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The Relationship Between Activating Affects, Inhibitory Affects, and Self-Compassion in Patients With Cluster C Personality Disorders

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In the short-term dynamic psychotherapy model termed “Affect Phobia Treatment,” it is assumed that increase in patients’ defense recognition, decrease in inhibitory affects (e.g., anxiety, shame, guilt), and increase in the experience of activating affects (e.g., sadness, anger, closeness) are related to enhanced self-compassion across therapeutic approaches. The present study aimed to test this assumption on the basis of data from a randomized controlled trial, which compared a 40-session short-term dynamic psychotherapy ($N = 25$) with 40-session cognitive treatment ($N = 25$) for outpatients with Cluster C personality disorders. Patients’ defense recognition, inhibitory affects, activating affects, and self-compassion were rated with the Achievement of Therapeutic Objectives Scale (McCullough et al., 2003b) in Sessions 6 and 36. Results showed that increase in self-compassion from early to late in therapy significantly predicted pre- to post-decrease in psychiatric symptoms, interpersonal problems, and personality pathology. Decrease in levels of inhibitory affects and increase in levels of activating affects during therapy were significantly associated with higher self-compassion toward the end of treatment. Increased levels of defense recognition did not predict higher self-compassion when changes in inhibitory and activating affects were statistically controlled for. There were no significant interaction effects with type of treatment. These findings support self-compassion as an important goal of psychotherapy and indicate that increase in the experience of activating affects and decrease in inhibitory affects seem to be worthwhile therapeutic targets when working to enhance self-compassion in patients with Cluster C personality disorders.

Keywords: Affect Phobia Treatment, self-compassion, short-term dynamic psychotherapy, cognitive therapy, Cluster C personality disorder

Empirical research has shown that negative attitudes toward self and self-criticism are central factors in a range of psychological disorders, including personality disorders (Gilbert & Irons, 2005). Positive changes in an individual’s attitudes toward self are commonly assumed to be necessary components of successful psychotherapy (Arnold, Farber, & Geller, 2000; Gibbons et al., 2009). Acknowledging the importance of working with patients’ critical

and judgmental attitudes toward self, several therapeutic approaches emphasize that treatment should help patients develop a more compassionate and caretaking stance toward themselves (Gilbert & Irons, 2005; Kabat-Zinn, 1990; Linehan, 1993; McCullough-Vaillant, 1997).

Self-compassion can be defined as having a kind, balanced, and supportive attitude toward oneself (Neff & Vonk, 2009). It implies

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treating oneself with kindness, even when making mistakes or not performing to one's best ability. It involves a capacity to acknowledge the reality of personal failings while keeping them in a nuanced perspective, and recognizing that imperfection is a shared aspect of human experience (Neff & McGehee, 2010). Self-compassion does not involve holding an unrealistically positive view of oneself (Neff & Vonk, 2009), but can be described as an antithesis to self-condemnation, self-criticism, and rumination about short-comings and lack of value.

Affect Phobia Treatment (APT) is a model of short-term dynamic psychotherapy (STDP) whose one of the aims is to help patients develop self-compassion (McCullough-Vaillant, 1997; McCullough et al., 2003a). Individuals with a Cluster C personality disorder (PD) may avoid activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection (Avoidant); have a strong fear of losing support or approval (Dependent); or hold themselves back carefully until they are sure that whatever they do or say will be flawless and perfect (Obsessive-Compulsive; *DSM-IV*, American Psychiatric Association, 1994; Benjamin, 2003). APT hypothesizes that patients' problems with lack of self-compassion can be traced to conflicts, fears, or shame surrounding emotions (McCullough & Magill, 2009). APT integrates psychodynamic and behavioral theory and reinterprets emotional conflicts as "affect phobias" (McCullough-Vaillant, 1997). In contrast to phobic stimuli that are external, affect phobias are internal, in that the phobic stimuli involve affects that cannot be tolerated by the patient.

The APT model is based on an understanding of two basic motivational affect systems, seen as products of both evolution and learning: an activating affect system that motivates approach behaviors, and an inhibitory affect system that motivates avoidance or withdrawal behaviors (e.g., Arnett & Newman, 2000; Gray, 1975; Shore, 2003; McCullough & Magill, 2009). Both affect systems can be adaptive, but within some forms of psychopathology, the inhibitory affects (shame, guilt, anxiety, and pain) can be regarded as being overstimulated. Experiential avoidance is assumed to protect the individual from re-experiencing past threats, such as rejection or reprisals (Elliot & Church, 2002). However, if avoidance of aversive experiences is so frequently exercised as to dominate an individual's life, then what originally had the function of protecting the individual can end up being life-inhibiting (Grawe, 2006). Sustained avoidance of aversive experiences is assumed to contribute to the development and maintenance of many psychopathologic disorders, including those of Cluster C personality disorders (Hayes, Wilson, Gifford, Follette, & Strohsal, 1996).

According to the APT model, therapeutic interventions are guided by the Triangle of Conflict (Menninger, 1958; Malan, 2001). The triangle enables collaborative exploration of the conflictual interplay of avoided affects, the anxiety, shame, guilt, or pain, which these emotional experiences generate, together with the defensive behaviors the individual uses to avoid the triggering of anxiety, shame, guilt, or pain. Within STDP and the APT model, psychological change is seen as a result of working toward solving emotional conflicts. The processes of increased recognition of own defenses (maladaptive patterns), regulation of inhibitory affects, and experiencing of activating affects are not expected to be unique for STDP, but are assumed to impact change across various

models of psychological treatment (McCullough et al., 2003a) (Figure 1).

Like STDP, cognitive therapy (CT) has also been developed to treat patients with personality disorders (Beck & Freeman, 1990). When working with maladaptive personality patterns, the goal of CT includes helping the patient see critical and devaluing core beliefs and assumptions about self as less veridical, and to transform critical core belief structures or schemas into more adaptive forms. Because individuals with Cluster C personality disorders are preoccupied with issues of self-definition, self-control, and self-worth (Levy et al., 1995), CT with this group of patients aims to further self-beliefs and self-schemas that enhance the individual's sense of worth and ability to be more flexible and less afraid of not always being in full control.

Several studies have established both STDP and CT as effective methods in treating long-standing personality disorders, including Cluster C disorders (Gude & Hoffart, 2008; Junkert-Tress, Schnierda, Hartkamp, Schmitz, & Tress, 2001; Leichsenring, Rabung, & Leibing, 2004; Winston et al., 1994). One randomized controlled trial (RCT) has shown that STDP and CT have equally good effects for outpatients with Cluster C personality disorders (Svartberg, Stiles, & Seltzer, 2004). To the best of our knowledge, no previous study has empirically examined whether patient processes, assessed as changes in the corners of the Triangle of Conflict during treatment, predict changes in patients' self-compassion across STDP and CT. In the present study, based on the RCT by Svartberg et al. (2004), we included both CT and STDP treatments so as to explore the proposition that the process variables under investigation will have similar effects in different forms of treatment (McCullough et al., 2003a). More specifically, the following hypotheses were tested:

1. An increase in recognition of one's own maladaptive defensive patterns from early to late in therapy will be related to higher self-compassion at the end of therapy.
2. A decrease in inhibitory affects from early to late in treatment will be related to higher self-compassion at the end of therapy.
3. An increase in the experience of activating affects from early to late in treatment will be related to higher self-compassion at the end of therapy.

Methods

Methods and Procedures

Material consisted of videotapes from Sessions 6 and 36 in all included treatments of a randomized controlled trial, comparing

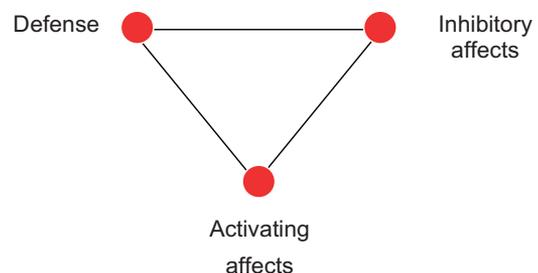


Figure 1. The triangle of conflict.

STDP with CT at the Norwegian University of Science and Technology, Trondheim, Norway (Svartberg et al., 2004). Detailed descriptions of the Trondheim RCT study have previously been published (Svartberg et al., 2004) and are described briefly here. The Norwegian Institute of Science and Technology Review Board approved the protocol. All participants provided written informed consent before participating in the study.

Participants

In all, 50 patients completed treatment in accordance with the preplanned schedule of 40 sessions. To be included, referred patients had to meet the criteria for one or more of the *DSM-III-R* Cluster C personality disorders or self-defeating personality disorder (appendixed in the *DSM-III-R*). At baseline, there were no significant differences on any variable between the two groups (STDP and CT). Regarding the selection of participants and demographic and clinical characteristics of the sample, 50% were female, 34% married, mean age was 33.4 (STDP) and 34.6 (CT). Of 50 patients, 31 (62%) had an avoidant PD, 17 (34%) an obsessive-compulsive PD, 10 (20%) a dependent PD, 3 (6%) a passive-aggressive PD, and 3 (6%) a self-defeating PD. Eleven (22%) of 50 patients had more than one PD. Please see Svartberg et al. (2004) for details.

Treatments

Affect phobia model of STDP treatment. This treatment was based on Leigh McCullough's (McCullough-Vaillant, 1997) treatment model for psychological disorders, which conceptualizes that psychologically based disorders result from a restricted affective tolerance because of affect phobias that block adaptive emotional and behavioral responses, including self-compassion.

The APT model is based on psychodynamic principles, but the therapist is free to use a range of techniques from various therapeutic traditions. Some main objectives regarding helping the patient include enabling the patient to recognize and relinquish defenses, to understand the meaning of past and new experiences and how they shape and uphold current affect phobias, the use of guided imagery to experience previously avoided affects, and use of behaviorally focused techniques to practice new and more adaptive ways of responding in difficult situations.

Cognitive therapy. CT treatment was based on a model of Beck et al. (1990) to treat personality disorders, which views such disorders as originating in pathologic core beliefs. The therapist focuses initially on coexisting Axis I pathology, and then on recognizing, understanding, and evaluating negative automatic thoughts, assumptions, and core beliefs and schemas. The objective is to transform such belief structures or core schemas into more adaptive forms. The therapist uses three main techniques: Guided imagery to bring the patient to understand the meaning of past and new experiences and how they shape and uphold current beliefs; homework assignments focused on attempting new adaptive responses; and cognitive, behavioral, and emotion-focused techniques for calling into question pathologic core beliefs and for developing new and more adaptive beliefs and behavior.

Regarding the integrity and differentiability of the two treatment models, STDP and CT were shown to differ according to theory in their emphasis on central techniques and strategies. STDP had

significantly stronger focus on work with the defenses ($t(48) = 4.0, p \leq .001$) and transference work ($t(48) = 3.33, p \leq .002$), whereas CT had significantly stronger focus on supportive strategies ($t(48) = 2.2, p \leq .02$), homework assignments ($t(48) = 5.6, p \leq .0001$), and agenda setting ($t(48) = 9.9, p \leq .0001$). Please see Svartberg et al. (2004) for details.

Therapists

The STDP therapists were three psychiatrists and five clinical psychologists, with a mean of 9.2 years of clinical experience (standard deviation [*SD*] = 3.6). All therapists were trained in the STDP model by Leigh McCullough, attended seminars, and received supervision on video-taped sessions. The CT therapists included six clinical psychologists, with a mean of 11.2 years of clinical experience (*SD* = 4.3). All therapists were trained in the CT model and received supervision on video-taped sessions as well as in seminars from CT experts.

Achievement of Therapeutic Objectives Scale

McCullough et al. (2003b) developed a coding system, The Achievement of Therapeutic Objectives Scale (ATOS), which can be used to assess patient behaviors. The ATOS provides an indication of where the patient is in the process of reaching the therapeutic objectives that are hypothesized to facilitate therapeutic change (for a review, see Siefert, Defife, & Baity, 2009). The ATOS can be used to investigate whether patients' achievement of increased defense recognition, decreased inhibitory affects, and increased experience of activating affects predict their self-compassion at the end of psychological treatment. According to McCullough et al. (2003b) the ATOS is transtheoretical in that an increase in defense recognition, a decrease in inhibitory affects, and an increase in activating affects are assumed to be common change processes and not unique to STDP. The ATOS has demonstrated good-to-excellent inter-rater reliability in four reliability studies with experienced clinicians (intraclass correlation [*ICC*]: .61-.84; McCullough et al., 2003c). Clinical psychology students can learn to rate the scale at a fair-to-good level after 15 hours of training (*ICC*: .42-.71; Schanche, Nielsen, McCullough, Valen, & Mykletun, 2010). The scale has demonstrated adequate discriminative validity (see Valen, Ryum, Svartberg, Stiles, McCullough, under review) when assessed in line with the multitrait-multimethod matrix (Campbell & Fiske, 1959). The experience of activating affect subscale of ATOS has been demonstrated to have adequate construct validity ($r = .70$, Carley, 2006) when compared with the Experiencing Scale (Klein, Mathieu-Coughlan, Kiesler, 1986).

Raters

To examine the videotapes from the RCT study, student raters were recruited from participants ($N = 65$) in 16-hr training courses on how to use the various ATOS subscales. Three courses were arranged as an optional part of the ordinary clinical psychology program at the Norwegian University of Science and Technology. All students were required to complete a reliability test of 10-min segments of 25 therapies at the end of their formal training. After having individually viewed and rated a 10-min segment, the stu-

dents submitted their ratings online and received a feedback report with deviation calculations together with expert explanations by the ATOS authors. Students who reached an inter-rater reliability score (ICC, model (1,1), Shrout & Fleiss, 1979) equal to or above .70, were considered calibrated and invited to be judges in the present study ($N = 7$). Students who fell short of the required ICC levels but who still wanted to participate in the study ($N = 4$) were given additional training, and accepted as judges when they reached a calibrated level. In addition to the student raters, three licensed psychologists enrolled in a doctoral program at the Norwegian University of Science and Technology and University of Bergen, all previously certified as reliable raters of ATOS, participated in the study.

Collection of data. Pairs of raters were randomly assigned to rate the 99 available sessions. The pair of judges usually included one licensed psychologist and a clinical psychology graduate student. The team members were periodically rotated according to scheduling availability. After reviewing each 10-min video segment, individual judgments were made for each subscale. Judges rated all the ATOS subscales, with the exception of two judges who focused on defense recognition and self-compassion. Data on inhibitory affects in one late session of CT were missing because of these two raters' restricted focus. After rating an entire segment, the team members arrived at a final rating by consensus. Individual segment ratings of the judges were then pooled across segments to derive a mean session rating. The raters rated one early and one late session of therapy, typically Sessions 6 and 36. When Sessions 6 or 36 were not available on tape, the session closest to that number was used. This happened in 15% of the sessions, generally as a result of technical difficulty with recording. Raters were blind to patient scores on the Symptom Checklist-90 (SCL-90), the Inventory of Interpersonal Problems (IIP), and the Millon Clinical Multiaxial Inventory (MCMI) for both pre- and post-testing. Efforts were taken to ensure that judges were blind to treatment modality, but this information was occasionally revealed by the patient or the therapist on the videotape. Importantly, all raters reviewed video tapes from both treatment conditions (STDP, CT) on a random basis. The analysis of inter-rater reliability yielded an average ICC (1,14) coefficient of .84, $p < .0001$, indicating excellent inter-rater agreement between pairs of raters (Vangeugden, Laenen, Geys, Renard, & Molenberghs, 2004). ICC levels between pairs of raters for the various ATOS subscales for STDP and CT, respectively, were as follows: sense of self = .87 and .73, defense recognition = .65 and .60, inhibitory affects = .72 and .65, and activating affects = .70 and .68. ICCs from .60 to .74 are considered good, and above .74 as excellent (Shrout & Fleiss, 1979).

Outcome Assessment

A measure of patients' self-compassion was provided by the Sense of self subscale of the ATOS. The Sense of self subscale is a composite scale which measures the compassionate quality of patients' self-descriptions. Ratings of patients' self-descriptions are based on the individuals' verbal report of their attitudes of kindness toward themselves in instances of pain and failure. Ratings are also based on patients' ability to hold both positive and negative aspects of self in a balanced awareness without reacting with self-attack, self-negation, or negative self-statements. In ad-

dition, ratings are based on patients' ability to be in touch with their wants and needs, and have a positive self-regard without it being inflated and grandiose. The quality of an adaptive sense of self, as measured with the ATOS, largely captures the same attitude of kindness toward self as is found to be inherent in the concept of self-compassion defined by Neff (2003), Gilbert (2009), and Germer (2009).

The compassionate quality of patients' self-descriptions was registered and rated once early in treatment (Session 6) and once late in treatment (Session 36) in each of the 50 treatments. Each rating was made on a 0–100 scale divided into 10 levels. Each level contained operational definitions that guide categorization of observable behaviors. For further details regarding rating levels, see Appendix 1.

In addition to the ATOS ratings, an outcome battery of self-report measures was applied, as reported in a study by Svartberg et al. (2004). A measure of symptom distress was provided by the Global Severity Index of the SCL-90–R (Derogatis, 1983). The total mean score of the full version (127-items) of the IIP (Horowitz, Rosenberg, Baer, Ureno, & Villaseñor, 1988) was used to assess patients' problems with assertiveness, intimacy, sociability, submissiveness, control, and responsibility for others. The MCMI (Millon, 1984) was used as a measure for personality disorders, and for Cluster C pathology.

Process Assessment

Measures of patients' level of defense recognition, inhibitory affects, and activating affects were provided by three of the seven ATOS subscales: Defense recognition, Experience of inhibitory affects, and Experience of activating affects. Each rating was based on a 0–100 scale, which was divided into 10 levels.

The *Defense Recognition Subscale* is a composite scale that dimensionally measures the degree of clarity and comprehensiveness of patients' description of conflictual patterns and maladaptive behaviors. Being able to recognize one's reaction patterns involves understanding the potential etiologies of emotional conflicts. For further details regarding rating levels, please see Appendix 1.

The *Inhibitory Affects Subscale* is a composite scale that measures the intensity and duration of a group of inhibitory affects including shame, guilt, anxiety, or pain, as demonstrated in non-verbal bodily responses such as vocal tone, lowered head, clenched fists, sighs, visible muscular tension and trembling, as well as verbal statements of discomfort. The Inhibitory affects subscale is the only subscale rated in reverse; that is, higher levels indicate more maladaptive responses.

The *Activating Affects Subscale* measures intensity of arousal of affects that are considered adaptive, but conflicted, for the patient. It is a measure of how much of the specific and previously avoided affects are experienced by the patient, not a mere registration of any affective display. For each 10-point segment of the scale, a predominant conflicted activating affect is identified. When rating the predominant affect of a segment, a distinction is made between primary adaptive affects and secondary maladaptive or defensive affects (McCullough-Vaillant, 1997).

Statistics

Pearson product-moment correlation coefficients were used to assess associations between the various ATOS variables. Tests of multicollinearity were also conducted. Paired sample *t* tests were used to test changes over time, and independent *t* tests were used to examine differences between STDP and CT. Hierarchical regression analyses were used to test the specified hypotheses, with scores on the Sense of self (self-compassion) subscale in Session 36 as the dependent variable. Initial levels of patients' self-compassion were entered in the first step as a covariate. In the second step, form of treatment (STDP vs. CT) was entered as a dichotomous variable to control for a potential difference in treatment modality. Then, to control for the patients' initial levels of defense recognition, inhibitory affects, and activating affects, the early measurements of these predictor variables were entered in step 3. Next, in accordance with McCullough-Vaillant's (1997) model of change, increase in defense recognition was entered in step 4, decrease in inhibitory affects in step 5, and increase in activating affects in step 6. Finally, the interactions between the form of therapy (STDP vs. CT) and change in each of the independent variables (defense recognition, inhibitory affects, and activating affects) were entered simultaneously in step 7.

To investigate the relationships between changes in self-compassion and psychiatric symptoms (SCL-90), change in interpersonal problems (IIP), and change in personality pathology, hierarchical regression analyses, controlling for prescores, were applied. SPSS 15.00 was used.

Results

Preliminary Analyses

Table 1 summarizes the correlations between the four ATOS variables. Paired *t* tests indicated increase in early (#6) to late (#36) levels of self-compassion ($t(47) = -4.183, p < .001$), increase in early to late levels of defense recognition, $t(48) = -3.667, p < .01$, decrease in early to late levels of inhibitory affects, $t(47) = 4.958, p < .01$, and increase in early to late levels of activating affects, $t(48) = -2.683, p < .01$, for the total sample. Self-compassion demonstrated significant and large effect gains over the course of treatment ($d = .77$) for the whole sample. Table 2 summarizes the means, *SDs*, *Ns*, and tests of differences between STDP and CT for the dependent and independent variables. Inde-

pendent *t* tests indicated no significant differences between STDP and CT in patients' ATOS variables neither early nor late in therapy, nor in change from early to late in therapy.

Higher levels of self-compassion in Session 36 were moderately, but significantly associated with improvements on the self-reported outcome measures at the end of treatment: IIP ($r = .48, p = .01$); MCMI ($r = .40, p = .04$); and SCL-90-R ($r = .43, p = .03$). Moreover, adaptive change in self-compassion from early to late in therapy also significantly predicted a decrease in psychiatric symptoms (SCL-90-R; $t = -3.386, p = .002$), interpersonal problems (IIP; $t = -2.879, p = .006$), and personality pathology ($t = -2.558, p = .014$), when prescores were statistically controlled for. Higher numerical values represent more adaptive self-compassion scores and lower numerical values represent more adaptive SCL-90, IIP, and MMCI scores. Because the change scores were estimated through subtracting early therapy scores from late therapy scores across each scale, the correlation of changes in self-compassion and on these three self-report measures are negative.

Testing Hypotheses

Table 3 summarizes the results of the hierarchical regression analysis. Neither early levels of self-compassion, treatment type, early levels of defense recognition, early levels of inhibitory affects, nor early levels of activating affects predicted self-compassion near the end of treatment, when entered in their respective steps. Changes in defense recognition entered in step 4, inhibitory affects entered in step 5, and activating affects entered in step 6, significantly predicted self-compassion toward the end of therapy. However, the significant predictive effect of change in defense recognition disappeared when the effect of change in activating affects was entered in step 6. Interactions between form of therapy (STDP vs. CT) and change in each of the independent variables, entered in step 7, were not significant.

To cast further light on the relationships between the four ATOS variables, several additional hierarchical regression analyses were conducted. First, when the effect of early scores of the dependent variable was statistically controlled for, early levels of self-compassion did not predict late levels of defense recognition ($t = 1.54, p = .13$), late levels of inhibitory affects ($t = -1.00, p = .33$), or late levels of activating affects ($t = -1.18, p = .24$). Second, early levels of defense recognition neither predicted late

Table 1
Correlations Between the ATOS Variables

Measure	1	2	3	4	5
1. Self-compassion early	—				
2. Defense recognition change	-.103	—			
3. Inhibitory affects change	.152	-.244	—		
4. Activating affects change	-.291*	.514**	-.347*	—	
5. Self-compassion late	.263	.339*	-.377**	.496**	—
6. Self-compassion change	-.427**	.370**	-.486**	.647**	.760**

Note. The change scores were calculated by subtracting early therapy scores (#6) from late therapy scores (#36) across each subscale. The Inhibitory affects subscale is rated in reverse, that is, higher levels indicate more maladaptive responses.

* $p < .05$. ** $p < .01$.

Table 2
Means, SDs, Ns, and Tests of Differences Between STDP and CT for the ATOS Variables

Variables	STDP			CT			Whole sample			<i>t</i>	<i>p</i>	<i>d</i>
	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>			
Self-compassion												
Early	34.93	12.57	25	38.07	13.77	25	36.502	13.15	50	-.841	.404	
Late	49.05	20.73	23	48.45	16.64	25	48.74	18.51	48	.111	.912	
Change	13.60	17.70	23	10.38	21.71	25	11.92	19.75	48	.560	.578	.77
Defense recognition												
Early	43.12	13.21	25	43.50	14.05	25	43.32	13.50	50	-.10	.921	
Late	55.73	14.98	24	49.87	14.05	25	52.74	15.20	49	1.362	.180	
Change	12.20	16.91	24	6.36	18.11	25	9.22	17.60	49	1.165	.250	.66
Inhibitory affects												
Early	58.56	17.17	25	55.96	15.03	25	57.26	16.02	50	.57	.571	
Late	46.18	17.53	24	44.29	14.87	24	45.24	16.11	48	.402	.689	
Change	-12.33	17.92	24	-11.67	15.91	24	-12.00	16.77	48	-.135	.893	.75
Activating affects												
Early	28.77	11.95	25	30.03	10.12	25	29.40	10.90	50	-.402	.69	
Late	38.22	15.34	24	32.84	17.57	25	35.47	16.57	49	1.14	.26	
Change	10.02	16.08	24	2.80	16.53	24	6.34	16.54	49	1.547	.129	.43

Note. STDP = short-term dynamic psychotherapy; CT = cognitive therapy; *d* = Cohen's *d* (pooled SD) for Whole sample change.

levels of inhibitory affects ($t = -1.71, p = .09$) nor late levels of activating affects ($t = 1.40, p = .17$). Finally, early levels of inhibitory affects did not predict late levels of activating affects ($t = 1.40, p = .17$).

Discussion

This study was conducted in the context of a randomized controlled trial of patients with Cluster C personality disorders. We found that patients who underwent 40 sessions of STPD or CT significantly demonstrated an increase in self-compassion toward the end of treatment. Increase in self-compassion from early to late in therapy also significantly predicted pre- to post-decrease in psychiatric symptoms, interpersonal problems, and personality pathology.

As predicted, decrease in levels of inhibitory affects and increase in levels of activating affects during therapy were significantly associated with improved self-compassion toward the end of therapy. Thus, hypotheses 2 and 3 were supported by these results. Increase in levels of defense recognition also predicted improved self-compassion (Hypothesis 1), but not when changes in activating affects were statistically controlled for. This suggests that increased defense recognition is related to, but does not uniquely explain increase in self-compassion.

Patients in CT and STDP had an equivalent increase in self-compassion. This finding supports the assumption that positive change in an individual's attitude toward self are a common component of successful psychotherapy (Arnold et al., 2000; Gibbons et al., 2009). A reason CT is equivalent to STDP in enhancing self-compassion in patients with Cluster C personality disorders may be that CT for personality disorders focuses on the elucidation of core beliefs and assumptions underlying an individual's automatic thoughts and self-statements (Beck et al., 1990; Young, 1990/1999). An individual's negative core self-beliefs can typically comprise contents such as "I am unlovable" or "I am a failure." Even if furthering self-compassion is not defined as an explicit goal in CT for personality disorders, a central objective is to help the patient see critical and devaluing beliefs and assump-

tions about self as less veridical, and to transform critical belief structures or core schemas into more adaptive forms. It is to be expected that an adaptive core self-belief is more nuanced, kinder, and involves acceptance of own human imperfection. One could thus make the claim that furthering self-compassion might be an actual, but often undefined, goal of CT for personality disorders.

Self-compassion is theoretically assumed to be related to psychotherapy outcome, but this empirical relationship has yet to be fully validated in quantitative studies on clinical samples. Our finding that increase in self-compassion from early to late in therapy significantly predicted pre- to post-decrease in psychiatric symptoms, interpersonal problems, and personality pathology, supports the assumption that self-compassion furthers mental health.

Our finding that an increase in the experiencing of previously avoided affects is a predictor of improved self-compassion, supports the inclusion of affect exposure as a therapeutic intervention when working with self-critical patients with Cluster C personality disorders. The predictive role of increase in activating affects is in line with other theoretical positions claiming that contact with, and tolerance for, one's feelings has a positive impact on the individual's view of and attitudes toward oneself (Gilbert & Irons, 2005; Safran & Greenberg, 1991; Rogers, 1961; Silberschatz, & Sampson, 1991; Monsen, Odland, Faugli, Daae, & Eilertsen, 1995). A common denominator in these theories is the assumption that having the opportunity to experience one's feelings within a psychologically safe and accepting environment will assist the individual in using the feelings as a trustworthy and reliable guide to behavior, and to gradually develop a more realistic and less judgmental attitude toward self and a higher ability to tolerate ambivalence and contradictions.

In the present study, the ATOS coding of activating affects is based on visible or audible displays of patient's affects during the session. Only affects judged to be contributing to the access of adaptive action tendencies are rated within the activating affect category. Hence, it is not *any* affective display, but rather an

Table 3

A Summary of the Hierarchical Regression Analysis Examining the Predictive Role of Changes in Levels of Defense recognition, Inhibitory Affects and Activating Affects From Early to Late in STDP and CT Predicting Enhancement of Patients' Self-Compassion

Steps	Variable	Unstandardized coefficients		Standardized coefficients		Sig.	95% confidence interval for <i>B</i>	
		<i>B</i>	<i>SE</i>	β	<i>t</i>		Lower bound	Upper bound
1	1. Self-compassion, Early	.381	.200	.274	1.909	.063	-.021	.784
2	1. Self-compassion, Early	.391	.203	.281	1.927	.060	-.018	.800
	2. CT vs. STDP	-1.113	2.689	-.060	-.414	.681	-6.532	4.306
3	1. Self-compassion, Early	.180	.233	.129	.772	.444	-.291	.651
	2. CT vs. STDP	.180	2.60	-.030	-.216	.830	-5.809	4.688
	3. Defense recognition, Early	.316	.236	.225	1.339	.188	-.161	.792
	Inhibitory affects, Early	.103	.222	.090	.465	.644	-.345	.552
	Activating affects, Early	.506	.321	.290	1.570	.122	-.142	1.154
4	1. Self-compassion, Early	.117	.178	.084	.656	.515	-.242	.476
	2. CT vs. STDP	2.309	2.042	.125	1.131	.265	-1.817	6.436
	3. Defense recognition, Early	1.023	.220	.730	4.653	.000	.578	1.467
	Inhibitory affects, Early	.079	.169	.069	.468	.642	-.262	.421
	Activating affects, Early	.175	.251	.100	.698	.489	-.332	.683
	4. Defense recognition, Change	.802	.144	.743	5.565	.000	.511	1.093
5	1. Self-compassion Early	.088	.162	.063	.545	.589	-.240	.417
	2. CT vs. STDP	1.536	1.881	.083	.817	.419	-2.268	5.341
	3. Defense recognition Early	.766	.218	.547	3.515	.001	.325	1.207
	Inhibitory affects, Early	-.217	.183	-.189	-1.185	.243	-.587	.153
	Activating affects, Early	.189	.229	.108	.825	.415	-.275	.653
	4. Defense recognition, Change	.611	.146	.566	4.179	.000	.315	.906
	5. Inhibitory affects, Change	-.434	.145	-.382	-3.004	.005	-.726	-.142
6	1. Self-compassion, Early	.234	.164	.168	1.427	.162	-.098	.566
	2. CT vs. STDP	1.575	1.771	.085	.889	.379	-2.010	5.159
	3. Defense recognition, Early	.335	.270	.239	1.241	.222	-.212	.882
	Inhibitory affects, Early	-.107	.178	-.093	-.600	.552	-.467	.253
	Activating affects, Early	.607	.275	.347	2.208	.033	.051	1.164
	4. Defense recognition, Change	.262	.198	.243	1.326	.193	-.138	.663
	5. Inhibitory affects, Change	-.329	.143	-.289	-2.305	.027	.618	-.040
	6. Activating affects, Change	.473	.193	.412	2.452	.019	.083	.864
7	1. Self-compassion, Early	.256	.162	.184	1.583	.122	-.072	.584
	2. CT vs. STDP	3.331	1.132	.180	1.492	.145	-1.200	7.862
	3. Defense recognition, Early	.401	.270	.286	1.487	.146	-.147	.950
	Inhibitory affects, Early	.053	.189	.046	.280	.781	-.331	.437
	Activating affects, Early	.639	.270	.365	2.363	.024	.090	1.188
	4. Defense recognition, Change	.301	.194	.279	1.553	.129	-.093	.695
	5. Inhibitory affects, Change	-.286	.149	-.257	-1.925	.062	-.588	.016
	6. Activating affects, Change	.471	.195	.410	2.417	.021	.075	.867
	7. Therapy (CT vs. STDP) ×							
	Defense recognition, Change	-.247	.124	-.252	-1.999	.053	-.498	.004
	Inhibitory affect, Change	-.053	.126	-.059	-.418	.678	-.309	.204
	Activating affect, Change	-.005	.141	-.004	-.034	.973	-.292	.282

Note. STDP = short-term dynamic psychotherapy; CT = cognitive therapy.

increase in previously avoided activating affects that predicts increased self-compassion.

Even though CT assigns affects a subordinate role in favor of cognitions, both CT and STDP operate with a theory of psychopathology in which the primacy of one component of psychic life over the other is not sharply defined (Alberti, 2010). In the cognitive model of personality disorders (Becket al., 1990), core beliefs are not pure cognitions but complex structures embracing cognitions closely connected to affects. Activation of core beliefs or schemas concerning unlovability or failure is assumed to be associated with the triggering of affects and with affect-laden memories of past and recent events. A CT therapist aims to alter core beliefs by focusing on recent and past events which evoked hot cognitions (emotional material in STDP terms). It is important to bear in mind that the CT model in general shares the assumption deeply embedded in the STDP model that cognitions are most

effectively altered when they are actively processed during affect activation. It is thus not surprising that enhancing self-compassion through CT in individuals with Cluster C personality disorders involves experiencing increased levels of activating affects.

A more surprising finding was that increased levels of activating affects as a predictor of increased self-compassion were equally strong predictors in STDP and CT. Even though guided imagery and emotion-focused techniques are used as interventions to access affect both within STDP and CT for personality disorders, previous research indicates that there is a greater emphasis on affective interventions in STPD than in CT (Ablon & Jones, 1998; Jones & Pulos, 1993; Blagys & Hilsenroth, 2000). It is possible that the impact of the assumed greater affect focus in STDP may have been modulated by the patients' Cluster C personality disorders. According to Diener, Hilsenroth, & Weinberger (2007), we do not at present have sufficient knowledge of whether there might be

theoretically relevant moderator variables, such as Axis II disorders or features that may influence the impact of affective oriented interventions. In the present study, patients in both forms of therapy experienced moderate levels of activating affect during treatment. It is possible that there would have been larger differences between the impacts of affect focused interventions in a study that would include patients with a higher initial affect tolerance. More research is needed to examine the role of specific therapeutic interventions with Cluster C patients; for example, through detailed evaluation of cases in both CT and STDP treatments.

Given the intertwined nature of shame, self-devaluation, and criticism (Gilbert, 1998), it was expected that lowering shame and other inhibitory affects would contribute to more self-compassion. Regulating the intensity of inhibitory affects may help the individual to access a mind-set that is less fixated on catastrophes and more conducive to self-compassion. The predictive value of decreased inhibitory affects supports the importance of including reduction of inhibitory affects as a specific therapeutic objective when working with self-critical patients with a Cluster C personality disorder.

Therapeutic interventions specified to regulate patients' inhibitory affects are highly similar in STPD and CT. This might explain why these two approaches are equally effective in reducing patients' inhibitory affects. According to McCullough et al. (2003a), the connection between activating affects and inhibitory affects are mediated by cognitions, often catastrophic in nature, such as "I will never stop crying," or "I will destroy relationships if I show my anger". These catastrophic expectations are founded on unrealistic and negative ideas about self and others. Regulation of anxiety, guilt, pain, and shame are primarily aimed at correcting such catastrophic cognitions associated with the experience of activating affects.

In addition, it is likely that patients' adaptive interactions with the therapists contributed to regulation of inhibitory affects within both STDP and CT. Although we can only speculate about the mechanism(s) by which inhibitory affects are regulated, a reduction of inhibitory affects might be interpreted as an indication that a corrective emotional experience for the patient has taken place. A corrective emotional experience can be described as a reparative experience; reparative in the sense that a good, or more satisfying experience than expected, is provided for by the therapist (Alexander & French, 1946). Patients' judgmental attitudes toward themselves might be formed on the basis of negative and emotionally overwhelming experiences and scenes in their past; for instance, being bullied at school or being neglectfully or harshly treated by one's parents. Through interacting with the therapist in ways that reduce inhibitory affects, patients may be able to anchor their attitudes toward themselves in these more present time interactions.

The findings of the present study support the notion that patients' affective processes, captured by ATOS, can be defined as common patient processes across CT and STDP. Increased experience of activating affects and regulation of inhibitory affects seem to be common processes of change in STDP and CT when aiming to change patients' personality characteristics, such as attitudes toward self. Several contemporary authors emphasize the need to move beyond the constraints of theoretical orientation and to use the knowledge base in psychopathology to develop more broad-based treatments (Goldfried, 1993; Hayes & Newman, 1993; Alberti, 2010). The findings in this study lend support to such a line of reasoning.

With regard to treatment, the results indicate that the capacity to experience activating affects, along with a regulation of inhibitory affects, should be central targets when working to enhance self-compassion. This finding emphasizes the importance of attending to the balance between provoking and regulating affects when working with self-critical Cluster C patients. This dual therapeutic focus is also consonant with Malan's proposition: In exposing patients to previously avoided affects, the therapist must be aware of the degree of anxiety or pain with which avoided feelings are associated, as well as the patient's capacity to bear them (Malan, 2001). Negotiating a balance between affect exposure and regulation of inhibitory affects is also in line with the principle of regulating the speed of exposure and remaining within the patient's "window of affect tolerance" (Ogden, 2009). Gaston and Ring (1992) found that therapists of unimproved patients emphasized affects more than did therapists of improved patients. Attuned and graded emotional exposure thus seems to be the more sensitive and effective curing mechanism, not the insistent emphasis on "the more affects 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 (McCullough & Magill, 2009). Thinking in terms of gradually improving patients' affect tolerance may serve as a reminder of this dual therapeutic focus.

The present study has several potential strengths and limitations which merit discussion. Data were collected from an RCT with manualized treatments. Inter-rater reliability scores were computed. All raters were uninformed about the research hypotheses being tested, and they were blind to treatment outcome. Pairs of raters were randomly assigned to rate the 99 available sessions. The outcome measure applied is a personality characteristic that captures potential vulnerabilities to stressful events, and as such, a measure that has been recommended by Blatt, Zuroff, & Hawley (2009). Affective experiences and sense of self are psychological phenomena that patients are not always able to give an actual account of. It is therefore also a strength that ratings of the process variables and the main outcome variable in this study are based on direct observations of patient behavior and self-descriptions over time. By observing video recordings of entire therapy sessions, nuances in patient behavior that would be hard for the patient to self-report could be registered and rated. Another strength of the study is that it is empirically demonstrated that enhancement of self-compassion is significantly associated with both a decrease in interpersonal problems, personality pathology, and psychiatric symptoms following treatment.

A major limitation of the study is that defense recognition, activating affects, inhibitory affects, and self-compassion were measured at just two points during treatment (early and late). With the current set of data, we cannot identify with certainty what caused the growth in self-compassion. We can only draw conclusions about the predictive value of changes in levels of inhibitory affects and activating affects. An alternative to the correlation approach could be the use of multiple points of measurements to determine whether specific patient processes precede changes in self-compassion. With multiple measurement points, it would also be possible to estimate a growth curve showing how levels of defense recognition, inhibitory affects, and activating affects might influence self-compassion in different phases of treatment.

Another limitation in data collection was the fact that the same individual rated the various subscales of the ATOS within one session. Even though all raters achieved good reliability ($ICC < .70$, Shrout & Fleiss, 1979) after training, there is a risk that scores may have been influenced by a halo-effect, with overall impression of the patient influencing the rating of each subscale. To investigate this, we compared intercorrelations between the various subscales in the present data set with intercorrelations in a second data set (Schanche et al., 2010) where raters applied only two subscales at a time. No systematic differences emerged. Hence, there was no evidence of an increased halo-effect when rating six rather than just two subscales at a time. Also, one may argue that the match between greater adaptive changes in self-compassion ratings of the ATOS and adaptive changes on the SCL-90, IIP, and MCMI support the reliability of the self-compassion subscale. If ATOS self-compassion were unreliable, we would probably not see these changes of this rater variable effectively paralleling patient's self-reported improvements in areas of symptoms, relational problems, and personality pathology. However, more research is needed to investigate a potential halo-effect of simultaneous rating of the various subscales of ATOS.

The raters of the study were not blind to session number being rated. It is therefore possible that this information may have influenced how they perceived the phenomena they were rating. We would thus advise future studies to mask session number written on the DVDs that are given to the raters.

The finding that the greater adaptive changes in self-compassion ratings of the ATOS are associated with adaptive changes on the SCL-90, IIP, and MCMI supports the construct validity of the self-compassion subscale. The construct validity of the ATOS subscales has, however, not been tested extensively. More research is needed to demonstrate that the scales capture the constructs they are hypothesized to measure. The present study was also based on a small sample of patients with Cluster C personality disorders, so caution is warranted in generalizing findings. Replications and extensions are required.

Conclusion

The results show that increase in experience of activating affects and decrease in inhibitory affects from early to late in therapy independently predict levels of self-compassion at the end of treatment in both STDP and CT. Increase in defense recognition did not uniquely predict enhancement in self-compassion. Adaptive changes in self-compassion from early to late in therapy also significantly predicted pre- to post-improvement in psychiatric symptoms, interpersonal problems, and personality pathology in patients with Cluster C personality disorders. In future studies, it would be of interest to include multiple points of measurement to establish whether increase in defense recognition, decrease in inhibitory affects, or increase in activating affects precede changes in self-compassion, possibly also on a within-session level.

It would also be of interest to look at the temporal relationship of both defense recognition, inhibitory affects, and activating affects with self-compassion within phases or significant moments in treatment. It might be that the levels of these specific patient processes within certain phases of treatment contribute differently to furthering self-compassion than the general level of these process variables. Finally, one might include a measure of therapist

intervention that contributes to the regulation of inhibitory affects and experiencing of activating affects. This could shed further light on the mechanisms by which self-compassion is enhanced within therapy.

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(Appendix follows)

Appendix 1

Excerpts of levels of ATOS subscales which are based on the following categorization:

Sense of self subscale

- Highly adaptive sense of self (91–100 range) is represented by great but healthy pride in own's strengths (not grandiose), high affirmation of own wants and needs, without being demanding, a very realistic but highly compassionate attitude towards own weaknesses. Great sense of self-compassion and self-acceptance, with almost no self-blame.

- Moderately adaptive sense of self (50–60 range) is represented self-compassion and self-acceptance that is only slightly greater than level of devaluation or grandiosity. Only moderate affirmation of own wants and needs, and only a little more compassion and self-acceptance than self-blame.

- Maladaptive (critical) sense of self (0–10 range) is represented by having little or no pride, or extreme grandiosity, denying or ignoring wants and needs, little or no ability to acknowledge and accept limitations, and almost no self-compassion or self-acceptance but extremely destructive self-blame.

Defence recognition subscale

- Excellent recognition of maladaptive behaviour patters (90–100 range). The patient gives a clear, comprehensive description of maladaptive patters. The patient describes clearly and fully how patterns is transferred from past to present and present excellent descriptions of reasons for maladaptive responses, including meanings and secondary gain.

- Moderate recognition of maladaptive behaviour patterns (50–60 range). The patient gives partial descriptions of maladaptive patterns. The patient presents no past-present links and has no insight in why maladaptive behaviors occur or secondary gain.

- No awareness of maladaptive behavior patterns (0–10 range). The patient does not see maladaptive patterns on own, nor when therapist points it out. No apparent interest in recognizing maladaptive responses. Disagrees or becomes angry/

belligerent when maladaptive responses are pointed out. No awareness or resists awareness. No mention of anxiety or inhibitory affect.

Inhibitory affect subscale

- Extreme inhibitory affect (90–100 range) is characterized by extremely high levels of anxiety, guilt, shame and pain; e.g., body movement and muscles are extremely tight, voice is hesitant or trembling, guardedness, and tremendous discomfort.

- Moderate Inhibitory affect (50–60 range) is characterized by moderate levels of inhibitory feeling; e.g., tightness, tension, and rigidity in body movement and muscles, moderate hesitation in tone of voice, moderate trembling, moderate shakiness, hesitance, sighing, guardedness, vigilance.

- No Inhibitory affect (0–10 range) is characterized by almost no visible anxiety or shame; e.g., behavior and vocal tone that is very calm and unguarded, a relaxed body with no evident muscle tension, and no discomfort.

Activating affect subscale

- High activating feeling (91–100) is represented by a patient being in touch with an emotion in a deep and sustained manner, as shown in facial affect, behavior or vocal tone, and experiencing significant relief as a result of this emotional exposure.

- Moderate activation (50–60), is represented by a patient shedding some tears, experiencing moderate anger, or showing moderately tender feelings in facial affect, behavior or vocal tone, and experiencing moderate relief as a result of this emotional exposure.

- Low or no activation, (0–10 range), is represented by a patient showing no facial or other bodily experience of emotion, and reporting no inner experience of affect, and no experience of relief.

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