

The Capacity for Self- Observation in Psychotherapy

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Abstract

The phenomena of self-awareness and self-observation are thought by many to be uniquely human qualities, and questions about how they develop have engaged philosophers and spiritual thinkers throughout history. More recently these issues have come to occupy psychologists, psychotherapists, and researchers of diverse clinical psychology orientations as well.

This dissertation aimed to explore conceptual issues and empirical measurement methods related to the phenomena of self-awareness and self-observation capacities. The four included studies approached this from different angles: Study I used mainly qualitative methods to study post-treatment processes, in particular the phenomenon of self-analysis, related to continuing clinical improvement after termination of long-term psychotherapeutic treatments. The main finding was that self-analysis seemed to be related to continued clinical improvement after formal ending of therapy, but contrary to our hypothesis there was no difference between psychotherapy and the more intensive psychoanalysis in this regard. Study II tested the measurement of mindfulness by self report questionnaires in a sample of experienced Buddhist meditators. The findings confirmed relationships between the measure of mindfulness and psychological well-being, but raised doubt about the instrument's sensitivity to change at high levels of mindfulness. Study III compared different methods for measuring theoretically related concepts of self-awareness and self-observation: mindfulness, mentalization (Reflective Functioning), and affect consciousness. This study showed surprisingly and intriguingly little common variance particularly between affect consciousness and mentalization/mindfulness. Finally, study IV found that in patients diagnosed with clinical depression, an application of the Reflective Functioning scale to a brief interview

about depressive symptoms predicted aspects of the initial psychotherapy process better than the usual application of the Reflective Functioning scale to the Adult Attachment Interview.

In conclusion, it seems that there are several forms of self-observation, and that these different forms may not be strongly related to each other. Moreover, it seems likely that self-observation skills vary significantly across contexts. The Reflective Functioning scale may be especially context sensitive and the implications of differences in Reflective Functioning may need to be studied using contextually appropriate methods (e.g. RF about depressive symptoms as opposed to RF about attachment). Methods for measuring mindfulness may be too little context sensitive, making this concept seem more stable (trait-like) than it is according to theory.

Taken together, these four studies show the complexity of research on such an elusive concept as self-observation. The relationships between variables related to self-awareness and self-observation, their measurements, and their relationships to the psychotherapy process seem more complex than would be expected from most current theories. A model for thinking about different forms of self-observation in the process of change in psychotherapy is tentatively proposed.

Contents

1. INTRODUCTION	1
1.1. HISTORICAL BACKGROUND	1
1.2. PSYCHOANALYTIC THEORIES OF SELF-OBSERVATION	2
1.3. SELF-OBSERVATION IN CONTEMPORARY ACADEMIC PSYCHOLOGY.....	5
1.3.1. <i>Emotional Intelligence (EI)</i>	5
1.3.2. <i>Empathy</i>	5
1.3.3. <i>Psychological Mindedness</i>	6
1.3.4. <i>Alexithymia</i>	7
1.3.5. <i>Mindfulness</i>	7
1.3.6. <i>Metacognition</i>	9
1.3.7. <i>Mentalization</i>	12
1.3.8. <i>Affect Consciousness/Affect Integration</i>	16
1.4. SUMMARY AND CONCEPTUAL DISTINCTIONS.....	16
1.4.1. <i>Self vs Other Observation</i>	17
1.4.2. <i>Cognitive vs Affective Observation</i>	17
1.4.3. <i>Implicit vs Explicit Observation</i>	19
1.4.4. <i>State vs Trait Models of Self-Observation</i>	19
2. AIMS OF THE PRESENT THESIS.....	21
3. SUMMARY OF INCLUDED STUDIES	23
3.1. ARTICLE I. SELF-ANALYSIS AND POST-TERMINATION IMPROVEMENT AFTER PSYCHOANALYSIS AND LONG-TERM PSYCHOTHERAPY	23
3.1.1. <i>Methods</i>	23
3.1.2. <i>Results</i>	24
3.1.3. <i>Discussion</i>	24
3.2. ARTICLE II. STUDYING MINDFULNESS IN EXPERIENCED MEDITATORS: A QUASI-EXPERIMENTAL APPROACH	25
3.2.1. <i>Methods</i>	25
3.2.2. <i>Results</i>	25
3.2.3. <i>Discussion</i>	26
3.3. ARTICLE III. REFLECTIVE FUNCTIONING, AFFECT CONSCIOUSNESS, AND MINDFULNESS. ARE THESE DIFFERENT FUNCTIONS?.....	27
3.3.1. <i>Methods</i>	27
3.3.2. <i>Results</i>	28
3.3.3. <i>Discussion</i>	28
3.4. ARTICLE IV. PATIENT REFLECTIVE FUNCTIONING AS PREDICTOR OF EARLY PSYCHOTHERAPY PROCESS IN THE TREATMENT OF DEPRESSION.....	29
3.4.1. <i>Methods</i>	29
3.4.2. <i>Results</i>	29
3.4.3. <i>Discussion</i>	30

4. DISCUSSION.....	31
4.1. SELF-OBSERVATION AND AFFECT REGULATION	32
4.2. CONTEXTUAL (STATE) ASPECTS OF SELF-OBSERVATION	33
4.3. MEASUREMENT ISSUES	34
4.4. SELF-OBSERVATION: A CLINICAL PROCESS PERSPECTIVE.....	36
4.5. SUGGESTIONS FOR FUTURE RESEARCH	39
5. REFERENCES	41

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List of papers

This thesis is based on the following papers:

- I. Falkenström, F., Grant, J., Broberg, J., & Sandell, R. (2007).
Self-analysis and post-termination improvement after
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American Psychoanalytic Association*, 55(2), 629-674.
- II. Falkenström, F. (2010). Studying mindfulness in experienced
meditators: A quasi-experimental approach. *Personality and
Individual Differences*, 48(3), 305-310.
- III. Falkenström, F., Solbakken, O. A., Möller, C., Lech, B.,
Sandell, R. & Holmqvist, R. (Submitted). Reflective
Functioning, Affect Consciousness, and Mindfulness: Are
these different functions?
- IV. Falkenström, F., Ekeblad, A., Sandell, R. & Holmqvist, R.
(Manuscript). Patient Reflective Functioning as predictor of
early psychotherapy process in the treatment of depression.

“... why should we not calmly and patiently review our own thoughts, and thoroughly examine and see what these appearances in us really are?”

Plato, Theaetetus

"Mindful should you dwell, monks, clearly comprehending; thus I exhort you. And how, monks, is a monk mindful? When he dwells contemplating the body in the body, earnestly, clearly comprehending, and mindfully, after having overcome desire and sorrow in regard to the world; and when he dwells contemplating feelings in feelings, the mind in the mind, and mental objects in mental objects, earnestly, clearly comprehending, and mindfully, after having overcome desire and sorrow in regard to the world, then is he said to be mindful."

Maha-parinibbana Sutta, Last Days of the Buddha

1. Introduction

In this introductory section the theoretical foundations for concepts of self-observation are described. This section is followed by a description of the four included empirical papers. First, however, a brief overview of how some concepts are used in this thesis:

Self-observation is used here as an overarching term for any process in which the self is taken as object of attention and/or reflection. Self-observation refers to observations and reflections about the self in the present moment. *Mindfulness* is a special type of self-observation; that is attention to the experience of the self in the present moment without cognitive elaboration. *Self-reflection* is another type of self-observation, a process of cognitive inquiry about the self. The terms *mentalization* and *meta-cognition* are related to self-reflection, although they usually include reflections about others as well. Another closely linked term is *self-analysis*, which is broader in its scope than self-observation in that it encompasses thinking about the self that is not tied to the present moment (e.g. developmental reflections). *Insight*, on the other hand, is defined as new understandings about self, others, or the world. *Self-insight* is insight specifically about the self, the product of successful self-observation (or self-analysis). The capacity for self-observation can be seen as a necessary (but probably not sufficient) condition for insight. More detailed descriptions of these and other terms will be provided in the theoretical introduction below:

1.1. Historical background

The value of a capacity for self-observation, self-reflection, or insight, has been emphasized both in ancient Indian traditions

(most notably in Buddhism) and in ancient Greek philosophy (as captured by the inscription on the Delphi temple: *know thyself*).

A highly developed theory of the value of insight and self-observation is found as early as in Buddhist scriptures from almost two thousand five hundred years ago. In these scriptures is described the system of practice that according to the Buddha ultimately leads to complete freedom from suffering. Doing justice to this system is too complex in a few sentences in this historical introduction. Very briefly, the core of the Buddhist spiritual path concerns the importance of insight into the characteristics of existence; that all things are impermanent, in constant change and thus also devoid of an unchanging self or soul, and finally that basing happiness on anything impermanent will inevitably lead to suffering. The key to happiness is to gain insight into these characteristics of existence, and through that insight be liberated from clinging onto impermanent objects and instead develop compassion for all living beings. This insight is gained through close observation of the details of moment-to-moment experience by way of the self-observational capacity of mindfulness (Falkenström, 2003; Kabat-Zinn, 1990, 1996; Nyanaponika, 1962).

The first to discuss self-observation in modern Western psychology at any depth was probably William James (1890), in his distinction between the experiencing *Me* and the observing *I*. Wundt, in discussing introspection as a method for scientific research considered *self-observation* as narrowly limited to consciousness and distorted by the non-separation of subject and object, and for this reason flawed as scientific method. On the other hand, *internal perception* was supposedly a more objective process resembling external perception, making it more usable for scientific purposes (especially if research subjects had special training; Danziger, 1980).

1.2. Psychoanalytic theories of self-observation

Sigmund Freud was probably the first Western scholar to systematically apply self-observation and self-reflection with the aims to generate self-awareness and self-knowledge – in Freud's opinion with expected positive therapeutic consequences. His self-

analysis, in *The Interpretation of Dreams* (Freud, 1900), focused on his own dreams but provided a more general technical model for later psychoanalysts to promote insight in their patients – and themselves. In his classical outline of psychoanalytic technique, Etchegoyen (1999) notes that the term *insight* was seldom used by Freud himself, but it was rather English speaking analysts in Europe and America who coined it. Nevertheless, this usage is very much in line with Freud's own thinking. In the early topographical model of the mind, the goal of psychoanalysis was defined as “making the unconscious conscious” which clearly points to the importance of insight. Later, when the structural model was introduced, the goal of analytic treatment was redefined in the famous statement “where id was, there shall ego be” (Freud, 1933). Etchegoyen also notes that Ferenczi, one of Freud's early followers whose thinking in many respects antedated modern psychoanalytic developments, tended to use not the word *Einsicht*, but *Selbstbeobachtung*, which translates into English as *self-observation*.

An article by Sterba (1934) describes how patients in psychoanalytic treatment are expected to develop a *therapeutic split in the ego*, with one part experiencing and another being the observing part. This split is enhanced through identification with the analyst's analyzing function. The article points to the importance not only of gaining knowledge about the self, but also of the importance of, to some degree, establishing the very ability to observe the self. In early psychoanalysis the ability to observe the self was considered a criterion for analyzability, while Sterba's article pointed to the possibility that self-observational capacity may actually develop during the process of therapy.

As Freud noted towards the end of his life, in *Analysis terminable and interminable* (1937), continued self-analysis may be necessary throughout life (Hoffer, 1950; Horney, 1942). This is so because new experiences and new developmental phases bring up new challenges, and there is thus a continued need for self-observation and self-analysis in order to handle these situations.

Bion (e.g. 1962) described the parental function of *containment* as imperative for the development of the child's capacity to understand mental states. The process of containment means receiving the child's emotional expressions and translating them

The capacity for self-observation in psychotherapy

into meaningful information that is conveyed back to the child, who in time, with repeated such cycles, internalizes this capacity for translating its own raw impressions into meaningful information. Bion (1959) also described the disastrous consequences for the child's capacity for self-observation when the infantile containment process has gone wrong. In somewhat more esoteric terms Bion (1970) described something he called *Faith in O*. By this he meant openness to the emotional reality of the moment, clearly reminiscent of the attitude of mindfulness (Eigen, 1985; Falkenström, 2007).

More contemporary psychoanalytic authors have used the term *the third position*, or simply *the third* to describe self-observation (Britton, 1998). This term is a kind of object relations version of Sterba's observing ego, and is seen as most critical when there are breakdowns in therapeutic collaboration, which has been termed alliance ruptures (Aron, 2006; Safran & Muran, 2000; Safran, Muran, & Eubanks-Carter, 2011). In such situations the first and second positions are the respective perspectives of analyst and patient, who are locked into polar opposite roles, each reinforcing the other. This is the typical situation in alliance ruptures and in interpersonal conflicts in general. In order to get out of this one of the participants has to "step to the side" mentally and interpersonally in order to make space for reflection. These more modern approaches point to more situational (state) aspects of self-observation, while the older concepts seemed to be more clearly personality variables (trait).

When assessment of insight and other psychoanalytically-based concepts related to self-observation are concerned, it is more or less in the nature of psychoanalytic thinking that no formal measurement will be able to reveal the partly unconscious and preconscious phenomena. Thus, assessment is generally based on observation, listening, confrontation, clarification, interpretation, and working-through in the clinical psychoanalytic situation. This approach has been criticized as unscientific by scholars both within and outside psychoanalysis (e.g. Fonagy, 2003; Grünbaum, 2004).

1.3. Self-observation in contemporary academic psychology

1.3.1. *Emotional Intelligence (EI)*

In 1983 Gardner (2004) introduced his idea of multiple intelligences, of which two were the interpersonal and intrapersonal ones. Whereas *interpersonal intelligence* was defined as the ability to understand others, *intrapersonal intelligence* has to do with self-reflection generating a deep understanding of oneself, one's emotions and reactions. Later Salovey and Mayer (1989) introduced the concept of Emotional Intelligence (EI). It has since been defined in a variety of ways, and EI researchers have not agreed on any common definition.

Definitional problems notwithstanding, it seems that the capacity for self-observation would fit well into the framework of EI. Stating this, however, does not help much in understanding what self-observation is.

1.3.2. *Empathy*

The word *empathy* was invented in the late 19th century as a translation of the German word *Einfühlung*. Early definitions separated cognitive and affective types of empathy, but later researchers have questioned the possibility of discriminating these components (Baron-Cohen & Wheelwright, 2004; Duan & Hill, 1996). One way of transcending the distinction between cognitive and affective types is to say that empathy is the reaction to observing or imagining other people's experiences (Davis, 1983). The reaction to others' experiences can be both cognitive (i.e. thinking about the other person's feelings) and affective (i.e. feeling moved by the other's feelings). Choi-Kain and Gunderson (2008) add that empathy also requires maintaining a stable sense of self-other distinction. Sympathy, pity, and compassion are, however, usually seen as distinct from empathy, referring more to a sense of wanting to help or relieve the other person of distress. Finally, empathy can be seen both as trait and as state. Most definitions regard empathy as a more or less stable personality trait, but within the clinical literature the state approach is not uncommon (Barrett-Lennard, 1981; Duan & Hill, 1996). In this

later definition empathy is regarded as an interactional process which varies within individuals (and dyads) over time and context.

Although related to self-observation, empathy is usually regarded as primarily other-directed rather than directed towards the self.

1.3.3. *Psychological Mindedness*

The term *psychological mindedness* has its origins in the psychoanalytic literature on indications for psychoanalysis.

According to Appelbaum (1973) the term became widespread after having been used as one of the patient variables within the Psychotherapy Research Project at the Menninger Foundation. The definition provided by Appelbaum seems to hold more or less today: “A person's ability to see relationships among thoughts, feelings, and actions, with the goal of learning the meanings and causes of his experiences and behaviour” (p. 36). Within this definition reflections about both self and others are included, although the emphasis is on the self (“... of *his* experiences and behaviour”, emphasis added). Another conceptualization was offered by Farber (1985): “...a trait which has at its core the disposition to reflect upon the meaning and motivation of behavior, thoughts, and feelings in oneself and others” (p. 170). Here it is obvious that reflection about self and others are given equal weights.

The psychological mindedness concept has been operationalized more recently by McCallum and Piper (1996). Their definition of psychological mindedness is closely tied to psychoanalytic theory, even more so than Appelbaum's. The McCallum and Piper (1996) interview-based procedure for assessing psychological mindedness was developed to predict success in psychoanalytically oriented psychotherapy, and thus it reflects the abilities that are presumed to be required within such treatments. Psychological mindedness as defined by McCallum and Piper include identification of intrapsychic conflict, unconscious motivation, defensive processes, and the causal linking of these processes. The McCallum and Piper measure has been found to predict outcome in both psychodynamic group and individual

therapy (McCallum & Piper, 1996; McCallum, Piper, Ogodniczuk, & Joyce, 2003).

Another measure of psychological mindedness, the Psychological Mindedness Scale, was developed by Conte (Conte, Plutchik, Jung, & Picard, 1990; Conte, Ratto, & Karasu, 1996). The Psychological Mindedness Scale is a self-report inventory of 45 items, and it has also been shown to predict outcome in psychodynamic therapy.

Psychological mindedness seems clearly described as a personality trait, i.e. it is assumed to be more or less stable over time and situation.

1.3.4. *Alexithymia*

The concept of *alexithymia* literally means lack of words for feelings, and was coined by Sifneos (1972, 1996) after having observed a subgroup of psychosomatic patients who demonstrated a striking lack of fantasies and difficulty in describing how they were feeling. The concept of alexithymia highlights the problems associated with absent or severely restricted capacity for self-observation.

Sifneos and his coworkers believed that alexithymia had organic rather than psychological causes (Sifneos, 1996; Sifneos, Apfel-Savitz, & Frankel, 1977), although they acknowledged the possibility of some cases developing alexithymia secondary to trauma (Freyberger, 1977). Because of the requirement for reflection on feelings in dynamic psychotherapy, Sifneos considered alexithymia as a contraindication for this form of treatment.

1.3.5. *Mindfulness*

During the last two decades *mindfulness* has become extremely influential in Western psychology, particularly as a form of stress reduction. The stress reduction program of Jon Kabat-Zinn was the first mindfulness treatment where Buddhist principles were translated into western terms. This treatment program stays quite close to its Buddhist roots (although de-emphasizing the religious and moral aspects). It consists of eight weeks of mindfulness training, and is provided for such diverse problems as anxiety,

chronic pain or illness, sleep disturbances, fatigue etc (Kabat-Zinn, 1990).

The mindfulness concept has influenced several developments in modern clinical psychology, especially within the field of Cognitive-Behavioral Therapy. Starting in the early nineties, new CBT treatments were developed that did not fit into the old CBT framework, mainly because they did not emphasize change (in behavior or thinking) as much as previous theories did but focused equally on acceptance of “what is” (Hayes, Follette, & Linehan, 2004). Examples are Dialectical Behavior Therapy (DBT; Linehan, 1993), Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999), and Functional Analytic Psychotherapy (FAP; Kohlenberg & Tsai, 1991). These treatments (especially ACT) also defined the optimal outcome of treatment as *psychological flexibility*. Psychological flexibility in this context is defined as the capacity not to be automatically driven by mental states but to be able to observe them with acceptance and to choose how to behave according to internal values. This focus makes modern behavioral theories more similar to theories influenced by psychodynamic/psychoanalytic than classical behavior therapy. Indeed, several authors have noted the similarity between the mindfulness concept and psychoanalytic concepts such as *free association* (Epstein, 1995) and *evenly hovering attention* (Rubin, 1985).

The term mindfulness refers to the conscious direction of attention towards observing the course of events in the present moment. This observation is characterized by conscious attempts at reducing cognitive elaboration in order to observe things as they appear, setting any preconceptions aside as to how they should be. Although the term is usually reserved for introspective attention to thoughts, feelings, bodily sensations etc., it is also sometimes used for attending to external reality such as sounds and sights. In principle mindfulness could also be used for attending to other people’s internal states, but this usage is seldom described in the mindfulness literature. This is probably because internal states of others cannot be observed directly but need to be inferred through imaginative cognitive operations, and for that purpose the observation stance of mindfulness becomes extremely difficult.

Mindfulness is described in the Buddhist literature as a state concept, i.e. fluctuating from moment to moment. Still, it is likely that there is also a habitual aspect of mindfulness, in that some individuals are more prone to being mindful than others. For example, the more or less explicit assumption behind the idea of practicing mindfulness is that this state will then be accessed more easily. Although Western psychologists have made some progress in measuring mindfulness, most of these attempts capture only the habitual, trait aspect of mindfulness (e.g. Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006). Because of the difficulty of assessing mindfulness in someone else, all mindfulness measures to date are self-report questionnaires. The measurement of a habitual aspect of mindfulness with self-report may be problematic, since it is not clear if an individual who is habitually non-mindful will be able to know this.

1.3.6. *Metacognition*

The term *metacognition* has its origins in cognitive psychology (e.g. Flavell, 1979), and as such it is usually defined as *thinking about thinking* (Lysaker, Gumley, & Dimaggio, 2011). Flavell (1979) distinguished between *metacognitive knowledge* and *metacognitive experiences* (sometimes also called *metacognitive monitoring*). Metacognitive knowledge consists of general knowledge or beliefs that individuals have about their own (or someone else's) cognitions. Metacognitive experiences on the other hand concern cognitions about cognitions in a given moment. A third type would be *metacognitive regulation*, which consists of strategies to change the status of thinking (Wells, 2007).

Wells (Papageorgiou & Wells, 2000, 2001; Wells, 2007, 2011; Wells & Carter, 2001; Wells & Matthews, 1994) has designed a theory of psychopathology and a cognitive therapy treatment based mainly on the first of these definitions, *metacognitive beliefs*. For instance, Generalized Anxiety Disorder is thought to be maintained largely by positive and negative beliefs about worrying. An example of positive metacognitive beliefs about worry would be that worrying is a good way of problem solving or that it can prevent bad things from happening, while an example of negative metacognitive beliefs would be that worrying is harmful.

Social phobia, on the other hand, is thought to be largely caused by maladaptive inward attention to a distorted image of how the self appears to others. Interestingly, these formulations point to the negative effects of exaggerated and/or distorted self-observation on psychological functioning (Wells, 2002). For example, the meta-cognitive treatment for social phobia, according to Wells, consists (among other things) of training in *outward* attention to balance the exaggerated tendency for inward attention in these patients.

There are also metacognition theorists who focus more on the *metacognitive experiences/regulation* dimensions. Despite the apparent focus on thoughts as the object of metacognition (*thinking about thinking*), authors with a constructivist cognitive therapy orientation include *thinking about feelings* in both self and others within the concept (Dimaggio, et al., 2009; Dimaggio & Lysaker, 2010; Liotti & Intreccialagli, 1998; Lysaker, Gumley, et al., 2011). The Metacognitive Assessment Scale (MAS; Semerari, et al., 2003) is an observer measure that has been developed for measuring these types of metacognitive capacities. It is designed to be applied to psychotherapy session transcripts. The MAS is based on a “modular” hypothesis of metacognition, meaning that there are several distinct though related aspects of metacognition and that deficient metacognition (for example in personality disorders) is best described in the form of profiles of these metacognitive aspects. The scale separates metacognition about self from metacognition about others, and it also further subdivides self and other metacognition into the following sub-parts: identifying mental states, relating mental states to behavior or other mental states, differentiating internal from external, and integrating mental states into a coherent narrative. Finally, the MAS also includes a separate scale for metacognitive mastery, that is the ability to work through one’s representations and mental states in order to find effective action or coping strategies.

Other cognitive-behavior therapy researchers discuss metacognitive *awareness* or metacognitive *monitoring* as a type of awareness in which mental states are experienced as “events in the mind” rather than as inherently parts of the self (Sheppard & Teasdale, 2000; Teasdale, et al., 2002). This means that in metacognitive awareness mental states are distinguished from the

internal observer and the result of this is that mental states are not identified as “the self” as much (because the self is also the observer).

Deficits in metacognitive awareness have been found to be associated with relapse in depression, and the preventive effect of cognitive therapy on depression relapse relative to patients discontinuing antidepressant medication has been found to be mediated by an increase in metacognitive awareness. Because of the emphasis on awareness rather than reflection, this term is much more reminiscent of mindfulness than other metacognition concepts. Indeed, the concept of metacognitive awareness seems to have originated from studies of Mindfulness Based Cognitive Therapy for depression (Segal, Williams, & Teasdale, 2002).

The concept of *theory of mind* can be seen as a metacognition kind of concept. Theory of mind has been defined as the ability to impute mental states to oneself and others (Premack & Woodruff, 1978). The theory of mind builds on the more basic capacity for *meta-representation*, or generation of *second-order representation*. This awkward-sounding concept seems to be based on the philosophical view that reality is never apprehended directly; all experiences are representations of reality. Meta-representation, then, entails representing our representations of reality (Baron-Cohen, Leslie, & Frith, 1985). The theory of mind concept has roots in philosophy but was introduced in psychology through the study of autistic children. Specifically, Baron-Cohen, et al. (1985) proposed that the extreme social impairment of autistic children is caused by an underlying impairment in the capacity to form a theory of mind.

Most of the versions of metacognition discussed so far seem to share a relatively stable trait model. Although metacognition is described as possible to change with treatment, it does not seem to be supposed to change from one moment to the next or from one context to another. An exception is the connections between metacognition and attachment theory outlined by Main (1991).

From an attachment theory viewpoint, Main (1991) described metacognition as an essential part of the healthy functioning of the attachment system from early childhood to adulthood. The forms of metacognition most relevant for attachment theory are the *awareness of an appearance-reality distinction* (i.e. things may not

be as they appear), *recognition of representational diversity* (i.e. the same thing may appear differently to different persons), and *recognition of representational change* (i.e. thoughts and feelings may change over time). The multiple incompatible internal working models of attachment seen especially in insecure-ambivalent attachment are according to Main not possible without significant deficits in metacognitive monitoring. Indeed, in the scoring and classification system for the Adult Attachment Interview (Main, Goldwyn, & Hesse, 2003), metacognitive monitoring is one of the scales associated with secure states of mind with respect to attachment (although the scale is still described as being “in draft”). Because metacognitive monitoring deficits as described by Main are connected to the attachment system, they may not be apparent in non-attachment contexts and are thus more state-like than most of the other metacognition theories reviewed. Main’s discussions of metacognitive monitoring also inspired the developments of mentalization theory.

1.3.7. *Mentalization*

Although the term *mentalization* is commonly used within cognitive and developmental psychology more or less interchangeable with metacognition and theory of mind (e.g. Frith & Frith, 2012), the following section will deal with a development of mentalization theory particularly influential within clinical psychology and psychotherapy. This theory, developed mainly by Peter Fonagy and his colleagues (e.g. Allen, Fonagy, & Bateman, 2008; Bateman & Fonagy, 2006; Fonagy, Gergely, Jurist, & Target, 2002; Fonagy & Target, 1996, 2000; Target & Fonagy, 1996), is an extension of psychoanalytic theory combined with attachment theory and research (Bowlby, 1980, 1988; Main, Hesse, & Goldwyn, 2008; Main, Kaplan, & Cassidy, 1985), philosophy of mind (Dennett, 1987), and theory of mind research (Baron-Cohen, et al., 1985). The concept of mentalization is defined as the capacity to understand human behavior in terms of underlying mental states, i.e. thoughts, feelings, wishes, needs etc (Fonagy, Target, Steele, & Steele, 1998). The term refers both to self-reflection and to reflection on other people’s behavior as being expressions of mental states.

Mentalization is thought to emerge as an integration of developmentally earlier states of mind, particularly the so-called *psychic equivalence* and *pretend modes* of functioning (Fonagy & Target, 1996; Target & Fonagy, 1996). *Psychic equivalence* means that internal and external worlds are treated as one and the same, which may be experienced as frightening if frightening fantasies are experienced as externally real. The opposite of *psychic equivalence*, and developmentally later, is the *pretend mode*. In *pretend mode* the internal and external worlds are experienced as completely separate. This means that there is no experience of a relationship between internal experiences and the external world. In this state fantasies are less frightening, but the downside is a sense of isolation and detachment. Most importantly in the present context, it would seem that in none of these modes is there any real possibility for self-observation. Only in the integrated mode of *mentalizing*, which normally starts to develop around the age of four, is there a possibility to observe internal experiences as representations that are both separate from external reality and at the same time connected to the external world.

The link between mentalization, as described by Fonagy and his coworkers, and attachment, is quite complex. Developmentally, mentalization is linked with secure attachment in that representations (words, images etc) that are needed for reflecting on mental states are thought to emerge out of the attachment figures' *congruent* and *marked* mirroring (Fonagy, et al., 2002). *Congruent* mirroring means that the caregiver's expressions more or less correctly map onto the child's actual experience, while *marked* means showing through gestures, affective display etc that what is reflected back is the infant's emotions and not the caregiver's own. Especially important is that the attachment figure treats the infant as an intentional being, because only then can the child learn to treat him/herself as a being with intentional mental states.

Support for these theoretical assumptions is given by research showing that mentalization is enhanced in securely attached children (for summary, see Fonagy, 2008; Fonagy, et al., 2002). On the other hand, recent research (Bartels & Zeki, 2004) has shown that the activation of the attachment system tends to *inhibit* areas of the brain associated with mentalization. This apparent

paradox is most likely explained by the fact that the attachment system is activated in contexts of fear, where the need for security overrides the exploratory system that is needed for successful mentalization (Liotti & Gilbert, 2011). On the other hand, Target (2008) concludes that secure attachment in the context of consistently benign family experiences may not lead to more than average mentalization capacity. Persons with exceptional capacity for mentalization as shown by the Reflective Functioning Scale are usually those with secure attachment *despite* difficult family experiences (so-called earned security; Main, et al., 2003).

Mentalization (at least the explicit type of mentalization measured by the Reflective Functioning Scale) could thus be seen as a kind of coping mechanism mostly needed in the face of difficult or even traumatic experiences. Difficult or traumatic experiences may thus either result in an *inhibition* of mentalization capacity, as for example with persons who develop borderline personality disorder (Bateman & Fonagy, 2004), or it may *stimulate* mentalization as a way of overcoming or processing difficulties. It is as yet unknown what factors contribute to the one outcome as opposed to the other, but it seems likely that there is some kind of critical threshold for traumatic experiences above which mentalization is defensively shut down rather than stimulated.

Deficit in mentalization has been posited as the most important factor underlying borderline personality disorder (Bateman & Fonagy, 2006), and partial deficit in mentalization has also been related to other psychiatric conditions, such as panic disorder (Rudden, Milrod, Aronson, & Target, 2008), depression (Falkenström, 2010; Lemma, Target, & Fonagy, 2010), and PTSD (Markowitz & Meehan, 2009). Mentalization-based psychotherapy treatments have been developed, first and foremost for borderline personality disorder (Bateman & Fonagy, 2004), but in recent years mentalization-based treatments have come to encompass populations such as antisocial personality disorder, eating disorders, self-harming adolescents, substance abusing mothers, families etc (Bateman & Fonagy, 2012).

The original measure of mentalization is the Reflective Functioning scale (Fonagy, et al., 1998), applied to the Adult Attachment Interview (George, Kaplan, & Main, 1985). Because this observer measure is both difficult to learn and extremely time-

consuming, researchers have been trying to find other ways of measuring mentalization. One such attempt is a brief Reflective Functioning interview developed by Rudden, Milrod, Target, Ackerman, and Graf (2006). The authors of this brief interview has taken some of the evaluative questions from the AAI that are necessary for scoring Reflective Functioning, but left other parts that are not necessary for scoring. So far, however, little validation research has been done on the RF interview. The RF scale or some modifications of it has also been applied to other interviews including the Parent Development Interview (Slade, Aber, Bresgi, Berger, & Kaplan, 2004) and the Panic-Specific Reflective Functioning interview (Rudden, et al., 2006).

Mentalization is both a trait and state term. Although definitely regarded as a relatively stable trait that differs e.g. between persons diagnosed with borderline personality disorder and those without personality disorder, it is also often described as a state that can fluctuate between contexts (e.g. attachment vs non-attachment contexts). The term mentalizing (mentalization reformulated as a verb) has become increasingly popular and points to this state aspect of the term (e.g. Allen, et al., 2008; Bateman & Fonagy, 2012).

Perhaps the main distinction between mentalization and psychological mindedness would be that mentalization is postulated as more state dependent while psychological mindedness is described as relatively stable across contexts. Another aspect that seems to separate mentalization from psychological mindedness is the focus in mentalization on the attachment context. This difference may have important consequences. There are theoretical (Fonagy & Target, 1997) and some preliminary empirical (Fonagy, 2008) reasons to believe that mentalization in attachment contexts is not highly correlated with general mentalization capacities.

It is not really clear what difference, if any, there is between metacognition and mentalization. The metacognition concept developed by the constructivist cognitive therapy groups seems more or less indistinguishable from that of mentalization. Indeed, like the British mentalization group, the interest of these researchers is on metacognition as a deficit in severe mental disorders such as schizophrenia and personality disorders.

1.3.8. *Affect consciousness/Affect integration*

Influenced by the affect theories of Tomkins (e.g. 1962, 1991) and self-psychological psychoanalytic theories (e.g. Stolorow, Brandchaft, & Atwood, 1987), Monsen (Monsen, Eilertsen, Melgård, & Ødegård, 1996; Monsen & Monsen, 1999) developed a theory of *affect consciousness*. In this conceptual framework affects are seen as primary motivating forces in the psyche, along with drives, homeostatic life support processes, and pain.

According to Tomkins a finite number of innate, universal affects exists, and these provide an amplifying function on other systems (cognitive, motor, perceptual, memory, etc). The affects provide information on the state of the self and its relationship with the external world, by establishing predictable relationships between the internal and external worlds. Integration of the signal function of affects with other systems is thus of vital importance for the coherence of the individual's experience (Solbakken, 2011).

Monsen's group has developed a method for the assessment of affect consciousness, the Affect Consciousness Interview (ACI; Monsen, et al., 1996). The ACI is an operationalization of affect integration, and refers to the "mutual relationship between activation of basic affective experiences and the individual's capacity to consciously perceive, tolerate, reflect upon and express these experiences" (Solbakken, Hansen, & Monsen, 2011).

The focus of affect consciousness as defined by Monsen and his coworkers is on affects experienced within the self. An extension of the affect consciousness theory and assessment has recently been made to incorporate also consciousness about affects as observed in others (Lech, Andersson, & Holmqvist, 2008). Affect consciousness is described mostly as a stable trait phenomenon, and there is some empirical evidence for this view (Lech, Holmqvist, & Andersson, 2012).

1.4. Summary and conceptual distinctions

Obviously, the topic of self-observation has been found useful in several, more or less different, conceptualizations. Choi-Kain and Gunderson (2008) made three distinctions about types of mentalization that are relevant to this discussion of self-

observation; one between self or others as the object of observation, one between cognitive and affective types, and one between implicit and explicit. These dimensions seem to offer a meaningful way to distinguish between the various concepts reviewed above.

1.4.1. Self vs other observation

Some of the concepts concern the self only (mindfulness, observing ego, older versions of psychological mindedness and some versions of metacognition and affect consciousness), others only (empathy), or both self and others (mentalization, emotional intelligence, newer versions of psychological mindedness, and some versions of metacognition and affect consciousness).

An important question is whether self- and other-observation are distinct psychological processes, or if there is one common process underlying both? According to modern intersubjective or relational psychoanalytic theories (from which mentalization theory partly originates), there can be no understanding of self without understanding the reciprocal influence between self and others. Stated differently, the self is defined in relation to the other and vice versa. Interestingly, although for completely different reasons, Buddhist meditation theories (from which mindfulness originates) come to the same conclusion that self- and other understanding is the same. In these latter theories mindful self-observation leads to understanding of universal causes of suffering, and the insight into these principles is thought to generate compassion for all beings (Young-Eisendrath, 2008).

1.4.2. Cognitive vs affective observation

The distinction made by Choi-Kain and Gunderson (2008) between cognitive and affective types of mentalization can be further subdivided into the *object* and *process* of observation (see also Gullestad & Wilberg, 2011). The *object* of self-observation is usually thoughts or feelings, but can in principle include any experience. Some concepts seem to refer more to observations on thought processes, such as in metacognitive psychotherapy for schizophrenia (Lysaker, Buck, et al., 2011), while other concepts such as affect consciousness (Monsen & Monsen, 1999) are

focused on awareness of feelings. Mentalization usually refers to reflection on all kinds of mental states such as thoughts, feelings, intentions, wishes etc; and mindfulness is even broader, encompassing awareness of any type of experience (not just mental states but any kind of interoceptive or exteroceptive sense impression).

The *process* of observation can be divided into one more cognitively oriented type of observation involving *reflection* on mental states (as seen in mentalization, psychological mindedness, and metacognition), and another type involving *awareness and tolerance of experiencing* mental states without much cognitive elaboration (as in the awareness/tolerance aspects of affect consciousness, mindfulness and metacognitive awareness/monitoring). Somewhere in between can be found the capacity for identifying and naming feelings and affects (or the incapacity to do so; alexithymia). This distinction has been emphasized by researchers of different orientations (e.g. Damasio, 1999; Stern, 1985). Farb, et al. (2007), using functional magnetic resonance imaging (fMRI), showed that distinct neural networks seem to underlie what they called *narrative focus* (i.e. reflection type of self-observation) and *experiential focus* (i.e. awareness type of self-observation). According to the authors, the narrative focus is a higher order cognitive function supporting the awareness of a self extended across time, while the experiential focus is an evolutionary older structure creating a sense of self out of momentary exteroceptive and interoceptive bodily sensory processes.

The relationship between the awareness and reflection processes of self-observation seems complex. On the one hand it seems that awareness to some extent is more basic than reflection, in that at least some measure of awareness is required for reflection. Without the basic distinction between the observer and the observed, there can be nothing to reflect upon. Theories of awareness also point out that in order for self-observation to be effective, experience needs to be not just observed, but tolerated and preferably accepted. If experience is not accepted as it is, the individual will be motivated (more or less consciously) to change or get rid of it and reflection is likely to be influenced by this. Thus

what may appear as reflections may then just be disguised attempts at changing an internal state that is experienced as aversive.

On the other hand, theories about reflection types of self-observation (especially mentalization theory) point out that better understanding of the relationships between internal and external and the causal relationships of mental states is likely to make aversive mental states easier to tolerate and accept. What is not understood is usually much more frightening and thus more difficult to tolerate. Thus, reflective self-observation is also likely to influence awareness.

1.4.3. *Implicit vs explicit observation*

Implicit memory concerns overlearned procedures that operate automatically outside conscious awareness, while *explicit* memory consists of intentional recollections of experiences or information. Applied to self-observation, the dimension of implicit versus explicit can be thought of as referring to the distinction between explicit, declarative reflection on mental states, in contrast to implicit, more or less automatic, “non-reasoned” registering and processing. The reflective type of self-observation process can probably occur both consciously and subconsciously, the latter being what in everyday life is experienced as intuition. While such “implicit experiences” may be familiar to most of us, they may be difficult or even impossible to assess scientifically. At any rate, most measurement instruments of mentalization, metacognition, and affect consciousness seem to tap mostly into the explicit, or declarative, mode.

The awareness type of self-observation, on the other hand, is per definition conscious. Indeed, it can perhaps even be regarded as the very paradigm of consciousness.

1.4.4. *State vs trait models of self-observation*

Finally, an additional dimension that has been discussed to some extent in the concept descriptions above is the one of state vs trait models. As discussed, some self-observation terms emphasize state aspects (fluctuations with time and context) and others emphasize trait aspects (stability over time and context but with individual differences). There are few examples of pure state concepts, but

The capacity for self-observation in psychotherapy

mindfulness as used in Buddhism and in ACT seems quite heavily state dependent.

2. Aims of the present thesis

As the literature review in the previous section shows, the idea that a capacity for constructive self-observation is critical to psychological development and health is central to several contemporary psychological theories. Empirical research on these concepts has, however, lagged behind, largely because until relatively recently no adequate measurement instruments have existed. Still it is unknown to what extent existing measurement instruments tap into the same phenomena. The aim of this dissertation is threefold: (1) to clarify the conceptual distinctions and similarities between concepts of self-observation, (2) compare measurement instruments used to study self-observation, and finally, (3) to test the predictive power of some of the measures on aspects of the psychotherapy process.

Study I had as its aim to study self-analysis, which according to psychoanalytic theory should be a specific outcome of psychoanalysis, and to relate this to post-treatment outcome. The aims of the following three studies were first to test the validity of quantitative measurement methods used for studying self-observation, in particular the Five Facet Mindfulness Questionnaire (Studies II and III) and the Reflective Functioning Scale (Study III and IV). A second aim was to test the predictive power of patient self-observation capacity in the form of Reflective Functioning on the early process of psychotherapy (Study IV).

The capacity for self-observation in psychotherapy

3. Summary of included studies

3.1. Article I: Self-analysis and post-termination improvement after psychoanalysis and long-term psychotherapy.

Few if any psychotherapy research studies focus on post-treatment processes. Even rarer are long-term follow-up studies of long-term psychoanalytically oriented psychotherapy or psychoanalysis that focus on post-treatment processes. In the Stockholm Outcome of Psychoanalysis and Psychotherapy project (Blomberg, Lazar, & Sandell, 2001), one of the results of the quantitative analyses was that patients in psychoanalysis continued to improve after termination to a higher degree than patients in long-term psychotherapy.

3.1.1. *Methods*

In order to study what post-treatment processes could account for these findings we selected 20 patients from the project who were interviewed on two occasions, one and two years after termination. As a first step, the interviews were studied qualitatively using a multiple case study design and a phenomenologically informed approach. This analysis ended up with four categories of different types of post-treatment development that were created from these case studies. In the second step use of these four categories was compared between the two types of treatment (psychoanalysis and psychotherapy). The last step in the analysis was again quantitative. The categories of post-treatment development were correlated with growth curves based on factor scores from the three quantitative outcome measures used in the project; the Symptom Checklist – 90 (Derogatis, 1974), the Sense of Coherence Scale (Antonovsky, 1987), and the Social Adjustment Scale (Weissman & Bothwell, 1976).

3.1.2. *Results*

Results indicated that the variation within the treatment groups was large, and that development may continue in several ways after termination. Four categories of post-treatment development were identified from the qualitative analysis; *post-treatment practice on problematic patterns identified in therapy, self-analysis, self-supporting strategies, and other causes for continuing development*. The most striking difference between psychoanalysis and psychotherapy was not, as hypothesized, in the self-analytic function, but in various self-supporting strategies described by former analysands but not at all by former psychotherapy patients. Self-analysis was used equally often in both groups. The final quantitative analysis showed that only the self-analysis category was significantly correlated with post-termination improvement across both treatment types.

3.1.3. *Discussion*

The difference between psychoanalysis and psychotherapy groups in terms of described self-supportive strategies was discussed in terms of pre-treatment patient characteristics, i.e. more so-called introjective patients may seek or be referred to psychoanalytic treatments, which would explain the autonomous stance of self-support. Another possibility would be that this autonomous stance was learned as an adaptation to the relatively less directive treatment of psychoanalysis.

Probably the most important finding of the study was the relationship between self-analysis and post-treatment outcome. Patients who in their follow-up interviews reported self-analytic efforts, i.e. efforts to understand difficulties arising in their lives in a similar way that they did in their treatments, reported better post-treatment outcome in terms of symptom reduction, sense of coherence, and social adjustment.

Limitations of the study include the possibility that the patients selected for the qualitative analysis were not completely representative of the larger sample of patients in the STOPP project, the use of only one person doing the major part of the qualitative analysis, and finally that the results cannot be

conclusively interpreted as causal given the correlational nature of the study design.

3.2. Article II: Studying mindfulness in experienced meditators: A quasi-experimental approach.

The mindfulness concept, defined as bare attention to internal and external sense impressions without judgment or prejudice, has a central position in Buddhist meditation. Descriptions of mindfulness and mindfulness training can be found in more than 2000 years old Buddhist scriptures (Robinson & Johnson, 1997). In the last two decades mindfulness has been adopted by researchers and clinicians in Western psychology and psychotherapy, and measures of mindfulness have been developed. Little is known about how well these measures work in its original context, Buddhist meditation.

3.2.1. Methods

We tested two different self-report measures; The Kentucky Inventory of Mindfulness Skills (KIMS; Baer, Smith, & Allen, 2004) and the Five Facet Mindfulness Questionnaire (FFMQ; Baer, et al., 2006; Baer, et al., 2008; Lilja, et al., 2011), in a study of mindfulness in experienced meditators. The design was a quasi-experimental intervention study. Seventy-six experienced meditators were included, 48 who were participating in an intensive meditation retreat in the *Vipassana* (insight meditation) tradition and 28 who did not. Retreat participants had scheduled meditation practice from early morning to late at night, and were encouraged to practice mindfulness of moment-to-moment experiences throughout the whole day. Mindfulness was measured before and after the retreat, and was also related to well-being measured by the General Population version of the Clinical Outcomes in Routine Evaluation (GP-CORE: Sinclair, Barkham, Evans, Connell, & Audin, 2005).

3.2.2. Results

The groups studied were very experienced meditators; the average number of years of meditating was more than 16 in the intervention

group and about 11 in the comparison group. Correlation analyses in the pre-intervention data showed that self-reported mindfulness was strongly related to well-being, with the exception for the observing subscale of the FFMQ. The acceptance and acting with awareness subscales were associated with meditation experience, although most of these correlations disappeared when age was controlled for statistically. Mindfulness increased after the retreat (significant pre-post effect), but the increase was not significantly larger for retreat participants than for the control group (non-significant between-groups effect). However, well-being increased more in the retreat group than the control group, and increase in mindfulness was associated with increase in well-being in both groups.

3.2.3. Discussion

Taken together, the results give a mixed picture of the validity of the mindfulness scales in an experienced Buddhist meditation group. The cross-sectional analyses generally confirmed the validity while the longitudinal analyses were less convincing. It is possible that the mindfulness scales that were developed to be used in normal populations or in clinical samples are less sensitive to the types of change that occur when experienced meditators engage in an intensive meditation retreat. Although there were no clear indications of ceiling effects, it may be that the items are less sensitive in the high range. Future studies using item-response theory (IRT) analysis could show more light on these issues.

Limitations of the study include the non-randomized design, which introduces a risk for bias in the between-group comparisons. Another limitation is the few measures; a broader range of measures could have given a more nuanced picture of the types of outcomes that intensive meditation gives. On the other hand it is likely that more measures would have lead to more attrition since that would have required more time and effort of participants. Qualitative in-depth interviews would be an interesting alternative for the study of the effects of intensive meditation.

3.3. Article III: Reflective Functioning, Affect Consciousness, and Mindfulness: Are these different functions?

The capacity for self-awareness and understanding of mental states such as emotions, thoughts, intentions etc has been emphasized as important for psychological health and adaptive interpersonal functioning by many contemporary clinical psychology researchers and clinicians of diverse theoretical origins. *Mentalization* is defined as the capacity to understand human behavior in terms of underlying mental states, i.e. thoughts, feelings, wishes, needs etc (Fonagy, et al., 1998). The term refers both to self-reflection and to reflection on other persons' behavior in terms of mental states.

Affect consciousness refers to the “mutual relationship between activation of basic affective experiences and the individual’s capacity to consciously perceive, tolerate, reflect upon and express these experiences” (Solbakken, et al., 2011, p. 5), and is the process thought to underlie integration of affect in cognition, motivation, and behavior. Finally, *mindfulness* is defined as the deliberate direction of attention to the present moment with an attitude of acceptance (Kabat-Zinn, 1990, 1996). Mindful self-observation is characterized by attempts to observe things directly, as they appear in each moment, setting any evaluations or preconceptions aside as to how they should be.

Although differing in several aspects the above described concepts share a focus on affect regulation by means of attending to thoughts and feelings in the present moment and their measures would be expected to overlap.

3.3.1. *Methods*

To study the relationships between these concepts, data from a group of psychotherapy students ($N = 46$) was used. Mentalization, operationalized as Reflective Functioning (RF; Fonagy, et al., 1998) was rated on transcripts of a brief version of the Adult Attachment Interview, the Five Facet Mindfulness Questionnaire (FFMQ; Baer, et al., 2006) was used to measure mindfulness, and the Affect Consciousness Interview-Self/Other version (ACI-S/O; Lech, et al., 2008) to measure affect consciousness. We hypothesized a moderate positive overlap between these measures.

3.3.2. *Results*

There was a small but statistically significant relationship between RF and FFMQ, but surprisingly no relationship between AC-S/O and RF or FFMQ. Post-hoc exploratory analysis showed a relationship between consciousness of others' affects and a reduced version of the RF scale where the high end had been cut off due to ambiguity of the meaning of higher than normal RF ratings.

3.3.3. *Discussion*

Results confirm that mentalization and mindfulness share some common variance, but contrary to expectations affect consciousness seems to be largely different from RF and mindfulness. A possible explanation is that both mentalization and mindfulness measure capacities for *regulating* affects (i.e. containing and reducing intolerable affect instead of acting out) by means of understanding (mentalization) or attention regulation (mindfulness). Affect consciousness measures a capacity for *using* the information value in affects. As such, it would seem that affect consciousness measures a healthy aspect of normal human functioning, while Reflective Functioning measures a kind of coping or processing mechanism that is needed at times of stress.

The results are also discussed in terms of different methods variance, in that all three measures are scored in different ways; mindfulness is scored by self-report, RF from AAI transcriptions by a trained rater, and Affect Consciousness from video recordings of the Affect Consciousness Interview by another trained rater. This makes the comparisons between these measures particularly stringent, since similar methods variance could not have biased parameter estimates upwards as is common in research comparing constructs measured by the same method (Campbell & Fiske, 1959; Podsakoff, MacKenzie, & Podsakoff, 2012). However, the study also has limitations; statistical power to detect small correlations was low and some results were based on post-hoc exploratory analyses increasing the risk for type I error.

3.4. Article IV: Patient Reflective Functioning as predictor of early psychotherapy process in the treatment of depression.

In recent years the concept *mentalization* (Fonagy, et al., 2002), has attracted a lot of interest from clinicians and researchers within the field of clinical psychology and psychotherapy. However, there is virtually no research on mentalization and the psychotherapy process. We hypothesized that the initial psychotherapy process would be experienced as more difficult for both patient and therapist when patients had lower capacity for mentalization, because their difficulty understanding behavior in terms of mental states would interfere with the demands of psychotherapy.

3.4.1. Methods

Using data from two ongoing randomized controlled trials of psychotherapy for depression (Interpersonal, Psychodynamic/Relational, and Cognitive Behavioral), we studied mentalization in 45 patients (15 men and 30 women) diagnosed with DSM-IV Major Depressive Disorder. Mentalization was measured as Reflective Functioning (RF; Fonagy, et al., 1998) on the Adult Attachment Interview (George, et al., 1985).

Additionally, a new measure of Depression-Specific Reflective Functioning (DSRF), measuring mentalization about depressive symptoms, specifically, was tested. Psychotherapy process was measured using the Working Alliance Inventory – Short form (Tracey & Kokotovic, 1989) and the Feeling Checklist (Holmqvist & Armelius, 1994). These instruments were completed after each session by both therapist and patient, although because we were primarily interested in the *initial* psychotherapy process only data from the first four sessions were used.

3.4.2. Results

The average RF on the AAI was low ($M = 3.1$; $SD = 1.2$), but variation in RF did not predict any aspect of the initial psychotherapy process. Higher DSRF predicted better working alliance and more positive feelings, as rated by the patient.

3.4.3. Discussion

The low RF in depression replicates two previous studies (Fischer-Kern, et al., 2008; Taubner, Kessler, Buchheim, Kächele, & Staun, 2011), and may help explaining why maternal depression is a risk factor for infant developmental problems (Cummings & Davies, 1994; Lyons-Ruth, Connell, Grunebaum, & Botein, 1990). If the results for DSRF are replicated, this measure, which is comparably easy to administer and score, may be useful for identifying patients who are not easy candidates for psychotherapy. It may be that RF on the AAI predicts aspects of the treatment termination process better than initial phase, because the attachment system may more likely be triggered by the impending loss of a supportive therapy relationship.

4. Discussion

This dissertation had among its aims to explore conceptual and measurement methods related to the phenomena of self-awareness and self-observation capacity. The four included studies approached the capacity for self-observation from different angles: Study I used mainly qualitative methods to study post-treatment processes related to continuing clinical improvement after termination of long-term psychotherapeutic treatments and in particular the phenomenon of self-analysis believed by some psychoanalysts to be a unique outcome of psychoanalysis. The main finding was that self-analysis seemed to be related to continued clinical improvement after formal ending of therapy, but contrary to our hypothesis there was no difference between psychotherapy and psychoanalysis in this regard. Study II tested the measurement of mindfulness by self report in a sample of experienced Buddhist meditators. The findings confirmed relationships between the measure of mindfulness and psychological well-being, but there was a question about the instrument's sensitivity to change at high levels of mindfulness because there was no difference in change in mindfulness between the intensive retreat participants and the control group. Study III compared different methods for measuring theoretically related concepts of self-awareness and self-observation; mindfulness, mentalization, and affect consciousness. This study showed surprisingly and intriguingly little common variance, particularly between affect consciousness and mentalization/mindfulness. Finally, Study IV found that in a group of clinically depressed outpatients Reflective Functioning was very low. Also, a measure of depression-specific mentalization predicted aspects of the initial psychotherapy process better than the more general mentalization

in the context of attachment measured by the Reflective Functioning scale.

Taken together, these findings point to the complexity of research on such elusive concepts as self-awareness and self-observation. Although most researchers and clinicians within the field agree to the importance of these concepts, the actual relationships between these variables, their measurements, and their relationships to the psychotherapy process seem more complex than would be expected from most current theories. Additionally, it would seem, particularly from the results of study III and IV, that different concepts related to self-observation, although superficially similar, may tap into different aspects of self-observation that may be important in different contexts.

4.1. Self-observation and affect regulation

The RF scale has been said to measure the capacity to use reflection as a kind of symbolic buffer against the effects of adversity or trauma. In this context explicit mentalization in the form of RF may be important in order to contain and process such experiences. However, in the absence of adversity, or – we may speculate – when processing of difficult experiences is finished, there may be no need for explicit mentalizing beyond a basic level. Thus, very high scores on the Reflective Functioning scale may indicate that the individual has an ongoing need to contain and process difficult experiences.

Levy, et al. (2006) used the RF scale as an outcome instrument in psychotherapy for Borderline Personality Disorder, showing that RF increased more in Transference Focused Psychotherapy than in Dialectical Behavior Therapy and Supportive Psychotherapy. In the treatment of BPD, RF may be appropriate as an outcome measure because BPD patients have been found to score very low on the RF scale and are likely to be in need of effective affect regulation. However, in other populations RF may not be the best indicator of therapy progress since the best outcome indicator may not be a very high RF score but rather reduced need for high levels of RF, that is, improvement in the capacity to contain and cope with adverse experiences.

Affect consciousness, on the other hand, may be a less ambiguous indicator of psychological health. Theoretically, a well-developed capacity for using the signal value of affects and letting this inform thinking and behavior indicates a well-integrated and smoothly functioning self-structure. There is less ambiguity about the meaning of high levels on this measure – although this remains to be shown empirically.

The position of mindfulness in regard to affect regulation is complex. On the one hand, mindfulness seems to point to a capacity to experience life fully with presence and acceptance (i.e. implying good affect regulation skills). On the other hand, it is possible for mindfulness to become too self-focused and too focused on “letting go” of experiences. There is some clinical literature on the defensive use of mindfulness (Epstein, 1990; Kornfield, 1993), emphasizing among other things the risk that individuals with an avoidant attachment style use mindfulness techniques as a way of suppressing disturbing thoughts and emotions. The finding that the Observe subscale of the FFMQ, which in content seems to measure the most central aspect of the traditional mindfulness construct, in some populations is related to more rather than less psychopathology also seems to point to this risk (Baer, et al., 2006; Baer, et al., 2008).

4.2. Contextual (state) aspects of self-observation

Complicating the comparisons between different forms of self-observation is the fact that the Reflective Functioning scale supposedly measures mentalization in the specific context of attachment relationships, while none of the other measures used in the present thesis does. The AAI is designed to “surprise the unconscious” (George, et al., 1985), and the probing of difficult and traumatic experiences in the interview would theoretically be expected to activate the attachment system analogously to the separation from mother and introduction of the stranger in the Strange Situation Procedure (Ainsworth, Blehar, Waters, & Wall, 1978) used to score infant attachment. The capacity for RF scored on the AAI may thus be expected to be most important in situations where the attachment system is activated.

The results of both Study III and IV may have been affected by this contextual effect. In Study III RF on the AAI was compared to measures of self observation that are not limited to attachment contexts. In Study IV RF was used to predict reactions in the early phase of psychotherapy, which may or may not be experienced as an attachment context. Our ad hoc decision to focus on the initial treatment phase was based on the idea that pre-treatment patient factors would be most important for the process in the early phase of treatment because later in therapy therapist, treatment, and therapist-patient matching factors may affect the process more, rendering pre-treatment patient factors such as RF/DSRF less important. However, the findings of Study IV point to the fact that what is most important, at least in the early phase of treatment, is the patient's capacity for mentalizing about depressive symptoms. This was demonstrated by the finding that Depression-specific RF predicted aspects of the early therapy process while RF on the AAI did not. The task of the early phase of brief psychotherapy for depression is probably focused on finding a psychological explanation for the depressive symptoms that both therapist and patient can agree upon. In this context, it is likely that patients who already are thinking to some extent of their problems in psychological terms are at an advantage to those who do not. In retrospect it seems natural that this aspect of mentalizing would be more important in this particular context than general attachment-context mentalizing would be. It may be that in the early phase of brief treatment for depression the attachment system is not active, but the attachment system may more likely be activated in the final phase of treatment with the impending loss of a supportive therapy relationship.

4.3. Measurement issues

In Study III we grappled with the difficulty of comparing instruments across observer perspectives; that is self-report measures compared to trained observer ratings and observer ratings of different interviews focusing on different subjects. Because different concepts could only be measured using particular standardized and validated methods, we were left with the inevitable comparison between different concepts measured from

different observational perspectives. As noted in the Discussion of Study III, this makes the comparisons between measures all the more stringent because variance due to the same measurement methods could not bias the comparisons toward stronger correlations (Campbell & Fiske, 1959; Podsakoff, et al., 2012).

It is common in psychology research to compare different self-report instruments without taking possible halo-effects (Thorndike, 1920) into account. This possible source of bias is not often discussed in clinical psychology journals. Bodner (2006) showed that 66% of articles published in social and personality psychology and 33% in clinical psychology used self-report questionnaires as the sole measurement method. A recent review of method bias in psychological research (Podsakoff, et al., 2012) showed that relationships between constructs measured using the same method were inflated by between 133% and 304% compared to when different methods were used. Because of the possible problems of comparing different self-report instruments with each other, predictions that hold across measurement perspectives are more trustworthy because they are unlikely to be biased upwards because of common measurement method.

In Study III there was one such example of a relationship across measurement perspectives in our primary analyses, the correlation between RF and the FFMQ. In Study I the presence or absence of self-analytic efforts rated by an external observer correlated significantly with patient rated symptom change over the years after termination of treatment. Similarly, the relationship found in Study IV between observer-rated Depression-Specific RF and patient ratings of the early therapeutic alliance was also significant across measurement perspectives. However, the comparison between mindfulness questionnaires and well-being questionnaires in Study II is an example of a situation where an irrelevant source of variance due to common measurement methods may have biased results. It may, for instance, be that individuals who happened to be in a good mood this particular day rated both higher mindfulness and more well-being due to this mood state. Incidentally, relationships between self-report measures from different time points (as for example in repeated measurements and in particular cross-lagged designs where it is possible to control for

bidirectional causality) may be less vulnerable to such bias (Podsakoff, et al., 2012).

The measurement of mindfulness by the FFMQ may treat mindfulness too much as a trait concept compared to the original concept. Also, as the findings of Study II indicate, there may be a problem that the scale does not differentiate well between levels of high mindfulness.

4.4. Self-observation: A clinical process perspective

A distinction was made in the Introduction (section 1.11.2) between awareness (typified by mindfulness) and reflection (typified by Reflective Functioning) types of self-observation processes. Although Study III showed a small correlation between measures of these types of self-observation, a more complex view of the relationship between reflection and awareness may be needed. Such a model is described below. Although admittedly speculative, it is consistent with some clinical theories and empirical research and may prove useful as a clinical tool while awaiting further empirical validation.

As early as in the mid-sixties, Deikman (1966) hypothesized that mindfulness training facilitates “deautomatization” of psychological structures. This term refers to the well-known phenomenon of automatization, whereby previously difficult tasks requiring full attention gradually through practice become possible to perform without conscious attention. Automatization has the advantage of saving attention resources, so that not all attention needs to be directed for instance to the moving of the legs and keeping of balance while walking. De-automatization means the undoing of automatization, which would be required when correcting something that has been learnt the wrong way. This is accomplished by re-investing actions and perceptions with attention. Deikman’s idea was that mindfulness practice could facilitate the deautomatization of problematic internal psychological structures. This deautomatization would lead to a temporary regression in psychological functioning toward more “primitive” perceptual and cognitive functioning, thereby

explaining the unusual experiences sometimes encountered during meditation practice (Deikman, 2000).

A model for self-observation may be to think of the awareness and reflection types of observation as complementary, and that optimal therapeutic development is characterized by a dialectical process of shifting between these modes over time (see Figure 1). The idea is that reflection is a cognitive (“top down”) operation needed to maintain an integrated identity that is felt to be more or less the same over time and space (Erikson, 1956). Direct awareness, on the other hand, ensures contact with experiential reality, which is needed for vitality and openness to new experiences (Stern, 1985).

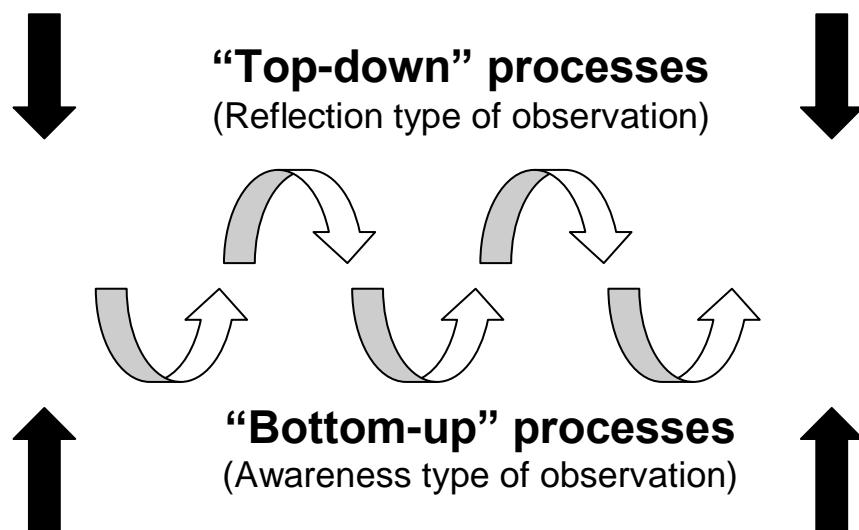


Figure 1. *The dialectical relationship between reflection and awareness types of self-observation.*

Following this line of thought further, deficits in reflection type of self-observation would lead to vulnerability to experiences of disintegration, lack of meaning, and unpredictability of events. This may be most clearly seen in patients with borderline personality disorder. On the other hand, rigid clinging to cognitive “reflection” type of self-observation may lead to the kind of stagnation and lack

of openness to new information about self and others more reminiscent of neurotic and obsessive personalities.

The model should not, however, be interpreted as “top-down” and “bottom-up” processes being complete opposites. That would mean, for example, that individuals with deficient reflective capacities would be more mindful. Research rather shows that the “top-down” processing mode is the default, as shown in fMRI studies where similar brain activity is displayed in resting states as when participants are engaged in tasks requiring a “narrative focus” (Christoff, Gordon, Smallwood, Smith, & Schooler, 2009; Farb, et al., 2007; Mason, et al., 2007). Although this kind of research has not, to my knowledge, been done on individuals with Borderline Personality Disorder, individuals with BPD are more likely to desperately cling to dysfunctional (polarized) views of self, others, and the world (i.e. top-down processes) as a way of defending against unbearable affect than to be mindfully aware of moment-to-moment experiences (Linehan, 1993).

As the model implies, therapeutic development ideally proceeds as a dialectical interplay between these modes of functioning. When anxiety is high, reflection may be called upon to help modulate and contain affect. Conversely, when the “top-down” processing mode is too dominant, increased awareness of affective experiences may be needed to *deautomatize* rigid and/or dysfunctional patterns of thinking. This may lead to a temporary “disintegration”, in that an organized identity that provided stability and predictability is relinquished in order to be re-organized (Epstein, 2000; Falkenström, 2003, 2007).

A direct clinical implication would be that therapists need to focus their interventions differently depending on if their patient is currently too rigid and closed or more disintegrated/flooded with affect. A rigid patient may need interventions directing attention more toward direct experience, especially affective experiences. Examples of such interventions are found in the experiential (Gendlin, 1996; Greenberg, Rice, & Elliott, 1996) and affect-focused (Fosha, 2000; McCullough, et al., 2003) traditions. Such interventions direct the patient’s attention to the here-and-now experience, especially when discussing affectively charged subjects. Examples could be questions “What are you feeling at this

very moment?” or directions “Could you try to stay with this feeling without trying to change it, just to see what happens?”. Other interventions with the same objective are described by Curtis (2012).

A disintegrated patient, presumably overflowed by strong affects (either as a more or less enduring personality disposition as in BPD or as a temporary crisis) would be more helped by cognitively focused interventions, helping the patient find meaning in events. Interventions with this aim seem especially well developed in Mentalization Based Treatment (Bateman & Fonagy, 2004). Such interventions ask for evaluations of experiences, for instance “Why do you think you did that?” or “Can we try to understand what is happening between us right now?”

4.5. Suggestions for future research

The present thesis indicates a clear need for more research on the Reflective Functioning scale. There is especially a need to understand better the implications of Reflective Functioning scored on the Adult Attachment Interview. Future studies should develop and test specific predictions of low respectively high RF on the AAI on relevant external criteria. There is also a need to replicate the original studies of RF (e.g. Fonagy, et al., 1996; Fonagy, Steele, Steele, & Moran, 1991) by independent research teams in order to make sure that the findings are robust. If possible it would also be important to find ways of scoring RF that are less difficult and time-consuming than scoring from verbatim transcriptions of the full AAI.

There is also a need for further research comparing different measurement instruments such as the FFMQ, the AC-scales, and RF. In particular, it will be important to compare prediction models on external criteria rather than just compare the measures with each other.

The possible implications of low average RF in clinical depression (as found in Study IV) will be important to study further. First of all it will be important to establish if RF increases to normal levels when depression remits. If so, the depressive state is probably the cause of lowered RF. If not, it is more likely that low RF is a risk factor for developing depression. In that case it

The capacity for self-observation in psychotherapy

will be important to develop treatments that focus on this particular risk factor. Finding ways to reduce risk of recurrence in depression is an extremely important task for research since depression has been found to be associated with very high levels of recurrence (e.g. Burcusa & Iacono, 2007; Judd, 1997).

In addition, if the low RF is responsible for the link between parental depression and child behavior problems, it will be important to establish if mentalization increases when depression remits. If not, it may not be enough to treat these parents' depression, but some kind of mentalization-enhancing intervention might also be needed.

Finally, the idea of a capacity for self-analysis as an outcome of long-term psychotherapy will also be important to study further. Post-treatment process research is virtually non-existent, and much more can be learned about it.

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