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Improving self-esteem through integrative group therapy for personality dysfunction: Investigating the role of the therapeutic alliance and quality of object relations

Katie Aafjes-van Doorn[1] | David Kealy[2] | Johannes C. Ehrenthal[3] | John S. Ogrodniczuk[2] | Anthony S. Joyce[4] | Rainer Weber[5]

[1]Ferkauf Graduate School of Psychology, Yeshiva University, New York, NY

[2]Department of Psychiatry, University of British Columbia, Vancouver, Canada

[3]Institute of Medical Psychology, Heidelberg University, Heidelberg, Germany

[4]Department of Psychiatry, University of Alberta, Edmonton, Canada

[5]Clinic for Psychosomatics and Psychotherapy, University of Cologne, Cologne, Germany

Correspondence
Katie Aafjes-van Doorn, Ferkauf Graduate School of Psychology, Yeshiva University, Rousseau Building, 1165 Morris Park Avenue, Bronx, New York, NY 10461.
Email: katie.aafjes@yu.edu

Abstract

Objective: We aimed to investigate change in self-esteem through intensive group treatment for personality dysfunction, by exploring: (a) the relationship between patients' experience of therapeutic alliance and improvement in self-esteem during treatment, including patients' quality of object-relations (QOR) as a possible moderator; and (b) the association between improvement in self-esteem during treatment, and depressive symptoms 9 months later.

Method: Eighty patients with personality dysfunction, consecutively enrolled in a group-oriented treatment program, were assessed at pretreatment, posttreatment, and 9 months follow-up.

Results: Especially for patients with lower QOR, alliance predicted self-esteem change during treatment. In addition, change in self-esteem during treatment predicted follow-up depression severity, even when controlling for within-treatment symptom change.

Conclusions: Patients with impoverished inner relational representations may benefit more from a secure alliance in terms of improving their self-esteem. Change in self-esteem may also be important in preventing relapse of depressive symptoms in people with personality dysfunction.

KEYWORDS
alliance, group treatment, object-relations, personality dysfunction, self-esteem

1 | INTRODUCTION

The concept of self-esteem captures what we feel about ourselves (Tesser, 2000) and has been defined as feeling satisfied with oneself and one's abilities (Rosenberg, 1965). In other words, self-esteem reflects one's subjective sense of value as a person (Orth & Robins, 2014). Self-esteem greatly impacts individuals' attitudes, emotional experiences, future behavior, and long-term psychological adjustment (Judge, Erez, & Bono, 1998; McGee, Williams, & Nada-Raja, 2001; Rugel, 1995). High self-esteem refers to both cognitive and affective aspects of a generally favorable evaluation of the self, and has a strong relation to happiness, whereas low self-esteem refers to an unfavorable definition of the self, whether accurate or not (Baumeister, Campbell, Krueger, & Vohs, 2003; Rosenberg, 1965), and is more likely associated with psychopathology, including depression (Roberts & Kendler, 1999; Roberts & Monroe, 1994) and interpersonal problems (Baumeister et al., 2003; Dinger, Ehrenthal, Nikendei, & Schauenburg, 2017; Rugel, 1995).

Patients with personality dysfunction are particularly vulnerable to low self-esteem, which may exacerbate other problems—such as interpersonal and social functioning—and impede overall recovery (Ichikawa, & Mochizuki, 2014). As a function of impaired self-definition (Luyten & Blatt, 2013), diminished self-esteem among this population may represent an aspect of compromised identity—a core feature of disordered personality (Ehrenthal & Benecke, 2019; Zimmermann et al., 2012). In this way, problematic self-esteem may be a primary, defining a feature of personality dysfunction, on a continuum of severity and impairment. However, given the difficulties in interpersonal and social functioning often experienced by individuals with personality dysfunction (Williams & Simms, 2016), diminished self-esteem may also reflect cognitive-affective appraisals of the self that are secondary to these problems. Thus, patients may experience a reduced sense of worth secondary to disappointments or failures in social relationships and occupational pursuits. Moreover, primary self-esteem distortions likely compound appraisals of these difficulties, making it harder for individuals with personality dysfunction to escape cycles of negative self-perceptions.

These appraisals of the self—manifest as low self-esteem—may, in turn, contribute to depressive symptoms, maladaptive defenses, and avoidant or compensatory behaviors. Research has shown, for example, that low self-esteem is a vulnerability factor for depression (Orth, Robins, Meier, & Conger, 2016), predicts externalizing behaviors (Donnellan, Trzesniewski, Robins, Moffitt, & Caspi, 2005; Wissink, Deković, Yağmur, Stams, & de Haan, 2008), and motivates avoidance (Heimpel, Elliot, & Wood, 2006). In this way, poor self-esteem in the context of personality dysfunction could be part of a vicious cycle that maintains symptoms of distress and holds individuals back from pursuing adaptive life goals. Thus, patients with personality dysfunction may have much to gain from treatment that addresses self-esteem difficulties and restores more adaptive self-appraisals.

When individuals are locked in pathological patterns of functioning with entrenched negative views of self, as is the case with personality dysfunction, change in self-esteem can be an important objective across psychotherapies (Cummings, Hayes, Cardaciotto, & Newman, 2012). Cognitive therapies, for example, try to challenge and change the beliefs that underlie negative self-evaluations (Beck, Rush, Shaw, & Emery, 1979; Scott, 2001), and psychodynamic therapies typically focus on interpersonal contexts and improving insight regarding the development and meaning of low self-esteem (e.g., Busch, Rudden, & Shapiro, 2004; Luborsky et al., 1995). Treatments for personality dysfunction often integrate components of these and other therapeutic approaches to maximize various mechanisms of action within a heterogeneous patient population (Clarkin, Cain, & Livesley, 2015; Kvarstein, Nordviste, Dragland, & Wilberg, 2017). Some research suggests that patients with personality dysfunction can achieve improved self-esteem through integrative therapies. In a comparative study of inpatient

treatment for patients with a borderline personality disorder, Roepke et al. (2011) found that dialectical behavior therapy contributed to significant improvement in aspects of self-esteem compared with a waiting-list control. In a randomized COMET trial of a group therapy involving behavioral and imaginal techniques, patients who received this treatment in addition to their regular therapy achieved significant improvement in self-esteem compared to those assigned to their regular therapy only (Jacob et al., 2010). In addition to their integrative nature, it is thought that the group format of these treatments for personality dysfunction, whereby the patient receives support, validation, and feedback from other patients, may contribute to strengthened self-esteem. Such findings pave the way for further research regarding changes in self-esteem in psychotherapy for personality dysfunction. A particular gap in knowledge concerns the relation between within-therapy treatment process and improvement in self-esteem over the course of therapy.

Given the accumulation of empirical support for the therapeutic alliance as an important factor in contributing to symptom improvement (e.g., Falkenström, Granström, & Holmqvist, 2014; Flückiger, Del, Wampold & Horvath, 2018), it is possible that patients' experiences of a positive alliance could be involved in the modification of self-esteem through psychotherapy. Indeed, as a reflection of the patient's feelings about the therapeutic relationship, the alliance may be particularly implicated in self-esteem change. Patients who feel secure in their relationship with the therapist may feel emboldened to engage in affectively-charged exploratory work in therapy that allows them to challenge their self-appraisals and reconsider their sense of self (Ronningstam, 2017). Alternatively, the alliance may reflect the patient's sense of a novel positive experience with the therapist, implicitly contributing to greater feelings of self-worth. This accords with the notion of therapy offering the patient a "corrective relational experience," defined as a novel, affectively-charged experience of a treatment relationship that counters expectations of self-other interactions (Huang, Hill, Strauss, Heyman, & Hussain, 2016).

The alliance, however, does not necessarily function in the same way for all patients (Zilcha-Mano, Muran et al., 2016). Patient characteristics may be important moderating factors of the relation between alliance and outcome. The patient's quality of object relations (QOR) is one such characteristic that may affect the alliance and its impact on therapy outcome (Høglend et al., 2011). QOR can be defined as the quality of an individual's representations of self and others, and their associated affect, which in turn contribute to relatively stable patterns of interpersonal functioning (Huprich & Greenberg, 2003). QOR is conceptualized as a continuum that spans from primitive to mature functioning. The patient's QOR has been examined as a predictor or moderator of treatment response in a variety of studies (e.g., Dirkx & Zevalkink, 2016; Lindfors, Knekt, & Virtala, 2013) and seems to offer better utility than conventional diagnostic categories in predicting outcome (e.g., Høglend et al., 2008). Object relations theory posits that QOR may moderate the effect of the alliance, because early internalized relationships influence how the individual will experience a subsequent relationship with the therapist. For example, low QOR, a hallmark feature of various personality disorders, tends to reflect hypersensitivity to perceived rejections and deflated self-image upon separation from objects (Piper & Duncan, 1999). Low-QOR patients might thus struggle with translating the positive therapeutic relationship into a therapeutic gain (as suggested by Connolly et al., 1999). Indeed, low QOR has been shown to challenge the formation and maintenance of a positive working alliance (Karpiak & Benjamin, 2004; Muran, Segal, Samstag, & Crawford, 1994), and outcome in short-term individual therapy (Piper & Duncan, 1999; Piper, Ogrodniczuk, & Joyce, 2004).

2 | AIMS

The present study was aimed at further investigating the change in self-esteem through intensive, integrative group treatment for personality dysfunction. The main objective was to explore the relationship between patients' experiences of the therapeutic alliance and improvement in self-esteem during treatment—in terms of whether the alliance is associated with self-esteem change—and whether patients' QOR would exert a moderating effect on this relationship in intensive, integrative group psychotherapy. In other words, the study sought to examine whether

the alliance had a differential impact on changes in self-esteem depending on patients' level of QOR. We hypothesized that the QOR of patients with personality dysfunction would function as a moderator of their experience or use of the alliance in integrative and intensive group psychotherapy. Since high QOR tends to reflect better overall functioning, we hypothesized that high QOR would facilitate patients' obtaining greater benefit—with regard to change in self-esteem—from a positive alliance in the group. While the relation between self-esteem and depression is important, for the first research question we sought to disentangle these constructs to examine the change in self-esteem beyond depressive symptom change. Thus, in testing this hypothesis we aimed to control for the change in depressive symptoms during treatment.

A secondary objective was to explore whether improvement in self-esteem during treatment—disentangled from improvement in depressive symptoms—would be associated with long-term outcome in other aspects of psychopathology, such as depressive symptoms, 9 months following treatment. In a recent study, improvement in self-esteem during intensive multimodal psychotherapy treatment for depression predicted lower levels of depression 6 months after termination (Dinger et al., 2017). Based on these findings, we hypothesized that improved self-esteem in treatment would predict better depression outcomes at follow-up. In other words, we expected that positive changes in self-esteem would contribute uniquely to later depression recovery. If a similar result *of self-esteem change and later depressive symptoms* were found among patients with personality dysfunction, it would further indicate the importance of addressing self-esteem in *intensive treatment for this population.*

3 | METHOD

3.1 | Participants and setting

Participants were 80 consecutively admitted patients who completed treatment in the Evening Treatment Program (ETP) of the Department of Psychiatry at the University of Alberta Hospital in Edmonton, Canada. The ETP is an intensive outpatient group therapy program aimed at facilitating improved well-being and social functioning for individuals with personality dysfunction. The ETP provides intensive treatment in a manner that allows preservation of important daytime activities such as employment or childcare. Primary admission criteria are (a) the presence of significant personality dysfunction (i.e., significant traits of personality disorder or meeting full criteria for a diagnosis of personality disorder); (b) engagement in a meaningful daily activity, such as employment, education, parenting, or volunteering; (c) a capacity for group participation; and (d) a minimum age of 18 years. Exclusion criteria include active psychosis (e.g., schizophrenia), organic mental disorder, acute suicidality, active substance abuse in need of primary attention, significant intellectual impairment, or active treatment at another mental health service. Inclusion and exclusion criteria are evaluated in clinical intake interviews by program staff. The data were collected in accordance with the principles outlined in the Declaration of Helsinki and the American Psychological Association standard ethical guidelines. Institutional research ethics approval was obtained for the study, and patients who took part provided written informed consent before participation.

Of the 80 participants, most were female (70%; $n = 56$) and Caucasian (95%; $n = 76$), with an average age of 37.6 ± 10 years. Forty-four percent ($n = 35$) were living with a partner. Most participants (69%; $n = 55$) reported having obtained some form of postsecondary education. Seventy-three percent ($n = 58$) were employed at the time of admission to the ETP. As criteria for admission to the ETP, all patients suffered clinically significant personality dysfunction, with 65% ($n = 52$) meeting criteria for at least one personality disorder. Thirty percent ($n = 24$) fulfilled criteria for two or more personality disorders—the most common being avoidant (36%; $n = 29$), obsessive-compulsive (25%; $n = 20$), borderline (24%; $n = 19$), and paranoid (10%; $n = 8$) personality disorders. Nearly all patients (94%; $n = 75$) met criteria for at least one Axis I diagnosis, including major depressive disorder (49%; $n = 39$), obsessive-compulsive disorder (49%; $n = 39$), agoraphobia or other specific phobia (45%; $n = 36$), bipolar disorder (33%; $n = 26$), and social phobia (30%; $n = 24$). Nearly all patients (91%; $n = 73$) had received some form of psychiatric treatment in the past. A subsample of $n = 43$ patients completed follow-up assessments between 7 and

12 months (average of 9 months) after therapy completion. Patients who provided follow-up data did not differ significantly in terms of personality disorder diagnosis, QOR, or self-esteem at baseline.

3.2 | Treatment

Treatment in the ETP is exclusively group-oriented, involving various groups through which patients progress, attending five evenings per week, 4 hours per evening, over an 18-week period. Patients enter the program on a rolling admission basis, with one or two patients beginning each week and a similar number being discharged each week; there are typically 25 patients in the program at any given time. Treatment is delivered in a modular integrative approach that targets various aspects of personality dysfunction (Clarkin et al., 2015; Livesley, Dimaggio, & Clarkin, 2016) using a staged sequence of group treatment experiences (Piper, Rosie, Joyce, & Azim, 1996). This integrative approach allows for multiple areas of clinical focus, including symptom management, insight, and the development of emotional and interpersonal abilities. Thus, skill development and social rehabilitation modules are integrated with insight-oriented therapeutic group work under an overall psychodynamic-relational theoretical orientation. Three six-week "phases" progressively address (a) therapeutic skill acquisition, as in the management of symptoms and emotion regulation; (b) focused therapeutic work, as in the exploration of conflicts around intimacy and dependency; and (c) consolidation of gains and therapeutic termination. Each evening begins with a large psychodynamic group (attended by all patients) that uses an interpretive focus to address here-and-now issues among the patients, program-related concerns, and residual material from previous sessions. This is followed by a series of groups involving insight-oriented psychotherapy and rehabilitative and skills-oriented groups, using interventions from the cognitive-behavioral and interpersonal orientations, as well as art, vocational, and physical exercise group interventions. Although patients' personal treatment goals are emphasized (Kealy, Joyce, Weber, Ehrenthal, & Ogrodniczuk, 2018), no individual treatment is provided. Patients participate in one small psychodynamic group throughout their tenure in the program while rotating through all other groups. This group serves as patients' "home group" in which their therapeutic progress is discussed in the context of the various program components, and in relation to their intra- and interpersonal dynamics. The interdisciplinary treatment team (a psychiatrist and five therapists from the disciplines of occupational therapy, psychology, and psychiatric nursing) regularly communicate about patients' progress to ensure coordinated treatment.

3.3 | Measures

3.3.1 | Self-esteem

Self-esteem was assessed at pretreatment and posttreatment using the Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965). The RSES is a 10-item scale for assessing levels of self-esteem (Rosenberg, 1965), and after five decades remains the most widely used measure of self-esteem. RSES items, such as "All in all, I am inclined to feel that I am a failure" or "I am able to do things as well as most other people," are rated with responses ranging from strongly agree to strongly disagree; a Guttman scoring procedure provides a unidimensional score that reflects one's overall view of the self. Given our interest in poor self-esteem as a reflection of the pathological sense of self, higher RSES scores indicate lower self-esteem in the present study. The RSES has shown to have good internal consistency (Alessandri, Vecchione, Eisenberg, & Łaguna, 2015), predictive validity (Kaplan, 1980), and equivalence over time (Marsh, Scalas, & Nagengast, 2010).

3.3.2 | Depressive symptoms

Depressive symptoms were assessed at pre- and posttreatment, and at one-year follow-up, using the Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996), a 21-item self-report measure of depressive symptom severity, addressing symptoms such as depressed mood, hopelessness, suicidal ideation, sleep disturbance, and

appetite change. The BDI-II is commonly used in psychiatric outpatient services and has excellent internal consistency (Cronbach's alpha = .92). It also has well-established content validity and is good at differentiating between depressed and nondepressed individuals (Beck et al., 1996; Richter, Werner, Heerlein, Kraus, & Sauer, 1998).

3.3.3 | Therapeutic alliance

The therapeutic alliance, referring to the working relationship between patient and therapist, was assessed using a measure of the alliance previously used in group therapy studies, and well-suited to the ETP due to its brevity and ease of administration (Edmonton Therapeutic Alliance Scale; Joyce, Piper, & Ogrodniczuk, 2007; Piper, Ogrodniczuk, Lamarche, Hilscher, & Joyce, 2005). This measure consists of four items by which the patient rates the degree to which he or she (a) was able to talk about private important material, (b) felt understood by the therapist, (c) understood and worked with what the therapist said, and (d) felt the session enhanced understanding. A six-point Likert-type scale was used, ranging from 1 (very little) to 6 (very much). The internal consistency of this measure has been found to be high (Cronbach's alpha of .91; Joyce et al., 2007). Patients' alliance ratings were provided at Week 5 of the program, reflecting their experience of the therapeutic alliance through approximately the first third of treatment, and in reference to their "home group" (small psychodynamic group including its therapist), which we regarded as a proxy for perceptions of the program as a whole.

3.3.4 | Quality of object relations

The Quality of Object Relations Scale (QORS; Azim, Piper, Segal, Nixon, & Duncan, 1991), an interview-based instrument, provides for the assessment of an individual's patterns of establishing and maintaining relationships, through childhood, adolescence, and adulthood. Such patterns are presumed to reflect enduring inner psychological representations of self-other relations. The QORS involves a manual-guided (Piper, McCallum, & Joyce, 1993), semistructured interview conducted by trained clinicians. The interviewer considers behavioral manifestations, affect regulation, self-esteem regulation, and historical antecedents in the assessment of QOR. Behavioral manifestations include descriptions of typical relationship patterns as well as observed interactions within the QORS interview. The interviewer considers the following five levels of object relations: (a) primitive, involving intense reactivity to separation and/or inordinate dependence on others for a sense of identity; (b) searching, indicating a tendency for short-lived optimism followed by disillusionment in relationships as substitutes for earlier objects; (c) controlling, involving ambivalence and struggles to control and avoid being controlled; (d) triangular, referring to real or fantasized triangular or competitive relationships; and (e) mature, indicating mutually fulfilling relationships that encompass the capacity for tenderness and mourning. An overall dimensional score is derived, signifying the overall quality of an individual's relationship patterns and inferred inner representations. Higher scores are reflective of more mature levels of object relations. The QORS has been used in a number of studies, with consistently satisfactory levels of rater reliability (Høglend et al., 2006; Piper & Duncan, 1999) and concurrent validity (Lindfors, Knekt, Virtala, & Haaramo, 2013). QORS interviews for the ETP were conducted by trained clinicians ($n = 5$) who did not provide treatment to the participants. The intraclass correlation coefficient, based on five interviewers' ratings of 12 randomly selected cases, was $ICC(2, 1) = 0.68$.

3.3.5 | Severity of personality dysfunction

To control for the potential confounding effects of overall severity of personality dysfunction, we created a variable based on the number of diagnosed DSM-IV personality disorders (Ogrodniczuk, Piper, Joyce, & McCallum, 2001). This approach is an established method to quantify overall personality dysfunction (Tyrer & Johnson, 1996), and has been used across a range of studies (e.g., Clark, Nuzum, & Ro, 2018; Weekers, Hutsebaut, & Kamphuis, 2019).

Personality disorder diagnoses were based on the administration of the Structured Clinical Interview for DSM-IV Personality Questionnaire and the Structured Clinical Interview for DSM-IV Personality Disorders (First, Gibbon, Williams & Spitzer, 1998; First, Spitzer, Gibbon, & Williams, 1997). Psychiatric diagnoses on Axis I was determined by the computer-administered Structured Clinical Interview for DSM-IV (First et al., 1997). These interviews were administered by trained bachelor-level research assistants; diagnoses were validated by an ETP therapist and psychiatrist, both of whom saw the patient for the initial program intake.

3.4 | Data preparation

Statistical analyses were performed with SPSS version 25, including the PROCESS macro, version 3 (Hayes, 2018). Preliminary analyses were conducted to examine the overall change in self-esteem from baseline to posttreatment, to evaluate potential confounding variables, and to examine bivariate relationships among variables in the study. Potential confounding variables included age, gender, and severity of personality dysfunction. Improvement in depressive symptoms during treatment was also included as a covariate. Residual gain scores were calculated for self-esteem and depressive symptoms by regressing each pretreatment score on the posttreatment score, followed by division of the residuals by the standard deviation of the pretreatment score. The resulting scores were used to reflect pre- to posttreatment change in each variable, with greater negative residual gain scores indicating greater improvement. Zero-order correlations were conducted to examine the relationship between improvement in self-esteem and the other study variables.

3.5 | Data analysis

For our main analysis, regression analysis was conducted using the self-esteem residual gain score as the dependent variable. Week-5 alliance ratings served as the predictor variable. To conservatively estimate this association to change in self-esteem, we controlled for change in depressive symptoms by including the depressive symptoms residual gain score as a covariate. The potential moderating role of QOR was examined using the interaction term consisting of the product of QOR and patient-rated alliance, while also including the direct effects of these variables. Independent variables were mean-centered to decrease multicollinearity between the interaction terms and the corresponding main effects (Cohen, Cohen, West & Aiken, 2003). While we initially considered severity of personality dysfunction (represented by the number of personality disorders), gender, and age as covariates, no significant associations with changes in self-esteem were observed; hence these variables were omitted from the final model.

For our secondary analysis, using the subsample of patients who provided follow-up data ($n = 43$) at an average of 9 months posttreatment, zero-order correlations were again conducted to examine the aforementioned variables and depressive symptoms at follow-up. Linear regression was then employed, using follow-up depression scores as the dependent variable, with alliance ratings, self-esteem residual gain scores, and depression residual gain scores entered as predictors.

4 | RESULTS

4.1 | Preliminary analyses

Significant overall change in patients' self-esteem was found over the course of the ETP by comparing pretreatment severity, ($M = 0.75$; standard deviation [SD] = .26), with posttreatment severity, ($M = 0.31$; $SD = .28$), $t(79) = 12.75$, $p < .001$, constituting a large effect size, $d = -1.50$, 95% confidence interval [CI −1.86, −1.15]. Evaluation of potential confounding variables revealed no significant associations between improvement in self-esteem (reflected by residual gain score) and patients' age, gender, and a number of personality disorders. Improvement in self-esteem

was also unrelated to QOR (Table 1), but was associated with patients' alliance ratings, and, as expected, with improvement in depressive symptoms at the level of zero-order correlations.

4.2 | Therapeutic alliance and improvement in self-esteem

We examined the main effect of the therapeutic alliance on improvement in self-esteem, as well as the effect of an interaction between the alliance and QOR (Table 2). Change in depression and self-esteem is highly correlated here as shown in Table 1. There was no main effect for QOR. The main effect was observed for the alliance, while controlling for improvement in depressive symptoms. A significant interaction was also found between therapeutic alliance and QOR, accounting for an additional 4% of the variance in self-esteem improvement, beyond the main effect of the alliance and after controlling for change in depressive symptoms. Follow-up simple slopes analysis revealed that the association between the alliance and self-esteem improvement was strongest for patients with low QOR (−1 *SD*: $B = -0.329$; 95% CI [−0.524, −0.135]; $p = .001$) and remained significant for those at the mean level of QOR ($B = -0.147$; 95% CI [−0.262, −0.031]; $p = .013$), but was nonsignificant for patients with high QOR (+1 *SD*: $B = 0.036$; 95% CI [−0.155, 0.226]; $p = .710$). Thus, QOR moderated the alliance-self-esteem relation, in that a strong therapeutic alliance was predictive of greater improvement in self-esteem for patients with relatively lower levels of QOR (Figure 1).

4.3 | Change in self-esteem and follow-up depression

A subsample of $N = 43$ patients completed follow-up assessments of depressive symptoms between 8 and 12 months following completion of the ETP (on average, ratings were provided at 9 months post-termination). Depressive symptoms rated at follow-up were significantly associated at the level of zero-order correlations with therapeutic alliance, $r = -0.43$, $p = .004$, change in depressive symptoms during treatment, $r = 0.57$, $p < .001$, and improvement in self-esteem during treatment, $r = 0.60$, $p < .001$. Entered in a regression analysis, both depression and self-esteem residual gain scores remained significant in predicting follow-up levels of depression (Table 3). Thus, greater improvement in self-esteem during treatment was predictive of reduced depressive symptom severity in the year following program completion—accounting for 8% of the variance in follow-up depression scores—beyond the effect of prepost change in depressive symptoms.

5 | DISCUSSION

The present study aimed to investigate change in self-esteem through intensive group treatment for patients with personality dysfunction. Particular attention was given to investigating the role of the therapeutic alliance in

TABLE 1 Descriptive statistics and zero-order correlations between improvement in self-esteem, improvement in depression, therapeutic alliance, and quality of object relations among patients in the evening treatment program

	M (*SD*)	1	2	3
1. Self-esteem residual gain score	−.09 (.93)			
2. Depression residual gain score	−.12 (.86)	0.62**		
3. Therapeutic alliance, week 5	4.01 (1.44)	−0.40**	−0.33**	
4. Quality of object relations	3.75 (.98)	0.02	0.08	−0.09

Note: $N = 80$.
**$p < .01$.

TABLE 2 Regression analyses examining the therapeutic alliance and improvement in self-esteem, including the moderating effect of quality of object relations (QOR)

Dependent variable: self-esteem RGS	*b*	*SE*	*t*	*p*
Therapeutic alliance, week 5	−.147	.058	−2.535	**.013**
Quality of object relations	−.093	.084	−1.108	.271
Interaction of alliance × QOR	.186	.079	2.360	**.021**
Depressive symptoms RGS	.600	.097	6.216	**<.001**
R^2 = .469, $F(4, 75)$ = 16.570, p < .001				

Note: Boldface indicates significant results. N = 80.
Abbreviations: RGS, residual gain score; *SE*, standard error.

contributing to an improvement in self-esteem during treatment, including the potential influence of patients' QOR on this relationship. While patients' experiences of the alliance were overall associated with a change in self-esteem, a significant moderation effect was found for QOR, in that the relationship between the alliance and self-esteem change was stronger among patients with lower QOR. Thus, patients with impoverished inner relational representations appeared to derive greater benefit from a secure alliance with regard to achieving improved self-esteem through group treatment. For patients with relatively high levels of QOR, the relation between the alliance and self-esteem change was nonsignificant.

A secondary objective of the study was to evaluate whether improvement in self-esteem during treatment would help to maintain reduced depressive symptoms later on—that is, that changing self-esteem might contribute to recovery from mood-related distress among this group of patients who might be vulnerable to symptomatic relapse in the year following treatment. Gains in self-esteem accounted for a unique portion of the variance in

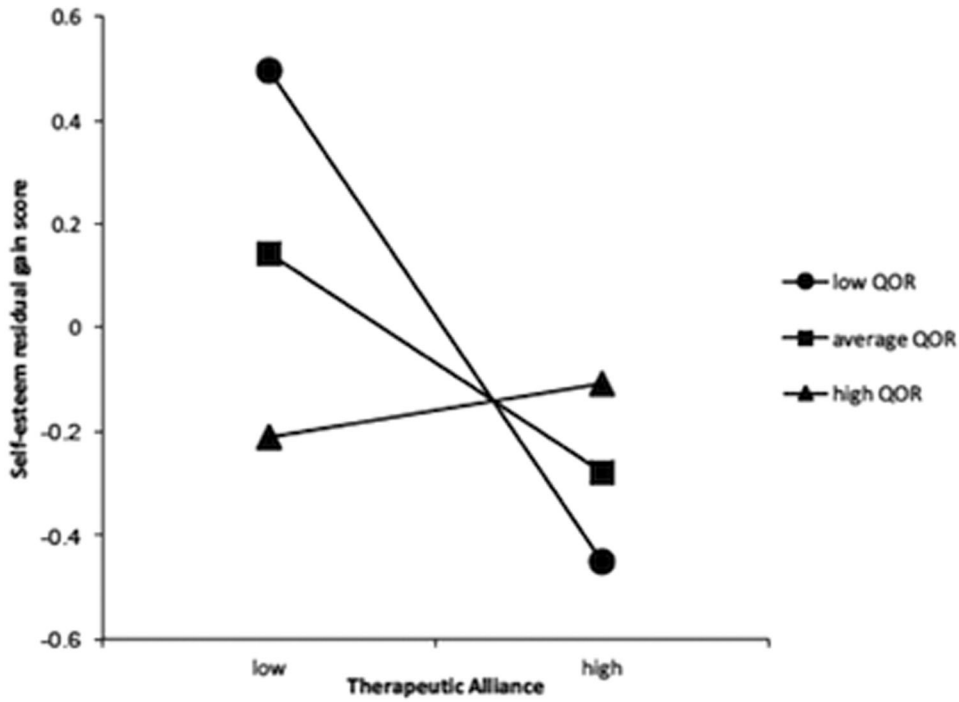

FIGURE 1 Illustration of simple slopes regarding the moderating effect of quality of object relations in the association between therapeutic alliance and improvement in self-esteem

TABLE 3 Hierarchical regression analysis of depressive symptoms at 9 months' follow-up and change in self-esteem during treatment

	b (*SE*)	*β*	*t*	*p*
Step 1				
Therapeutic alliance, week 5	−.088 (.035)	−.316	−2.548	**.015**
Depressive symptoms RGS	.266 (.066)	.497	4.012	**<.001**
R^2 = .416, $F(2, 40)$ = 14.261, **p < .001**				
Step 2				
Therapeutic alliance, week 5	−.060 (.035)	−.216	−1.749	.088
Depressive symptoms RGS	.186 (.071)	.348	2.639	**.012**
Self-esteem RGS	.167 (.068)	.341	2.444	**.019**
R^2 = .494, $F(1, 39)$ = 12.679, **p < .001**				

Note: Analyses predictive of follow-up depressive symptoms. Boldface indicates significant results. $N = 43$.
Abbreviation: RGS, residual gain score.

predicting lower depressive symptoms at follow-up, beyond the effect of pre- to posttreatment improvement in depression.

The finding that patients with lower QOR seemed to obtain the most benefit from the therapeutic alliance may be reflective of these patients having the most to gain from a corrective relational experience in enhancing their sense of self. These patients are likely to have had histories of difficult and frustrating interpersonal relations (as indicated by the QORS), which might have become internalized as expectations of subsequent interactions and patterns of responses that perpetuate relational disappointments. While this may be expected to present a challenge to therapeutic relationships (Connolly et al., 1999), the present findings suggest that low-QOR patients were able to translate a positive therapeutic relationship into favorable changes to their self-esteem. This finding is in line with some previous work indicating alliance-derived gains for patients with low-QOR (Høglend et al., 2011). For low-QOR patients, positive alliance ratings—against a background of negative relational experiences—may reflect favorable experiences of the group program that go some measure toward correcting inner relational representations and allow for an expansion of their sense of self (Boston Change Process Study Group, 2010; Waldron, Gazzillo, Genova, & Lingiardi, 2013). Thus, the alliance for patients with low QOR may stimulate a shift in long-held relational convictions and patterns, producing concomitant revisions to their self-esteem. The therapist's responsiveness, combined with the program's overall emphasis on empathic understanding, may disrupt these patients' grim expectations of fraught and rejecting interactions. This may allow low-QOR patients to learn and practice new ways of relating, serving as a basis for improved self-appraisal.

Patients with low QOR tend to have early relational experiences characterized by an insufficient or inconsistent sense of interpersonal security. Ratings of a positive alliance among these patients may reflect their development of a relatively novel sense of belonging. Thus, their relationships to the therapist, to group members, and to the group as a whole might offer an experience of the self as part of the group that can serve as a source of esteem (Smith, Murphy, & Coats, 1999). Given the multicomponent and multiprofessional nature of the ETP, these patients may also have experienced an "adaptive institutional transference" (Matarazzo, 2012; Pulido, 2011), an additional level of alliance toward the overall program. Moreover, the alliance may reflect patients' sense of collaboration in working on therapeutic tasks (Bordin, 1979), such as the practice of talking about emotional and interpersonal experiences, which may be particularly relevant for people with low QOR. In this way, the group may serve as a training ground for mentalizing and the initial experimentation with the opening of epistemic trust in a social context (Fonagy, Campbell, & Bateman, 2017; Glenn, 1987). Group members with fraught relational backgrounds, including caregivers whose communications were unreliable, might finally be able to experience the interpersonal security necessary to develop some trust in observations made by others (Fonagy et al., 2017). This growing trust

may, in turn, allow patients to better utilize feedback from other group members in building more realistic self-appraisals.

The finding that the alliance-outcome relationship was nonsignificant, at least with regard to change in self-esteem, for patients with high QOR is intriguing. These patients, whose lifelong relational patterns were relatively more coherent and stable, fared just as well as low-QOR patients in self-esteem improvement over the course of treatment. That self-esteem gains were not associated with the experience of the alliance suggests the possibility of a different mechanism by or in the context of which patients with higher QOR modify self-esteem through intensive group psychotherapy. Individuals with higher QOR may enter treatment with expectations of being responded to in a reasonable manner, thus deriving less of a corrective relational experience and perhaps utilizing other aspects of the program—such as insight (Jennissen, Huber, Ehrenthal, Schauenburg, & Dinger, 2018), affect (Diener, Hilsenroth, & Weinberger, 2007), or social rehabilitation activities (Korostiy, Kozhyna, & Zelenskaya, 2013) to foster more adaptive self-appraisals.

Our finding of an alliance-QOR interaction in predicting change in self-esteem might add weight to previous research (Høglend et al., 2011) that indicated QOR as an important moderator of the relationship between the therapeutic alliance and outcome. Researchers investigating the alliance could consider the potential for the alliance to function differently according to patient characteristics such as QOR. Further empirical evidence of the differential effects of the alliance according to patients' relational patterns may add a greater degree of nuance to clinical recommendations regarding alliance development and maintenance, as clinicians can contemplate which patients may utilize the alliance in particular ways for particular therapeutic gains (Kealy, Ogrodniczuk, Piper, & Sierra-Hernandez, 2016). In the context of group therapies for personality dysfunction, further research is needed to understand other aspects of the treatment process that may interact with QOR in contributing to improved self-esteem and other identity-related outcomes.

With regard to the second research question, change in self-esteem during treatment was predictive of follow-up depression severity, even after accounting for during-treatment symptom change. In other words, the greater the improvement in self-esteem achieved during treatment, the less depressed the patient appeared to feel during the posttherapy follow-up period. This further supports the potential value of focusing on self-esteem as a treatment outcome in the context of personality dysfunction and suggests that change in self-esteem may be an important target in preventing relapse of depressive symptoms. The extent to which the therapist and the group members are able to engender feelings of validation and understanding in patients with these features—a process which could take considerable time—may be an important factor in determining therapeutic outcome, as this seems to be directly related to the patient's constructive participation in the therapeutic process (Luyten, Lowyck, & Blatt, 2017). This in-treatment change in their sense of self and others may then facilitate later change in depressive symptoms (Zilcha-Mano, Chui et al., 2016). Future research could consider additional longer-term outcomes, like social functioning, as emerging from self-esteem improvement.

5.1 | Limitations

First, the internal validity of this naturalistic longitudinal study design was limited by the lack of a control group, such as a "treatment as usual" group, or some sort of "bonafide treatment alternative" group. Thus, our findings should be considered preliminary until studies using experimental designs address the questions we investigated. Second, several limitations to the generalizability of the current findings should be noted, including those associated with the predominantly female and Caucasian sample. Moroever, the study also used a relatively simple method of assessing the severity of personality dysfunction as a potential confound. Future research should employ more comprehensive, dimensional assessment of personality dysfunction. Another limitation was the relatively low ICCs for the QOR measure. Also, given that ruptures and negative therapy process are particularly pronounced in people with personality dysfunction, future studies should consider alliance negotiation and fluctuation during treatment (Doran, Safran, & Muran, 2016). Furthermore, assessment of therapy process was limited to alliance

ratings, obtained during the first third of the treatment program. The ETP contains multiple components, with participants moving through various groups, and with frequent changes to group membership due to the rolling admission of patients into the program. Thus, it is possible that various other aspects of the program accounted for a greater portion of the variance in self-esteem change, including interactions among group members and therapist effects that were not captured by the alliance ratings. Although we do not know which aspects of the program influenced the alliance-outcome relationship, the findings are nevertheless in line with the overall arc of the alliance literature that suggests that the alliance supersedes treatment models in contributing to the outcome (Horvath, 2011; Wampold & Imel, 2015). Future replication studies could explore the role of self-esteem in treatment outcomes of different psychotherapy approaches and identify related processes and helpful therapy strategies that will eventually result in higher self-esteem.

In sum, the current study offers a first step in furthering our understanding of change in self-esteem through group psychotherapy for patients with personality dysfunction. The findings of our study indicate that patients with personality dysfunction with relatively more impoverished inner relational representations derive greater benefit from a positive alliance when it comes to improving their self-esteem. Moreover, within-treatment change of self-esteem in group treatment for personality dysfunction was related to long-term outcome in depressive symptoms. If this finding is replicated across different samples and treatment settings, it underlines the importance of focusing on the improvement of self-esteem as stabilization against the risk of relapse of depressive symptoms.

ORCID

Katie Aafjes-van Doorn http://orcid.org/0000-0003-2584-5897
David Kealy http://orcid.org/0000-0002-3679-6085

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