contrast, Valen et al. (2011) found no significant differences between the CT-treatment and the STDP-treatment on measure of exposure (affect restructuring) when investigating the same sample as the current study. However, these results did not differentiate between affects, and did not explicitly investigate differences in techniques between the two treatments. Nonetheless, STDP's explicit emphasis on anger restructuring could indicate that the treatment would be more adept at exposing for it.

Finally, the significant association between higher levels of anger restructuring late in treatment and more symptom reduction at treatment termination, independent of treatment condition, remained significant when statistically controlling for the effects of levels of inhibition (i.e. anxiety, shame, guilt) late in treatment. Thus, an increase in anger restructuring leads to symptom reduction even if inhibiting affects are high. This is somewhat surprising, as it is in contrast to the framework of the triangle of conflict; in order to access and experience activating affects, defences must be alleviated, and inhibiting affects must be reduced (Malan, 1995). In the framework Leigh McCullough Vaillant (1997c), therapist's interventions should be anxiety regulating rather than anxiety provoking, in order to aid the highly defended patient to face the painful and difficult process of experiencing and expressing underlying affects, inhibitions and defences. This is in contrast to Davanloo's anxiety provoking framework, where breaking through the resistant to underlying murderous impulses and the accompanying intense guilt and grief that follow, require strong confrontation (Davanloo, 1987). The results of the present study can be interpreted to be more in support with Davanloo's provoking treatment, as anger restructuring occurs independently of level of inhibition. Furthermore, the results from Town et al. (2012) underlined confrontation as the most effective therapeutic technique to promote the highest levels of immediate affect experience. At the same time, anxiety regulating therapy integrate several of the other highlighted techniques from Svartberg et al. (2004) and Town et al. (2012), such as support and work with defences and transference. Furthermore, regulating and supportive therapy can be experienced as more pleasant to the patient and thus enhance the therapeutic alliance, which is demonstrated as imperative to treatment success regardless of treatment modality (Flückiger, Del Re, Wampold, & Horvath, 2018; Horvath, Del Re, Flückiger, & Symonds, 2011). Notwithstanding, it can be argued that in the treatment of patients with the cluster C personality disorders, anxiety provoking treatment can prompt anger restructuring and lead to symptom reduction.

The results from the current study further indicate that regardless of time of measure (early or late), it is the total degree of anger restructuring throughout treatment that is of importance for improvement and symptom reduction. As noted earlier, a meta-analysis by Diener et al. (2007), demonstrated that therapist's facilitation of patients affect restructuring over the course of psychodynamic therapy was associated with significant improvement in patients' health and the therapeutic alliance. Specifically, the more therapists facilitated affective experiencing and expression in the patients, the more positive changes the patients exhibited. The results further suggested the importance of close supervision by the use of videotapes on methodological quality of the studies (Diener et al., 2007). The current study used independent raters of videotaped sessions using ATOS improving the methodological quality of the study.

The present study supports that a focus on anger restructuring is beneficial regarding symptom severity for the entirety of the cluster C personality disorders. This gives evidence to the notion that anger phobia could represents a common denominator for the cluster, and that anger restructuring is expedient. A study concerning social rank and anger expression, underscored that inferior self-perceptions or submissive behaviour significantly affect anger suppression (Allan & Gilbert, 2002). These types of behaviours would be consistent with the cluster C personalities and could shed further light on the relationship between the anxious personality traits and anger suppression. A larger sample size with the same cluster with follow-up is encouraged to see whether the positive effects of anger restructuring prevails.

Furthermore, our findings indicate that the effects of exposure to the activating affect anger leads to symptom reduction independent of inhibiting affects (i.e. anxiety, shame, guilt). Thus, an increase in anger leads to symptom reduction even if inhibiting affects are high. A reduction in inhibiting affects and an increase in the activating affect anger has a positive impact on the outcome variables independently of each other. If the level of inhibiting and activating affects are somewhat independent of each other, therapists could work with one or the other in therapy and still achieve a positive outcome for the patient. This would have important clinical implications with regard to the focus of therapeutic interventions. Highly resistant patients will not easily relinquish their defences, and a more productive focus can thus be on affect exposure (Frederickson, 2013b).

Strengths and Limitations

The treatment given in this trial is manual-based, and thus enables replication of the study and comparison with other manual-based studies. The therapists were highly trained and experienced, and supervised by the founders of their respective treatment modalities. The use

of independent, reliable raters that were unaware of the research hypothesis, the treatment modalities and outcomes, ensured the use of ATOS as a reliable process measure. In contrast to the use of self-report measures, ATOS allows direct observations of patients' behaviours and affects that can be difficult for them to assess themselves.

Maladaptive expressions of anger, such as temper tantrums, ranting and whining receive low scores on the emotional intensity scale in ATOS (scaled 1-100) (McCullough, Kuhn, Andrews, Kaplan, et al., 2003; McCullough, Larsen, et al., 2003). One can question whether emotionality can be measured on a scale of intensity, or that the reality of in-session exposure also involves fluctuating between emotional expressions, including other emotions than anger, and intellectual reflections around anger expressions. In this context, vitality might by an important term; the ability to have mental vigour and draw up boundaries for one self.

The present study has several limitations regarding result reliability. As a result of strict inclusion criteria and excluded patients for anger restructuring in sessions, the number of participants is low. A small sample size yields low statistical power, meaning that there have to be large differences between groups in order to reach statistical significance. In spite of this, the current study has uncovered statistically significant results. However, the generalisability of these results is more limited, and further research on larger sample sizes is warranted.

There were no pre-treatment ratings on level of anger restructuring for the participants, meaning that there were no means to measure levels of anger restructuring from pre- to early in treatment. Thus, it cannot be determined whether levels of anger restructuring early in treatment indicated pre-treatment levels, or an increased level of anger restructuring from the first six sessions of treatment. If the latter is true, this suggest that CT may enhance higher levels of anger restructuring earlier in treatment than STDP. Patients with higher levels of anger restructuring early in treatment can also signify good responders to treatment. Nevertheless, total amount of levels of anger restructuring throughout treatment is the most important predictor for reduced symptom reduction at treatment termination.

A unilateral emphasis on anger can inevitably lead to the neglect of other important underlying affects. The effects of other affects than anger is not examined in the present study. It begs the question whether there are other important affects that influence symptom severity for cluster C personality disorders. Studies on affect experience and expression do not, thus far, differentiate between affects, but rather focused on activating affects in general (i.e. Anger, grief/sadness etc.) (Abbass, Sheldon, Gyra, & Kalpin, 2008; Diener et al., 2007; Winston et al., 1994). The present study had a specific emphasis on anger restructuring for a patient group that has a difficult and inhibited relationship with the affect. Anger is a problematic and overwhelming emotion that can be experienced as frightening to hold. It is an emotion that can

create distance between oneself and others. It can thus be argued that anger is an especially phobic emotion for several patient groups. Specifically, patients that have avoidance-tendencies and where fear of alienation is dominating. It can furthermore be argued that the restructuring of one affect, in the present study anger, nevertheless can facilitate acceptance of other affects. This can lead to greater self-acceptance, which in turn can allow the patient to accept the complexities of their emotions (Campbell-Sills, Barlow, Brown, & Hofmann, 2006).

It can be proposed that some of the effects shown in this study is caused by the effect of unlocking the unconscious. That in part, by experiencing and expressing anger, it allows access to even deeper levels within themselves, and thus promote change (Davanloo, 1996; Town, Abbass, & Bernier, 2013). The large treatment effects in a study of depressed patients with major unlocking of the unconscious is suggested to relate to the degree of emotional processing in treatment (Town et al., 2013). This is in accordance with the hypothesis that exposure to a feared affect can promt a release and acceptance of emotions and further therapeutic insight. A unilateral emphasis on anger restructuring in cluster C personality disorders thus appear to be warranted, and facilitate change and improvement of symptom distress.

Clinical Implications

An important clinical implication from this study is that the activating affect anger can seem more significant in therapy for cluster C than first assumed. If this is an underlying core pathology within the cluster, it will have important clinical implication in regard to the direction and content of treatment and clinical practice. An important contribution in this sense, is that anger restructuring seems to be more independent of treatment modality than one would expect. This could indicate that anger restructuring is part of the common denominators of therapy for this cluster. The CT-condition had the most increase in anger restructuring early in treatment. Good responding patients can benefit early from the effects of treatment, and thus avoid a lengthy and costly treatment. The STDP-condition had a significantly higher increase of anger restructuring throughout treatment, and the therapeutic technique of confrontation can be an instigator for high levels of anger restructuring late in treatment. The results may give therapists a direction in the treatment of cluster C personality disorder by focusing on anger restructuring, and thus help them to become more assertive and in turn alleviate symptoms, and perhaps even personality pathology.

If the level of inhibiting and activating affects are somewhat independent of each other, therapists could work with one or the other in therapy and still achieve a positive outcome for the patient. This would have important clinical implications with regard to the focus of therapeutic interventions. In addition, the intensity of pressure in therapy will also be influenced

by the findings. This being in accordance with the aforementioned anxiety provoking or anxiety regulating techniques, conveying that confronting the patient's affect phobia can be an effective treatment, even without emphasising inhibitory affects and defences.

Another important clinical implication is the effect on symptom reduction. An emphasis on anger restructuring gave the patients a subjective feeling of improvement and an experience that their daily symptoms did not seem as prominent as before treatment. This was shown by the reduction on SCL-90-R at treatment termination. Improvement in the patient's own sense of well-being and daily functioning has implications for the patient's way of living. In clinical practise, patients functioning is a significant measure of development. The fact that the patient's subjective feelings of symptom reduction were significant in the present study, can allow the patients to experience change in their daily lives without being scored as recovered in the sense of personality pathology. The results from the follow-up indicate that a further reduction of personality pathology occurred during the 2 years, signifying that the lessons from short-term therapy can be integrated and internalised after treatment has ended (Svartberg et al., 2004).

Looking Further

Based on the current findings and the general lack of research on the subject of angers influence in cluster C personality disorder, and furthermore, axis I disorders, there is a need for more research on the subject. The current study demonstrates the effect of anger restructuring in therapy on patient's subjective feelings of distress. In diagnoses where anger is inhibited and feelings of shame and guilt arise as a response to the emotion, enabling an adaptive experience and expression of the emotion can allow the person to establish important boundaries around themselves, and assert themselves and their needs. Future studies should have a differentiated affect focus when looking at treatment outcome to further investigate this association.

Svartberg et al. (2004) concluded in their follow-up after two years, that around 40% of the patients had recovered from core personality pathology, measured with Millon Clinical Multiaxial Inventory (Millon, 1983), and this effect was highest in the STDP-condition. A reason for the delayed improvement could be that personality functioning is more resistant to change than symptoms and subjective well-being measured by SCL-90-R. This notion is supported by Howard, Lueger, Maling, and Martinovich (1993), noting that changes in life functioning, including but not exclusively personality pathology, are slower to occur than changes in subjective distress. Several other studies have underscored the continued improvement of personality pathology in several personality disorders after treatment termination, chiefly after treatments that last longer than 30 sessions or that are inpatient treatment options (Bateman & Fonagy, 2006; Per Høglend, 1993; McMain, Guimond, Streiner,

Cardish, & Links, 2012). On the other hand, it could be attributed to an indication that Millon Clinical Multiaxial Inventory capture different domains than does the SCL-90-R. Furthermore, it is suggested that severe personality pathology within cluster C benefited the most from increased levels of anger/assertiveness in treatment (Galgerud, 2012). This could indicate that not only is exposure to anger beneficial, but that the more severe the pathology is, the more prominent is their fear and subsequently avoidance of anger. One can theorise that anger restructuring can lead to improvement in personality pathology after treatment termination. The need to further investigate the long-term effects of anger restructuring in therapy on personality pathology seems a warranted focus of further studies.

Conclusions

The main finding in the present study is that higher levels of anger restructuring in patients with cluster C personality disorder leads to significant symptom reduction at treatment termination in both cognitive therapy and short-term dynamic psychotherapy. Moreover, an additive treatment effect was demonstrated, indicating that higher levels of anger restructuring late in treatment were significantly more associated with symptom reduction at treatment termination in STDP compared to CT. The findings underscore the importance of anger as an assertive affect that creates vitality in the person to set boundaries for themselves. Furthermore, the results emphasise the significance of affects in therapy, specifically anger, and the treatment of affect phobia. Importantly, these effects occur independent of treatment modality and levels of inhibition. To finally conclude; anger is a friend indeed. The hope is that patients are able to experience and express a range of affects without having their emotions accompanied by shame, anxiety or guilt, and instigating defences that cover up their true emotions. The ultimate goal is to have emotions without emotions having us.

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Tables

TABLE 1. Demographic and clinical variables between treatment groups at pre-test (N = 35).

	AGE M (SD)	FEMALE N (%)	SCL-90-R M (SD)
CT	33.2 (8.28)	8 (42)	1.17 (.74)
STDP	33.6 (10.25)	9 (56)	1.33 (.60)

Note: CT = Cognitive Therapy STDP = Short-term Dynamic Psychotherapy

TABLE 2. Means and standard deviations for anger restructuring early and late for both treatment groups (N = 35)

	EARLY	**LATE**
	M (SD)	**M (SD**
CT	34.0 (13.18)	30.36 (18.07)
STDP	26.55 (8.98)	39.45 (16.92)

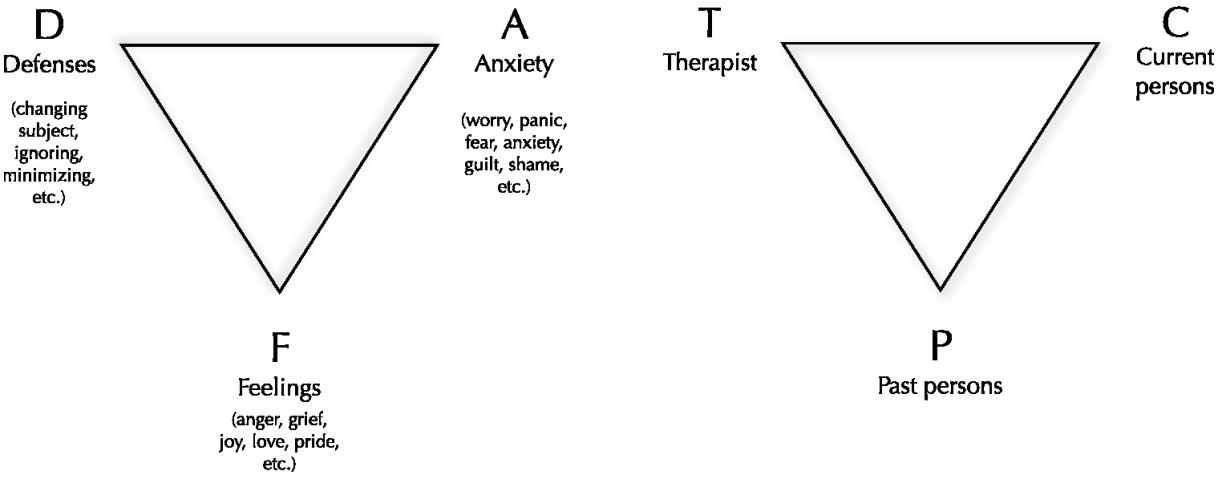
Note: CT = Cognitive Therapy STDP = Short-term Dynamic Psychotherapy

TABLE 3. Prediction of SCL-90-R (post) with anger early and late in both treatment conditions and inhibition as control (N = 35).

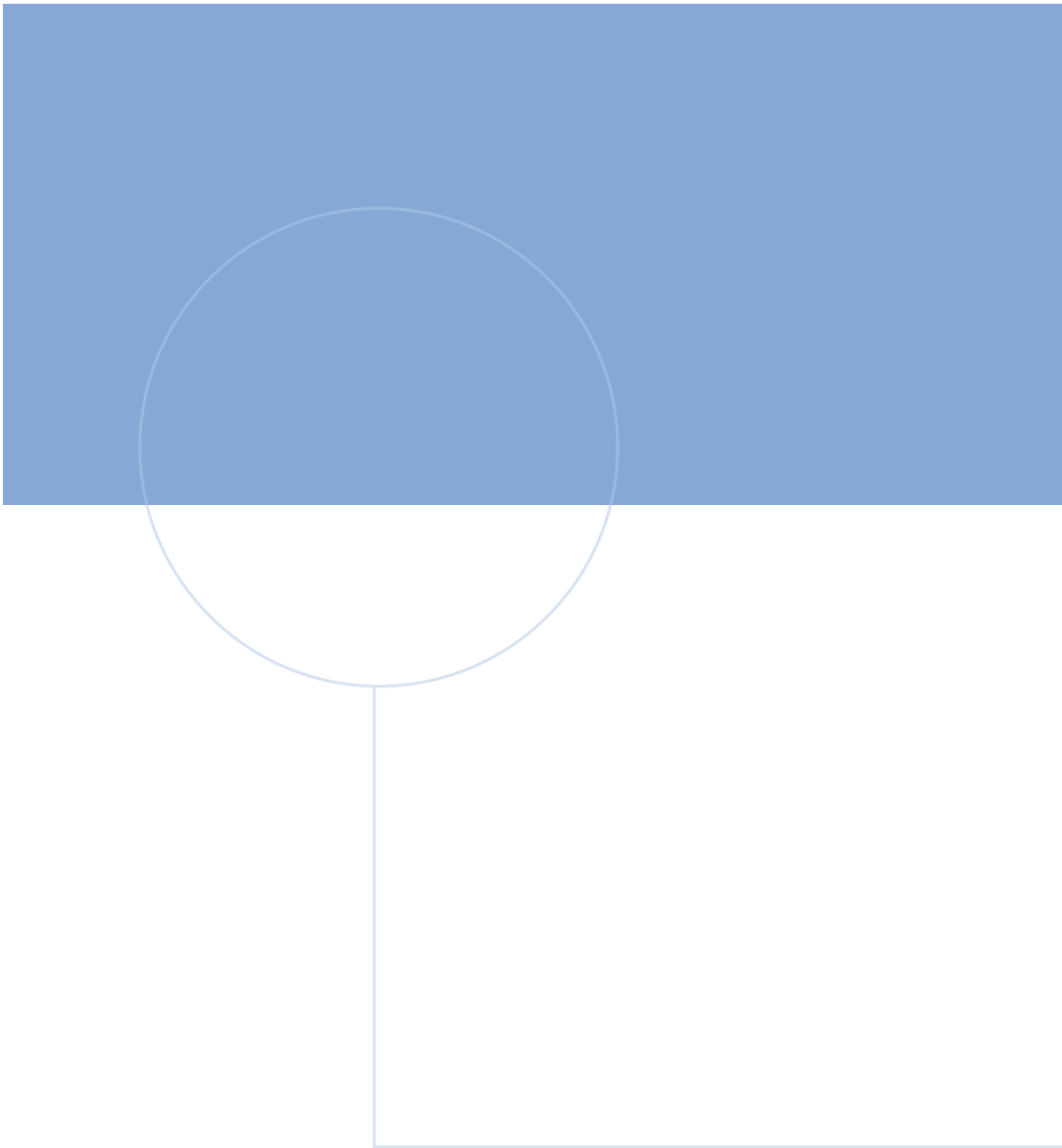
STEP	VARIABLE	R	R SQUARE	R SQUARE CHANGE	F CHANGE	SIG. F CHANGE
1	SCL-90-R pre	,569[a]	,323	,323	15,778	,000***
2	Treatment	,576[b]	,331	,008	,380	,542
3	Anger early	,645[c]	,416	,085	4,488	,042*
4	Anger early x treatment	,649[d]	,422	,006	,298	,589
5	Anger late	,731[e]	,535	,113	7,029	,013*
6	Anger late x treatment	,784[f]	,615	,080	5,848	,022*
7	Inhibition late	,853[g]	,728	,113	11,175	,002**

Note. SCL-90-R = Symptom Checklist 90 Revised; *p < .05. **p < .01. ***p < .001.

Appendix



Appendix showing Malan (1995) triangle of conflict and triangle of persons.



NTNU
Norwegian University of
Science and Technology