

Patients' Affective Processes Within Initial Experiential Dynamic Therapy Sessions

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Research has indicated that patients' in-session experience of previously avoided affects may be important for effective psychotherapy. The aim of this study was to investigate patients' in-session levels of affect experiencing in relation to their corresponding levels of insight, motivation, and inhibitory affects in initial Experiential Dynamic Therapy (EDT) sessions. Four hundred sixty-six 10-min video segments from 31 initial sessions were rated using the Achievement of Therapeutic Objectives Scale. A series of multilevel growth models, controlling for between-therapist variability, were estimated to predict patients' adaptive affect experiencing (Activating Affects) across session segments. In line with our expectations, higher within-person levels of Insight and Motivation related to higher levels of Activating Affects per segment. Contrary to expectations, however, lower levels of Inhibition were not associated with higher levels of Activating Affects. Further, using a time-lagged model, we did not find that the levels of Insight, Motivation, or Inhibition during one session segment predicted Activating Affects in the next, possibly indicating that 10-min segments may be suboptimal for testing temporal relationships in affective processes. Our results suggest that, to intensify patients' immediate affect experiencing in initial EDT sessions, therapists should focus on increasing insight into defensive patterns and, in particular, motivation to give them up. Future research should examine the impact of specific inhibitory affects more closely, as well as between-therapist variability in patients' in-session adaptive affect experiencing.

Keywords: experiential, psychodynamic, affect experiencing, insight, anxiety

In the past 30 years, a growing number of psychotherapy process studies have indicated that patients' in-session emotional arousal may be a key component of effective psychotherapy, regardless of therapeutic orientation (Coombs, Coleman, & Jones, 2002; Diener, Hilsenroth, & Weinberger, 2007; Greenberg, 2008; McCullough & Magill, 2009; Whelton, 2004).

Therefore, an important task for further research is to elucidate the processes that contribute to adaptive affect experiencing during therapy.

One therapy orientation that explicitly views patients' in-session experience of adaptive affects as a primary change mechanism is Experiential Dynamic Therapy (EDT; Osimo & Stein, 2012). EDT may be regarded as an umbrella term for a group of short-term psychodynamic models that are derived from the pioneering work of Malan (1979) and Davanloo (1990), including Intensive Short-Term Dynamic Psychotherapy (ISTDP; Abbass, 2015), Accelerated Experiential-Dynamic Psychotherapy (Fosha, 2000), Experiential Short-Term Dynamic Psychotherapy (Osimo, 2003), and Affect Phobia Therapy (APT; McCullough, Kuhn, Andrews, Kaplan, et al., 2003). Recent meta-analytic findings suggest that EDT is effective in reducing symptoms and increasing functioning across a variety of psychiatric conditions (Lillengren, Johansson, Lindqvist, Mechler, & Andersson, 2016).

A central unifying feature of all EDT models is the use of the Triangle of Conflict (TOC; Malan, 1979) to formulate patients' core affective conflicts and guide therapist interventions directly in sessions (Osimo & Stein, 2012). According to the TOC, patient defenses (D) and anxiety (A) block the experience and expression of underlying adaptive affects (F), which leads to maladaptive

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ways of relating and/or symptom formation. Consequently, in therapy, the EDT therapist continually strives to (a) help patients become aware and let go of maladaptive defenses, (b) regulate anxiety, and (c) help patients access and viscerally process the underlying adaptive affects.

Further, the initial session (traditionally termed the ‘trial therapy’; Davanloo, 1990; Della Selva, 1996; Osimo & Stein, 2012) is viewed as particularly significant for initiating the change process in EDT. This extended session (usually 2–3 hr) involves exploration and formulation of the core affective conflict (using the TOC) underlying the patients’ presenting problems and/or symptoms, as well as the assessment of patient capacities. The session typically begins with exploration of a specific example of the patient’s problems with a particular focus on what feelings were evoked in the situation. During this exploration, the therapist helps the patient observe and let go of maladaptive defenses and/or regulate anxiety with the purpose of helping the patients access their underlying feelings as rapidly as possible directly in the session. Thus, unlike regular psychiatric intake sessions, the EDT therapist typically does not take a structured interpersonal or (mental) health history, but rather aims at initiating corrective emotional and relational experiences at the earliest opportunity.

The initial EDT session may be considered a therapeutic intervention in its own right and research indicates that single EDT trial therapy sessions are associated with moderate therapeutic gains (Aafjes-van Doorn, Macdonald, Stein, Cooper, & Tucker, 2014; Abbass, Joffres, & Ogrodniczuk, 2008), which are not typically observed after standard intake assessments (Abbass et al., 2009). This is also in line with a larger body of research suggesting that the early phases of treatment play an important role in determining therapy outcomes (Lutz, Stulz, & Köck, 2009). In fact, early changes may account for the greatest amount of improvement in therapy (Ilardi & Craighead, 1994; Tang & DeRubeis, 1999) and are a good predictor of treatment outcome (Fennell & Teasdale, 1987; Haas, Hill, Lambert, & Morrell, 2002). Therefore, understanding possible change mechanisms at play during initial sessions is a significant area for further research.

To study the process of change in EDT (as well as in other therapy models, see Valen, Ryum, Svartberg, Stiles, & McCullough, 2011), McCullough, Larsen, et al. (2003) developed the Achievement of Therapeutic Objectives Scale (ATOS). The ATOS is a video-based observer rating system that measures patients’ in-session behaviors related to seven specific therapeutic objectives (Berggraf, Ulvenes, Wampold, Hoffart, & McCullough, 2012), four of which are used in this study (Insight, Motivation, Inhibition, and Activating Affects).¹ Insight and Motivation correspond to the (D) pole of the TOC and assess to what degree the patient is aware of and motivated to give up maladaptive defensive patterns. Inhibition measures patient behaviors related to the (A) pole of the TOC (modified by McCullough, Larsen, et al., 2003 to include shame, guilt, and pain besides anxiety), and Activating Affects measures the degree to which the patient experiences the underlying adaptive affect (i.e., adaptive forms of grief, anger, closeness, pride), corresponding to the (F) pole of the TOC. These four ATOS scales are typically rated every 10 min of a given therapy session, capturing in-session fluctuations in these processes.

Several studies have used the ATOS to investigate the relationship between patients’ affect experiencing in EDT and outcome

(Bhatia et al., 2009; Schanche, Stiles, McCullough, Svartberg, & Nielsen, 2011), suggesting a positive relationship between an increase in Activating Affects during treatment and outcome, including reduction of psychiatric symptoms, increased interpersonal functioning, and gains in self-compassion. However, to our knowledge, no published study has explored the relationship between ATOS scales and patients’ experiencing of affect on a “micro-level,” that is, directly within a single therapy session.

Thus, the purpose of the present study is to investigate processes related to patients’ affect experiencing in initial EDT sessions. We specifically aim to test three theoretical relationships derived from EDT theory, using the ATOS—scales Insight, Motivation, Inhibition, and Activating Affects. Specifically, we hypothesize that:

1. *Higher levels of Insight will be associated with higher levels of Activating Affects.* From the viewpoint of EDT theory, patients need to see and understand maladaptive defenses to let go of defenses and access the underlying adaptive affect. This is also in line with research that points to the importance of insight associated with emotional processing, arousal, and elaboration (Greenberg & Malcolm, 2002; Milbrath et al., 1999; Pennebaker & Seagal, 1999).
2. *Higher levels of Motivation will be associated with higher levels of Activating Affects.* Additionally, EDT theory suggests that greater levels of motivation to let go of maladaptive defenses make way for the experience of the adaptive affects underneath. This is also in line with the general notion of motivation as a crucial factor for change in psychotherapy (Prochaska & Prochaska, 1999; Orlinksky, Ronnestad, & Willutzki, 2004).
3. *Lower levels of Inhibitions will be related to higher levels of Activating Affects.* Lastly, EDT theory suggests that adaptive affects are avoided owing to their association with excessive anxiety (and/or other inhibitory feelings), constituting an “affect phobia” (McCullough, Kuhn, Andrews, Kaplan, et al., 2003). Thus, adaptive affect is more likely to emerge when inhibitory affects are kept at low levels.

The levels of these variables may vary between patients (e.g., the general level of Insight or Inhibition may differ between patients), as well as within patients (e.g., the same patient may have different levels of Insight or Inhibition at different time points in the therapy process). Because we are interested in individual therapy processes, we aim to test our hypotheses by examining the within-person effects (Curran & Bauer, 2011) of Insight, Motivation, and Inhibition on Activating Affects. Additionally, as EDT theory also suggests a temporal relationship between the variables (i.e., defenses and anxiety need to be reduced for the underlying adaptive affect to emerge), we further aim to explore whether

¹ The remaining three subscales (i.e., New Emotional Learning, Sense of Self, and Sense of Others) measure alterations in the patients’ adaptive emotional capacity in daily life, as well as changes in internal representations of self and others (McCullough, Larsen, et al., 2003). These scales are not presumed to show in-session fluctuations, are rated only following the session as a whole, and are therefore not included in this particular study.

within-person changes in Insight, Motivation, and/or Inhibitory Affects in one 10-min segment predict the level of Activating Affects in the following segment. Elucidating these relationships may provide important information for the development of EDT theory and practice, as well as inform a range of other psychotherapy approaches that emphasize patients' in-session affective experience.

Method

Patient Sample

The current study uses data that were collected in a previous study investigating the prepost effects of initial EDT sessions (Aafjes-van Doorn et al., 2014). The sample consisted of 31 patients who sought treatment at two secondary care specialist psychology services within the United Kingdom National Health Service. Most patients (72.4%) were female and the average age was 37 years ($SD = 11.2$). The patients were assessed as severely to moderately impaired, with Global Assessment of Functioning (American Psychiatric Association, 2000) scores ranging from 32 to 63 ($M = 48$; $SD = 7.7$), and reported depression, anxiety, and interpersonal problems as their most frequent complaints (for more details on the research setting and patient sample, see Aafjes-van Doorn et al., 2014).

Intervention

The initial EDT sessions were conducted by two male clinical psychologists; each with >8 years' clinical experience and with at least 3 years of recent intensive training in EDT. One therapist treated 23 patients and the other treated 8. The average length of the initial EDT session was 150 min ($SD = 30$, range 69–211), with no significant differences between therapists (mean diff. = -16.337 , $SE = 12.13$, $t(29) = -1.347$, $p = .188$).

For the original study, the patients completed standardized self-report measures at two time points: before the initial session and just before the following appointment (approx. 2 weeks later). These measures indicated that, on the group level, the initial EDT session was associated with a large prepost effect (Cohen's $d = 0.79$) on the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM; Barkham, Mellor-Clark, Connell, & Cahill, 2006), a small to moderate effect ($d = 0.35$) on the Brief Symptom Inventory-18 (BSI-18; Derogatis, 2001) and a small effect ($d = 0.23$) on the Inventory of Interpersonal Problems-32 (IIP-32; Barkham, Hardy, & Startup, 1996). With the initial EDT session alone, five patients (16.1%) reached both reliable and clinically significant change (Jacobson & Truax, 1991) on the CORE-OM, BSI-18, or IIP-32, respectively. There were no significant differences between the therapists in patients' severity of symptoms at baseline (CORE-OM, mean diff. = -15.314 , $SE = 9.667$, $t(29) = -1.582$, $p = .124$; BSI, mean diff. = -3.109 , $SE = 6.387$, $t(29) = -0.487$, $p = .630$; IIP, mean diff. = -12.095 , $SE = 8.835$, $t(29) = -1.369$, $p = .182$), nor in terms of prepost change scores (CORE-OM, mean diff. = -0.503 , $SE = 1.735$, $t(29) = -0.290$, $p = .774$; BSI, mean diff. = -1.027 , $SE = 4.262$, $t(29) = -0.241$, $p = .811$; IIP, mean diff. = 3.006 , $SE = 7.029$, $t(29) = 0.428$, $p = .182$).

Measures and Rating Procedure

The ATOS (McCullough, Larsen, et al., 2003) was used to measure patient in-session behaviors relevant for this study (see introduction). The ATOS system has been subjected to several psychometric studies indicating that the included subscales measure distinct constructs that may be rated reliably by trained raters (Carley, 2007; McCullough, Kuhn, Andrews, Valen, et al., 2003), are sensitive to change (Valen et al., 2011) and capture variance attributable to differences among individuals (Berggraf et al., 2012). Specifically, the following four ATOS subscales were used:

1. *Insight* – This subscale measures the patient's verbal recognition and understanding of his/her own patterns of maladaptive behavior or defensiveness. This may be evident in (a) how clearly the patient describes maladaptive patterns of thoughts, feelings, and/or behaviors with explicit examples, and/or (b) to what degree the patient reports understanding why and how maladaptive/defensive patterns began and are maintained (secondary gain, meaning, causes, and with whom).
2. *Motivation* – This subscale measures the patient's degree of motivation to change or give up maladaptive patterns of thoughts, feelings, and/or behaviors. This may be indicated verbally and/or through expressions of dislike, undesirability, or sorrow related to recognizing the cost of defenses or maladaptive behaviors.
3. *Inhibition* – This subscale measures the patient's level of inhibitory affects as indicated by the overall intensity of anxiety, guilt, shame, or pain. This may be evident in verbal report, vocal tone, nonverbal behaviors, and/or observable physiological signs, such as trembling, tension or shifting (anxiety), blushing or head down (shame or guilt) or wincing, groaning or whimpering (pain).
4. *Activating Affects* – This subscale measures the level of emotional arousal of the adaptive but conflicted feeling currently in focus in the session. The intensity of arousal may be indicated by (a) the patients' vocal tone, facial expression, nonverbal or charged verbal statements during a session, (b) the duration of the affective arousal, and (c) subsequent expressions of relief.

All 31 initial EDT sessions were video-recorded and rated by one of three independent raters, who rated 10, 10, and 11 complete sessions, respectively. The sessions were divided into 10-min segments and the raters were instructed to provide a specific score, ranging from 0 to 100, on each of the four ATOS scales at the end of each segment. Before rating the sessions, all three raters attended a weeklong training by the developers of the ATOS, as well as extensive rating practice via an online training tool (<http://www.atostrainer.com>; McCullough, Bhatia, Ulvenes, Berggraf, & Osborn, 2011). The raters reached satisfactory agreement (ICC = .65, .70, and .72, respectively; Cicchetti, 1994) with expert ratings of 25 video segments used for training.

Data Analysis

Because our data are hierarchically structured (i.e., repeated ATOS scores are nested within patients who are nested within therapists), we decided to analyze the data using a multilevel growth model approach (MLM; e.g., Singer & Willet, 2003). We also considered MLM to be the method of choice because it enables us to estimate the within-person effects (see below) of the predictors on Activating Affect across session segments. Further, our naturalistic design is unbalanced with regards to measurement points (i.e., the initial sessions varied in length, resulting in different numbers of rated segments per patient). This is appropriately handled with MLM estimation (Raudenbush, 2001), as long as the basic assumption of Missing at Random is not violated (Little & Rubin, 2002). In this case, this means that the probability of missingness (i.e., shorter initial EDT sessions) should not be correlated with the patients' level of Activating Affect at the point of missing data, which we found no reason to assume.

Before main model building, we conducted exploratory analyses on all variables to examine individual trajectories over session segments. We also examined variability at therapist level and calculated intraclass correlations (ICC; see Wampold & Serlin, 2000) to estimate therapist effects for each variable. In this context, the ICC may be interpreted as the percentage of the total variability in a variable that can be attributable to differences between therapists. We found no indication of between-therapist variability in any of the predictors (Insight, ICC = .00; Motivation, ICC = .00; Inhibition, ICC = .02), but there was some notable between-therapist variability in our dependent variable (Activating Affects, ICC = .13), suggesting that about 13% of the total variance in Activating Affect may be owing to differences between our two therapists. However, the variance component at the therapist level was not significant (Wald Z test $z = 0.684, p = .494$). Given that we only had two therapists in our sample (which makes a three-level analysis inappropriate; Snijders & Bosker, 2012), we decided to proceed with two-level analyses (i.e., repeated ATOS measures at Level 1 and patients at Level 2) and include a dummy-coded therapists variable (Therapist Difference, coded 0 = Therapist 1, 1 = Therapist 2) as a fixed effect predictor in the models to control for possible therapist effects in Activating Affects.

Three models were estimated to investigate our hypotheses. First, we modeled a basic growth model for the development of Activating Affects across session segments (Model 1). The 10-min session segments were time-coded 0–19 and this variable (Time) was entered as a fixed effect. Because our exploratory analyses indicated a nonlinear pattern of Activating Affects across segments a quadratic term (Time²) was also added, which improved model fit (change in Akaike's Information Criterion [AIC] = -2.1). Different covariance structures for the residuals were compared and a first-order autoregressive structure was chosen based on best model fit (i.e., lowest value of AIC). We also entered Time and Time² as random coefficients (in addition to the random intercept); however, as AIC did not improve with adding Time, and a random quadratic model did not converge, they were both discarded. Lastly, we added Therapists Difference as a fixed effect predictor, which further improved model fit (change in AIC = -8.2). Thus, Model 1 yields an intercept that may be interpreted as the average level of Activating Affects during the first 10-min segment for patients treated by Therapist 1, Time indicates the average change

in Activating Affects per segment, Time² adjusts for the nonlinear pattern in Activating Affects over time, and Therapist Difference indicates the average differences between Therapist 1 and 2 in patients' Activating Affects across segments.

This basic growth model effectively separates between-person variance in our dependent variable (i.e., average Activating Affects for each patient) from within-person variance (time-specific deviations from each patient's growth in Activating Affects). However, as our time-varying predictors (e.g., Insight, Motivation, and Inhibition) contained both between-person and within-person variance, these were disaggregated manually using person-mean centering (Curran & Bauer, 2011; Raudenbush & Bryk, 2002; Singer & Willet, 2003). This procedure involves subtracting the person-specific mean of the predictor (i.e., each patient's average ATOS score across time points) from the patient's predictor score for each segment, yielding a variable that treats individual variation in the predictor as deviations from zero. Any presence of time trends in the predictors is also adequately controlled for (i.e., detrending) because Time was included as a covariate in our basic growth model (Wang & Maxwell, 2015).

To test the within-person effect of each predictor on Activating Affects, all three person-mean centered predictors were then entered in Model 2. Lastly, to explore whether the level of Insight, Motivation, and/or Inhibition in one 10-min segment would predict the level of Activating Affects in the next segment, we computed time-lagged predictor variables by shifting their values one segment forward. These were then entered in Model 3.

To obtain standardized estimates of the within-person effects of our predictors in Models 2 and 3, we calculated β coefficients using the standard formula: $\beta = B(SD_x/SD_y)$. Primary alpha level was set to .05 and tests were performed without correction for familywise error rate (e.g., Bonferroni) owing to the primarily exploratory aim of the study (Bender & Lange, 2001). All models were estimated using Restricted Maximum Likelihood within the SPSS (v. 20) software package.

Results

The 31 sessions yielded 466 10-min segments with an average of 15 ($SD = 2.8$; range 8–21) segments per patient. Averaged across all segments, the ATOS scores were in the low to moderate range for Activating Affects ($M = 37.4$; $SD = 13.2$; range 0–81), Insight ($M = 51.0$; $SD = 11.9$; range 15–80), Motivation ($M = 43.8$; $SD = 11.7$; range 5–71), and Inhibition ($M = 49.5$; $SD = 15.1$; range 11–88). In terms of our predictors, exploratory analyses indicated nonsignificant linear trajectories across session segments for Insight (intercept = 52.7, estimate = -0.26, $p = .063$) and Motivation (intercept = 42.8, estimate = 0.12, $p = .254$), while a significant decrease was observed for Inhibition (intercept = 52.8, estimate = -0.51, $p = .004$).

The fixed-effects estimates of our multilevel models are presented in Table 1. Model 1 displays the basic growth model indicating the development of Activating Affects across session segments. The intercept suggests that, on average, patients treated by Therapist 1 experienced a low amount of affect (32.37 points on ATOS Scale) during the first-session segment with a significant increase of about 1.72 points per segment (Time). The quadratic component (Time²) is in the negative direction (estimate = -0.07), which indicates an inversed

Table 1
Fixed Effects Estimates From Two-Level Models Predicting Activating Affects Across Session Segments

Variables	Model 1		Model 2		β	Model 3		β
	Estimate	95% CI	Estimate	95% CI		Estimate	95% CI	
Intercept	32.37**	[28.06, 36.68]	33.16**	[28.95, 37.36]		34.32**	[29.27, 39.37]	
Time	1.72**	[-.80, 2.64]	1.55**	[-.69, 2.41]		1.30*	[-.20, 2.41]	
Time ²	-0.07**	[-.13, -.02]	-.07**	[-.12, -.02]		-.05	[-.12, -.01]	
Therapist difference	-6.47*	[-12.89, -.05]	-6.51*	[-12.93, -.02]		-7.09*	[-13.59, -.60]	
Insight			.14**	[.04, .23]	.13**	.09	[-.02, .20]	.08
Motivation			.37**	[.24, .50]	.26**	.09	[-.05, .24]	.06
Inhibition			-.05	[-.17, .06]	-.04	-.04	[-.16, .08]	-.03

Note. Model 1 indicates the development of Activating Affects across session segments; Model 2 includes the individual effect (within-person) of each predictor on Activating Affects; Model 3 indicates the within-person effects of the time-lagged predictors on Activating Affects. CI = confidence interval. * $p < .05$. ** $p < .01$.

u-shaped pattern of Activating Affects across the session. Further, on average, Therapist 2 differed about 6.47 points in patients Activating Affects across segments, which indicated a significant difference ($p < .049$). In terms of overall mean difference, the between-therapist effect in Activating Affects was of medium size ($d = 0.59$). As an illustration, the predicted values of Activating Affects under Model 1 are presented in Figure 1.

The within-person effects of the predictors are tested in Model 2. In line with our first and second hypotheses, both Insight (estimate = 0.14; $\beta = .13$, $p = .005$) and Motivation (estimate = 0.37; $\beta = .26$, $p < .001$) were positively related to higher levels of Activating Affects in each segment. The effect of Inhibition was in the expected direction (estimate = -0.05 , $\beta = -.04$), but non-significant ($p = .368$); thus, our third hypothesis that lower Inhibition would be related to more Activating Affects was not supported. The therapist difference was also significant under Model 2 ($p = .47$).

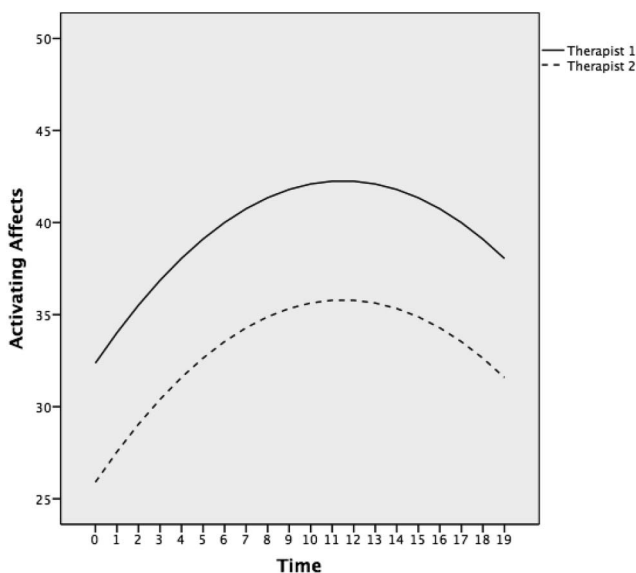


Figure 1. Predicted mean values of Activating Affects across session segments per therapist (Model 1).

Model 3 displays the effects of the predictors on the time-lagged Activating Affects variable. Although the estimates are in the expected directions (Insight, estimate = 0.09, $\beta = .08$, $p = .743$; Motivation, estimate = 0.09, $\beta = .06$, $p = .827$; Inhibition, estimate = -0.04 , $\beta = -.03$, $p = .637$), none of the ATOS variables significantly predicted the level of Activating Affects in the next segment.

The autoregressive correlations ($\rho = .39$, $\rho = .37$, and $\rho = .38$, respectively) were significant under all three models, indicating a moderate consistency in Activating Affects from segment to segment. Likewise, the residual variance components and random intercepts were also significant, suggesting that there is unexplained between- and within-patient variability in Activating Affects under all three models.

Discussion

To the extent of our knowledge, this is the first study to explore the development of patients' adaptive affect experiencing across initial EDT sessions and its relationship with other in-session processes. We used a well-validated process rating system (ATOS) and trained reliable raters, providing segment-by-segment information on theoretically relevant constructs. The total sample of 466 rated segments provided adequate power for the model estimations and the multilevel procedures applied enabled us to test our hypotheses on the individual level; that is, how within-person changes in Insight, Motivation, and Inhibition relate to Activating Affects directly in session segments.

The basic growth model (Model 1) indicated that, on average, patients' adaptive affect experiencing across session segments followed an inverted u-shaped pattern (see Figure 1). This general pattern is consistent with the underlying EDT therapy model because affect would be expected to increase as patient and therapist collaboratively explore patients' problems and approach avoided affects in the initial session. The decrease in affect at the end of the session may indicate that the later parts were typically used for recapitulation and creating a plan for the work ahead. However, it should be kept in mind that there was significant residual variance in our models, suggesting that the specific pattern of affect activation across session segments may look different for individual patients.

Turning to our hypotheses, we expected that patients' segment-by-segment affect experiencing would be positively related to their

corresponding level of Insight and Motivation, as well as negatively related to their level of Inhibition. Results of Model 2 supported the first two of these hypotheses, indicating that the more the patient was aware of and motivated to let go of defensive patterns, the more adaptive affect was experienced in the same segment. The effects were small to moderate (i.e., $\beta = .13$, $\beta = .26$), and the stronger effect for Motivation suggests that the patient's immediate impetus to move against his or her own destructive patterns may be particularly important. Notably, as we separated within-person from between-person variance in our analyses, the results should be interpreted at the individual level; that is, the results indicate changes relative to the individual patient's average level of Insight and Motivation in the session. Thus, on a moment-to-moment basis, therapists should be attentive to each patient's individual understanding of and readiness to give up their defensive patterns because even small, patient-specific, increases in these factors may promote more adaptive affect experiencing in the session. In EDT, this would correspond to the basic process of "defense restructuring" (McCullough, Kuhn, Andrews, Kaplan, et al., 2003), which involves identifying and clarifying defenses that are active in the moment, as well as "turning the patient's Ego against defenses" (Della Selva, 1996) by examining their negative consequences (Abbass, 2015; Frederickson, 2013).

In contrast, Model 2 did not support our third hypothesis because lower levels of Inhibition were not significantly associated with higher levels of Activating Affect. One possible explanation for this lack of association is related to the Inhibition scale of the ATOS. As this scale collapses observations of anxiety, guilt, shame, and pain (which are all seen as blocking the use and expression of the activating affects, see McCullough, Kuhn, Andrews, Kaplan, et al., 2003; McCullough, Larsen, et al., 2003) into one single rating, it may not adequately differentiate important affective phenomena. It is possible that patients' level of anxiety, guilt, shame, or pain have different associations with the level of adaptive affect experiencing. For example, some versions of EDT (e.g., ISTDP; Abbass, 2015) view anxiety, which is experienced physiologically in the voluntary nervous system, as a signal that activating affects are becoming mobilized. From this perspective, anxiety would be expected to *increase* as adaptive affects are approached, and instead of focusing on reducing patients' anxiety, therapists' interventions would be aimed at keeping anxiety within a tolerable range. This is also in line with some basic theories of change (e.g., Yerkes-Dodson Law), suggesting that moderate levels of anxiety are necessary for emotional activation and change in neural growth, new learning, and effective functioning (Doidge, 2007; Ogden, Minton, & Pain, 2006; Wu et al., 2010). In contrast, clinical experience suggests that even small amounts of maladaptive shame may affect the therapeutic process negatively (Dearing & Tangney, 2011). Thus, our result may reflect that the Inhibition scale of ATOS does not adequately differentiate between anxiety levels that may be necessary (or at least unavoidable) from anxiety and/or other inhibitory affects that may inhibit adaptive affects and/or new learning even at low levels. Future research should ideally include separate scales for anxiety, guilt, shame, and pain to explore this possibility in more detail.

It is also possible that a decrease in anxiety, guilt, shame, or pain is only important for adaptive affects to emerge when such inhibitory affects are at a particularly intense level. Because the average level of Inhibition ($M = 49.5$) was in the moderate range and our

exploratory analysis indicated a significant decrease across session segments, Inhibition may generally have been low for detecting a direct relationship with Activating Affects. Our hypothesis of a linear relationship between decrease in Inhibition and increase in affect experiencing might have been too simple and possibly better represented by a nonlinear model. In any case, the lack of relationship between Inhibition and Activating Affects may indicate that the understanding of anxiety and other inhibitory affects in EDT theory needs consideration, particular with regards to the APT model from which the ATOS is primarily derived (McCullough, Kuhn, Andrews, Kaplan, et al., 2003; McCullough, Larsen, et al., 2003).

Although our results indicated positive effects for Insight and Motivation, it should be kept in mind that the relationships in Model 2 are correlational. It may well be that an increase in Activating Affects *precedes* increases in Insight and Motivation within each segment rather than the other way around. To explore possible temporal relationships between our predictors and adaptive affect experiencing, we estimated a time-lagged model (Model 3). The estimates were all in the expected direction, but none were significant. Thus, we could not establish any temporal relationships between the predictors and Activating Affects and, hence, our study is limited when it comes to casual interpretations of the relationships found. One possible reason for the lack of significant temporal effects is that 10-min segments may be too wide a window into these in-session processes. Although it is the recommended session division in the ATOS manual (McCullough, Larsen, et al., 2003), clinical experience suggests that affect experiencing (as well as patients' levels of Insight, Motivation, and Inhibition) may well fluctuate within 10 min. One implication of our results is that, to approach causal interpretations, future studies of patients' in-session affective processes (using ATOS or other process coding systems) could benefit by using a more fine-grained approach, perhaps even looking at the emergence of adaptive affects at the level of the speaking turn (Town, Hardy, McCullough, & Stride, 2012).

Interestingly, while we found no indication of between-therapist variability in our predictors, our dummy-coded therapist variable proved significant, suggesting that our two therapists differed in terms of their patients' general affective arousal levels across the initial sessions (see Figure 1) with a medium effect size ($d = 0.59$). This may indicate that personal characteristics of therapists are related to patients' affect experiencing in sessions. Another possibility is that the two therapists, although both were specifically trained in EDT, differed in their use of specific interventions. Previous studies have indicated that patients' affective arousal is related to therapists orienting them toward affect (Ulvenes et al., 2014), as well as their use of clarification, confrontation, and support (Town et al., 2012). Because we did not include any measure of therapist characteristics or in-session use of interventions, we cannot say which may have accounted for our results. However, the indication of medium-size therapist differences in Activating Affect should be interpreted cautiously given that we only had two therapists in this study. The difference may reflect sampling error and we cannot generalize beyond the specific therapists used. Further, as there was no indication of therapist differences in effectiveness in the original study, the implications of our finding is not clear. Nevertheless, the results suggest that

between-therapist variability in patients' accessing and processing of adaptive affects is an important area for future research.

Limitations

Several additional limitations with this study warrant mentioning. First, we were not able to include outcome data from the original study in our growth models because we only had two measurement points (i.e., before and 2 weeks after the initial session). Thus, we were unable to link patients' in-session affect experiencing directly with treatment outcome, though such associations are indicated in previous research (Bhatia et al., 2009; Diener et al., 2007; McCullough & Magill, 2009; Schanche et al., 2011). Also, we did not have access to data on any other process measure that might have been relevant as an immediate session outcome. For example, the impact of affect experiencing on the therapeutic alliance might have been particularly interesting given our focus on initial sessions (Ulvenes et al., 2012). Future studies should combine within-session process measures with session-by-session outcomes to investigate the immediate and delayed impact of affect experiencing on outcome and other relevant process measures (e.g., alliance).

Further, although the initial session is regarded as an important impetus for change in EDT, it remains unclear if our results are generalizable to other types of initial therapy sessions or remain valid as the treatment process continues. Several studies have found that sessions later in treatment show higher levels of activating affect and lower levels of inhibitory affect than earlier sessions (McCullough & Magill, 2009), which might suggest that patients' levels of Insight, Motivation, or Inhibition relate differently to adaptive affect experiencing in later sessions.

Lastly, our results should also be interpreted within the context of our specific sample. Although the mixture of presenting problems and symptoms may be fairly representative of patients seeking treatment in typical psychiatric outpatient settings, the variability in patient characteristics limits conclusions regarding the importance of in-session affective processes for particular patient groups. For example, it is possible that reduction of inhibitory affects may be differentially associated with affect experiencing for patients presenting with primarily anxiety or depression symptoms.

Clinical Example

We will illustrate the clinical material that lies behind the ATOS by describing one particular patient.² "Mary," a mother in her 30s, lost her 3-year-old son in an accident around 10 years ago. Since that time, Mary has suffered with anxiety and depression. During the initial EDT session, the therapist helped Mary to gain insight into her defenses and increase her motivation to give them up, at the same time as regulating her anxiety and helping her to tolerate her adaptive experience of grief.

Following an initial focus on regulating Mary's high levels of inhibitory anxiety in the session (Inhibition = 61), which included Mary's fear that she might be compulsorily admitted into the psychiatric hospital, Mary indicated her motivation to explore her feelings: "It's something I wanted to do—like face your fears, obviously, I wanted to get help for myself" (Motivation = 45). The therapist encouraged Mary to explore the conflicted and terribly

painful feelings surrounding her son's death, while recognizing her inhibitory anxiety and the associated defense of self-blame blocking access to her feelings. The therapist, together with Mary, explored her self-blame and the possibility of letting it go. For example, he enquired: "How would you feel towards someone else going through this?"; Mary's reply that she would feel "compassionate towards them" indicated her increased motivation to give up this defense. Mary was then able to articulate the heavy cost of her defenses: "I've felt dead for so many years in what I'm feeling and who I am" (Insight = 80; the highest score in the session). Having laid this groundwork, Mary and her therapist were able to access higher levels of underlying adaptive affect, reaching a peak around 80 min into the session, when the therapist asked Mary to imagine holding her dead son and to put her feelings into words. Mary experienced a deep adaptive grief (Activating Affect = 81), as illustrated in the following excerpt.

Therapist: *You need to be really gentle with the part of you that's hurting right now. In your tummy, in your chest.*

Mary: *Hurts here* [touching her chest gently].

Therapist: *Do you get a sense of the emotion there?*

Mary: *Missing him. Missing him so much.*

Therapist: *Tell him.*

Mary: *I do tell him all the time.* [Tearfully] *I miss you so much.*

Therapist: *And my heart aches without you.*

Mary: *It does. It feels huge* [rubbing chest gently, tearful].

Therapist: *It's a huge ache.*

Mary: *It's almost like a ball. It gets bigger and bigger.*

In the final part of the session, Mary was noticeably more relaxed (Inhibition falling to 31, indicating low inhibitory affect). When followed up 2 weeks later, Mary's scores on the outcome measures showed a reduction of symptoms as well as a statistically reliable increase in her self-compassion and remoralization. Near the end of the initial EDT session, she described her experience of the session as follows:

"It feels fine. It feels good. I'm expressing myself more than I usually do. I'm putting myself more in the picture. I usually just talk, but now I'm trying to see myself in that picture. Trying to take myself in the morgue and that. But in a funny way I feel more relaxed now . . . It's what I wanted. I've been shut down for so many years I didn't know how to open up and be truthful."

² The clinical case material reported here complied with the ethics code of confidentiality. The authors ensured confidentiality in the following ways: This patient signed specific informed consent to participate in research and education and discussed the details of this consent with the researcher. To protect confidentiality, the patient's personal details have been disguised and identifiable information about her life, work and family have been removed. Further, specific historical and current events experienced by this patient have been omitted, altered, or combined with that of multiple patients to further protect patient confidentiality.

Conclusions

In summary, our results suggest that, to help patients experience higher levels of adaptive affect directly in session, therapists should focus on helping patients increase their immediate understanding of maladaptive avoidance patterns, as well as their individual motivation to turn against such patterns and face adaptive affects. Focusing on reducing anxiety and other inhibitory affects in general may not necessarily increase affective activation; indeed, maintaining a moderate level of anxiety might be desirable for an effective treatment process. The Inhibition scale in the ATOS system may need revision and/or expansion to better understand the impact of diverse forms and/or levels of anxiety, guilt, shame, or pain. Future research should consider dividing sessions into smaller units for assessment of affective processes, inclusion of repeated measurement of outcome over sessions, as well as inclusion of a sufficient number of therapists to further investigate possible therapist effects in patients' in-session affect experiencing.

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