

**REFLEXIVITY AND THERAPEUTIC CHANGE IN THE
COGNITIVE-CONSTRUCTIVE PSYCHOTHERAPY
OF PANIC DISORDER**

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Master's Thesis research

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Autumn 2000

Abstract

Reflexivity and Therapeutic Change in the Cognitive-Constructive Psychotherapy of Panic Disorder

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Master's Thesis research in psychology, December 2000

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The subject of this research is the process of therapeutic change in cognitive-constructive psychotherapy of panic disorder. The purpose was to construct an accurate categorical process model that aptly represents and describes the main phases of the therapeutic change process, to create a more elaborate and refined theoretical basis for understanding the change in question, and to illustrate this change through examples of speech in therapy. We used the text provided in therapy by two cases and theoretical knowledge along with a previously formed model of change to construct a new model. This model is a dynamic description of the process of change, which is separated into three distinct main categories: the reactive position, reflexivity and the reflexive position. Each of these main categories consists of panic-specific subcategories. The model in itself is theoretically bound to the base concept of the I-Me –dialectic that produces human experience. We found that reflexivity is a necessary precondition of lasting change. That is, it does not guarantee change in its own right, but potentializes the change that is actualized in the reflexive position.

Key words: cognitive-constructive psychotherapy, I-Me –dialectic, panic disorder, reactive position, reflexive position, reflexivity, therapeutic change

Tiivistelmä

Tutkimuksemme kohteena on terapeuttinen muutosprosessi paniikkihäiriön kognitiivis-konstruktivistisessa psykoterapiassa. Tarkoituksena oli luoda kategorinen prosessimalli, joka osuvasti kuvaa terapeuttisen muutoksen keskeiset vaiheet. Pyrimme myös sitomaan em. mallin ja teoreettisen tiedon kiinteästi toisiinsa. Käytimme terapiassa tuotettua puhetta havainnollistamaan mallin kuvaamaa muutosprosessia. Rakensimme uuden mallin käyttämällä kahden tapauksen terapiassa tuottamaa puhetta, teoreettista tietoutta ja aiemmin luotua kategorista mallia. Malli kuvaa dynaamisesti muutosprosessia, joka on jaettu kolmeen erilliseen pääkategoriaan: reaktiiviseen positioon, refleksiivisyyteen ja refleksiiviseen positioon. Jokaiseen pääkategoriaan sisältyy myös paniikkispesifejä alakategorioita. Mallin teoreettisena pohjana on ihmisen kokemista tuottavan I-Me – dialektiikan käsite. Tutkimuksemme mukaan refleksiivisyys on välttämätön muttei riittävä ehto pysyvälle muutokselle. Toisin sanoen, se ei itsessään takaa muutosta, mutta synnyttää potentiaalin joka aktualisoituu refleksiivisessä positiossa.

Avainsanat: I-Me –dialektiikka, kognitiivis-konstruktivistinen psykoterapia, paniikkihäiriö, reaktiivinen positio, refleksiivinen positio, refleksiivisyys, terapeuttinen muutos

Introduction

This thesis revolves around and focuses on the concept of reflexivity in the context of therapeutic change. This concept has been used in the field of psychology more or less synonymously with concepts such as metacognition, agency, reflectivity, self-monitoring, recursiveness and self-consciousness (Rennie, 1992). Rennie (1992) refers to Lawson (1985), who describes reflexivity as “turning on the self”. Earlier research on the subject has produced a dimensional and categorical model for understanding the underlying processes in therapeutical change (e.g. Mikola & Oksanen, 1999; Sarlin & Syrjäläinen, 1999). The opposing ends of this dimension have been identified as the reactive and reflexive positions; the former referring to the starting point or reason for therapy, the latter to the end-goal of therapy. In other words, the dimension is a theoretical description of the cognitive and experiential processes that take place in moving from the reactive position to the reflexive one. The whole therapeutic process has been divided into qualitatively distinct process categories and subcategories in order to reveal the relations between reflexivity and therapeutical change.

In order to understand the phenomenon of reflexivity, it is necessary to examine the subject and object of reflexivity, i.e. the self. Guidano (1991) continues the tradition of making a theoretical distinction between the experiencing (I) and the observing (Me) aspects of the self. This division of the self into two inextricably intertwined elements describes the unified and continuous process that produces the experience of existence and gives it its meaning. The most important purpose of this dynamic, self-organizing and dialectical process is to uphold the integrity and cohesiveness of the self. Greenberg, Rice & Elliot (1993) have adopted a similar I-Me –dialectic in understanding the human experience of being-in-the-world. The continuous dialectical relationship between the non-propositional, automatic and direct experience of being and the propositional and symbolic evaluation of this experience create a conscious and meaningful sense of existence for the individual. In this process the I, i.e. the direct experience, is always one step ahead of the meaning-giving Me. In short, human experience can be understood as the dialectical interaction between a fast emotional reactive system and a slower, more conceptual and abstract cognitive system.

The I-Me –dialectic is mediated through certain cognitive-emotional structures or schemes. Greenberg and Paivio (1997, p. 3) define emotion schemes as involving “a set of organizing principles, constructed from the individual’s innate response repertoire and past experience, that interact with the current situation and generate current experience. Schemes are highly personal and idiosyncratic, laden with emotional memories, hopes, expectations, fears, and knowledge gleaned from lived experience.” Emotion schemes are more than static mechanisms that generate current experience. By “determining” the emotionally laden and complex impressions of things and experience in general, they also guide conscious thought and overt action, e.g. decision making. In other words, these schemes function as the basis for organizing experience and action. From this point of view, emotions are seen as central factors in not only feeling but also knowing.

Guidano (1991, p. 33) uses the concept of a personal meaning organization to describe the “*unitary ordering process* in which continuity and internal coherence are sought in the specificity of the formal, structural properties of its knowledge *processing*, rather than in definite semantic properties of its knowledge *products*”. In other words, the content of the ordering process is of secondary relevance; it is not as important to ask what it contains but *how* the contents have been formed and are continually formed through certain deep syntactic rules. Personal meaning organizations and emotion schemes concern different psychic domains: the former direct and uphold the functioning and organization of the psyche as a whole, whereas the latter concern the production of experience. In a sense, emotion schemes and personal meaning organizations can be understood as processes that mediate and direct the dialectical interaction between the I and the Me, which in turn gives rise to human experience.

We define reflexivity as a dynamic state where the aforementioned I-Me –dialectic is brought into the focus of conscious awareness. In this state of reflexive awareness, the individual is able to step out of and place himself beside his own experience, making it possible to observe it from the “outside”. Reflexivity does not automatically entail changes in the I-Me –dialectic or the cognitive-emotional structures related to it, but is a necessary condition for these changes to actually take place. That is, it potentializes therapeutic change. Thus, we conceptually and practically separate the phenomena of reflexivity *an sich* from the therapeutically bound concept of the reflexive *position* as the end-goal of the therapeutic process. Reflexivity is the necessary predecessor to the

sought after reflexive position, making it in a sense the cornerstone or turning point in the whole therapeutic process.

If this state of reflexive awareness is not achieved, emotional experiences may be felt as negative and compulsive, making them appear incomprehensible and confusing and lead to behavior that the individual himself does not understand the roots of. In spite of and because of this unawareness, the individual has “no choice” but to act as he does on the basis of these immediate and threatening experiences. Because they seem so threatening, these experiences must be excluded from the self and often lead to their compulsive control. This gives birth to a vicious cycle that worsens the situation, making the problem all the more problematic. This immediate and unaware mode of experience and behavior is defined as reactivity, and in therapy, the reactive position.

The purpose of cognitive-constructive psychotherapy is to enable the client to create a new and alternative way of relating to an experience that is personally problematic and restrictive. This alternative relation is achieved through the cognitive-emotional schematic reorganization of the I-Me –dialectic. The goal is to understand the deep syntactic rules of the self-process, not to focus on the semantic surface level of knowing as is done in traditional rational cognitive therapy (Guidano, 1991). In other words, the therapeutic process aims at understanding what the problematic experience is about, why the client’s relation to himself and the world is as it is and why he experiences it as he does. According to Guidano (1991), the quality and structure of the change process depends on the level and quality of reflexive self-awareness, which can also be seen as an instrument of reorganization. The role of emotions in change is essential; only feeling can change emotions. That is, the emotion schemes and personal meaning organizations are not receptive to structural changes if the emotion-laden experiential process that they co-produce and direct is not brought into awareness.

The therapeutic model used in this research consists of five phases (Toskala, 2000). In the first phase, the client is guided into recognizing his problematic experience as an inner process, originating in the self. To bring this about, the client is asked to focus on bodily sensations, thoughts and feelings associated with the problematic experience. In other words, the experience of the I is examined before the Me gives it its usual, problematic interpretation. The I-Me –dialectic is slowed down in order to understand how one’s experience is produced.

In the second phase, the client is encouraged to conceptualize and reformulate his problematic experience in order to reach its essential core and give it a new, more descriptive name. The use of traditional clinical classifications is avoided because they do not appropriately capture the essence of psychic problems. This renaming is often a precondition for a better understanding of how the client constitutes the problematic experience.

The purpose of the third phase is to guide the client into creating an alternative relation with this experience. The client is gradually encouraged to step out of and place himself beside the experience so that it may be explored more openly. In other words, the I-Me –dialectic is brought into the focus of reflexive self-awareness. Gradually, the feeling of agency over one's emotions increases, which in turn makes them less threatening and restrictive. When the experience that was earlier felt as problematic is consciously integrated into the self, it ceases to be something that must be excluded and controlled, and is no longer alien and undesirable to the self. Naturally, the client does not use and is not encouraged to use the abstract conceptual terms used in theory and research. Rather, he is supported in describing the experience in his own words.

In the fourth and fifth phases, the problematic experience is examined intersubjectively, i.e. in relation to others. In the fourth phase, the focus of attention is on current relationships with important people, such as family and friends, and how the problematic experience is generated and manifested in them. In the fifth and final phase, a minor excavation is made into past events and relationships to understand how this particular mode of experience was formed. The unearthing of past issues is not in itself curative; it must promote and advance the understanding of present-day I-Me - dialectics. This historical examination contains the risk of becoming a means of justification for the current problem. Because of this, the basic question of therapy must always be 'how?' instead of 'what?'. Both phases aim at a deeper understanding of how the self is constituted in the present.

In this thesis, reflexivity is researched in the context of cognitive-constructive psychotherapy for panic disorder patients. According to the DSM-IV Classification (Davison & Neale, 1996, pp. 144-145), panic disorder belongs to the category of anxiety disorders. In panic disorder there is a sudden and often inexplicable attack of a host of symptoms – labored breathing, heart palpitations, chest pain, feelings of choking

and smothering; nausea, dizziness, sweating, and trembling; and intense apprehension, terror, and feelings of impending doom. It is diagnosed as either with or without agoraphobia, the former being much more common, and typically begins in early adulthood.

Guidano (1991) differentiates four types of personal meaning organizations and dominantly places panic disorder into the phobic personal meaning organization, which is characterized by the need for security. Panic disorder as a reactive position can be understood as a mode of experiencing where the individual reacts immediately and unconsciously in the aforementioned ways (nausea, dizziness, etc.) to signals from either within or outside himself that are interpreted as threatening to the feeling of personal security. This threat is experienced as an extreme and primitive state of distress that must be controlled. It can be understood as the overwhelming distress of a child that has not been met and shared. The interpretation and the behavior that it entails are automatic; the individual feels overwhelmed and powerless to prevent it. The individual does not see the panic as something originating in the self; instead, according to Liotti (1991), it is often attributed to a somatic or psychic illness that is not part of the self-process.

We examine the therapeutic process at two levels: the more general dimension of reactivity-reflexivity and the more specific categories and contents of panic disorder in this process of change. We assume that the transition from the reactive position to the reflexive one is in essence the same in all anxiety disorders treated in cognitive-constructive therapy. The specific disorders give this general process its more specific and characteristic contents.

Our purpose is to continue the ongoing cognitive-constructive psychotherapy research carried out at the University of Jyväskylä and 1) construct a more accurate categorical process model that aptly represents and describes the main phases of the therapeutic change process from the reactive position to the reflexive one and create a more elaborate and refined theoretical basis for understanding the change in question, and 2) illustrate the therapeutic change described in the categorical process model through two case studies.

The research process

The therapy

The cognitive-constructive psychotherapy for panic disorder patients was carried out from September to December in 1999. The therapy was conducted by the Psychotherapy Clinic of Research and Education at the University of Jyväskylä. The therapist was an experienced psychotherapist of cognitive therapy. The possibility to partake in this therapy was announced in the local newspaper. Each potential participant was interviewed by the therapist, who chose four persons – three men and one woman – into the group. Two of the participants had been previously diagnosed as having panic disorder, the other two self-reportedly suffered from symptoms associated with the disorder. The youngest participant was 45 and the oldest was 59. At this point, none of the participants were working. The three men were married with children and the woman was single.

The therapy situation can be described as individual therapy in a group setting; each participant was encouraged to focus on his or her own therapeutic processing rather than group dynamics. With the consent of each participant, the sessions were recorded on video- and audiotape for further analysis. Along with the therapist and the participants, one of the researchers passively took part in the session, while the other was supervising the recording process. The therapy process consisted of twelve ninety-minute sessions, in which the five phases mentioned in the introduction were carried out, with two sessions used for each phase. The first session was used to introduce to and prepare for the process and contents of the upcoming cognitive-constructive therapy and the last session was used as a “round-up” for the completed process. The group gathered for one last meeting with three of the participants in May 2000. The purpose of this meeting was to discuss and evaluate life after therapy and the constancy of possible change.

Research methods

This research consists of two case studies. The chosen cases are assumed to represent the researched phenomenon aptly. In this research, the phenomenon of interest is the therapeutic change process from the reactive position to the reflexive one. We have chosen a successful and an unsuccessful case in order to reveal and understand the essential and most important factors in this process. The successful case was a 45-year old male, who was married with two children. The unsuccessful case was an unmarried 57-year old female. Success in therapy was evaluated on the basis of personal reports before, during and after the process. All of the participants were asked to fill out three questionnaires before and after therapy. Two of these questionnaires were used in the evaluation (see Appendices 1 & 2, see Table 1). Also, a personal description of possible change and progress was written by each client after the therapy process (see Appendix 3). Questionnaire 2 and the personal description provided information that was assessed qualitatively. Questionnaire 2 provided graphic information of change that was evaluated by a comparative overlook of the 'before' and 'after' answers. In other words, possible change was assessed on the basis of a rough visual estimation. The personal descriptions were treated as giving direct information of the cases' personal experiences concerning the therapeutic process and possible change.

Table 1. Scores for questionnaire 1.

	Successful case (M)	Unsuccessful case (E)
Score before therapy	58	64
Score after therapy	99	72
Overall change in points	+41	+8

Minimum score = 23, Maximum score = 138

In case study research, the theoretical model has a central role in data collection and analysis. A solid theoretical foundation gives more explicit guidelines for the analysis of

the data and reduces the role of vague intuition (Yin, 1994). In short, the research is hypothetic-deductively orientated.

The therapy process produced about 400 pages of transcribed text data. The research proceeded as follows: 1) All text produced by the researched cases was taken into analysis and *segmented* according to the principle that each segment of text is comprehensible by itself and contains one idea, episode, or piece of information (Tesch, 1990). 2) These segments of text were *placed into an already existing organizing system* of panic-specific process categories (see Syrjäläinen & Sarlin, 1999) in order to evaluate the validity of these categories. The purpose of this was to initiate a dialogical process with the text and see which categories were compatible and whether they needed to be refined or whether new categories needed to be created. During this process, we discovered the existing organizing system to be insufficient and static in the sense that it did not capture the processive and dynamic nature of the change process.

3) On the basis of the aforementioned dialogue and theoretic exploration and contemplation, we *created a new organizing system*, i.e. a model that combined the strengths of the old system with new insights. The purpose of the this new system was to function as a rough or preliminary model of change and was created as a basis for reinitializing a dialogue with the text. Another main objective was to give the new system a more solid theoretical basis, i.e. to combine the description of the therapeutic change process with a coherent theoretical conceptual system. 4) We began the *categorization* of the whole text according to the new system. We began *testing the compatibility* of this system by placing each segment of text into the newly formed process categories. A category was understood to receive support and confirmation whenever it appropriately described the content of a segment of text. In other words, whenever a segment of text was placed into a certain category, this category corroborated its own place in the process model. If a certain novel theme recurred often and was theoretically relevant to the change process, we added a new category; if the text did not support a certain category, we left it out. In short, there is nothing in the model that can not be found in the text. In this manner, the text in itself acted as the final jury in convicting whether a certain category was created, retained or left out.

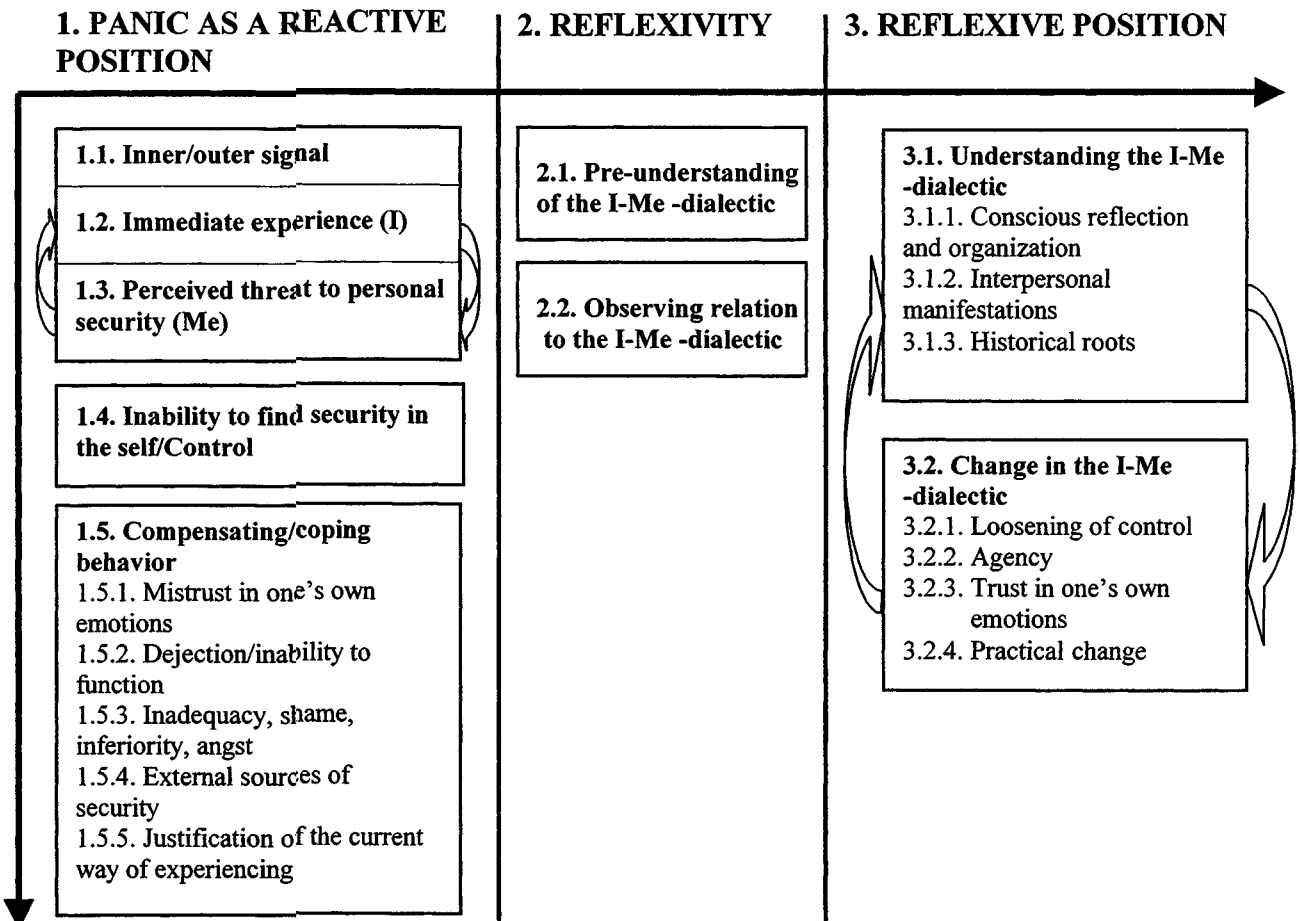
5) This dialogical process refined and redefined the contents of this model, resulting in *the final categorical process model of therapeutic change*.

The reliability of the final categorization was tested by selecting three therapy sessions, one from the first, one from the second and one from the final third of the therapy process. The two researchers each separately categorized the selected sessions according to the final process categories. The sessions used comprised of 103 segments of text. The uniformity of the categorizations was calculated by dividing the number of the same categorizations between the raters by the overall number of segments (85/103). This led to a percentage of 83%. According to Taipale (1989), the generally accepted criteria for reliability in research is 80%. The categorization can therefore be seen as reliable.

Results

The main result of this research is a newly formed categorical process model of therapeutic change (see Table 2). The model functions at two levels: a more general level that is assumed to apply to all anxiety disorders treated in cognitive-constructive psychotherapy and a more specific level that applies to panic disorder only. The general level consists of three main categories that describe qualitatively distinct phases in the change process. The panic-specific level consists of subcategories that give the main categories a more disorder-specific content. The central objective of the new model is to stress the processive nature of therapeutic change and illuminate the relations between the different parts of the process. We will use the two cases' speech to exemplify each category.

Table 2. Categorical process model of therapeutic change



1. The reactive position

Reactivity in itself consists of a maladaptive I-Me –dialectic and all the emotions, cognitions and actions related to it. The reactive self-process in panic disorder proceeds in the following manner.

The process is initiated or triggered by an inner or outer signal (1.1.), e.g. a social situation or a certain thought.

T: “When do the panic attacks usually occur?”

M: “I can’t say that there is any typical situation. Just a few days ago I had a strong... it came while I was walking with a friend, it was a completely calm situation --- I noticed I didn’t have my medication with me and it was a long way back to where it was. That might have caused the situation.”

E: “In the department store waiting in a long line makes me nervous... --- And at the bus-stop, if I get there too early the waiting makes me nervous.”

In this situation, the immediate experience (1.2.) is perceived as a threat to the personal security of the self (1.3.).

E: “It comes on so forcefully, it feels as if a blood vessel will burst in the head --- I can’t understand my thoughts anymore, everything is all mixed up... and my hands and limbs all shake.”

M: “The panic attack is like... it contains fear. It also involves a fear of dying and the loss of all control. --- Fear that you can’t control what’s happening anymore.”

Like a maladaptive feedback mechanism, this threat increases and emphasizes the intensity of the immediate and anxiety-causing bodily sensations such as heart palpitations, dizziness, sweating, etc. This vicious cycle in turn intensifies the

experience of personal threat, which leads to a fear of complete self-disintegration and loss of self-control, impending doom, or other personal catastrophies. In other words, the immediate experience of the I is given an instant and unconscious meaning of personal threat by the Me. It is difficult to consciously separate this process into different phases, since it takes place so quickly and automatically. After repeatedly experiencing this cycle, some of the specific contents of personal threat may become permanent modes of thinking separate from the panic attack itself.

The inability to find security in the self and console oneself in a state of acute distress leads to the need to control this threatening experience. The maladaptive I-Me – dialectic can not be integrated into the conscious concept of the self and must therefore be repressed in order for the self to maintain a sense of security (1.4.). The downside of this control is the loss of contact with one’s own self-process and emotions. Because of this control, panic-related emotions are alien to the self.

E: “I began panicking when I had to go to the doctor... --- But I can’t help it, no matter how hard I tried to rationalize, and then the next day I had to go to the pharmacy, and I panicked again and couldn’t control it, not until it was over.”

M: “Facing those feelings... it’s such an overwhelming state that if... I’m too frightened to get into those feelings because they contain all that terrifying chaos that sucks you even deeper.”

Control and the inability to face the problematic self-process entail certain modes of behavior and emotional experience that function as ways of coping or compensating for the lack of touch with one’s inner process (1.5.). Some of these modes can be seen as defense mechanisms that uphold functioning in daily life, while others are more clearly negative “byproducts” of unsuccessful control.

Unsuccessful control produces several modes of negative behavior and experience. The right for the existence of one’s emotional experience is perceived as unjustified and emotions are therefore mistrusted, which leads to the inability to share them with others (1.5.1.). The surrounding world is perceived as not understanding or tolerating one’s

way of experiencing. This gives rise to a feeling of mistrust towards other people, which in turn increases the feeling of being alone with one's problems.

M: "I feel that people don't listen to me or give me space. --- It has something to do with this insecurity. I don't trust other people. I don't trust them to listen when I speak. --- There is no space for my feelings, so I have to stay silent."

M: "The last time I had an attack I wondered afterwards why I couldn't talk about it with a safe and good friend of mine. Even though I was feeling horrible, I succeeded in covering it so well that he didn't notice it at all. Even though I thought I would die on the spot."

The maladaptive I-Me –dialectic consumes both psychic and physical energy, which often leads to a state of dejection and an inability to function in everyday situations (1.5.2.), e.g. holding a job. The fear of having a panic attack restricts one's life-space – all energy is funneled into surviving.

M: "At this point I've drifted into a position where I'm too exhausted to do anything at all. --- It consumes all my energy. No matter how much I want to do things I can't get myself to get up and go and start doing them."

Unsuccessful coping with the maladaptive self-process naturally leads to negative feelings such as inadequacy, shame, weakness and an all-absorbing existential angst (1.5.3). In this manner, control is self-defeating, since it entails these negative feelings.

M: "I would just like to shout for the sake of shouting, shout to release some of that bad feeling."

E: "Wild horses couldn't have dragged me into this world if I'd been asked for permission. It's like, do I have the right to exist, I somehow need to apologize for my own existence..."

E: “When I take care of business at offices or bureaus, I get a feeling of inferiority, that the others are above me. Especially in the bank I feel that they’re at a higher level and I’m not as good as them, I’m helpless, especially if the panic comes along right there and then.”

Other modes serve as defense mechanisms that enable the individual to function more adequately, and may in this manner be understood as positive. It must be noted, however, that ultimately these mechanisms do not serve the process of change in I-Me – dialectics. A typical way of controlling inner turmoil is to turn to external sources of security (1.5.4.). This consists of actions and thoughts that serve the purpose of diverting one’s attention from anxiety-provoking inner processes. This mode of behavior can be used to escape from the actual situation or state of having a panic attack or to prevent it from occurring. Taking refuge in external sources can manifest in many ways, e.g. escaping physically, seeking the company of other people, praying, drinking alcohol, or engaging in recreational activities and personal hobbies.

E: “I have some animal friends that bring me joy. --- This Saturday a friend’s pet enabled me to walk a long distance, I could somehow walk easier by following and watching the animal.”

M: “Like we talked earlier about her having those walking sticks, I had a bicycle with me just for security, just in order to have something secure.”

Another defense mechanism serves the purpose of understanding and justifying one’s current self-process without seeking significant inner change (1.5.5.). One may, for example, recall incidents from the past that have actually had a significant effect on the development of the current problematic experience. However, these recollections often uphold and justify the maladaptive I-Me –dialectic and are not seen as potential tools for therapeutic change.

E: “Because I have such terrible starting conditions, I can’t expect myself to be like others, because I’ve been sick since I was a teenager. I

should accept that I'm in this condition and shouldn't compare myself to others, since they've probably lived in better conditions. If they had had the same conditions as me, they could be even worse."

E: "My teenage years were so difficult... --- My childhood was cut off so violently that I feel that I still haven't recovered from it, it was left unfinished. I would have still wanted to be a child."

All in all, defense mechanisms aid practical everyday functioning, but can not in themselves lead to radical structural and processive changes in the self. They can be problematic, if they prevent reflexive self-awareness.

2. Reflexivity

Reflexivity is the phase of transition from the reactive position to the reflexive one. The essential nature of reflexive self-awareness is the individual's insight that the problematic experience is construed *within one's own mind*, i.e. the inner process of the self produces experience as it is. This can be understood as a preunderstanding of the I-Me –dialectic (2.1.), which is accompanied by a courage and desire to dig into one's own self-process. At this stage, the nature of the inner process is still vague and inarticulate to the individual, and in a sense, out of focus. In time, this search will lead to the discovery and recognition of the maladaptive I-Me –dialectic.

M: "This thought has just entered my mind that... would I want to somehow... because the experience is so chaotic, would I want to live it through in order to make it, in a way, more controllable? --- I can't follow my own footprints, I can't follow my own thoughts. Maybe there is some sort of space in this state (of mind) that wants more life-space for itself. This came into my mind for the first time right now."

T: "Let's continue this interrupted journey. The journey is interrupted by control and after control often comes escape, a need to just run

away, a need to control myself, a need to survive. Let's continue the journey from here into all that fear and distress and other feelings that might come along.

M: "Right now I feel that there might be some empty space there, which means I might be able to go and fit in there. I might have the courage to do it. Like last time we were here, something happened that got me into a really emotional state and I expected all the anxiety and everything else to come along. I said earlier that I'm no longer so afraid of that, because it might not necessarily be all that chaotic..."

The individual is able to initiate a dialogue with this process by stepping out of and placing himself beside it (2.2.). This observing relation to one's experience may manifest itself in a very concrete fashion, i.e. when a panic attack is coming on, the individual stops whatever he is doing to inspect and examine his current experience and emotions. This requires a fair amount of courage, keeping in mind that the problematic experience is an enormous threat to the personal sense of security.

M: "When I was driving to Jyväskylä, I felt that now it's coming, that panic is hitting me. Then I thought right away that I'll just let it come, if it really comes on strong I'll just pull over to the side of the road and see what happens. I can't really describe my thoughts but once again, nothing happened."

M: "Earlier it (panic) was completely overwhelming, but now I can take a look inside it."

At this point, contact has been made with one's I-Me -dialectic, but a clear understanding of its functioning and structure has not yet been attained. The change process, however, has begun: now that contact has been achieved and compulsive control has decreased, the experience is remarkably less threatening in nature. The peak of the panic attack has been cut off. The possibility of an alternative way of relating to the problematic experience opens the gate to permanent and deep-reaching change in the self. Once the problematic experience is accepted as a part of the conscious self, it

loses its threat and no longer needs to be controlled, and thus ceases to be problematic in a reactive fashion.

3. The reflexive position

The reflexive position can only be understood in the context of the therapeutic change process as the end-goal of therapy and the polar opposite of the reactive position. A central component of the reflexive position is understanding (3.1.), which is guided and deepened by certain therapeutic themes or strategies. The objective of understanding is to make the problematic experience less detached and more adaptively integrated in to the self. In a sense, the reflexive position is the actualization of the potential created by reflexive self-awareness. At this stage the individual analyzes, organizes and describes his inner process in his own words (3.1.1.). In other words, he consciously reflects on the I-Me –dialectic that produces his experience.

M: “We’ve been talking of certain situations that sound off an alarm, a sort of warning signal... --- It says here that it can be an open or high place, a crowd, a limited or closed space, and so on. For me it’s that ‘and so on’, it’s an image that comes from within myself and not from the outside, even though what’s happening around me effects it. It sort of develops and grows inside and when the warning comes it’s really close to panic. --- I make misjudgments, my inner sensors are too sensitive in a way.”

M: “Can I draw a picture? --- Right now I feel that, I’ll put it here, here’s the control and here’s the panic, and here is the starting point. For me it could be anxiety. And this control tries to prevent the panic from occurring. --- Now there is an opening here. I can see the other side now, and the panic does not take up all this space. --- Earlier this whole thing was chaotic, but now I can take a peek inside the other side. I feel that this line will begin shortening and in between all that

bad feeling and behavior will decrease if all goes well. (See illustration below.)

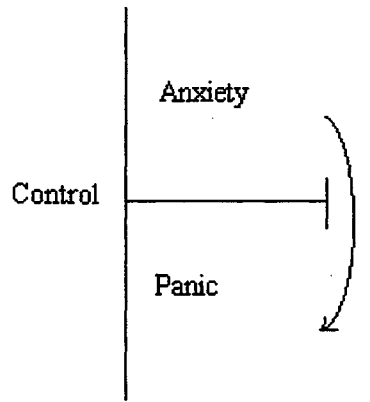


Illustration 1. M's example drawing illustrating change

This conscious reflection leads to a deeper understanding of the self and what constitutes it. This includes understanding why the process is/was maladaptive and problematic, how one attempted to control and exclude it from conscious experience, and how and why this control attempt failed. In short, it is the understanding of one's own (formerly) reactive I-Me –dialectic.

As reflexive self-awareness is achieved, a preunderstanding of both the interpersonal manifestations and the historical roots of current being-in-the-world begins to develop. Two therapeutic strategies are used to elaborate the understanding of these themes and to create a more holistic sense of how panic and existence are intertwined. The first of these strategies focuses on interpersonal relationships, especially close and personally meaningful ones. The individual discovers that panic is embedded in his personal manner of being-in-the-world, which manifests itself in relation to other people (3.1.2.). For example, the individual understands how and why he has been unable to share his problematic emotions with others (see 1.6.1.).

M: "I haven't shared my own distress with anyone, because I've felt that I'm the one who has listened to and received other peoples'

worries, and I've wondered why. Maybe I've had some sort of fear of losing something, that if I shared my distress with others they would just disappear. It's like I've had a brake on. But my thoughts have changed somewhat."

M: "I've been very afraid... what have I been afraid of? If I give too much of myself away, it will disappear. But that can't happen, in fact, it's quite the opposite."

The other strategy is a small-scale excavation into the past, i.e. incidents and experiences that are considered relevant to the formation of the maladaptive I-Me – dialectic are examined. The individual begins to understand the historical roots of his current manner of being-in-the-world, which enables the problematic experience to be integrated into the self more fully (3.1.3.).

M: "I've felt very strongly that what happened as a child... I would call it suppression, that word would aptly describe how the expression of feelings has been prevented, which forms a direct link to the present day. It's related to all this panic and anxiety and nervousness.

M: "My mother – I've just realized – somehow transferred her own distress and fears into me --- and now I behave in the same way at home. I feel insecure if I'm not told exactly when someone will be returning home. This is starting to open up a little, it's easier..."

In contrast to the reflexive, change-producing use of historical examination is the reactive justification of the current problematic experience on the basis of past events (see 1.5.5.).

As understanding increases and deepens, the integration of the formerly problematic experience into the self is corroborated. This entails deep structural changes in the I-Me –dialectic and the cognitive-emotional mechanisms that mediate it (3.2.). This dialectical change manifests itself in several ways. Emotions are no longer controlled and perceived as threatening (3.2.1.). The individual permits himself to live through a

larger scale of emotions, enriching his experiential world. When unsuccessful control is no longer an issue, the negative emotions related to failure also relent (see 1.5.3.).

M: "Right now I would like to behave in a direct way. --- It could be the wrong way to get involved in things but (I'd like to behave) in a way where I don't have to put on the brakes. I feel like something has been released, and this group encourages me to do what I feel."

M: "I'm rather proud of myself, that I have the courage, it requires a lot of courage to be a partner (with one's feelings). --- That I can place myself beside them, look at them, and see what happens... to just let them come along."

The sense of agency over one's emotions increases, which leads to a feeling of being able to manage one's life better (3.2.2). The previously problematic emotions no longer take control of the individual and reactively determine behavior. Instead, they are now used in a more adaptive fashion.

M: "What is significant is that I somehow take my own life more into my own possession, even though I observe it from the outside, it's a paradoxical thing, but I'm more in my own possession..."

M: "I framed this thought of yours, the one about taking control of the rudder. This crystallizes how I think of my life. What follows from this, I don't know. But it would be great to live by that rudder and not have someone else control it."

This increases trust in one's own emotions as positive and purposeful phenomena (3.2.3.). The individual understands he has the right to feel his own emotions and share them with others if he wants to (see 1.5.1.).

M: "I've changed my conception of the resistance of the outside world. I talked with a good friend of mine... --- We talked on the phone for

about two hours and I was completely honest and open with him. --- His (positive) reaction was a surprise to me.

--- I didn't behave according to expectations, that is, I told him straightforward what I think and didn't pay attention to his opinions, which were actually in my own head. I bypassed the preconception of what I thought was expected of me."

M: "Surprisingly, I've come to recognize the fear of failure now, which has prevented me from doing things, which is also related to this panicking in some sort of way. Now I have the courage to go closer to the borders and even cross them, I'm not afraid anymore. Even though I might fail, it doesn't matter. When I get into a situation where I start to feel afraid, I can say 'I'm afraid' or just leave."

All these changes improve the quality of living and broaden the horizon of possibilities (3.2.4.). Previously bound psychic energy is freed and channeled into work, hobbies and recreational activities. The individual is capable of setting his sights on and planning the future. All in all, he becomes more capable of enjoying life.

M: "A lot has happened to me lately. I live a completely different life than before. I started working in a job two weeks ago that I never thought I could do. I set out to see if I could do it. Surprisingly, I've been able to put up with the pressure. --- The panic has resided for now."

M: "Something concrete... hmm... I've brought back all the clay and plasters and all that. I'm going to start doing ceramics again. Everything seems interesting. Woodwork, which I've done a lot. Things like that."

At this point, it is important to emphasize the processive and dynamic nature of therapeutic change. Once reflexivity is achieved, change in the reflexive position occurs in a cyclical, delinear and parallel manner. The reflexive position is not a static end-

point to therapy, rather, it is an active state or space of self-understanding. In other words, the process of deeper understanding and dialectical change are intertwined and proceed simultaneously. The structure of therapy explicitly guides the order and content of change. For example, the order in which the issues of interpersonal manifestations and the historical roots of the problematic experience are brought up is a matter of therapeutic choice. At the same time, implicit changes can be assumed to take place.

Discussion

The main purpose of our research was to create an accurate categorical process model that aptly represents the main phases of therapeutic change in cognitive-constructive psychotherapy. At a more specific level, the model was supposed to describe the change process from the reactive position to the reflexive position in panic disorder. Related to this was the goal of creating a more elaborate and refined theoretical basis for understanding the change in question. The second purpose was to illustrate the therapeutic change described in the categorical process model through two case studies.

The main purpose of this research was fulfilled by constructing a novel and dynamic process model of therapeutic change on the basis of a continuous dialogue between the data and theory. We assume that this model captures the *processive nature of change* more fully and accurately than previously created models of change in cognitive-constructive psychotherapy. In addition, we have lifted the phenomenon of reflexivity into the foreground and made it a necessary precondition of lasting change in the I-Me – dialectic. It potentializes permanent dialectical and structural changes in the self-process, but does not necessarily bring them about. The phenomenon of reflexivity in itself has been distinctly separated from the reflexive position, which is understood as the actual manifestation of the potential generated by reflexive self-awareness. This distinction between the reactive position, reflexivity and the reflexive position is a novel one, along with the weight and importance given to the phenomenon of reflexivity in itself.

It is more difficult to assess how well the goal of theoretical elaboration and refinement was reached in this research. The concept of theoretical refinement itself raises questions concerning the nature of this 'refinement'. To illuminate the refinement in this research, it is appropriate to examine and compare the starting point and results of research to attain a more clear picture of the possible change in theoretical knowledge. The starting point of our research was an earlier categorization of therapeutic change in panic disorder, which in turn was based on the concepts of reactivity and reflexivity (Sarlin & Syrjäläinen, 1999). It is important to note that research focused on therapeutic change and reflexivity in cognitive-constructive

psychotherapy is very scarce. Keeping this in mind, research on the subject of reflexivity is, in effect, inevitably 'theory-refining'.

Even though the earlier categorization gave us a good foundation to build on, we found it to be a rather static and unorganized description of the change process. In addition, it was insufficiently bound to clearly defined theoretical concepts that explicate change at the theoretical level. Our goal was to integrate the description of therapeutic change into a clearly defined theoretical framework. We did this by binding the concepts of reactive position, reflexivity and reflexive position and the process model of change to the theoretical base-concept of the *I-Me –dialectic* (Guidano, 1991). For example, our definition of reflexivity is based on this idea of a dialectical self-process that produces experience. In this manner, we have succeeded in theoretical refinement.

The evaluation of how well or to what extent the second goal of this research was reached is rather straightforward and uncomplicated. As we stated earlier, there is nothing in the model that is not in the text provided by the two cases. In short, it was matter of finding segments that most aptly describe the nature of each category.

The evaluation of the successfulness of qualitative research and case study research in particular can be difficult because of the lack of simple and straightforward evaluation methods. Yin (1994) proposes four criteria that can be used for the evaluation of success: 1) constructive validity, 2) internal validity, 3) external validity and 4) reliability.

First, constructive validity refers to the successful operationalization of concepts. In other words, the constructive validity in this research refers to how well the created categorical process model 'fits' the data. We improved the constructive validity by continuously testing the model against the data, until the match was accurate. Second, the internal validity is relevant when research focuses on causal explanations. Since this research is more descriptive in nature, internal validity is not a central issue. Third, the external validity refers to the generalization of the results. In case study research, the results are generalized analytically, i.e. they refer to theory rather than a certain population. In this research, the categorical process model is a theoretical assumption concerning therapeutic change in panic disorder. Fourth, reliability refers to the repeatability of the research process. Due to the dialogical nature of the construction of the new process model, it is impossible to repeat this process in exactly the same way. It

is more appropriate to evaluate the reliability of the final model than the process that led to its creation. This reliability turned out to be good, which in turn increases the constructive validity of the model.

Categorizing segments of speech raises questions concerning the relation between the speech act and that which is spoken of, i.e. the content of speech. Is the purpose of speech primarily to construct reality or to refer to something that already exists? In our opinion, these two stances do not necessarily cancel each other out. However, in our categorization method we have dominantly taken the latter one, assuming that speech primarily indicates experience, although it can also produce it. One can speak of experiences that are not presently active, for example of a panic attack that occurred yesterday or of the shame related to it. On the other hand, speaking of one's inner processes may produce novel experiences and insights. For example, reflexive speech can be action that organizes experience in a certain manner for the first time.

Another interesting and often problematic relation is the one between speech and change, especially its (possible) causal nature. A radical or more socially oriented constructivism holds the assumption that speech is action that constructs or changes reality, be it psychic or social or both. In other words, it is the *cause* of change. We adopt a more moderate and unfashionable viewpoint and assume that causality is a two-way street that can run in both directions. If speech is the cause of change, change can not occur without speech. If, however, speech is not a necessary precondition of change, change can be assumed to occur without it. The problem can be shifted to a more general level: is verbal reflection, be it speech or writing, necessary in order to organize experience in an alternative way? We have defined reflexivity as a state where the inner process of I-Me –dialectics is brought into the focus of *conscious awareness*. We have also defined reflexivity as a necessary precondition for therapeutic change to occur. In this case, verbal reflection is simply the most effective way to organize experience and bring it into conscious awareness. In therapy, it is a tool that is used to dig into the self. We assume that speech and change can exist independently of each other. For example, one can speak of personal change without *actual* change in the self-process. Toskala (1996) notes that novel awareness is not in itself a sufficient indicator of change in the self. This new awareness must manifest itself in the *praxis of life*. Simply put, 'talk is cheap' if it has nothing to do with real life behavior.

The complexity of the relation between speech and inner processes is clearly illustrated by reflexivity, which is a theoretical concept that is difficult to operationalize. It is assumed to describe a phenomenon that can be indicated in speech only indirectly and implicitly. In therapy, speech will most likely *imply* the existence of reflexivity rather than be explicit speech *of* reflexivity. This makes researching the phenomenon of reflexivity a difficult task; it requires a 'theoretical faith' that the concept actually describes an existing human process that is essential in therapeutic change. This 'faith' was enforced by comparing the unsuccessful case with the successful one. The former did not reach a state of reflexive self-awareness and could not proceed on to the reflexive position, where the potential change of the self process is actualized. This is clearly illustrated by the fact that she did not produce any segments of speech that could be categorized under the main categories of 'reflexivity' or 'the reflexive position'. The latter, however, proceeded from reflexive self-awareness to deep-reaching change contained in the reflexive position. The permanence of this change received further validation in the follow-up session six months later, where the client declared that he "had been cured of panic (disorder)".

The aforementioned problems of speech and change concern therapy at a very practical level. We have defined reflexivity as the conscious awareness of the inner self process. It seems that this awareness requires the ability to verbally reflect and organize experience at a very abstract level. In other words, in order to achieve therapeutic change, the client must have the potential for reflexive self-awareness. Individuals vary in this capability according to their childhood development (Fonagy, Steele, Steele, Moran & Higgitt, 1991). The potential for reflexive self-awareness is universally human, but each individual has his own unique ability to reach and utilize it. This was clearly illustrated in the therapy process used in this research. The successful case had a striking ability from the very beginning of therapy to reflect and appropriately verbalize his experiences at an abstract level, at the same time remaining firmly in touch with them. In his self-report, he described this as a "feeling of being a step ahead of something already planned, moving with ease from one step to the next as if a warm wind had pushed me forward". The unsuccessful case, on the other hand, never reached this state of reflexive self-awareness, her speech and thoughts focusing on concrete issues. This is epitomized in her self-report, where she stated that "therapy has not removed my fear of the dentist."

The time given in the researched therapy process to reach a state of reflexivity is rather short (twelve ninety-minute sessions). Given the fact that individuals differ in their ability to reach this state, the appropriateness of this type of therapy in a group setting can be questioned. The limited amount of time is a detriment to those individuals who process thoughts and emotions related to the problematic way of experiencing more slowly. The time limit also increases the educative nature of therapy: the therapist must make outlines and summarize central themes from time to time, even though the possibility exists that individuals have understood and reflected on them in varying degrees. Individual therapy naturally facilitates a more idiosyncratic approach, taking into account personal differences. It also makes possible a more comprehensive bonding between the client and the therapist, which can be assumed to create a safer environment and a stronger sense of security that allows self-exploration. In a group setting this can be compensated in some measure by bonding with clients with similar problems. It must be noted that cognitive-constructive therapy is primarily practiced as individual therapy.

The twelve-session therapy model is a pre-structured process that focuses on each clients' inner processing and experiences. At worst, the five-phase structure of therapy can turn out to be rigid and inflexible, restricting individual 'timetables' of change. It can be assumed that this type of therapy is most effective with a homogenous group and least effective with a heterogenous one. It is only natural that groups tend to be heterogenous, especially as their size increases. We hold that reflexive self-awareness is a necessary precondition of change. Therefore, the therapeutic process should be flexible in giving space and time to each individual to reach this state of reflexivity. Moving on 'prematurely' is hardly useful and does not aid in reaching one's inner process. The main benefit of this individual therapy in a group setting seems to be an economical one. It's predetermined structure does not take into account individual differences sufficiently enough. Even though identifying and sharing experiences with other individuals with similar problems is a positive aspect of working in a group, it does not not necessarily support reaching reflexive self-awareness. In the end, each individual is on his own with his own self process.

The importance and relevance of research can be evaluated on the basis of its practical implications. In this case, attention should be focused on the question whether or not research aids the development of the therapy process. Our research results imply

that reflexivity is the cornerstone of therapy. Therefore, it is of extreme importance that clients be supported in achieving this reflexive self-awareness. First, this process must be given the *time* it needs. Second, it requires a *secure* therapeutic atmosphere; the therapist must facilitate, support and set forth conditions where the emergence of reflexivity is possible. At a more specific level, the created categorical process model gives a rather detailed description of the processes that build up panic and the behavior related to it. This is useful information for the therapist, who can utilize it to support the client who is encouraged to slow this reactive process down and examine it. As knowledge of panic as a reactive process increases, the ability of the therapist to facilitate reflexivity increases.

The language used by the therapist has a central role in helping the client to search for and find his problematic I-Me –dialectic. Naturally, the therapist can not use theoretical terms of the kind used in this research. The therapist in this research often used both verbal and visual metaphors to aid in the understanding of how the self process is generated. This brings us back to the issue of the ability to think in abstract terms. This therapy is, in essence, quite an abstract affair to begin with. This is not to say that experience or panic in itself is abstract; rather, the understanding of how experience is construed requires an element of abstraction that may be difficult to reach by some individuals. What kind of language would be most suitable in facilitating understanding is an open question.

The categorical process model set forth in this research should be tested further to evaluate its validity and usefulness. This could be done by applying the model to other cases of panic disorder to see whether it is comprehensive or in need of further refinement. We can not assume that change occurs in the same fashion in substantially different therapeutic circumstances, even though it may comprise of similar components. It would therefore be most appropriate to test and evaluate the model in the context of cognitive-constructive psychotherapy used in this research.

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Appendix 1. Questionnaire 1

QUESTIONNAIRE

Name: _____

Evaluate on a scale of 1-6 how the following statements describe you in the problematic situation.

1. Disagree completely
2. Disagree somewhat
3. Disagree a little
4. Agree a little
5. Agree somewhat
6. Agree completely

1. Feelings or some bodily illness easily grab hold of me and I fear that I can't control myself.
2. I can clearly identify my feelings.
3. I strive to control my problematic feelings.
4. It is not that important to me how others see me.
5. Being able to find people that bring security is not always necessary.
6. I can clearly understand what my problematic feelings are about.
7. It is difficult for me to describe the ways I use to control my problematic feelings.
8. Finding security in some form is essential in all my relationships with other people.
9. I don't understand how earlier relationships could have effected the generation of my problematic feelings.
10. I believe that I will always be incapable of controlling my problematic feelings.
11. I trust in the fact that I can control my problematic feelings and my body.
12. It is difficult for me to identify what I'm actually feeling.
13. I let my problematic feelings show.
14. It is important for me to give a self-confident and capable impression of myself to others.

- 15. It is important for me to have a secure person to rely on.
- 16. I don't understand what my problematic feelings are all about.
- 17. When I experience problematic feelings, I can use alternative ways to control them.
- 18. Even though other people are important sources of security for me, I can survive on my own.
- 19. If I didn't have these feelings/problems, I would be satisfied with my life. (Not used in the score.)
- 20. I can understand my problematic feelings on the basis of earlier relationships.
- 21. I want to act independently.
- 22. I notice that I repeatedly attempt to use the same ways to control my problematic feelings.
- 23. I believe that in the future I will be able to be in an alternative relation to my problematic feelings.

Appendix 2. Questionnaire 2**QUESTIONNAIRE**

Name: _____

The purpose of this questionnaire is to map out how you relate to your problematic emotions (panic, anxiety, distress, etc.) Place a mark on the line on the spot that most accurately illustrates your relation to these feelings. For example, in part 1, if you feel that you control or suppress your problematic feelings a lot, place a mark on the right side of the line. If you feel that you relate to them openly, place a mark on the left side of the line.

-
- | | | |
|-----------------------|-------|--------------------------|
| 1. Open | ----- | Controlling/Suppressive |
| 2. Hopeful | ----- | Hopeless |
| 3. Able to face | ----- | Powerless/unable to face |
| 4. Courageous | ----- | Fearful |
| 5. Calm | ----- | Anxious |
| 6. Accepting | ----- | Shameful |
| 7. Non-ruminative | ----- | Ruminative |
| 8. Clear | ----- | Unclear |
| 9. Peaceful | ----- | Distressed |
| 10. Normal | ----- | Abnormal |
| 11. Solution-oriented | ----- | Submissive |
| 12. Permanent | ----- | Fluctuating |
| 13. Active | ----- | Dejected |
| 14. Forgiving | ----- | Self-accusatory |

Appendix 3. Personal description

Name: _____

Write a short summary of what this therapy has given to you. How has your relation to your problematic experience changed during therapy or has it changed at all? Why do you suppose this is so?