

Insight and Therapeutic Change

**An Empirical Study of the Association Between Insight and Therapeutic Change in
Short-Term Psychodynamic and Cognitive Therapy in Treatment of Cluster C
Personality Disorders: A Randomized, Controlled Trail**

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Abstract

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Title: Insight and Therapeutic Change: An Empirical Study of the Association Between Insight and Therapeutic Change in Short-Term Psychodynamic and Cognitive Therapy in Treatment of Cluster C Personality Disorders: A Randomized, Controlled Trail

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Objective: The objective in the present study was to examine the association between Insight and therapeutic change, and whether the increase on Insight and its association with therapeutic change differ among patients receiving short-term psychodynamic therapy (STPD) compared with patients receiving cognitive therapy (CT).

Method: The clinical data material used in this study derives from a randomized controlled trial on 48 patients with cluster C personality disorder receiving short-term psychodynamic therapy (STPD) or cognitive therapy (CT) over a series of forty sessions. Videotaped sessions early and late in treatment were analyzed using the Achievement of Therapeutic Objectives Scale (ATOS).

Results: Patients' level of Insight increased significantly during therapy for both the STPD and CT patient group. Insight was also found to be significantly associated with therapeutic change. However, we found no significant interaction effect between change in Insight and type of therapy.

Conclusion: The results presented in this study could suggest that insight operates as a common process mechanism or factor associated with therapeutic change across both STPD and CT.

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INTRODUCTION

The pursuit of insight have been regarded as one of the defining features of psychoanalytical therapy, and most psychoanalytical writers believe insight to be critical in effecting therapeutic change (Messer, & McWilliams, 2007). However, despite vast clinical literature, the empirical research investigating the role of insight in psychotherapy is surprisingly scarce and often inconclusive (Johansson et al., 2010). Kivlighan, Multon, & Patton (2000) found that changes in insight across treatment predicted symptom course. Several other studies have, however, been unable to detect the same association, showing no relationship between insight and favorable outcome in therapy (Crits-Christoph et al., 1984, ref in Connolly Gibson, Crits-Christoph, Barber, & Schamberger, 2007; Connolly Gibson et al., 1999).

Historically, insight has been viewed as a psychoanalytic or psychodynamic construct, and its status within many of the “non-dynamic” therapies, such as cognitive behavioral therapy (CBT), still remains disputed. Some studies have found insight to increase in patients given CBT treatment, but to a smaller degree than with patients given psychodynamic therapy (Connolly Gibson, et al., 1999; Grosse Holforth, et al., 2007), while other studies have found no such differences (Ablon & Jones, 1999). Thus, there is still considerable controversy and uncertainty concerning both the association between insight and therapeutic change, and its relevance as a therapeutic factor across different treatment modalities and diagnostic groups.

The present study is based on a sample of 48 patients with cluster C personality disorders (PD). The treatment of PDs has been an issue in clinical psychotherapeutic literature long before the PDs were placed on a separate axis in the third edition of *DSM* (American Psychiatric Association, 1980), particularly within the psychoanalytical perspective (Kernberg, 1984; Kohut, 1984), and more recently also within the cognitive-behavioral perspective (Linehan, 1993). However, despite its central position in clinical literature and the high prevalence of axis II disorders (Torgersen, Kringlen, & Cramer, 2001), relatively few empirical studies have been focusing on efficacy of psychotherapeutic treatment on patients suffering from PDs. Attention relating to effective treatment of PDs is, however, growing. In a large meta-analysis conducted by Perry, Banon, and Ianni (1999) targeting the effectiveness of psychotherapy on PDs, found that all fifteen studies included in the study reported significant improvement as a result of treatment, with an average effect size of 1.11 for self-report measures and 1.29 for observational measures. In four of the studies, a mean of 52% of

the patients remaining in therapy recovered – defined as no longer meeting the full criteria for PD – after a mean of 1.3 years of treatment.

However, due to beliefs concerning the pervasive, inflexible and enduring nature of PDs, short-term psychotherapeutic treatments have, at least in the past, been viewed as insufficient in imposing long-lasting, adaptive personality reconstruction within the individual (Eskedal & Demitri, 2006). A growing number of clinical research have, however, challenges this assumption. In the study by Svartberg et al (2005), on which the data material in the present study derives from, found the both short-term psychodynamic (STPD) and cognitive therapy (CT) imposed long-lasting therapeutic change in patients with cluster C PDs. Similar findings have also been reported in several other studies examining the effectiveness of short-term psychotherapy on patient diagnosed with PDs (Barber, Morse, Krakauer, Chittams, & Crits-Christoph, 1997; Hardy, et al., 1995; Linehan, 1993).

The efficacy of psychotherapeutic treatment, both on mental disorders and the promotion of psychological health and well-being, has been presented in a vast number of clinical research studies and subsequent meta-analysis (Smith and Glass, 1977; Wampold, 2001; Lambert, 2004). However, efficacy studies do not tell us how or why psychotherapy works, nor can they identify the active ingredients or therapist actions associated with therapeutic change. Much on this note, Kazdin (2007) gives the following diagnosis of the field of psychotherapeutic research:

We know well that therapy “works,” i.e., is responsible for change, but have little knowledge of why or how it works (p. 2).

Kazdin points out the insufficiency in scientific knowledge about why psychotherapy work, or more precisely what the mechanisms of therapeutic change really are? However, more and more clinical research is now focusing on the in-depth, process research requested by Kazdin and others, developing new instruments in the quest to assess and measure the specific mechanisms believed to be associated with therapeutic change. Within this new era of progressive, psychotherapeutic research, McCullough, Kuhn, and Andrews (2003) developed the Achievement of Therapeutic Objectives Scale (ATOS). The ATOS is designed to assess patients’ attainment of specific treatment objectives identified as important change

mechanisms (McCullough et al., 2003), both in dynamic psychotherapy and in psychotherapy in general. Both the process measure (Insight) and the outcome measure (Sense of self) in the present study are assessed using the ATOS.

The present study seeks out to examine whether the proposed association between insight and therapeutic change also can be identified in the current sample of patients with cluster C PDs receiving STPD or CT over a series of forty sessions. If increase in insight is found in both STPD and CT and if it is associated with therapeutic change in both conditions, then this would further support the notion that insight operates as a common process mechanism or factor in both treatment modalities.

THEORETICAL AND EMPIRICAL BACKGROUND

Insight

The pursuit of insight is generally regarded as a defining feature of psychoanalytic- and dynamic therapies. The concept of insight makes its appearance in many different contexts and is given variety of different meanings in psychoanalytic- and dynamic literature. Although Sigmund Freud made almost no direct reference to the concept of insight, his thinking and beliefs about the human psyche surely paved the ground for later analytical writers. The psychoanalytic goal of bringing unconscious conflict to consciousness clearly can be related to the concept of insight and its importance as a central curative factor in psychoanalysis.

By the middle of the 20th century the focus on insight became more explicit. Patients' insight or awareness of psychological problems was believed to be an important indicative of the patients suitability for psychological treatment and expected prognosis (Messer et al., 2007). In later years, however, insight (and the improvement of it) has been viewed more as a "proof" of successful psychotherapy, and less as a precondition related to good prognosis. Thus, throughout the psychoanalytic and dynamic literature insight can be said to have been approached both as a means to an end and as an end in itself (Messer et al., 2007), i.e. both as the cause of change and as the result of change in and of itself.

The status of insight in cognitive-behavioral therapy still remains disputed, and it is typically not associated with behavioral - or cognitive - behavioral therapy. Early behaviorally oriented

scientists and researchers avoided the concept of insight due to beliefs that it involved unconscious processes (Cautela, 1993). Bandura (1969) viewed insight as a form of “social conversion” in which the patients learns and adopts the therapists’ point of view. Other writers, like Shoben (1960), recognized that insight might play a role in psychological recovery but merely as a consequence of more potent therapeutic interventions such as extinction and counter-conditioning. However, by the late 1960s, the introduction of a cognitive perspective in behavioral theory enabled a new and more accepting approach to the construct of insight (Grosse Holtforth, et al., 2007).

Despite its initial disclaim of insight, more and more cognitive-behavioral researchers now agree that insight can lead to therapeutic change. However, in order to fully adapt the construct into the cognitive-behavioral domain, insight needs to be defined in a way that makes sense within its own theoretical perspective. Grosse Holtforth et al. (2007) formulated insight as “newly acquired recognition or awareness of maladaptive cognitive schemas or maladaptive automatic thoughts” or simply as “the acquisition of new understanding” (p. 57). Hill, et al. (2007) defined insight as “a conscious meaning shift involving new connections” (p. 442). These redefinitions of insight made by cognitive-behavioral writers illustrate the transition the concept has made from its psychoanalytical origin. In the last few decades insight truly has become a therapeutic construct relevant within seemingly diverse theoretical orientations. Grosse Holtforth et al. (2007) point out the in order to fully make the transition into a theory neutral concept, insight have to be defined independently of what may facilitate it, and it should not be defined by terms related to any one theoretical orientation in particular. The terminology and descriptions used to define Insight¹ in the ATOS manual are formulated as theory neutral as possible (McCullough, Larsen, Schanche, Andrews, & Kuhn, 2008), enabling it to evaluate psychotherapies within a variety of different theoretical orientations.

Despite the central position of insight in clinical theory, the empirical research investigating its role in psychotherapy is surprisingly scares and often inconclusive (Johansson et al., 2010). There is some empirical evidence that insight do occur in CBT (Clarke, Rees & Hardy, 2004), but not to the same extent as in dynamically oriented therapy (Llewelyn, Elliott, Shapiro, Hardy, & Firth-Cozens, 1988). However, a study by Ablon et al. (1999) found no

¹ Insight is written with a capital letter (i.e. Insight) only when it refers to the ATOS factor.

significant differences in insight in CBT and interpersonal therapy, and that insight was related to outcome in both treatments. Connolly Gibbons et al. (2007) concluded after reviewing the empirical research on insight that there have been few studies measuring insight and how it is related therapeutic change, and the studies that have been conducted are typically characterized by its flawed methodology. Thus, any attempt to make sense of or to formulate some sort of direction based on the limited empirical work within this field is difficult and perhaps premature. In the Connolly Gibbons et al. (2007) review, of the eight studies that were included, only four of them found a positive relationship between insight and favorable outcome, whereas the remaining four did not. One of the studies in the Connolly Gibbons et al. (2007) review by Kivlighan et al. (2000) on patients without any specified diagnosis, showed a significant relationship ($r = .53, p < .5$) between insight and target complains. Kivlighan et al. (2000) also found that when patients were rated to have less insight in a session, they had more target complain distress the following session.

A study by Gallagher and Thompson (1982), not included in the Connolly Gibbons et al. (2007) review, found that brief insight-oriented psychotherapy can be effective in treatment of depression, with a substantial decrease in ratings of symptomatic distress at the end of treatment. Furthermore, studies on patients with schizophrenia have reported an association between reduced insight and increase in severity of reported positive symptoms, like delusions and hallucinations (e.g. Amador et al., 1994; Carroll, et al., 1999, ref. in Drake et al., 2004). In a cross-sectional study by Lam and Wong (1997), also not included in the Connolly Gibbons et al. (2007) review, on patients suffering from bipolar affective disorder, found that level of insight was correlated with patients' ability to cope with prodromes of mania. Insight was also found to have an impact on subjects' social functioning. Other studies, however, have been unable to identify any significant association between insight and treatment outcome (Gelso, Kivlighan, Wine, Jones, & Friedman, 1997; Diemer, Lobell, Vivino, & Hill, 1996). Gelso and colleagues (Gelso et al, 1997) evaluated the interaction of transference and insight in the prediction of outcome for clients receiving 12 session of counseling for personality problems. Neither intellectual nor emotional insight was found to be related to treatment outcome.

Perhaps one of the most important reasons for the seemingly random findings within this research field may be explained by the lack of a consensual definition of insight. However, in a recent effort to formulate a consensual definition, a group of leading researchers from

different theoretical orientations agreed on the following characteristics defining the construct of insight (Hill, et al., 2007). First of all, insight is (1) conscious and it involves both (2) new understanding and (3) the realization of past-present connections (p. 442). Hill et al. (2007) consensual definition of insight captures all of the main components defining Insight in the ATOS manual suggesting that its definition of Insight is coherent with recent developments made within the research field.

In sum, although there is a growing body of research lending support to the notion that insight is associated with therapeutic change, the existing data are ambiguous, and the knowledge about the relative importance of insight in different treatment modalities and diagnostic groups remains limited (Kallestad et al., 2010). The present study seeks to examine some of the fundamental questions still disputed within the field of insight research. For instance, how does insight relate to favorable therapeutic outcome? Does insight also “apply” in patients with complex mental problems such as PDs? Is the acquaintance of insight higher in patient groups given dynamically oriented therapies compared with other “non-dynamic” therapies? And furthermore, is the association between “therapeutically-induced” insight and therapeutic change stronger in dynamically oriented therapies compared with other forms of therapy? A recent meta-analysis by Connolly Gibbons et al. (2009) found this to be the case. Patient insight increased significantly more in the dynamic psychotherapies that implemented specific techniques to target understanding of interpersonal patterns than in cognitive therapies. Connolly Gibbons et al. (2007) also found that the changes in insight were significantly related to outcome. Given that the patient samples in this meta-analysis included a variety of different diagnostic groups, Connolly Gibson and colleagues pointed out the need for further research on important change mechanisms within specific treatments on more homogeneous samples, targeting specific disorders. As such, the results presented in the current study might be of relevance due to the specificity of treatment and relative heterogeneity of the diagnostic sample.

Common versus specific factors in therapy

It is well established that psychotherapy exercises a positive effect in reducing symptoms of mental disorders and promotes psychological health and well-being (Smith & Glass, 1977; Wampold, 2001; Lambert, 2004). Extensive research over the last decades have shown that most patients benefit from psychological treatment (70-80%) and about half (40-60%) will return to normal functioning (Lambert & Ogles, 2004). Still, some patients report little or no

significant change (15-20%) and some even deteriorate during the course of treatment (5-10%) (Lambert et al, 2004). This call for research on what factors make therapy effective across orientations.

Lambert et al. (1994) defined common factors as those elements or dimensions of treatment that are not specific to any one technique, and several researchers argue that it is the common factors that are the true change agents in any adoptive therapeutic process. Messer et al. (2002) states that the preponderance of evidence points to the widespread operation of common factors such as therapist-client alliance, therapist allegiance to the theoretical orientation, and other therapist effects in determining treatment outcome.

After reviewing a number of meta-analyses of psychotherapeutic outcome, Lambert et al. (1994) concluded that complete treatments have been shown to be superior to common factor controls, which in turn have been shown to be superior to no-treatment controls. The importance of the specific, therapeutic components in treatments has, however, been challenged by the failure to identify consistent differences between specific types of treatments modalities (Messer et al., 2002). However, in many of these studies the lack of homogeneity of the patient groups may explain why differences between treatment outcomes seem to be so random, and why many of them do not find significant differences at all. It may very well be that certain types of therapy in fact are more effective in treating certain groups of patients (e.g. affective disorders or certain types personality disorders), and that these differences in outcome disappear in the heterogeneity often seen in the samples (Winston, et al., 1994). The patient sample in the present study can be said to be relative heterogeneous, in that they all have been diagnosed with one or more of the cluster C PD(s). Differences between the two treatment groups, both on process measure (Insight) and outcome measure (Sense of self) could suggest that within this group of patients therapeutic change can be associated with specific therapeutic components. If insight, however, can be identified as a therapeutic factor associated with favorable outcome in both patient groups (i.e. both STPD and CT), then this may lend support to the notion that insight operates as a common process mechanism or factor across both treatment modalities, and that its association with therapeutic change is the same.

Personality disorders

PDs are defined as pervasive, inflexible and enduring patterns of inner experience and behavior that can lead to clinically significant distress or impairment in social, occupational or other areas of functioning (American Psychological Association, 1994, p. 630). The impact of PDs on the individual, family members, and society in general is considerable and has to be taken into account when assessment of PDs is made. Ruegg and Francis (1995) describe the vast and complex problems associated with PDs in the following manner:

PDs are associated with crime, substance abuse, disability, increased need for medical care, suicide attempts, self-injurious behavior, assaults, delayed recovery from Axis I and medical illness, institutionalization, underachievement, underemployment, family disruption, child abuse and neglect, homelessness, illegitimacy, poverty, STDs [sexually transmitted diseases], misdiagnosis and mistreatment of medical and psychiatric disorder, malpractice suits, medical and judicial recidivism, dissatisfaction with and disruption of psychiatric treatment settings, and dependency on public support. (pp. 16–17)

However, despite the severity and complexity of problems associated with PDs they have historically received less attention from researchers and clinicians than other psychiatric disorders such as depression and anxiety (Kernberg, Weiner, & Bardenstein, 2000). As such, the effectiveness of treatment on the various forms of PDs is relatively unexplored and historical beliefs on the poor prognosis of PD patients still remain.

In revisions made in the Diagnostic and Statistical Manual of Mental Disorder (DSM-IV, American Psychological Association, 1994), a set of general diagnostic criteria stating the chronic qualities of PDs were introduced. They are described as inflexible and pervasive patterns inner experience and behavior. This pessimistic view on PDs as chronic disorders resistant to change derived from early clinical research literature. In one review by Perry (1993) on 26 related studies, mainly on hospitalized patients, found that only a small number of patients suffering from PDs showed remission over a 15 year period. Such a pessimistic view holds the possibility of turning into a self-fulfilling prophecy where neither clinicians nor patients believe in change, and thus no change will happen (Arnevik, 2009).

Comorbidity

In the DSM-IV the PDs are organized on a separate axis from the symptom disorders (axis II, as opposed to axis I). The axis II diagnoses are thought to reflect more pervasive, underlying conditions, categorized in three different clusters, A through C (Ulvenes, 2008). Controversy concerning the organization of DSM-IV as a multi-axial diagnostic system still continues, and has to be taken into account when distinctions between the axes are made, both in research and in clinical practice in general. Are there in fact any qualitative differences between axis I and axis II disorders, or are these differences merely a matter of quantitative differences?

Many patients receive both axis I and axis II diagnoses. Research have shown that the degree of `axial-overlap` can range from 21-89% in outpatient population (Alnæs, & Torgersen, 1988), depending on type of disorder. Due to the high proportion of comorbidity in some patient groups, several researchers have argued that “matching” disorders from the opposing axis such as social phobia and avoidant personality disorder, obsessive-compulsive disorder and obsessive-compulsive personality disorder might share the same etiology, phenomenology, progress and treatment response (Rettew, 2000). In the present study 45 of the 48 patients was diagnosed with one or more axis I disorder(s), illustrating the large proportion of comorbidity often found within this patient group.

The original purpose of placing the PDs on a separate axis was to encourage the consideration of comorbid PDs in the context of more florid axis I disorders (American Psychiatric Association, 1980, p. 23). Several researchers have argued that a revision of the current classification of PD is overdue (Tyler, et al., 2007), and one can assume that revisions in the future are likely to be made. However, assessment of personality disorders, both in clinical research and in clinical practice, means accepting the classification of PDs as qualitatively different from the axis I symptom disorders. However, it does not mean that there might not be certain similar aspects or that there might not be an overlap of mechanisms and etiology between the two axes. More and more research suggests that there probably is (Rettew, 2000). In fact, the presence of “axial-overlap” between symptom disorders and PDs might explain why seemingly dissimilar disorders respond to the same treatment, again pointing to the importance of identifying common process mechanisms or factors, both across diagnoses and across different therapeutic orientations.

Characteristics of Cluster C Personality disorders

The cluster C PDs are the most prevalent cluster of PDs in the general population (1/10) as well as in outpatient clinic populations (>1/2) (Torgersen et al., 2001). However, quite few studies have been focusing on the psychotherapeutic efficacy and treatability of such disorders. One of the most important clinical implications of the high prevalence of cluster C PD, and for PDs in general, is the fact that it is related to poorer outcome in the treatment of axis I disorders (Hardy, et al., 1995). Moreover, underlying PDs is often overlooked and undiagnosed, leaving the maladaptive character structure untouched and untreated when patients are referred to treatment for more florid axis I disorders such as depression or anxiety. Consistent findings across a large number studies have found that standard brief treatments for axis I disorders often fail when axis II pathology also is present (e.g. Barber & Muenz, 1996; Markovitz, 2001). This calls for more research on effective, short-term treatment for patients suffering from PDs, and heighten awareness of the high prevalence of undiagnosed PDs in treatment of patients with symptom disorders.

Cluster C PDs are distinguished by the anxious and fearful behavior commonly seen in obsessive-compulsive PD (OCPD), avoidant PD (AvPD) and dependent PD (DPD). Cluster C PDs are generally viewed as less “dysfunctional”, and believed to be more treatable than cluster A and B (Eskedal et al., 2006). A study by Perry et al. (1999) found evidence suggesting a differential treatment effect both across the different clusters and between the different diagnoses within each of the three clusters. Patients with cluster B and C PDs responded significantly better to treatment compared with cluster A patients. These clustoral differences in treatability are in line with previous studies. Karterud, et al. (1992) found that patients with anxious or AvPD (cluster C) improved more than patients with borderline PD (cluster B), who in turn improved more than schizotypal PD patients (cluster A). Moreover, in all studies individuals with PDs did not improve to the same extent as those without PDs. These apparent differences in treatability between clusters C and cluster A and B may relate to the fact that individuals with cluster C PDs usually are more aware of their psychopathology (and it costs), generally have a desire to change and are more willing to undergo treatment (Eskedal et al.,2006).

PDs are explained from a combination of biological, psychological, and social factors (Sperry, 1995). Etiologically, biological predispositions like certain types of infant temperament styles have been found to be significantly related to development of cluster C

PDs later in life. There is for example some evidence suggesting that a timid infantile temperament may predispose the individual to avoidant patterns of behavior later in life (Eskedal et al., 2006). Further more, infants who exhibit fearful or withdrawing temperament style have been found to bear an increased risk of developing DPD, by eliciting overly protective relations from caretakers (Millon, & Davis, 2000). Moreover, the primary etiological factors of OCPD are believed to involve parental over-control, learned compulsive behavior, and focus on perfection (Sperry, 1995). The anxious and fearful patterns characteristic of these types of personality disorders typically severely impair their interpersonal functioning and are often associated with major axis I disorders, such as depression and/or anxiety. In this study 81% of the patients were diagnosed with current or previous episode(s) of major depression, while 73% was diagnosed with some sort of ongoing anxiety disorder.

Short-term psychotherapy in treatment of personality disorders

Short-term psychotherapy in its various forms has become a frequently used approach in psychotherapy. Most forms of short-term or brief psychotherapy, despite their apparent differences, have certain features in common. Besides brevity, there tends to be a specific focus for the therapy, the emphasis generally is placed on the “here-and-now”, the therapist typically plays a more active role, and frequently attention is devoted to coping with current problems (Garfield, 1997). Within psychotherapeutic outcome research, short-term treatments are typically defined as forty sessions or less. Although brief or short-term psychotherapy is quite different from traditional long-term psychotherapy, efficacy studies on short-term therapies have generally been positive. In a meta-analysis comparing the effectiveness of STPD and CBT on patients with PDs, Leichsenring and Leibing (2003) found an overall effect size of 1.46 for both treatment conditions. The effect size for CBT was 1.00, and 1.56 for STPD, providing evidence that both STPD and CBT are effective treatments of PDs.

Classical, long-term psychoanalytic/dynamic therapy have, however, traditionally been the “treatment of choice” for patients with complex mental disorders like PD(s), due to the belief that brief or short-term interventions would be insufficient in imposing adaptive personality reconstruction within the individual (Eskedal et al., 2001). However, it seems like important developments have been made. The current approach to treatment of patients with PDs are now more focused and structured, with the therapist taking a more active role in the therapy

process. Both forms of treatment in Svartbergs' et al. (2005) study can clearly be placed with in this new outlook on therapy.

Empirical literature on cluster C personality disorders

Despite the high prevalence, relatively few studies have been focusing on the efficacy of psychotherapeutic treatment on individuals diagnosed with cluster C PD(s). Most studies have been assessing PDs in general, and most of them do not meet the criteria of randomized, controlled trials.

A study by Barber et al. (1997) on patients with AvPD and OCPD found that both groups improved significantly on measures of PDs, anxiety, general functioning, and interpersonal problems as a result of the treatment (Supportive-expressive dynamic psychotherapy). In terms of differences between the groups, OCPD patients tended to have a faster decrease on symptom distress, and by the end of treatment only 15.4% of the OCPD patients met the criteria for diagnosis, while 38.5% of the AvPD patients retained their diagnosis. Based on these findings, Barber and colleagues points out that Supportive-expressive dynamic psychotherapy seems to be a relatively more effective treatment of OCPD patients, compared with AvPD patients. These findings are consistent with Barber et al. (1996) report the year before where interpersonal psychotherapy (IPT) yielded a better symptomatic improvement on patients with high levels of obsession and low levels of avoidance, while cognitive therapy was more effective for patients with opposite patterns.

In a comparative study by Hardy et al. (1995) on 27 patients with cluster C PD drawn from a larger sample of 114 patients with major depressive disorder given CT or IPT (Shapiro et al., 1994, ref. in Hardy et al., 1995), found that cluster C patients that received IPT continued to display significantly more severe symptoms compared with non-cluster C patients at the end of treatment. This difference was, however not found in the cluster C patients given CT.

Contrary to the findings in the study by Hardy et al (1995), Svartberg et al. (2005) found both STPD and CT to be effective in treatment of cluster C PD. In this study, based on randomized controlled trials, patients in both treatment conditions showed significant improvement on measures of symptom distress and interpersonal functioning at the end of treatment and this improvement continued to increase during the two-year follow-up period.

Sense of Self as a measure on outcome

Sense of self is a new psychological construct describing the individuals' degree of self-compassion and self-acceptance. In the ATOS manual self-compassion includes both self-care and self-worth, while self-acceptance captures the individuals' ability to acknowledge and accept one's own limitations and strengths in an adoptive and compassionate manner. Therefore, while sense of self can be said to be a new psychological construct it is built on already established psychological constructs.

Self-compassion involves the capacity to be touched by and open to one's own suffering, not avoiding or disconnecting from it, much in the same way that compassion in general involves being touched by the suffering of others in an emphatic and understanding manner. Despite the fact that research on the construct of self-compassion is scarce, there is good reason to believe that self-compassion promotes mental well-being. Neff (2003) proposed that individuals who are rated high on self-compassion should evidence greater psychological health than those with low self-compassion. Neff also suggested that self-compassion is likely to be associated with a variety of beneficial psychological outcomes, such as less depression, less anxiety, less neurotic perfectionism, and greater life satisfaction. Indeed, several studies have found self-compassion to be a powerful predictor of mental health. For instance, self-compassion has been found to be negatively associated with depression and anxiety, and positively associated with life satisfaction and social connectedness (Neff, Rude, & Kirkpatrick, 2007).

Self-acceptance, the second main component in Sense of self, involves the individuals' ability to acknowledge and accept one's own limitations and less favorable qualities in a realistic and adoptive manner. Ellis (1995) viewed the strengthening of an individual's self-acceptance as the cornerstone of psychological well-being. Studies that have examined the effect of unconditional self-acceptance on levels of psychological health have found that lower levels of unconditional self-acceptance were associated with higher levels of depression (Fleet et al., 2003, ref. in MacInnes, 2006), and on depression and anxiety both (Chamberlain, & Haaga, 2001). Given the personality traits characteristic of the cluster C PD(s), it is likely to assume that the mean levels of both self-compassion and self-acceptance are located on the "mal-adoptive" end of the scale, at least at the start of treatment, and that an increase in these self-concepts will be related to decrease in their maladaptive personality patterns, promoting favorable outcome. Moreover, given the earlier research findings on both self-compassion

and self-acceptance it reasonable to assume that Sense of self, as it is defined in the ATOS manual, relates to mental health and psychological well-being much in the same way. In order to evaluate the “validity” of Sense of self as a measure of therapeutic change and outcome, correlational analysis of Sense of self in relation to the standard outcome battery of self-report measures used in Svartberg et al. (2005) was included in analysis.

Hypotheses

The aim of the present study was to investigate the relationship between Insight and Sense of self in patients with cluster C PD(s) receiving STPD or CT.

I: Change in Sense of self will be significantly related to a change on standardized measures of outcome, such as symptom distress (SCL-90-R), interpersonal problems (IPP) and personality pathology (MCMI).

II: Change in Insight during treatment will be significantly associated to change in Sense of self.

III: Are there any significant differences in increase on Insight between the patient groups receiving short-term psychodynamic therapy and cognitive-behavioral therapy?

METHOD

Participants

With in the 5-year recruitment period, a total of 127 patients referred by two large psychiatric outpatient clinics, family doctors, and psychiatrists and psychologist in private practice were screened by an intake evaluator who was an experienced clinician and researcher. 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 PDs. All diagnostic evaluations were audio- or videotaped and were performed by the intake evaluator with the Structured Clinical Interview for DSM-III-R (SCID-II) (Spitzer et al., 1990, ref in Svartberg et al., 2005). A second diagnostician, an experienced clinical psychologist, reviewed a random sample of 20 SCID-II interviews. The combined agreement on the presence of one or more cluster C diagnoses and on the absence

of any other axis II disorder was 0.77 (Cohen's kappa). The patients who met the inclusion criteria and who did not meet the criteria for any cluster A or cluster B personality disorder returned within a week for a second diagnostic interview with the intake evaluator, who used the SCID-I interview to obtain DSM-III-R axis I diagnoses (Spitzer et al., 1990, ref in Svartberg et al., 2005). Additional exclusion criteria were current or past psychotic disorder, current substance dependence or abuse, current eating disorder, organic brain disorder and other serious physical illness, active suicidal behavior, refusal to have the therapy sessions videotaped, and refusal to discontinue other active treatment. A total of 51 patients were included. After completing a number of self-report questionnaires and undergoing a psychodynamically oriented evaluation interview by a second evaluator, 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 therapy, all patients completed treatment in accord with the preplanned schedule of 40 sessions. For more information see Svartberg et al. (2005)

Treatments and Therapists

In both treatments, sessions were 50 minutes long, videotaped, and held once per week. All therapists treated at least one patient as a training exercise before treating the patients who were enrolled in the study (Svartberg et al., 2005).

Short-term dynamic psychotherapy

McCullough Vaillant's short-term dynamic psychotherapy model (McCullough Vaillant, 1997) follows the fundamental structure of psychodynamic psychotherapy as outlined by Malan's triangle of conflict (i.e., defenses 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) (Svartberg et al., 2005). Specifically, the therapist 1) gently clarifies rather than confronts defenses, 2) empathizes with and exposes the underlying, conflicted affect, and 3) helps to regulate rather than to provoke anxiety. Three main treatment objectives represent the hypothesized change mechanisms: defense restructuring (recognizing and relinquishing defenses), affect restructuring (desensitization 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 (Svartberg et al., 2005).

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 (McCullough, 1997), 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. Each therapist treated an average of three patients (range=2–4). For more information see Svartberg et al (2005).

Cognitive therapy

Equipped with the cognitive model of personality disorders developed by Beck and Freeman (1990, ref. in Svartberg et al., 2005), 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, behavioral, and emotion-focused schema restructuring techniques to dispute core beliefs and to develop new and more adaptive beliefs and behaviors. Two main treatment objectives represent the hypothesized 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 behaviors (Svartberg et al, 2005).

The cognitive therapy therapist team consisted of six clinical psychologists. All but one 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 Beck-Freeman manual were closely monitored during the weekly supervision activities. Each therapist treated an average of four patients (range=1–5). For more information see Svartberg et al. (2005).

Treatment Integrity and Differentiability

Systematic checks on the integrity and differentiability of the two treatments were performed by two independent raters (with 2 and 4 years of clinical experience, respectively) using the Inventory of Therapeutic Strategies (Gaston et al., 1998, ref in Svartberg et al., 2005). The Inventory of Therapeutic Strategies rates therapists' interventions in terms of categories of intention (exploratory, supportive, or work enhancing), content, and object focus (e.g., therapist, others, self). Raters reviewed an entire early session (typically the sixth) and subsequently rated the frequency of Inventory of Therapeutic Strategies categories plus agenda setting and homework assignment. In analyses of data for categories that were rated reliably ($r > 0.65$; range=0.65–0.83, mean=0.73), two-tailed *t* tests showed that short-term dynamic psychotherapy and cognitive therapy differed in their emphasis on supportive strategies ($t=2.2$, $df=48$, $p < 0.02$; cognitive therapy had the stronger emphasis), work with defenses ($t=4.0$, $df=48$, $p < 0.001$; short-term dynamic psychotherapy had the stronger emphasis), transference work (i.e., therapist as focus) ($t=3.33$, $df=48$, $p=0.002$; short-term dynamic psychotherapy had the stronger emphasis), agenda setting ($t=9.9$, $df=48$, $p < 0.0001$; cognitive therapy had the stronger emphasis), and homework assignment ($t=5.6$, $df=48$, $p < 0.0001$; cognitive therapy had the stronger emphasis). As for work enhancing strategies, the emphases were equally strong in the two treatments ($t=0.03$, $df=48$, $p=0.50$). For more information see Svartberg, et al., (2005).

Measures

The main research tool for measuring both the process variable (i.e. Insight) and the outcome variable (i.e. Sense of self) used in the present study is the ATOS. The ATOS is a multi-dimensional rating procedure designed to measure specific patient behavior that indicate the degree to which the patient has absorbed or assimilated the therapeutic interventions

(McCullough et al, 2003). In contrast to psychotherapy process research that only focuses on type of intervention or the amount of therapy the patients has received, the ATOS measures the absorption or "receipt" of the therapeutic intervention that are given (McCullough, 2008).

Although the objectives rated by the ATOS derives from observation of STDP, the terminology and the descriptions used in the ATOS manual are as theory neutral as possible and the objectives overlaps with standard common factors in psychotherapy. ATOS can therefore be adapted to and used to evaluate psychotherapies within a variety of different theoretical orientations, not only STDP (e.g. Cognitive Behavioral Therapy (CBT), Interpersonal Therapy (IPT) and/or Dialectical Behavior Therapy (DBT)) (McCullough, et al., 2003).

The variables measured by the ATOS scale represent theory-derived, clinically relevant mechanisms. The ATOS contains of seven subscales that can be said to not only represent the main objectives of STDP, but common factors of psychotherapy in general. These subscales are; Insight, Motivation, Affect Experiencing, Affect Expression, Inhibition, Self Perception and Perception of Others. Each factor is scored on a scale from 1-100 scale, divided into ten-point levels, and the operational definitions are grounded in observable behaviors (i.e. expressed by the patient in session). The higher score the more adoptive behavior (e.g strong Insight into maladaptive patterns, or highly adoptive Sense of self in terms of self-acceptance and self-compassion) (McCullough, et al., 2003).

The ATOS scale is psychometrically strong (McCullough, 2008), showing moderate to excellent reliability in six reliability studies conducted in three countries (USA, Norway, and Italy) and excellent predictive validity (McCullough et al., 2003). ATOS has also demonstrated good construct validity and good discriminant validity (affect ratings = .7; Carley, 2006, ref. in Ulvenes, 2009). In terms of content validity (i.e. its ability to measure all facets of the seven different scales), the ATOS scale has been found to perform acceptable (Carley, 2007, ref. in Ulvenes, 2009). Reliability studies have also shown that raters can become reliable with relatively little training (8 to 21 hours of training) (Valen et al., 2008, ref in Ulvenes, 2009).

In addition, Global Severity Index (SCL-90-R), Inventory of Interpersonal Problems (IIP), and the Millon Clinical Multiaxial Inventory (MCMI) were included in the analysis to test the

correlational relationship between changes in Sense of self and changes in SCL-90-R, IIP, and MCMI during the treatment period.

Process measures

Insight measure patients level of understanding and/or awareness of his or her maladaptive patterns. The factors main components as it is formulated in the ATOS manual consists of: (1) Degree of clarity and fullness of verbal descriptions of maladaptive patterns of thoughts, feelings, and/or behaviors, exemplified by the patients. (2) Degree of ability to state why and how maladaptive/defensive patterns began and are maintained (i.e. their secondary gain, causes, and with whom).

Insight, within the STPD, involves the objective of defense recognition; that is to what extent the patient recognizes and/or understands his or her own patterns of defensive behavior or defensiveness. These maladaptive patterns of defensive behavior or defensiveness are thought to unable or block the expression of feelings (McCullough et. al, 2003). Within cognitive therapy, insight relates to how clearly the patients recognize his or her own maladaptive cognitive schemas or maladaptive automatic thoughts. Examples of category-scores on the insight scale follows:

21-30 Low recognition of maladaptive behavior patterns. Can acknowledge maladaptive patterns **only** when pointed out, but readily agrees when pointed out by therapist—with little elaboration. Lower level: Agrees without reluctance but does not elaborate further. Beginning awareness/insight.

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

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

Given the fact that the ATOS manual still remain in its developmental stages, there is not much ground research on the validity of the different subscales. In a correlational analysis, Kallestad et al. (2010) found that ATOS Insight showed adequate construct validity on four selected PQS items thought to be most related to insight. Nevertheless, the ATOS manual still remain in its early stages and feature change are likely to be made in order to enhance the scales validity.

Outcome measures

Therapeutic outcome can and have been defined in many different ways within the field of clinical research. Within the ATOS framework the two main factors that have indicated the strongest association to therapeutic outcome is New learning and Sense of self. While New learning involves the patients ability to appropriately express feeling, wishes and needs, Sense of self is designed to capture the patients self-perception – the degree of self-care, self-compassion, self-interest, and self-regard. In other words, how adaptive is the patients' view of self? The Sense of self factor captures the fundamental premise of psychological well being and the apparent objective in any therapeutic process.

The analysis in this study is based on the ratings of Sense of self at session six and thirty-six. The reason for choosing session six as the first measure and thirty-six as the final measure is based on the assumption that it will increase the stability of the measurement compared to the first and last sessions in the therapeutic process. Examples of category-scores on the Sense of Self scale follows:

21-30 Very maladaptive sense of self. Much shame in self. Little pride/some grandiosity. Almost no affirming of wants and needs. Minimal ability to acknowledge and accept limitations and minimal ability to control impulses. Minimal compassion and self acceptance of self regarding limitations. Much self-blame or shame.

41-50 Mixed maladaptive/adaptive view of self. Slightly more maladaptive than adaptive view of self. Slightly more shame than pride in self. Devaluation or grandiosity is slightly stronger than self-compassion or acceptance of limitations. Only moderately affirming of own wants and needs. Slightly more self-blame and shame than compassion for self.

61-70 Somewhat adaptive sense of self. Some pride in own strengths, and some affirming of own wants and needs. Some ability to acknowledge and accept limitations. Some compassion and self acceptance, but moderate self-blame or shame present.

Therapeutic change assessed by the *change scores method*

Changes on both the process variable (i.e. Insight) and the outcome variable (i.e. Sense of self, SCL-90-R, IIP and MCMI) was assessed using the *change score method*, subtracting score on session 6 or pre-treatment from score on session 36 or post-treatment respectively. A positive change score indicates increase in all of the target variables. In testing the first hypothesis on the association of change between Sense of self and SCL-90-R, IIP and MCMI, we analyzed the covariation using standard correlation. In the second hypothesis on the association between change on Insight and Sense of self using a hierarchical regression analysis.

RESULTS

The data was analyzed using the statistical program for the social sciences (SPSS), version 18.

Two of the patients from the original sample was excluded from the analyses because they did not meet the diagnostic criteria for any of the cluster C PD, but only the criteria for self-defeating PD.

Table I: Demographic and clinical characteristics of patients with cluster c personality disorders, receiving short-term dynamic psychotherapy and cognitive therapy

Characteristics	Patients who received Short-term Dynamic Psychotherapy (N=24)		Patients who received Cognitive Therapy (N=24)	
	Mean	SD	Mean	SD
Age (years)	32.6	9.4	33.5	7.3
	N	%	N	%
Gender (male)	11	46	14	58
Axis I diagnosis				
Major depression, current episode	7	29	12	50
Major depression, previous episode(s)	8	33	12	50
Dysthymia	6	25	2	8
Panic disorder	2	8	2	8
Agoraphobia	3	12	2	8
Social phobia	7	29	12	50
Generalized anxiety disorder	12	50	16	66
No diagnosis	2	8	1	4
Axis II diagnosis				
Avoidant PD	16	66	15	62
Obsessive-compulsive PD	8	33	9	37
Dependent PD	4	16	6	25
More than one PD	4	16	7	29

Preliminary analysis of patients' characteristics

Treatment groups did not differ significantly on any patient characteristics. Of the 48 patients submitted in present study, equal number of patients received one of the two types of therapy (N=24 in both STPD and CT). The mean age in the overall patient group was 33.0 (SD=8,37). On gender characteristic, 25 of the patients were men and 23 were female. In terms of diagnostic distribution, 60,4% (N=29) of the patients was diagnosed with AvPD, 35,4% (N=17) with OCPD, and 18,7% (N=9) with DPD. 23% (N=11) of the patients was diagnosed with more than one PD. No significant differences between groups in frequencies of pre-treatment axis II disorders were found. 81,2% (N=39) of the patients were diagnosed with current or previous episode(s) of major depression, while 73% (N=35) was diagnoses with some sort of ongoing anxiety disorder, including panic disorder, agoraphobia, social phobia, and generalized anxiety disorder. No significant differences between groups in frequencies of pre-treatment axis I disorders were found.

Overall changes

Table 1: Overall change; SCL-90, IIP, MCMI, Insight, Sense of self. Means and standard deviations (SD). Pairwise t-tests for change over time

	Pre therapy	Session 6	Session 36	Post therapy	<i>d</i>	Sig.
SCL-90(N=48)	1.20 (.65)			0.79 (.55)	.63	< .001**
IIP (N=48)	1.60 (.48)			1.26 (.55)	.68	.003**
MCMI (N=48)	210.8 (48.9)			189.5 (53.2)	.43	< .001**
Insight (N=45)		43.98 (13.11)	52.34 (15.63)		.63	.035*
Sense of Self (N=41)		35.28 (13.47)	47.73 (19.35)		.92	.046*

All changes are significant at a .05 level, and the direction of changes suggests symptom reduction and increase in mental well-being over time. Insight increased on average by 8.36 points ($p < .05$) between session 6 and 36, while Sense of self increased by 12.48 points ($p < .05$) between the same two sessions, an improvement by almost one standard deviation ($d = .92$).

Associations between Sense of Self and standardized outcome measures

Table 2: Correlation between the change in Sense of Self (session 6-36) and change in SCL-90, IPP and MCMI (pre-post treatment). *N* = 40 (*p*-value).

	Change SCL-90	Change IPP	Change MCMI
Change Sense of self	-.100 (.541)	-.095 (.559)	-.080 (.626)

The first a priori hypothesis predicted that increase in Sense of self would be significantly related to a decrease on symptom distress (SCL-90-R), interpersonal problems assessed by IIP, and psychopathology assessed by MCMI. This hypothesis was included in the analysis to evaluate the construct validity of the Sense of self scale as a measure on therapeutic change and treatment outcome. In the analysis we found that changes (increase) in Sense of self were associated with change (decrease) in symptom distress, interpersonal problems and psychopathology, but the correlations between them was not significant ($p > .05$) (see Table 2). These findings contradicts earlier research on related psychological constructs like self-compassion (Neff, 2003) and self-acceptance (Fleet et al., 2003, ref in Macinnes, 2006; Chamberlain and Haaga, 2001), and its negative associations related to symptom distress, maladaptive psychological functioning and psychopathology in general.

Association between Insight and Sense of self

The second hypothesis proposed that change in Insight during treatment would be significantly related to change in Sense of self. As shown in Table 1, the scores on both variables increased significantly over the course of treatment. The question in the second hypothesis relates to whether the two types of changes are significantly related to each other. Preliminary to this analysis, using an independent t-test revealed no significant differences in level of Insight at session 6 between the STPD and CT group, $t(45) = .10, p > .05$.

Table 3: Hierarchical linear regression. Dependent variable: change in Sense of Self

	Beta	R-square	R-square change	F-change	t
Block 1					
Change insight	.388	.151		6.754*	2.599*
Block 2					
Change insight	.358				2.527*
Sense of Self 6	-.335	.262	.111	6.568**	2.360*

* $p < 0.05$ ** $p < 0.01$

Using a hierarchal linear regression (table 3), where change in Insight was first entered as a predictor (Block 1), showed a significant positive association between increase in Insight and Sense of Self ($\beta = .356, p < .05$). The result indicate that the patients that gaining Insight into their maladaptive patterns also seem to express a more positive and adoptive Sense of self.

In block 2, the patients' *initial score* (i.e. score at session 6) on Sense of self was also entered in the model. This was done in order to examine whether the level of change in Sense of self

was dependent upon the patient's "preliminary level" of Sense of self. The significant and negative beta-coefficient for initial score on Sense of self suggest that the patients who had the lowest initial score on Sense of self increased the most on this factor during treatment. Interestingly, the association between change in Insight and change in Sense of self was relatively unaffected by entering initial score on Sense of self in the model. In sum, the results indicate that both Insight and Sense of self increased significantly during treatment, that patients that gain insight into their maladaptive patterns also seem to express a more positive and adoptive Sense of self, and that patients with the lowest initial score on Sense of self increased the most on this factor during treatment.

Differences between STPD and CT in gain on Insight?

The third and final hypothesis was formulated to examine if there were any significant differences in increase on Insight between the STPD and CT patient groups. The results showed that there was a significant main effect of insight over time [$F(1,43)=11.1, p=.002$], meaning that both groups increased their Insight over time. However, there was found no significant interaction effect between change in Insight and type of therapy [$F(1,43)=1.19, p=.282$]. The patients that were given STPD scored on average slightly higher on Insight (55.1) at the end of therapy compared with the CT patient (49.6), but this effect were not significant ($p >.05$).

The same analysis was repeated using Sense of self as the dependent variable. This gave the same conclusion as the above analysis; both groups increased on Sense of self throughout treatment [$F(1,39)=15.5, p <.001$], but no significant interaction effect between change in Sense of self and type of therapy, [$F(1, 39)=0.016, p=.899$] was found. The improvement on Sense of Self at the end of treatment were, on average, highly similar for both STDP (12.02, $d=.88$) and CT (12.82, $d=.94$) patients, both showing a large effect size.

Discussion

This current study has examined the relationship between patient Insight and outcome defined as change in the ATOS subscale Sense of self for patients with cluster C personality disorders receiving STPD or CT treatment over a series of forty sessions. The main findings in this study indicate that both patient group experienced significant increase in Sense of self at the end of therapy (session 36), compared with early in the therapy (session 6). In fact, patients with the lowest initial score on Sense of self improved the most, suggesting that the patients

suffering the most from maladaptive and devaluating self-perceptions also benefit the most from therapy. Moreover, the results indicate significant increase in Insight between the same two sessions for both patient groups. Using a hierarchical linear regression analysis on the overall patient group showed a significant positive association between increase in Insight and a more positive and adoptive Sense of Self ($\beta=.356, p < .05$). This result indicates that the patients that gain Insight into their maladaptive patterns also seem to express a more positive and adoptive Sense of Self. However, no significant interactional effect between change in Insight and type of therapy was found. Nor was there any significant interactional effect between change on Sense of Self and type of therapy. In fact, the improvements on Sense of self were highly similar in both treatment conditions.

The results presented in this study contradict the main findings made by Connolly Gibbons et al. (2009). Connolly Gibbons and colleagues found that patient insight changed significantly more in the dynamic psychotherapies that implemented specific techniques to target understanding of interpersonal patterns than in cognitive therapies. Although the increase on Insight in the current study was found to be higher in the STPD condition compared with the patients receiving CT, the differences between them were far from significant. The lack of significant interactional effect between changes on Insight and type of therapy are, however, in line with earlier findings by Ablon et al (1999) who found no significant differences in insight in CBT and interpersonal therapy, and that insight was correlated with outcome in both treatments.

Given that insight has been proposed as a common factor in psychotherapy, the lack of significant differences between the two groups on the improvement of Sense of self, may be partly explained (and may even have been predicted) by the lack of significant differences on improvement in Insight between the two treatment conditions. That is, it may be that the similarity in improvements on Sense of self found in the two treatment conditions may be explained by the similarity in improvements found on Insight. If this was to be the case, the findings presented in this study could suggest that insight operates as a common factor associated with therapeutic change across both STPD and CT, much in the same way that similarity in Insight and dissimilarity in Sense of self would be contradictory of the common factor hypothesis. However, the analysis conducted in this study is correlational, and cannot be applied in making any valid causal conclusions.

In sum, patient level of Insight increased significantly throughout the treatment process in both STPD and CT patient groups. Furthermore, there was a significant positive association between the increase on Insight and treatment outcome, defined as change on Sense of self. However, identifying the specific therapeutic interventions that facilitated patient Insight can not be done based on the current data material. What we do know, however, is that therapist actions throughout these sessions increased patient awareness of maladaptive patterns of thoughts, feelings, and/or behaviors. They also improved their ability to state why and how maladaptive or defensive patterns began and how they are being maintained. In fact, the overall level of Sense of self increased by almost one standard deviation ($d=.92$), suggesting a large effect size. However, it is reasonable to assume that patients in the two treatment conditions have acquired qualitatively different types of insight or explanations of their problems. If this is true, given the similarity in outcome, it may be that the "objective truth" of this insight is not as important as whether the explanation acquired makes sense to the patient. That is, insight, and its association with therapeutic change, may not be defined by what causes it (i.e. the specific therapeutic interventions), but by the increase in patients' self-understanding, in and of it self. This approach to insight is in line with Holforth et al. (2007) who stated that in order to fully make the transition into a theory neutral concept, insight have to be defined independently of what may facilitate it, and it should not be defined by terms related to any one theoretical orientation in particular. Within this approach to insight, the construct has been proposed as a common factor in psychotherapy, in that is hypothesized to represent one of the core processes mechanisms believed to underlie seemingly diverse psychotherapeutic orientations and theoretical approaches. Despite the obvious limitations in the current study concerning both the limited number of therapeutic approaches included (i.e. STPD and CT) and the limitations in the diagnostic sample (i.e. Cluster C PD), the results in this study may lend further support to the notion that insight operates as a common factor associated with therapeutic change in seemingly diverse therapeutic approaches.

Testing the construct validity of the Sense of Self as a measure on therapeutic change and treatment outcome, we found that although changes (increase) on Sense of self were associated with change (decrease) in symptom distress, interpersonal problems and psychopathology, the correlations between them was not significant ($p. >.05$) (see Table 2). These findings contradicts earlier research on related psychological constructs like self-compassion (Neff, 2003) and self-acceptance (Fleet et al., 2003, ref. in Macinnes, 2006; Chamberlain and Haaga, 2001), and its negative associations related to symptom distress,

maladaptive psychological functioning and psychopathology in general. However, these findings may suggest that even though both groups of variables (i.e. increase in Sense of self and decrease in symptom distress, interpersonal problems and psychopathology) clearly are associated with favorable outcome they measure qualitatively different aspects of adaptive therapeutic change. The lack of significance may also be due to the fact that the two variables were measured at different times in the treatment. While Sense of self was measured at session 6 and 36, the SCL-90-R, IPP and MCMI were measured before and after treatment. It is reasonable to assume that the time difference between the measures weakens correlational strength between Sense of Self and SCL-90-R, IIP, and MCMI. Moreover, the analysis testing the construct validity of Sense of self as a measure of therapeutic change is based on change scores. Using change scores provides a relatively easy method of assessing individual changes over time. It also makes it possible to test whether change on one variable covariates with change on another variable. However, the primary disadvantage in using change scores relates to the possibility of poor reliability because the reliability of the change scores depends on the reliability of each of the measures (i.e. T1, T2), and the strength of the correlations between them (i.e. the stronger the correlation is between T1 and T2, the more unreliable the change score turn out) (Lund, 2001). The consequence of poor reliability (i.e. high presence of random measurement error) relates to the possibility that relationship between sets of variable change score is underestimated. It is therefore reasonable to assume that relationship between changes on Sense of self and change on SCL-90-R, IIP and MCMI would have been stronger if we had more reliable change scores. More research have to be carried out in order to examine the true relationship between Sense of self and more standardized measures of outcome, such as SCL-90, IIP and MCMI.

“Failure” to identify differences in outcome related to theory specific therapeutic interventions has been the general conclusion made from psychotherapeutic research (Smith and Glass, 1977; Wampold, 2001; Lambert, 2004). The search for factors that are shared across therapies, as opposed to the factors that separate one from the other might be the preferred manner in which psychotherapeutic research should be conducted in the future. Patient insight has been proposed as one of the factors common across the different theoretical approaches to therapy. The results presented in the current study may lend support to the importance of insight in both STPD and CT, and the association between insight and therapeutic change.

Limitations

There are several possible limitations in the present study. First of all, the analysis made in this study is correlational, and any conclusions on the causal relationship between the variables are not possible. Second, the patient group in this study can be said to be relatively homogenous in terms of the diagnostic criteria (cluster C), which can limit the external validity of the results. However, as discussed earlier, several researchers argue that gaining insight through psychotherapy facilitates positive outcome on both axis I and axis II disorders (Ablon et al., 1999; Kivlighan et al., 2000; Amador et al., 1994; Dickerson et al., 1997; Carroll et al., 1999, ref. in Drake et al., 2004; Lam & Wong, 1997). Third, the treatments in this study were manualized and monitored by independent raters, which may limit generalizability of the results to everyday clinical practice where treatments typically are more individually tailored. This may limit its ecological validity if the treatment conditions in this study differ in important aspects from what takes place in more naturalistic therapy settings.

Forth, both process and outcome measures was scores by raters watching videotape of the sessions and not by patients them self. This can be viewed as problematic in some respects, in that observer ratings can differ from self-reports. However, in general self-report and observer-rated measures have shown high degree of reliability, especially within short-term treatment conditions (Perry et al., 1999). Fifth, research on the reliability and the validity of the ATOS is limited. However, the few studies that have been conducted suggest moderate to strong reliability (McCullough, 2008). Adequate construct validity on the ATOS subscale Insight on selected PQS items have also been identified (Kallestad et al., 2010). Nevertheless, the ATOS manual still remain in its early stages and feature change are likely to be made.

Sixth, measures on both Sense of self and Insight were attained at session 6 and 36.

Therefore, there might be substantial changes in both variables both before session 6 and after session 36 undetected in the current analysis. Because the level of pre-treatment Insight have not been scored, it is not possible to assess the extent to which change in Insight throughout the first five sessions predicted outcome. This might limit the conclusions made about insight gained during treatment (Kallestad, et al., 2010). Given that these are short-term treatments, this may be a particular important limitation because both treatments focus on the identification of maladaptive patterns and increase in self-understanding already in the early stages of therapy. However, the reason for choosing session six as the first measure and

thirty-six as the final measure is based on the assumption that it will increase the stability of the measurement compared to the first and last sessions in the therapeutic process.

Seventh, raters were given limited training, suggesting that the reliability of the ATOS scores may be questioned. Furthermore, although the raters did not know which treatment modality they were scoring (i.e. STPD or CT), it is reasonable to assume that they in fact knew. This could potentially bias their scores, in that raters may have preferred one treatment approach over the other. And eighth, the relative small sample size and insufficient power to detect differences may explain the lack of differences found in the present study.

Implications

The current study provides further support to the efficacy of short-term psychotherapy in treatment of complex mental problems such as PDs. Within a healthcare system bound by limited resources this may have important implications. Traditional beliefs concerning brief or short-term interventions as insufficient in imposing adaptive and long-lasting personality reconstruction in individuals with PDs are challenged by the findings presented, giving hope that more people suffering from these kinds of mental disorders can be helped in the future.

Conclusion and future direction

This current study has examined the relationship between patient insight and outcome defined as change in the ATOS subscale Sense of self for patients with cluster C PDs receiving STPD or CT over a series of forty therapy sessions. In sum, patient level of Insight increased significantly throughout the treatment process in both STPD and CT patient groups.

Furthermore, there was a significant positive association between this increase in Insight and treatment outcome, defined as change in Sense of self. Despite the obvious limitations in the current study concerning both the limited number of therapeutic approaches included (i.e. STPD and CT) and the limitations in the diagnostic sample (i.e. Cluster C PD), the results lend support to the notion that insight operates as a common process mechanism or factor associated with favorable outcome in seemingly diverse therapeutic processes.

The lack of any significant differences both on process measures (i.e. Insight) and outcome measures (i.e. Sense of self) between the STPD and CT condition, may provide a new perspective in future comparative research. The more we deconstruct the treatment objective and interventions defining and separating the different theoretical and clinical approaches in

psychotherapy, the more clearly we can identify the underlying, curative mechanisms associated with therapeutic change. The common factor shared in all forms of therapy is some sort of change, e.g. decrease in symptom distress and/or the promotion of psychological health and well-being. However, in order to identify the underlying, curative mechanisms' of therapeutic change one have to examine the causes of these changes striped of any theoretical term align to any one particular theoretical or clinical orientation.

Insight have been long been proposed to be associated with favorable outcome in dynamic therapy, and the concept of insight has in many ways “belonged” to the psychoanalytic and dynamic “community”. Research findings suggesting insight to occur only in psychodynamic therapy (or at least significantly more so) have continually reinforced the gap to other treatment modalities such as CBT and CT. However, important developments have been made, approaching and defining the construct of insight without any theoretical, causal descriptions. Wampold, Imel, Bhati, & Johnson-Jennings (2007) formulated the new approach to insight in the following manner;

We propose that insight involves obtaining a functional understanding of one's problem, complaint, or disorder through the process of psychotherapy and that insight is a beneficial common factor present in and critical to all psychotherapeutic orientations (pp. 119).

More research on the role of insight as a possible curative factor in psychotherapy is needed. Replications of the findings presented in this study may help further clarify the role of insight in STPD and CT on patients with cluster C PDs. Furthermore, it would be of interest to investigate whether the findings presented here also apply to other treatment modalities and other diagnostic samples.

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