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Henna Penttinen

Socially Phobic Clients' Self-Descriptions, Treatment Progress and Reflexivity in Short-Term Cognitive-Constructivist Group Psychotherapy

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ABSTRACT

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The aim of the research was to get information about different kinds of clients with social phobia and their therapeutic progress in cognitive-constructivist group psychotherapy. The aim was also to offer relevant information to clinicians working with socially phobic clients on how they could help the progress of the successful therapeutic change process of socially phobic clients, especially in early phases of the therapy when clients are developing a reflexive stance toward their own problematic experiences. Study I supported the view that negative self-image is central to social phobia, but this ranged from total piteousness to relatively few negative feelings of insufficiency. Three subgroups were formed on the basis of commonalities and differences of the self-descriptions which were observed: the other-oriented (n = 7), the isolated (n = 7) and the self-demanding (n = 3). These subgroups describe the different strategies that certain socially phobic persons habitually use when compensating for their social anxiety. In Study II, the treatment progress of clients from these three subgroups was explored, using qualitative assimilation analysis. Some similarities and some differences can be noted, although the clients progressed in their assimilation process to different degrees. The largest variance was in the isolated subgroup, as there were both successful and unsuccessful therapeutic change processes. Study III indicated that reflexivity seems to be a necessary condition for progress in early phases of the therapy process, but it is important to note that reflexivity can appear in diverse forms and at different levels. It appeared to be necessary for the therapist to work inside the client's therapeutic zone of proximal development (ZPD), since premature exposure to the therapist's conclusions, meant to increase the client's reflexivity, can be counterproductive. At this early assimilation stage, the client requires empathy prior to other interventions. The research as a whole emphasizes the challenges a therapist encounters when treating socially phobic clients with differing needs in a group format. Socially phobic clients may differ in many ways, including their compensatory strategies. Thus, a therapist's responsiveness and ability to work inside the therapeutic ZPD is necessary for successful therapeutic progress.

Keywords: social phobia, cognitive-constructive psychotherapy, change process, assimilation analysis, reflexivity

TIIVISTELMÄ (FINNISH ABSTRACT)

Penttinen, Henna
Sosiaalisesti foobisten asiakkaiden minäkuvailut, hoidossa edistyminen ja refleksiivisyys lyhytkestoisessa, kognitiivis-konstruktiivisessa ryhmäterapiassa
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Tässä tutkimuksessa tutkittiin sosiaalisesti foobisten terapia-asiakkaiden erilaisia minän kuvailuja sekä heidän terapeuttista edistymistään lyhytkestoisessa, ryhmämuotoisessa kognitiivis-konstruktiivisessa psykoterapiassa. Kiinnostuksen kohteena oli erityisesti terapiaprosessin alkuvaihe, jossa asiakkaat alkavat muodostaa refleksiivistä suhdetta omaan ongelmalliseen kokemukseensa. Ensimmäisen osatutkimuksen tulokset vahvistivat käsitystä siitä, että sosiaaliseen fobiaan liittyy keskeisesti kielteinen minäkuva, joka kuitenkin vaihtelee totaalisesta itsensä surkeaksi kokemisesta lievempiin negatiivisiin tunteisiin omasta riittämättömyydestä. Osatutkimuksessa muodostettiin kolme erillistä alaryhmää, jotka perustuivat terapiakeskusteluissa ilmeneviin minän kuvailujen yhdenmukaisuuksiin ja eroihin: muihin ihmisiin suuntautuneet (n = 7), eristäytyneet (n = 7) ja itseä kohtaan vaativat (n = 3). Alaryhmät kuvastavat erilaisia keinoja, joilla sosiaaliset jännittäjät pyrkivät kompensoimaan sosiaalista jännittämistään. Toisessa osatutkimuksessa tutkittiin eri alaryhmiin kuuluvien asiakkaiden terapiassa edistymistä, käyttäen tutkimusmetodina laadullista assimilaatioanalyysia. Alaryhmien välillä todettiin joitain yhtäläisyyksiä ja eroja, kun asiakkaiden terapiassa edistyminen vaihteli. Suurin vaihtelu oli eristäytyneiden alaryhmässä, jossa oli sekä onnistuneita muutosprosesseja, mutta myös prosesseja, joissa terapeuttista muutosta ei juurikaan tapahtunut. Kolmannen osatutkimuksen mukaan refleksiivisyys näyttäisi olevan välttämätön edellytys terapiassa edistymiselle terapiaprosessin alkuvaiheessa. On tärkeää kuitenkin huomioida, että asiakkaan refleksiivisyys voi ilmetä eri tavoin ja eri asteisena. Terapeutin työskentely asiakkaan terapeuttisen lähikehityksen vyöhykkeellä osoittautui välttämättömäksi, sillä liian aikaiset interventiot saattavat viedä terapeuttista prosessia taaksepäin. Terapiaprosessin alkuvaiheessa asiakas tarvitseekin empatiaa ennen muita terapeuttisia interventioita. Kaiken kaikkiaan tutkimus nostaa esiin haasteita, joita terapeutti kohtaa hoitaessaan ryhmämuotoisesti erilaisia tarpeita omaavia sosiaalisia jännittäjiä. Terapeutin herkkyys ja kyky työskennellä kunkin asiakkaan terapeuttisen lähikehityksen vyöhykkeellä on välttämätön edellytys terapiassa edistymiselle.

Avainsanat: sosiaalinen fobia, kognitiivis-konstruktiivinen psykoterapia, muutosprosessi, assimilaatioanalyysi, refleksiivisyys

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Taking into account the instructions given and comments made by the co-authors, the author of the thesis applied previously collected data, conducted the analyses and wrote the reports of the three individual articles as the first author.

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ORIGINAL PAPERS

1 INTRODUCTION

Anxiety in social situations is a main feature of social phobia. In spite of this and other shared features of socially phobic persons, there are many differing and individual features which inevitably arise in therapy situations and which demand sensitivity and responsiveness from the therapist. This research dealt with social phobia and its different manifestations in self-descriptions of socially phobic clients, focusing especially on variation in the therapeutic progress of different kinds of clients in short-term cognitive-constructivist group psychotherapy. The treatment model used in the research is based on the cognitive-constructivist approach to psychotherapy and change (Toskala & Hartikainen, 2005), which, like many short-term group psychotherapies, is a semi-structured treatment model. Cognitive-constructivist psychotherapy is based on structural-developmental cognitive therapy, presented by Guidano (Guidano, 1991, 1995; Guidano & Liotti, 1983) and Mahoney (1991), and the theoretical view of meaning of emotions of psychotherapy, a theory behind emotion-focused therapy (EFT) (Greenberg & Paivio, 1997; Greenberg, Rice & Elliot, 1993).

At the beginning of the research project, the treatment model in question was tentative in nature. Thus, the treatment model introduced in this research is a result of so-called learning-by-doing. As for data collection, the study setting was naturalistic in nature, and the treatment model gradually found its final form during the project. Currently, there are other effective treatment models for social phobia, such as cognitive behavioral group therapy (Heimberg & Becker, 2002) and individual cognitive psychotherapy (Clark, et al., 2006), which are based on different conceptualization and therapeutic strategies relative to cognitive-constructive approach. It is not the intention here to claim that this treatment in particular is superior. Instead it can be emphasized that the phenomena under study, such as self-descriptions of socially phobic clients and therapeutic progress within different kinds of socially phobic clients, are presumably general in nature and not only tied to this particular treatment model.

The practical aim of this research was to offer clinically relevant information for psychotherapists as they work with socially phobic clients. The intention was especially to clarify the challenges related to the group treatment of

socially phobic clients and in this way help clinicians confronting them. These challenges are assumedly shared across many different group treatment models for social phobia. The processes and phenomena related especially to the group were not under study.

1.1 Social phobia: a name for diverse problematic experiences

Social phobia is also called social anxiety disorder in DSM-5 (American Psychiatric Association, 2013). In this research, the term social phobia was used, referring to the diagnostic classification of the ICD-10, which defines it as an anxiety disorder characterized by an intense, irrational fear of one or more social or performance situations in which the individual believes that he or she will be scrutinized by others (Word Health Organization, 1992).

1.1.1 Diagnostic classification and epidemiology

Anxiety in a social situation is something that many of us have sometimes experienced. Usually it is an occasional moment of anxiety in a difficult social performance situation, such as public speaking. When a person experiences social anxiety, it often happens in a situation where, for some reason, it becomes particularly important for a person what others think of him or her. Some people, however, are debilitated by the fear of negative evaluation in almost all social situations. In extreme cases, a high degree of social anxiety can lead to a diagnosis of social phobia.

According to the fourth edition of the *Diagnostic and statistical manual of mental disorders* (DSM-IV), social phobia is defined as a persistent fear of one or more social or performance situations in which a person is exposed to unfamiliar people or the possible scrutiny of others (American Psychiatric Association, 1994). The condition "social phobia" was renamed "social anxiety disorder" in the fifth edition of the DSM. This change reflects a new and broader understanding of the condition in a variety of social situations (American Psychiatric Association, 2013). A typological distinction between interaction and performance social anxiety has been included in the definition of social phobia in the DSM-5, such that a person may have one or both types of social phobia and meet the diagnostic criteria for the disorder.

Regarding social phobia, there is considerable variance in prevalence findings of epidemiological studies of populations. Studies conducted in the USA and Europe, including Scandinavia, largely support the view that social phobia ranks among the most prevalent of the anxiety disorders in the general population, with cross-sectional lifetime estimates being 7–12% and 3–4% for current prevalence (four weeks to 12 months) (Wittchem & Fehm, 2003). In Finland, the prevalence of social phobia has been surveyed in a research Health 2000 in which 1% of Finnish people over 30 years old had suffered from it during the

last 12 months. In the follow-up study of young adults (aged 19–34), the lifetime prevalence was 3% (Suvisaari et al., 2009).

Diagnostic categorizing manuals, such as the ICD-10 (Word Health Organization, 1992) and the DSM-5 (American Psychiatric Association, 2013), provide standard classifications of mental disorders based on descriptions of symptoms agreed on by mental health professionals. Although they are important tools for communicating about mental problems, they have also been a target of many critics, especially concerning diagnostic overreach. For example, social phobia has many overlapping features with avoidant personality disorder. According to DSM-5 (American Psychiatric Association, 2013), avoidant personality disorder is characterized by a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation. Individuals who meet these diagnostic criteria are described as being extremely shy, inhibited in new situations, and fearful of disapproval and social rejection. Similar to other personality disorders, avoidant personality disorder becomes a major component of a person's overall character and a central theme in an individual's pattern of relating to others.

The diagnostic category of social phobia refers to a heterogeneous group of individuals who may differ in a number of ways, including fearfulness, anxiousness, shyness, self-consciousness, submissiveness and anger (Hofmann, Heinrichs, & Moscovitch, 2004). Heterogeneity is not, of course, restricted only to this diagnostic category. When treating individuals with social phobia, it is important to have some kind of understanding of what the problematic experience is composed of, because diagnostic criteria don't reach its nature accurately enough.

When considering the etiology of social phobia, some approaches emphasize biological and genetic vulnerability (see, e.g., LaFreniere, 2009; Stein et al., 1998), while others stress learning processes (see, e.g., McNeil, Lejuez, & Sorrel, 2010) and cognitive processes (Clark & Wells, 1995). In addition, there are views that consider mental problems from the point of view of a person's individual way of organizing their self and being in relation to the world (Guidano, 1995; Mahoney, 1991; Toskala & Hartikainen, 2005). Understanding of how a problematic experience is composed, as well as the possible background and dynamics of a problem, is essential because it affects the manner in which the mental health professional treats the clients with that kind of problematic experience.

1.1.2 Cognitive models of social phobia

Theorists in the field of cognitive psychotherapy emphasize that social phobia is connected to cognitive biases about the nature and outcome of social situations. For example, a negative self-image or negative representations of oneself in social situations (Hackmann, Clark, & McManus, 2000; Hirsch, Clark, Mathews, & Williams, 2003; Ng, Abbott, & Hunt, 2014; Vassilopoulos, 2005) have been seen as central to the onset and persistence of symptoms of social phobia. In Clark and Wells' (1995; see also Stangier, Heidenreich, Peitz, Lauterbach, & Clark,

2003) cognitive model, it is proposed that individuals with social phobia process negative aspects of themselves upon exposure to feared social situations. In this model, it is essential that the person with social phobia is worried about other's thoughts associated to oneself, desperately trying to give a good impression to others. When anxiety is aroused, it is maintained by four processes: the focusing of attention onto self and biased processing of self-related information; engagement in safety-behaviours; actual anxiety-induced performance deficits in social situations; and biased post-event processing of social situations. The authors suggest that people who are socially anxious are inclined to review in detail prior to the social event what they think might happen.

In their cognitive model of the generation and maintenance of anxiety in social/evaluative situations, Rapee and Heimberg (1997) emphasize the social phobic's mental representation of the self as seen by the audience. On encountering a social situation, an individual forms a mental representation of his/her external appearance and behavior as it is presumably perceived by an audience. The mental representation of the self as seen by an audience does not reflect how one actually views oneself, but is based on how the individual believes the audience views him or her at any given moment.

According to Rapee and Heimberg (1997), the mental representation of one's external appearance or behavior is presumably more negative for a person with social phobia than for people who are not socially anxious. This negative view of how others see one's appearance or behavior may be the result of actual deficits (e.g., physical disfigurement, deficits in social skills), distorted perceptions of one's appearance or behavior as seen by others, or both. Importantly, the social phobic's view of him/herself is probably not veridical. Allocation of attentional resources toward stimuli which elicit a negative evaluation means that the socially anxious individual will focus on and exaggerate those features of the mental representation of his/her appearance or behavior to others which are most likely to elicit criticism and ridicule.

According to Schlenker and Leary's (1982) theory concerning social phobia, a fear of negative interpersonal evaluation arises from two factors: the individual anticipates making an unwanted impression on others, and the individual is very concerned about or focused on the impression he or she is making. According to Hofmann (2007), a negative representation of the self increases apprehension about a potential social mishap, as the individual appraises his/her social skills as inadequate for the social task. Such beliefs motivate the use of safety behaviors and avoidance, as well as rumination after the social event, which furthers perpetuate social anxiety. Hofmann argues that the combination of these cognitive appraisals and attentional processes act to maintain anxiety by perpetuating negative self-perceptions and high estimates of social costs, which lead to more negative rumination. Also, there are many studies which have provided results consistent with this hypothesis (e.g., Papageorgiou & Wells, 2002; Wild, Clark, Ehlers, & McManus, 2008).

Social phobia can be also considered from the point of view of coping or compensatory strategy, a term used by Beck (1995) to define a behavioral strat-

egy that a person has developed to cope with a problem. According to Wells et al. (1995), social phobics use in-situation safety behaviors as maladaptive coping strategies to reduce the risk of negative evaluation by others (for example, as person fears that his/her face will go red, he/she keeps cool by opening windows or drinking cold water). According to Clark (1999), safety behaviors seek to prevent or minimize a feared catastrophe, and if everything goes well, socially phobic person is likely to think that it only went well because of using in-situation safety behaviors. In this way the basic fear persists. On the other hand, adaptive coping strategies are used to reduce anxiety but do not seek to avert an imagined catastrophe and therefore do not prevent disconfirmation of unhelpful beliefs (Thwaites & Freeston, 2005).

According to Clark and Wells (1995), the ruminations that a socially phobic person goes through in his mind before a feared situation sometimes lead to complete avoidance of the situation. Indeed, complete avoidance of social situations may be one coping strategy when a person has social phobia, but emotional solitude and isolation seem to be even more common (Alden & Auyeung, 2014; Olfson et al., 2000). Emotional isolation may be a way of coping with anxiety, and it can be seen as a compensatory rule, a term used by Beck (1996, 14), who describes the rule in this instance as follows: "If I avoid others, I can avoid rejection".

Intolerance of uncertainty (Whiting et al., 2014) has also been seen as a common cognitive trait in persons with social phobia, as well as perfectionism (Anthony, Purdon, Huta & Swinson, 1998; Brown & Kocovski, 2014). Shikatani, Antony, Cassin and Kuo (2015) found in their study that perfectionism and intolerance of uncertainty were both related to post-event processing in persons with social phobia. Post-event processing is proposed to be a key maintenance factor in social phobia (e.g., Clark & Wells, 1995).

Therapies based on a cognitive perspective of social phobia, such as cognitive-behavioral group therapy (Heimberg & Becker, 2002) and individual cognitive therapy (Clark et al., 2006), aim at reducing avoidance and safety behaviors. This approach has found support from empirical studies showing a connection between maintaining processes (avoidance, self-focused attention, anticipatory processing and post-event cognitive processing) and clinical improvement (Hedman et al., 2013; Mörtberg, Hoffart, Boecking, & Clark, 2015). Biran, Simons and Stiles (2002) found in their study that cognitive-behavioral therapy facilitated a change in the content of socially phobic clients' verbalization in the direction of a reduction in cognitive preoccupation with the symptomatology, as well as more readiness to venture into other social and interpersonal topics. Furthermore, the increase in reports of assertive social and verbal interactions outside of therapy was in line with the notion of generalization of treatment effects strongly emphasized by cognitive behaviorists. Cognitive-behavioral therapy combines cognitive therapy and exposure, and gradual exposure to challenging social situation is a central part of the treatment (Overholser, 2002).

1.1.3 A cognitive-constructivist perspective of social phobia

The constructive perspective emphasizes the operation of tacit (unconscious) ordering processes, the complexity of human experience, and the merits of a developmental, process-focused approach to knowing (Mahoney, 1995a). The essential feature of constructivism is its assertion that human knowing is active, anticipatory, and literally constructive (form-giving) (Mahoney, Miller, & Arciero, 1995). In contrast to the more passive portrayal of the mind and mental processes offered by nonconstructive theories, constructivism views mentation as proactive, generative, and embodied. In one sense, then, constructivism argues that humans are literal co-creators of the realities to which they respond.

Cognitive-constructivist psychotherapy and its view of mental processes and problems derive especially from the structural-developmental school of cognitive therapy represented by Guidano (1991, 1995; Guidano & Liotti, 1983) and Mahoney (1991). Guidano (1991, 5) envisioned self as a dynamic process of "construction and reconstruction of a reality capable of making consistent the ongoing experience of the ordering individual". Central to this dynamic organization is the dialectical interplay between the experiencing *I* and the observing, explaining *Me*. In his classic distinction between the *I* and the *Me*, William James (1890) presented the *I* as the self, as knower and as processor of experience. The *I* interprets and organizes experience in a subjective way. The *Me* is the self as known.

Guidano (1991) regards any individual knowing system as a self-regulating organization of personal meaning processes. A personal meaning organization is defined as a unitary ordering process in which continuity and internal coherence are sought in the specificity of the formal, structural properties of its knowledge-processing, such as flexibility, generativity and levels of abstraction. Guidano (1991; Guidano & Liotti, 1983) described four different kinds of cognitive meaning organizations, each reflecting some typical symptomatology for that particular cognitive organization: depressive, agoraphobic and phobic, obsessive-compulsive and eating disorder. Arciero and Bondolfi (2011) call these personality styles, thus anchoring a range of disorders to a single personality style. They also introduce a fifth personality style: personalities prone to hypochondria-hysteria.

In the cognitive-constructivist view, diagnoses and symptoms are secondary. It is more important to recognize the problematic experiences that reflect a particular meaning organization, and especially individual meanings in these experiences (Guidano, 1991; Toskala & Hartikainen, 2005). According to Guidano and Liotti (1983), it is possible that a disturbance shown by a patient as primary could be the development of a secondary aspect of the described syndromes. They describe as an example some patients who presented as their fundamental symptom a phobia of speaking in public or an anxiety of taking tests, who proved to have a cognitive organization very similar to the one pertaining to an eating disorder; persons having the cognitive organization of an eating disorder tend to define themselves mainly through others. Other patients

with a phobia of speaking had a cognitive organization similar to agoraphobia, depression, or obsessive-compulsive disorder, even though they required psychotherapy for problems definable as social anxiety. Indeed, the connection between a particular symptom and a particular meaning organization is not straightforward. Instead, in each individual case it is important to analyze the connection between the meaning organization and the problem experienced.

Toskala and Hartikainen (2005) use the term meaning organization of individualization and self-appreciation when referring to Guidano's (1991) meaning organization of eating disorders. They state that in addition to eating disorders, other typical manifestations of the problems in the individualization process are symptoms of social anxiety. According to Guidano (1991) and Toskala and Hartikainen (2005), a person's individualization process includes all of the processes that are necessary for a person to recognize his/her own uniqueness, and on the basis of these processes a person defines him/herself as an individual. A key part of one's defining oneself is self-esteem: a person needs to see him/herself in order to have another's valuation and acceptance. Central in one's individualization is recognizing different parts of oneself and accepting and including these parts. In social phobia, accepting one's own anxiety (and the meanings related to it) in social situations usually becomes problematic for a person. Guidano (1991) emphasizes that striving for an acceptable self-image becomes crucial in ontological understanding, as a person regulates the process of making one's appraisal of self both consistent and unitary.

According to Toskala (2001), persons with social phobia have a significant amount of experiences in which they remained unsure when valuing and accepting themselves. This tends to leave them dependent on other people's evaluations of them. This kind of dependence on other people's evaluation is taken into account also in cognitive models of social phobia (e.g., Clark & Wells, 1995; Rapee & Heimberg, 1997) and it is acknowledged in diagnostic criteria of DSM-5 (American Psychiatric Association, 2013). These kinds of problems in individualization development often lead to a situation where a person tries to gain other people's acceptance in a very compulsive way. This may cause strong anxiety in social situations (Toskala & Hartikainen, 2005). Indeed, acquiring and maintaining an acceptable self-image in social situations is an essential problem among persons with social phobia, because they process negative aspects of themselves in these situations.

Arciero and Bondolfi (2011, 159) see social phobia as a typical disorder in personalities prone to hypochondria-hysteria, which is "characterized by a way of perceiving the Self and of feeling situated that relies on a frame of reference that simultaneously employs a body-centred (inward) coordinate system and an externally-anchored (outward) one". They refer to Hofmann, Heinrichs and Moscovitch (2004), who introduced two possible dimensions of social phobia: fearfulness and anxiousness. According to Arciero and Bondolfi (2011), fearful social phobics attribute their fear of performing to panic attacks or bodily symptoms, which may occur during their performance. Anxious social phobics, by contrast, report greater distress and worrisome thoughts about evaluation by

others while performing a specific task. Arciero and Bondolfi see that these two different dimensions of social phobia reflect the diversity between the inward and outward polarities typical in personalities prone to hypochondria-hysteria. The fear of negative evaluation and bodily symptoms of anxiety are also mentioned in diagnostic criteria of social anxiety (DSM-5, American psychiatric association, 2013) and they are also included in cognitive and cognitive-behavioral models of social phobia (Clark & Wells, 1995; Rapee & Heimberg, 1997).

1.2 Therapeutic change

There are many perspectives on psychotherapeutic change. These depend, for example, on the theoretical approach adopted. Cognitive psychotherapy, being one of the most used and studied treatment models for social phobia, views that changing biased cognitive schemas and cognitive processing, such as for example allocation of attentional resources, is the best route to psychotherapeutic change, whereas the constructivist approach values subjective reconstructing of problematic experiences. The constructivist perspective is essential here, as the treatment model of the research was based on it more than on the cognitive view, especially its philosophical basis. Moreover, the meaning of emotions and the theory behind emotion-focused therapy (Greenberg and Paivio, 1997) were given special attention, as this theory also informed the treatment model. The assimilation of problematic experiences and reflexivity have received considerable attention in the psychotherapeutic research field, the former being the main analysis method of the research and the latter comprising the interest of Study III. Finally, it is essential to consider what kind of role a therapist has in advancing these therapeutically essential processes.

1.2.1 Cognitive and constructivist perspectives on psychotherapeutic change

Traditional cognitive therapists see that psychological adjustment requires active disputation and reality testing of negative and irrational self-statements, so that the individual becomes able to process information in a more accurate and mature fashion (Beck, Emery, & Greenberg, 1985). Cognitive therapy has evolved in many ways since Beck introduced it, for example by taking more into account each client's individual thoughts and images. For example, the main steps in Clark's individual cognitive therapy (ICT) for social anxiety are: (1) deriving an individualized version of the cognitive model using patient's thoughts, images, anxiety symptoms, safety behaviors and attentional strategies; (2) conducting behavioral experiments to demonstrate the adverse effects of safety behaviors and self-focused attention; (3) using video feedback to modify distorted self-imagery; (4) training externally focused attention; (5) conducting behavioral experiments to enable the patients to test the validity of their negative predictions in a variety of social situations; while dropping safety behav-

iors and/or enacting feared outcomes; (6) identification and modification of problematic anticipatory and post-event negative processing; and (7) identification and modification of dysfunctional assumptions (Hedman et al., 2013).

Cognitive therapy implies the correspondence theory of truth, which holds that the validity of one's belief system is determined by a degree of match with the real world, or at least with the facts as provided by one's senses (see Neymeier, 1995). In practice, cognitive psychotherapy aims at modifying a social phobic's distorted self-imagery, in order to change biased schemas into more realistic ones. Instead, constructivist psychotherapy, as well as cognitive-constructivist, focuses on both a broad survey of the structure and implications of a client's primary psychological constructs and a focused attempt to reveal the unconscious emotional truth of the meanings of his or her symptoms, with no attempt to invalidate them (Caro Gabalda, Neimeyer, & Newman, 2010; Neimeyer, 2010).

The differentiation of constructivist approaches from traditional cognitive psychotherapy created the first major conceptual debate in the field (Mahoney, 1995b). Like the broader postmodern zeitgeist from which it derives, constructivist psychotherapy is founded on a conceptual critique of objectivist epistemology (Neimeyer, 1995). As traditional rationalist cognitive psychotherapies are more realistic in nature, cognitive-constructivist therapy takes a step towards relationism, reflecting more postmodern thinking. This difference is epistemological in nature; epistemology asks questions about knowledge, beliefs and truths. Cognitive-constructivist psychotherapy considers knowledge from an ontological and epistemological perspective, in which knowing, consciousness, and all other aspects of human experience are seen from the point of view of the experiencing subject. The cognitive perspective holds that representations of the things in the world are relatively straightforward reflections of the way those things actually are.

In cognitive-constructivist therapy, the aim is to reconstruct an alternative, non-problematic relation to problematic experiences, which means also accepting these as parts of oneself. Cognitive-constructivist psychotherapy represents so-called critical constructivism. Mahoney (1995a, 53) defines it as follows:

> Critical constructivists admit to being hypothetical realists, but they deny that we can ever develop a metric of correspondence between ontological reality (the nature of things in themselves) and epistemological reification (the process of acting as if there were some orderly relation between the furniture of the universe and the architectural designs of our knowing processes).

According to Guidano (1991, 1995), the acting and experiencing *I* is always one step ahead of the current appraisal of the situation, and the appraising *Me* becomes a continuous process of reordering and reconstructing a person's conscious self-image. The aim of psychotherapy is to understand those feelings and experiences that earlier were experienced as unreal and outside the self as being the person's own internal feelings and experiences (Guidano, 1991).

1.2.2 Changing problematic emotional experiencing

There is wide consensus in the therapeutic research field that activating and processing emotions is important in psychotherapeutic change (Auszra, Greenberg, & Herrmann, 2013; Greenberg, 2010; Greenberg & Paivio, 1997; Greenberg, Rice, & Elliot, 1993; Hays, Beevers, Feldman, Laurenceau, & Perlman, 2005; Toskala & Hartikainen, 2005). In the group treatment model described in the present study, emotion-focused therapy, and especially the theory behind it (Greenberg & Paivio, 1997; Greenberg, Rice, & Elliot, 1993), was one therapeutic approach that the strategies of the model were based on. Generally, the goal in emotion-focused therapy is to promote emotional awareness and enhance clients' emotional processing.

Greenberg and Paivio (1997) specify different kinds of emotion processes: primary adaptive emotions, which are useful responses to the situation; secondary reactive emotions, which are a person's reactions to other, primary emotions; and primary maladaptive emotions, which arise directly but are based on an experience-based misconstruing of the situation. According to Greenberg and Paivio (1997) and Greenberg, Rice and Elliot (1993), facing painful experiences and feelings related to them is central for therapeutic change. It is important to reach primary feelings, such as sadness, fear or anger, but usually the starting point in therapy involves addressing secondary feelings that hide these primary feelings. For example, hate and disappointment can hide sorrow, and facing these feelings first opens possibilities to then experience sorrow.

In order to experience primary emotions in therapy, clients need to attend to, recognize, and stay focused on certain internal cues (Greenberg, Rice, & Elliot, 1993). The emphasis is always on personal agency: "I am feeling this" (Greenberg & Safran, 1987). When a person is experiencing primary adaptive emotions, it is best for them to be accessed and allowed to shape adaptive action. For example, a socially isolated person may believe that he would be happier if he had more friends, but he still fills his life with work. If he is able to face his feelings of sorrow and loneliness and then integrate these feelings into himself, it becomes possible for him to also be committed to sharing relationships. As a primary emotion, sorrow includes an intention to connect with other people (Greenberg & Paivio, 1997).

When feeling primary maladaptive emotions, a client benefits from a broad exploration of the emotional response that has become problematic (because it no longer fits the situation), accompanied by careful listening and the elaboration of other, subdominant primary emotions (Greenberg & Paivio, 1997; Elliot & Greenberg, 2007). In social phobia, shame is usually an essential emotion. When feeling primary maladaptive shame, a person experiences him or herself as inadequate in some way, unacceptable or worthless, which usually leads to withdrawal or hiding from others. It is essential that the client experiences him or herself as accepted by the therapist, even when exposing these kinds of vulnerable and hidden parts of the self.

According to Greenberg (2010), maladaptive shame is best transformed and undone by activating other, more adaptive emotional states. In emotion-focused therapy (EFT), one of the first goals is to arrive at a maladaptive emotion, such as shame, not for its good information and motivation, but in order to make it accessible for transformation. Construing a new meaning is easier when emotionally charged experiences are activated. This view is also supported by emerging evidence from cognitive neuroscience (Lane, Ryan, Nadel, & Greenberg, 2015). Subsequently, change is brought about by the activation of an incompatible, adaptive experience, such as empowering anger or self-compassion, which undoes the old response rather than attenuating it (Greenberg, 2010).

According to Toskala and Hartikainen (2005), one aim of therapy is to increase a client's awareness of those parts of him or herself that he or she doesn't accept, as well as to consider what kinds of consequences this has for the client. The aim is for the client to accept these deficiencies to oneself so that they would not be generalized to the whole selfhood. Change is based on construing a kind of new personal meaning, both affective and cognitive, for experiences which are problematic and experienced as separate from the self.

When a person experiences secondary shame, there can be, for example, beliefs adopted from one's family about what is suitable or acceptable behavior or ways of experiencing. Feelings and experiences contradicting these cause secondary shame, which is more casual than primary shame (Greenberg & Paivio, 1997).

Auszra, Greenberg and Herrmann (2013) emphasize that merely activating emotion is not in itself therapeutic and should not be an end itself. Therapists need to be provided with a map to distinguish between a client's emotional expressions that promote achievement of therapeutic process goals, which lead to change, and emotional expressions that hinder or are even detrimental to the change process. On the basis of their study, the authors suggest that activation of emotions has to be followed by some form of cognitive processing of the activated emotional experience. Thus, a primary emotional experience, once brought into awareness, has to be experienced in a manner that allows for further processing. This processing includes attending to the emotional experience, symbolizing it in words, congruence between verbal symbolization and non-verbal expression of the emotion, acceptance of the emotional experience, regulation of its arousal, and a sense of being the agent of the emotion. Finally, the emotion has to become differentiated over time (Auszra, Greenberg & Herrmann, 2013; Greenberg, 2010).

1.2.3 Assimilation model

There are some integrative approaches of the therapeutic change process, such as the stages of change approach (Prochaska & Norcross, 2007) or the integrated memory model (Lane et al., 2015). One of these accounts, the Assimilation of Problematic Experiences Model (Stiles, 1999; Stiles et al., 1991) segments therapy outcome into a sequence of developmental stages, each associated with specific client tasks, which are understood at the same time as micro-outcomes

(Kramer & Stiles, 2015). The model, developed through several theory-building case studies, is a theory of psychological change that depicts the self as a community of internal voices, composed of traces of a person's experiences (Honos-Webb, Surko, Stiles, & Greengerg, 1999; Stiles, 2001, 2002, 2011; Stiles et al., 1991). These internal voices may embody other people's activities, events, or any other interlinked complex set of experiences (Mosher & Stiles, 2009; Stiles, 2011).

In a healthy, functioning community, voices are easily accessed and can be called upon as needed. Voices are considered problematic when they represent foreign, discrepant, or traumatic experiences (Brinegar, Salvi, & Stiles, 2008). For example, when a person has social phobia, the problematic voice could represent a person's unsure or fearful side, which is not approved by the other voices of the person's internal community, as those demand a self-confident and perpetually fearless attitude. The assimilation model strives to show how a problematic voice becomes accepted and integrated into the dominant community of voices.

Assimilation is hypothesized to proceed according to an eight-level sequence, described by the Assimilation of Problematic Experiences Scale (APES; Honos-Webb & Stiles, 1998; Stiles, 2001; Stiles et al., 1991). Problematic or non-dominant voices are more or less rejected by the community. In extreme situations, problematic voices may be denied awareness or avoided (APES stages 0 or 1), in which case the therapeutic work entails bringing the voice into awareness (Honos-Webb et al., 1999). Theoretically, as an unwanted voice emerges into awareness, a voice that opposes it is called forth from the dominant community of voices (Honos-Webb & Stiles, 1998).

According to Brinegar, Salvi, Stiles and Greenberg (2006), a problematic voice theoretically becomes assimilated into the community by building meaning bridges to other voices. A meaning bridge is a word, phrase, story, theory, image, gesture, or other expression that has the same meaning for each of the voices it connects to. Meaning bridges connect voices through their common understanding, allowing them to emphasize and communicate with one another and engage in joint action. Meaning bridges thus allow voices to serve as resources: the voices can be called on when circumstances require their specific talents and capacities.

Honos-Webb and Stiles (2002) suggested that each assimilation stage might call for specific (responsive) therapist interventions. Meystre, Kramer, de Roten, Despland and Stiles (2014) conducted a theory-building case study that assessed which interventions were most effective at each of a client's stages of assimilation. For example, for accessing and elaborating unwanted thoughts, explicit and subtle guidance, as well as emphasizing feelings and focusing on the present experience, were associated with increments at particular assimilation stages. Meystre, Pascual-Leone, de Roten, Desplant and Kramer (2015) micro-analyzed in patient psychodynamic therapies and elaborated a detailed list of responsive interventions. For example, to responsively foster progress at the new understanding/insight assimilation stage 4, the therapist used psychody-

namically informed confrontative interventions, whereas responsive interventions at the lower, unwanted thoughts/avoidance assimilation stage 1 drew from a different set of interventions.

1.2.4 Reflexivity

The concept of reflexivity is central in this dissertation, as it was an essential element of the treatment model used, and it was also the interest of Study 3. The concept of reflexivity is manifold, and it has been used in psychotherapy research more or less synonymously with such concepts as metacognition, reflectivity, self-monitoring, recursiveness, and self-consciousness (Dimaggio & Lysaker, 2010; Rennie, 1992). Rennie (1992) refers to Lawson (1985), who describes reflexivity as turning back on oneself, a form of self-awareness. Rennie (1992) presented empirical evidence that forced the recognition of clients' reflexivity in psychotherapy. After that, at the latest, reflexivity is acknowledged to be an essential element in the psychotherapeutic process (Levitt, Lu, Pomerville, & Surace, 2015).

In Rennie's (2004) earlier definition, reflexivity is taken to mean self-awareness and agency within that self-awareness, as well as formation of intentions within self-awareness resulting from turning one's attention to oneself. Later, Rennie (2007, 2010) used the term radical reflexivity to describe how clients are aware of their self-awareness and agential in terms of this capacity.

According to Guidano (1995), being aware of oneself means reaching an explanation of the ongoing experience of being a unique, irreducible, and often unpredictable *I*. Awareness is a reflexive process for self-referencing immediate experience (*I*) in order to amplify consistent aspects of the perceived *Me* while inhibiting discrepant aspects. The ongoing, tacit experience is made consistent by the capacity of reflexive self-referring (Guidano, 1991). Thus, the ability to take a reflexive stance toward one's experience, feelings and thoughts is an important tool when maintaining and enhancing one's mental well-being.

Toskala and Hartikainen (2005) emphasize that reflexivity is a process and, as such, it includes different phases and different qualities, which are reflected in psychological problems and also in the succession of therapy. According to Toskala and Hartikainen, the phases included in gradual increasing of reflexivity are: directing attention to one's own immediate experience; recognizing experience; symbolizing and interpreting experience; creating a new kind of attitude and meaning related to experience; owning experience and integrating it in oneself; and endeavoring to create a regulatory and agentic relationship with this experience. These reflective processes proceed quickly and usually become so automatized that differentiating the different phases is difficult. In addition, as a person is in usual integrated state, the stream of reflexive processes is continuing. However, Toskala and Hartikainen see that a client's reflexive process is something that a therapist can support.

Leiman (2012; see also Tikkanen, Stiles, & Leiman, 2013) also emphasizes the change that happens in a client's self-reflection during therapy. He uses the term "observer position," which allows a flexible exchange between the per-

spectives of self and other. When clients enter therapy, they usually feel that they have no control of their problem and that their symptoms are dominating their life. Leiman describes this experience as the "object position." With the help of a therapist, clients assume the observer position and come to see their original problems in a new light. In this way, clients can gain the "subject position," where the feeling of agency is essential. The observer position described by Leiman can be seen as a parallel to reflexivity.

Reflexivity has also been paralleled with the notion of employing a meta-position. According to Hermans (2004), a well-developed meta-position allows one to stand above the ongoing stream of perception. In other words, the person takes the perspective of an author watching his or her voiced positions and how they function as actors in specific circumstances. As a result of this increased level of self-awareness, the person is able to strengthen his or her capacity of seeing relevant connections in life experiences. Hermans emphasizes that a meta-position is always connected to one or more internal or external positions (e.g., one represented by the psychotherapist), which are actualized at a particular moment and in a particular situation. Accordingly, the meta-position is a dialogical phenomenon, including both the outer dialogue with the therapist and the client's internal dialogue. This also implies that, depending on time and situation, different meta-positions can emerge.

In this research, it was emphasized that different levels of reflexivity can be observed in therapeutic discourse. The first level, forming a basis for assuming a reflexive stance, is achieved when a person turns towards the self and recognizes his or her own internal processes, such as feelings and thoughts. At the second level, such a turning to the self may allow the person to address and eventually analyze his or her interpretations based on these processes. Reflexivity at the first level can be defined as an observable utterance in the therapeutic discourse where the client takes an observational stance towards her own experiences or internal processes (e.g., "then I get this feeling of uncertainty"), and at the second level as an utterance where he or she makes observations about her own way of interpreting her experiences (e.g., "then this feeling of uncertainty makes me think that everybody else is critical of me"). Taking such a meta-observational stance at least implicitly expresses an understanding of people having their own personal perspectives, differing from the speaker's image of those perspectives.

When considering reflexivity, it is important to define its relation to the concept of mentalization. Mentalization refers to how humans make sense of their social world in terms of mental states that underpin their own and others' behavior (Fonagy et al., 1995; Fonagy & Target, 1996; Gullestad & Wilberg, 2011). Allen, Fonagy and Bateman (2008) define mentalizing as holding mind in mind, in other words attending to mental states in the self and others. One dimension of the concept is whether it is the self or others that is the object of mentalizing. From this point of view, reflexivity can be defined as mentalizing the self. Mentalization is also defined as a capacity to understand and interpret (both implicitly and explicitly) one's own and others' behavior as expressions of

mental states, such as feelings, fantasies, desires, motives, thoughts and beliefs (Allen, Fonagy & Bateman, 2008).

Indeed, reflexivity or self-reflection can also be considered as a person's ability or capacity. According to Bandura (2006), the meta-cognitive ability to reflect on oneself and the adequacy of one's thoughts, feelings and actions is the most distinctly human, core property of personal agency. Impaired reflexivity is related to different kinds of psychic disorders in early and later phases of life. Fonagy, Target, Steele and Steele (1998) have developed a manual and scale for the analysis and scoring of reflective functioning or mentalization, the Reflective Functioning Scale, which is applied to the Adult Attachment Interview. The term reflective functioning refers to the psychological processes underlying the capacity to mentalize, involving both self-reflective and interpersonal components.

Serious disturbances in self-reflective capacities appear, for example, in personality disorders and schizofrenia, as their reflective functions have been noted as being remarkably lower than those of a normal control group (Bateman & Fonagy, 2004; Fonagy et al., 1995). In personality disorders, poor insight has been connected to emotional difficulties (see, e.g., Fonagy et al., 1995). Fonagy and Target (1996) consider that difficulties of reflective functions are actually a difficulty of distinguishing between inner and outside reality, the result being a tendency to treat fantasies and thoughts as though they were a reflection of the outside world, which reduces a person's ability to reflect critically. In the case of schizophrenia, there are many theories about the reasons of poor insight, including framing poor insight as a symptom of cognitive dysfunction or as an attempt to avoid or ward off negative connotations of the illness (Lysaker, Buck & Ringer, 2007; Lysaker et al., 2011). In social phobia, worrying about others' thoughts associated to oneself (Clark & Wells, 1995) and distorted self-images (Rapee & Heimberg, 1997) may lead to difficulties with self-reflective skills, because a person's perception in social situations is quite self-centered.

1.2.5 Therapist's responsiveness and empathy

Responsiveness is defined as one's behavior being influenced by the emerging context. In psychotherapy, responsiveness is a ubiquitous characteristic of the therapist-client interaction (Kramer & Stiles, 2015; Leiman & Stiles, 2001; Mendes et al., 2016; Toskala & Hartikainen, 2005). In therapy, therapists respond to a client's requirements and characteristics which emerge in the therapy process, using the principles and tools of their approach. In a group-therapy context, this kind of customization is especially challenging, as there are different kinds of client requirements; clients have different characteristics, they are at different stages in terms of their problematic issues, and they probably benefit from different kinds of interventions.

In the work of the therapist, active responsiveness often appears as an attempt to be sensitive to and emphatically reflect experiences that the client is bringing up, as well as emotions and moods related to these experiences. Ac-

cording to Rogers (1980, 85), empathy is "the therapist's sensitive ability and willingness to understand the client's thoughts, feelings, and struggles from the client's point of view". The feeling of being understood and accepted by an engaged, empathic listener enables clients to disclose their most important and emotionally salient personal experiences to a therapist (Angus & Hardtke, 2006).

According to Angus and Kagan (2007), both therapist's attunement and communication skills are viewed as essential for sustained empathic engagement and the development of a secure, relational bond in psychotherapy. Specifically, therapist's empathic attunement skills are viewed as helping clients engage in active self-reflection for the expression and symbolization of primary adaptive emotions (Greenberg, 2010), in addition to sustaining clients' active self-reflection in the therapy hour and engendering a heightened sense of personal agency (Angus & Kagan, 2007; Bandura, 2006). The therapeutic bond (mutual liking and trust) has been found to be equally present in group and individual cognitive therapies for clients with social anxiety (Mörtberg, 2014).

Toskala and Hartikainen (2005) underline the individuality of each client: because every client is different in terms of how ready he/she is to receive empathic reflection, it is important that the therapist tries to accommodate his/her level of reflection to the conditions that the client has. For example, focusing reflection on emotions can be very confusing to a client whose relationship with his/her emotions is weak. In this case, especially at the beginning of therapy, reflection can instead emphasize the thoughts and aims the client is bringing up. Accordingly, a client who reacts during therapy in a particularly emotional way may at that stage be unable to receive the therapist's specific reflections. Then the aim should rather be to soothe the client, and actual reflection cannot be made until later.

Since a therapist's responsiveness is such an important element in psychotherapy, it is justifiable to claim that every individual client needs his/her own individual therapy customized especially for him/her. From this point of view, it is important that a therapist can smoothly customize his/her interventions according to the client's individual needs and therapeutic zone of proximal development (ZPD). Vygotsky's (1978) developmental concept of the ZPD was extended to the context of psychotherapy by Leiman and Stiles (2001) to refer to the space between the stage of therapeutic change process, called assimilation (Stiles et al., 1991), which the client can achieve in collaboration with the therapist. The therapeutic ZPD (or TZPD) may be different for each problem, and it shifts as the client makes progress with his/her problem. According to Mendes et al. (2016), in order to promote novelty and progress in the therapeutic process the therapist may press the client higher within the therapeutic ZPD, but if the client feels this movement as too risky (exceeding the ZPD), he or she will move back into a less challenging stage of change.

Some therapeutic approaches claim to standardize treatments by elaborating detailed manuals for interventions. In this study, the treatment was semi-structured; the therapist followed five therapeutic strategies tied to particular sessions, although no detailed manual was adhered to. Nonetheless, with or

without a manual, every psychotherapy is responsive, insofar as all therapists (and clients) respond to emerging contingencies at all time scales: during treatment assignment, treatment planning, forming alliances, choosing interventions, and adjusting tone and timing during the process. In group-therapy format, there are multiple emerging contingencies and factors because there are multiple clients. In group-therapy situations, a therapist has to decide where to concentrate and what to respond to, as each client has his or her own individual needs. Thus, in a group format, the structure of the treatment can be an important element and a guideline for the therapist.

According to Kramer and Stiles (2015), therapist responsiveness impacts effectiveness of psychotherapy, including process-outcome links and outcome effects. They state that appropriate responsiveness describes the observation that clinicians, in their daily work, tend to optimize their interventions by adjusting to circumstances: they try to do the right thing at the right time, considering the client, the context, and their therapeutic approach. Indeed, appropriate responsiveness is the essence of good practice, although it may be a problem for researchers who are trying to model and study what clinicians do (Stiles, 2013).

1.3 Aims of the research

This research studied clients with social phobia in a short-term cognitive-constructivist group psychotherapy, as well as the self-descriptions that appeared in this kind of treatment context. The aim was to obtain information about the feasibility of this particular treatment model and strategy for socially phobic clients. There was also a broader aim: to gain knowledge about the specific psychological phenomena related to treating socially phobic clients in a group-therapy format. There are many challenges with this format, as groups always consist of different kinds of clients. Thus, the therapist has to deal with many kinds of challenges, such as clients' heterogeneity, related to group format.

The aim of the research was pursuit by three studies. In Study I, the focus was not the treatment model, but rather socially phobic persons' ways of describing themselves in group therapy. Here it was asked: How do phenomena related to the self-image of socially phobic persons occur in a naturalistic group-therapy context? The aim was also to identify different subgroups of socially phobic clients on the basis of these self-descriptions.

In Study II, the attention was placed on the treatment model, and the interest was on the question of whether these different kinds of clients benefitted from it. Here it was asked: Are there possible similarities within and differences between the subgroups found in the progress of their therapeutic change process, technically speaking, in their assimilation process?

Finally, in Study III, the focus was on one particular assumed component of change, reflexivity, and its actualization with a certain client. Here the research

question was: How is progress in assimilation connected to increasing reflexivity in the case of a client with social phobia? With this, the aim was to clarify the meaning of reflexivity in a successful psychotherapeutic change process. In Study III, the focus was also directed on more or less successful therapeutic actions and their influence on the client's therapeutic process.

2 METHOD

This research was part of a research project that concerns the group-treatment model for social phobia. The project started in 1993 at the University of Jyväskylä Psychotherapy Training and Research Centre, when the first group was gathered. The aim of the project was to develop therapeutic strategies and techniques that support and contribute to clients' self-exploration and actualization of individual therapeutic aims. One important aim was also to develop a useful group-treatment model for the Finnish public health care system, in which there was a need to have effective and economically viable treatments for social phobia.

The group-treatment format took its final shape gradually, as a new group began every year until 2002. In addition to social phobia, persons with panic disorder and depression were also treated. These treatments were different adaptations of the cognitive-constructivist group treatment, depending on the particular diagnostic group. As new groups started every year, this offered a good opportunity for a naturalistic study about treatment progress and the therapeutic interventions used. This part of the research project examined clients with social phobia undergoing this treatment model.

2.1 Data

The primary data used in all three studies consisted of 24 videotaped sessions from two treatment groups of cognitive-constructivist short-term group psychotherapy for social phobia and verbatim transcriptions of those tapes, amounting to 665 pages of Microsoft Word document data files. Both group treatments included 12 weekly sessions of two hours' duration. The two groups utilized in this research were from 1998 and 1999. At the time of this project, the short-term cognitive-constructivist therapy treatment model had found its final form.

In Study I, the final data consisted of text segments containing participants' self-descriptions or self-related statements, 500 passages in total. These passages varied in length and structure, from short statements to extensive paragraphs. In Study II, one or two emerging central themes related to social anxiety were identified for each client. Parts of the data associated with the identified themes were collected from the transcripts of all 24 sessions. The final data consisted of 590 passages, which ranged in length from three lines to two pages.

In Study III, the final data consisted entirely of one client participant ("Miia") and her discussion related to the theme of her main problematic experience; the data were collected in 12 sessions, all videotaped and transcribed, along with the therapist's direct replies. In all, these constituted 25 pages (out of 42 total pages on all of Miia's turns in the discussion).

2.2 Participants

Clients entered treatment by contacting the University of Jyväskylä Psychotherapy Training and Research Centre in reply to a notification in the local newspaper about possibility of group therapy for persons with social anxiety. Fifteen female and two male clients (aged 24–50 years) – forming two separate therapy groups with seven (1998) and ten people (1999), respectively – participated in the research. One participant from the earlier group didn't go through the whole therapy process as the ninth session was her last session. All other participants went through all the five therapeutic strategies and mainly all the twelve sessions, although there were single non-attendances in single sessions with few participants.

The therapist, a male in his fifties, was a licensed and experienced psychotherapist. He had developed the cognitive-constructivist treatment model used here and was the leader of the research project concerning cognitive-constructivist group-treatment models for depression, panic disorder and social phobia.

2.3 Assessment

All seventeen client participants, assessed individually by the therapist before entering therapy, were informed about the course of the group treatment. The diagnostic criteria for social phobia were checked systematically in the assessment interview. The assessment interview was semi-structured, consisting of 12 main questions:

1. How would you describe your problematic experience in social situations? (in what kinds of situations etc.)
2. Since when have you experienced it?

3. What kinds of feelings do you have when you face this problematic experience in social situations?
4. What kinds of bodily sensations arise when you are feeling social anxiety?
5. What kinds of thoughts about you and others go through your mind when you are experiencing these problematic feelings in social situations?
6. What kinds of feelings and thoughts arise after the problematic social situation?
7. What do you think, why do you experience this kind of problematic social anxiety?
8. What kinds of means do you use when encountering these problematic social situations?
9. When you notice in yourself that you are starting to get anxious in social situation, how do you relate to these feelings?
10. Are there any uncertainty or anxiety in your important relationships, in any point?
11. How do you understand your social uncertainty when considering your important relationships in your childhood?
12. What thoughts do have about how to relief your social anxiety?

All clients reported anxiety in social situations, as well as varying degrees of anxiety-related physiological symptoms (e.g., sweating, trembling hands, and dizziness). Thus, they met the DSM-IV diagnostic criteria for social phobia. Also, the sort of the social anxiety was being considered, and some clients experienced mainly interaction social anxiety, some performance social anxiety and some experienced these both types. Possible comorbidity with other diagnoses were not specifically checked. All clients gave informed consent to be part of the study and to have the sessions videotaped.

2.4 Treatment model

The group-treatment model developed is a cognitive-constructivist, short-term form of group psychotherapy for socially phobic clients. Although the therapeutic strategies of the model are developed and adapted especially for the context of group therapy, they can also be adapted flexibly for individual therapies, in which different techniques can also be included in terms of each client's individual conditions. The therapeutic strategies and aims are based on meaning organization theory (Guidano, 1987; 1991; Guidano & Liotti, 1983), reflexive processes and emotion-focused therapy (Greenberg, 2002; Greenberg & Paivio, 1997; Greenberg, Rice, & Elliot, 1993). Cognitive restructuring of self-organization is seen as valuable therapeutic focus particularly in constructive cognitive treatment (see, e.g. Guidano, 1991; Mahoney, 1991), and it is important to recognize the self-organization of each particular client behind a diagnostic label.

Accordingly, the development of a client's reflexivity is seen as an essential element of the treatment model. One of the therapist's essential goals is to increase the clients' ability to reflect on their inner states and individual ways of experiencing and interpreting those experiences. Reflexivity is a central tool in treatment, as the therapist tries to help clients to adopt a new kind of reflexive stance toward their problematic experiences, in order that it would be possible to them to form a new kind of understanding and a more accepting relationship vis-à-vis these experiences. This aim includes an assumption that in this way, as a person accepts his/her earlier problematic aspects (for example, being unsure or fearful) as part of him/herself, challenging experiences in social situations would eventually stop being problematic (see also Hays, 2004). The theory of the meaning of emotions (Greenberg & Paivio, 1997) is central, as the aim is to support the kinds of reflexive processes that include the progressive recognizing and owning of one's own emotions.

The therapy was time-limited, consisting of 12 weekly two-hour sessions. Five therapeutic strategies based on the aforementioned cognitive-constructivist model of the constitution of problematic experience and on the therapeutic development of reflexivity were adopted in the group treatment. The clients were given brief written material concerning each strategy before that particular session. The first strategy (sessions 2 and 3) was to recognize the internal, cognitive and affective experiences – such as feelings, thoughts, bodily sensations, images – related to the problematic experience of each individual participant. This was done by considering and discussing situations in which social anxiety was experienced. This kind of active and conscious observing of one's own experiences is seen as a first phase when constructing reflexive processes (Toskala & Hartikainen, 2005). When experiences are threatening (as social situations in social phobia are usually experienced), one usually tries to direct one's perceptions towards those objects and things that may decrease the threat in the present moment instead of focusing on the contemporaneous experience and the feelings related to it. Observing one's relationship to problematic experiences is seen as the first and necessary phase of change.

Reformulation, the second strategy (sessions 4 and 5), included reconstruction of the problem on the basis of the individual's own inner process. At this point, both the client and therapist concentrated on the way in which the problem was constructed and what was most essential in the problematic experience, including possible explanations for it. The appropriate description of a problematic experience gives the opportunity to channel and communicate the psychic pain and, for example, threat of fragmentation of selfhood related to it (e.g. "this is my horrible shame that destroys me"). A therapist can emphatically try to validate a client's experience, which also enables the client him/herself to validate his/her own experience as a personal truth instead of an objective one. When giving this kind of space and justification to one's experience, feelings related to it enter into the therapeutic relationship, so it is possible to observe them together. Symbolizing, in other words giving the words to the experience

creates a bridge, so it is possible for it to be reached again later (Toskala & Hartikainen, 2005).

In the third strategy (sessions 6 and 7), the idea was to construct an alternative relation with the individual's problematic experience. The goal was a more allowing and accepting attitude toward oneself and one's own inner experience, which would enable integration of the problematic experience with the self. This also meant expanding the acceptable self (Toskala & Hartikainen, 2005). The fourth strategy (sessions 8 and 9) was to explore and clarify how problematic social phobic experiences appeared in present adulthood attachments and relationships. In the fifth and final strategy (sessions 10 and 11), the group contemplated the problematic experience in each client's early attachments to parents and other significant adults, and possible to peers. This was done by recalling significant experiences related to childhood and youth, and having an emotional connection to these memories.

The treatment was not based or mainly facilitated by the group processes, as the group setting was used only for the systematic application of the strategies described above. The clients were invited in turns to deal with their feelings and experiences related to the issues in question, mainly in dialogue with the therapist. Occasionally the clients did comment on each other's talking in the group, but group discussion was not systematically used. There was also a psychoeducational component in every meeting, in which the therapist clarified the strategy in question and outlined the clients' experiences related to it, making a summary of them on a flipchart. The treatment can be described as a mixture of prescriptive and exploratory approaches: prescriptive in that it was time-limited and structured, but exploratory in its basic philosophical approach.

2.5 Analysis

The first therapy group (1998) was already familiar to me, as I had followed the treatment in the sessions and transcribed half of the sessions some years earlier when doing my master's in psychology, as it was the data of my thesis. Years later, I returned to this data when I started doing my dissertation. The analysis began by watching all the videotapes from both of the two groups, which comprised 24 group-therapy sessions. Next, I transcribed the sessions of the second therapy group (1999), as no transcriptions of them were available, and I read the verbatim transcriptions of all the tapes (consisting of both groups).

The process of watching and transcribing the data was time-consuming but worthwhile, as it helped me to get an idea of each client and the course of her/his therapy process. Next, I identified the speech segments of each client and read the transcripts of all sessions several times, one client at a time, listing the topics that each client addressed in the order in which they were discussed. In this way, I went through all 17 participants in the first two studies, which included all the clients in both groups.

2.5.1 Study I

The data was analyzed qualitatively, using two main analysis approaches. In Study I, a generic data-driven approach (see McLeod, 2001) was used. This aimed to identify, describe, and classify the self-descriptions given by the client participants in the therapy sessions in question, and to find possible subgroups of socially phobic clients based on those aforementioned self-descriptions.

2.5.2 Studies II and III

The second main analysis approach was assimilation analysis (Honos-Webb et al., 1999; Stiles, 2001; Stiles et al., 1991), which was used in Study II and Study III. Assimilation is hypothesized to proceed according to an eight-level sequence, described by the Assimilation of Problematic Experiences Scale (APES; Honos-Webb & Stiles, 1998; Stiles, 2001; Stiles et al., 1991). In Study II, the treatment progress of clients belonging to the aforementioned subgroups was evaluated by means of assimilation analysis. Each client's one or two emerging central themes related to social phobia were identified and described. Each theme was cast in terms of a dominant and nondominant voice (see introduction section Assimilation model) and the selected passages associated with the identified themes were rated according to assimilation stages 0–7. Here the aim was to discover possible similarities and differences between the subgroups found in Study I, according to their progress in therapy.

In Study III, I sought to concentrate especially on what happens in dialogues between the client and therapist. I chose one informative case and, at the beginning of the analysis, started to read the transcriptions of her therapy process as open-mindedly as possible at that phase of the research. The assimilation analysis of the treatment progress of this particular client (Miia) had already been done in Study II, so I acknowledged that I already had some kind of idea of her change process, as the data was so familiar to me. When reading through the transcriptions again, my attention was drawn to the therapist's way of initiating the client's reflexive manner of contemplating her issues. This led to the third study question, which deals with the relationship between progress in assimilation and increasing reflexivity. I also noticed that there was a kind of interesting twist at stages 2 (vague awareness) and 3 (problem statement/clarification) of her assimilation process, so in the end I directed my attention especially at the progress in these stages.

When concentrating on stages 2 and 3, two questions were asked: First, did the assimilation process progress during that particular passage? Second, did the client take a reflexive stance during that particular passage? On the basis of the aforementioned observations, in the third part of the analysis I performed a detailed consensual qualitative analysis of how the therapist's interventions in three representative instances by means of responsiveness facilitated or failed to facilitate the assimilation process of the client and her growing reflexivity. In the assimilation model, reflexivity is given as one marker of stage

3 (problem statement/clarification) (Honos-Webb, Stiles & Greenberg, 2003). The assimilation model does not, however, elaborate on the definition of reflexivity, and one goal of Study III was to specify the meaning of reflexivity on assimilation stages 2 and 3.

2.6 Some ontological and methodological points

In this research, I approached the phenomena under study from the perspective of critical realism, stating that it is possible to gain (imperfect) access to a reality beyond discourse. The treatment model under study was based on a constructive, process-oriented methodology and view of human mind. In psychotherapy, although there are many therapeutic tools, such as art in its different forms (music, painting, and dance), usually words and verbal communication are the main tools by which psychotherapeutic change is pursued. This was the case also in this particular treatment model. The phenomena under study (self-descriptions, progress in assimilation within different subgroups of socially phobic clients, and reflexivity) were studied through words and language. If we assume that these phenomena are mental processes that happen in a person's mind, I would claim that we cannot empirically verify them completely and totally objectively.

Critical realism is a research perspective that rejects the "extreme realism" of traditional positivist approaches, but also "extreme relativism" (Sullivan, 2010). It holds that the phenomena studied in research are not completely constructions, but correspond to real entities or processes which exist independently of us. According to Sullivan (2010), research that explicitly adopts a critical realist position is still relatively uncommon in psychology. Knowledge and "truth" are recognized as being, to some extent, socially constructed. Nonetheless, truth claims can be evaluated against evidence. Therefore, when observing reflexivity in therapy speech, for example, the aim was to recognize reflexivity in speech. At the same time, there was an attempt to go, to some extent, beyond talk to observe a person's subjective reflexivity, which was constructed in her mind. This contains an epistemological and methodological assumption that talking reflects inner mental processes, in this case reflexive positioning in a person's mind and speech. Thus, it is inevitable that, concerning constructions of the client, constructions of the researcher may also exist. The construction process of the researcher and the discourse between the client and the researcher make it inevitable that access to the subjective constructions of the client is always imperfect.

In critical realism, language is not only seen as a simple reflection of the reality of the world, but also as having the capacity to shape our thoughts and conceptions of what is real. From this point of view, the aim of Study III was also to get a glimpse of how the assimilation process and reflexivity were (or were not) facilitated in therapeutic conversations between one client and the therapist.

3 OVERVIEW OF THE ORIGINAL STUDIES

3.1 Study I

Self-descriptions of socially phobic persons in short-term group psychotherapy.

In Study I, it was asked how socially phobic clients exhibit their self-images through self-descriptions expressed in a naturalistic group-therapy context. The commonalities and differences of the self-images were studied, as those self-images appear in the self-descriptions. It was also asked if it was possible to discover client subgroups based on the commonalities and differences of the self-descriptions observed.

There were many phases in the analysis. In the beginning of the analysis, individual registers of self-description for each participant were created, and on the basis of these, five subgroups were identified. Then, in a later phase of the analysis, it was decided that these five subgroups should be reduced to three client subgroups to best fit the data: other-oriented, isolated and self-demanding. These terms represented participants according to their coping strategy, although they were based on the data.

Finally, in terms of all self-descriptions without links to specific clients, seven categories of self-descriptions were found: three were experiential in nature (self as "miserable," "insufficient," "transparent") and four were compensatory in nature (self as "adjusting and pleasing others," "demanding toward self," "outsider, different, isolated," and "hiding and controlling some feelings and features in oneself"). The latter categories described the ways in which clients tried to manage their negative self-images; in other words, these categories described their compensatory strategies.

The results supported the view that negative self-image is central to social phobia, but as the study showed, such negativity varied from total self-pity to less negative notions of insufficiency. Some clients exhibited behavior described by only one category, while others showed both types of negativity in their self-

descriptions. The three subgroups seemed to describe the different strategies that socially phobic persons habitually use: (1) some conformed themselves to other's wishes and expectations, (2) some isolated themselves from others, and (3) some attempted to be perfect. One should still note that it appeared that some socially phobic individuals applied diverse coping and compensatory strategies, while others regularly adopted one particular compensatory strategy.

The findings of the study are clinically relevant in demonstrating how the multitude of self-experiences and compensatory strategies may appear in a client's descriptions of self in a group-therapy context. Cognitive restructuring of self-organization is seen as a valuable therapeutic focus, particularly in cognitive-constructivist treatment, and it is important to recognize the self-organization of each client behind the diagnostic labels. The descriptive categories and subgroups found in the study offer a useful tool for therapists to adopt and utilize this information directly in their therapeutic work.

3.2 Study II

Progress in assimilation of problematic experience in group therapy for social phobia: A subgroup analysis.

Study II examined the possible similarities within and differences between three subgroups of clients with social phobia in the progress of their assimilation process (stages 0–7) during time-limited, cognitive-constructivist group psychotherapy. The three different subgroups found in the earlier study were defined on the basis of their main coping and compensatory strategies: (1) other-oriented (n = 7), (2) isolated (n = 7) and (3) self-demanding (n = 3).

Based on 17 clients, a total of 25 problematic themes of assimilation were identified and described, with each client having one or two problematic themes related to social anxiety. The themes were described in terms of their dominant and non-dominant voices (E.G. "I must be successful and flawless/I can also be weak and unsure"), and many of them seemed logically related to the subgroup inclusion of the client. After selecting the text passages associated with the identified themes, the passages were rated on the Assimilation of Problematic Experiences Scale (APES; Stiles et al., 1991). Some similarities and some differences between the subgroups could be noted. The self-demanding subgroup was the most homogeneous, as all clients within this group progressed well in their assimilation process during the treatment, reaching APES stage 6 (problem resolution). The two other subgroups, the other-oriented and the isolated, were more heterogeneous, as the change processes of the clients varied.

The largest variance in the progress of assimilation was in the isolated subgroup, in which two clients only reached stage 2 (vague awareness), but three clients progressed to stage 6 in at least one of their problematic themes. One client who didn't attend to the last three sessions, was in this subgroup, reaching stages 3 and 4 in her problematic themes. When considering the possi-

ble effect of the group format of the treatment on the results, it is notable that the two clients who benefitted least were both in this subgroup, and also the one client who discontinued the therapy after the ninth session. For clients whose social anxiety management strategy is to withdraw from other people, the group format applied in this study might not be the most suitable form of therapy. In group therapy, clients are expected to expose personal and possibly painful experiences to others, and this is precisely what clients using social isolation as a coping strategy seek to avoid. Thus, an explicit selection process and assignment to a proper form of treatment would seem to be essential. On the other hand, although most of the clients who benefitted least from the treatment were in the isolated subgroup, belonging to this particular subgroup did not automatically mean that the client could not benefit from the treatment. Indeed, the factors contributing to a successful treatment of clients with social anxiety are more complex than simply the confirmed diagnosis of social phobia or the use of certain therapeutic techniques.

3.3 Study III

Assimilation, reflexivity and therapist responsiveness in group psychotherapy for social phobia: A case study.

Study III was a case study where it was asked how for one participant in a therapy group, progress in assimilation at stage 2 and progressing to stage 3 were connected to increasing reflexivity, and how the connection between the two could be seen in the context of a semi-structured model of group psychotherapy for social phobia. The participant chosen was from the isolated subgroup identified in the first study. Her therapeutic change process was successful as she progressed from APES stage 2 to stage 6 during the course of the treatment. Also, more and less successful therapeutic actions were looked at, as detailed qualitative analysis was made for three representative instances; here it was asked how the therapist's responsiveness facilitated or failed to facilitate the assimilation process of the client and her growing reflexivity. It was acknowledged that the group format puts restrictions on the degree to which the therapist can customize his or her interventions.

A detailed analysis of 13 conversational passages revealed that progress in assimilation happened only when the client took a reflexive stance towards her inner experience or outer actions. There were a few instances when she took a reflexive stance, but no progress in assimilation could be noted. It could thus be concluded that reflexivity seems to be a necessary condition for progress in assimilation both at APES stages 2 and 3, but the model should recognize that reflexivity can appear in diverse forms and at different levels.

A qualitative analysis of three conversational episodes showed how therapist responsiveness facilitated the client's increased reflexivity and progress in assimilation. When the therapist incorrectly evaluated the client's ability to ac-

cept the point of view that was offered, the assimilation process did not proceed. This highlights the problematic nature of working outside the client's therapeutic zone of proximal development (ZPD or TZPD) (Leiman & Stiles, 2001), in which premature exposure to the therapist's conclusions, meant to increase the client's reflexivity, can actually be counterproductive. It is possible that such a mismatch can happen more easily during early phases of change, where the client is aware of the problem but cannot formulate it clearly or reflect on it. At this early assimilation stage, in this case at stage 2, the client needed empathy and for the therapist and client to share the expression of all the voices, both the dominant and the non-dominant, problematic ones. As a conclusion, it is important for the timing to be right when a client's reflexivity is encouraged. Also, the reflexive stance should not be seen as a goal in and of itself, but as one alternative stance that can be adaptively adopted when needed.

4 DISCUSSION

This research focused on self-descriptions of clients with social phobia and therapeutic progress within three identified subgroups. Then, one client's therapeutic change process was studied in more detail, focusing on one assumed component of change: reflexivity. In the beginning of the research, the first step was to explore self-descriptions of socially phobic persons in group-therapy situations. It was found that although most of the clients shared negative self-image (the self-descriptive categories of "miserable" and "insufficient"), they also differed in how they described themselves and how they coped with their anxiety. Finally, three subgroups were identified: Other-oriented, Isolated and Self-demanding.

As a second step, the treatment progress of clients from these three subgroups was explored by means of qualitative assimilation analysis. Some similarities and some differences could be noted, although all clients progressed in their assimilation process to different degrees. The largest variance was in the Isolated subgroup, where there were both successful and unsuccessful therapeutic change processes.

In the third and final step of the research, one client's therapy process was chosen for more explicit examination. Here it was asked how for one participant in a therapy group, progress in assimilation at stage 2 and progressing to stage 3 was connected to increasing reflexivity, and how the connection between the two could be seen in the context of a semi-structured model of group psychotherapy. Here the client was chosen from the Isolated subgroup; her therapeutic change process was a successful one in which she progressed from APES stage 2 to stage 6 during the course of the treatment. Reflexivity, in the sense of taking an observational position in respect to the self, appeared to be a necessary condition for progress in assimilation at stages 2 and 3. The therapist's responsiveness and sensitivity to the client's readiness to receive new perspectives also appeared to be important when encouraging the client's reflexivity.

4.1 Compensating for negative self-image

In Study I, the theory of socially phobic persons having negative self-image (see e.g., Clark & Wells, 1995) received support, as most of the clients expressed self-descriptions belonging to the categories of "miserable" and "insufficient." The third self-descriptive experiential category was "self as transparent and a fear of being exposed," with expressing of fears that unwanted features of self would be exposed to others. In addition, four categories were compensatory in nature. These compensatory categories described the ways in which socially phobic clients tried to manage social situations in spite of their negative self-images: trying to fulfill the expectations and demands of others ("the self as adjusting and pleasing others"), aspiring to be perfect ("the self as demanding toward self"), resorting to withdrawal and isolation ("the self as outsider, different, isolated"), and hiding and controlling some feelings and features in oneself ("the self as hiding and controlling some feelings and features in oneself").

According to Wells et al. (1995), social phobics use in-situation safety behaviors as coping strategies to minimize the risk of negative evaluation by others. It is an interesting question to what degree these compensatory strategies, found in Study I, are actually safety behaviors or when they can be seen as adaptive coping strategies. In social phobia, safety-seeking behaviors prevent disconfirmation of social phobia-related negative beliefs and have a negative impact on social interaction (Clark & Wells, 1995). According to Salkovskis, Clark and Gelder (1996), behaviors used to increase safety may be adaptive if the fear is based on a realistic threat, but it is unnecessary if the feared situation does not pose actual danger. According to Clark (1999), safety behaviors seek to prevent or minimize a feared catastrophe, whereas adaptive coping strategies seek to reduce anxiety but do not seek to prevent an imagined catastrophe.

In their study, Plasencia, Alden and Taylor (2011) found two main safety-seeking strategies: avoidance, referring to behaviors such as limiting speech and low self-disclosure, essentially attempting to hide the self, and impression management, including strategies to closely monitor and control one's behavior in order to present a more socially acceptable, albeit somewhat artificial, self. Both of these strategies were associated with factors hypothesized to maintain social phobia. Both strategies can also be seen as appearing in compensatory strategies and subgroups found in Study I; a group of Isolated clients (who tended to avoid anxiety-provoking situations) resembling avoidance, and a group of "Other-oriented" clients (who tended to adjust their own behavior to the wishes and expectations of others) and Self-demanding clients (who had an excessively demanding attitude toward the self) resembling, to some degree, impression management. The compensatory categories of "the self as adjusting and pleasing others" and "the self as demanding toward self" can also be seen resembling impression management.

The compensatory categories found in Study I can indeed be seen as representing safety behaviors, but they can also describe socially phobic clients'

compensatory strategies more extensively, not being tied only to socially anxious situations. For example, the case of the client in Study III was from the Isolated subgroup, and her self-descriptions contained, in addition to isolative behavior, many descriptions of loneliness and experiences of being rejected by others.

According to Alden and Auyeung (2014), most individuals with severe social anxiety are not physically or socially isolated, but they exist in a state of emotional solitude, emotionally isolated because their negative self-views and fears impede the development of emotionally meaningful relationships. This is in accord with observations of feelings of loneliness in this study. From a cognitive-constructivist point of view, it is important that the client understands the connection between one's isolative behavior and feeling of loneliness, as well as the way that he or she perpetuates the problem by avoiding emotional encounters with others. But it is also important, perhaps even before the former, for the client to be able to face and share with the therapist the personal meanings related to these problematic issues: what are the fears and threats connected to emotionally meaningful relationships, which prevent forming them?

Considering this kind of emotional solitude, it might be challenging for a socially phobic client to open up his/her feelings and emotions in therapy, especially in a group-therapy format. Since facing one's primary emotions is essential in psychotherapy (Greenberg & Paivio, 1997) it is important that the therapist have suitable ways to help the socially phobic client to contemplate these emotions. This also requires a safe and reliable relationship with the therapist and, presumably, a trustworthy atmosphere in a treatment group.

4.2 Reconstructing negative self-identity in a group therapy setting

In a group-treatment format, clients have multiple possibilities to observe alternative ways of constructing one's problematic experience. There are usually some shared experiences, but inevitably some deviant experiences as well. When therapy clients share a negative self-image, as usually is the case in a therapy group of socially phobic clients, they usually notice differences as well as similarities when sharing these self-related experiences. This gives them an opportunity to mirror and reconstruct their own problematic self-identity. In cognitive-constructivist therapy, the aim is to reconstruct an alternative, non-problematic relationship to problematic experiences, in this case a problematic self-identity. From this point of view, the group-therapy format provides important possibilities for the process of reconstruction, since clients have more possibilities to see alternatives from other clients with social phobia.

Striving for an acceptable self-image is crucial for a person (Guidano, 1991; Toskala & Hartikainen, 2005). When contemplating different self-descriptions and self-images in a group-therapy setting, clients usually notice that they have

differing perceptions about what is acceptable in the self. This gives them the opportunity to process those sides of themselves that they find difficult to approve, while some other client may be able to accept something similar in him/herself. This may allow the constructing of a new kind of self-image which is no longer negative. According to Angus and Kagan (2013), narrative expression offers a wide experiential space to connect with others and reflect on personal experience, and it seems to be particularly helpful, and even necessary, under stressful circumstances. Psychotherapy can be characterized as a specialized interpersonal activity entailing emotional transformation, meaning construction and story repair. In group therapy, in addition to the therapist, there are also other possibilities to connect with others, namely, the other clients in the group.

4.3 Therapeutic progress in different subgroups

As Study II showed, there were some similarities and some differences between the three subgroups of clients with social phobia in the progress of their assimilation process during time-limited, cognitive-constructive group therapy. The Self-demanding subgroup was the most homogeneous, as all clients within this subgroup progressed well in their assimilation process during the treatment, reaching APES level 6. The two other subgroups, Other-oriented and Isolated, were more heterogeneous as the change processes of the clients varied.

When looking at the four clients who progressed to lower than stage 5, it is notable that three of them belonged to the Isolation subgroup. When considering these differences between the three subgroups, it is important to pay attention to possible differences between the magnitude of social anxiety clients had. In diagnostic criteria of DSM-5 there is a typological distinction between interaction and performance social anxiety, such that a person may have one or both types of social phobia (American Psychiatric Association, 2013). In this study, clients were not separated on the grounds of the type or the magnitude of their social phobia. It is possible that the three clients of the subgroup of Self-demanding had a more narrow performance social phobia and that may be one issue affecting the better therapeutic progress of the clients of this subgroup, although it's not possible to reliably evaluate this. Also, when the main strategy used to manage social anxiety in this particular subgroup is to aspire for ever-better achievements, this strategy may also affect the client's performance in treatment.

Also, it is possible that there have been diagnostic comorbidity especially in the subgroup of Isolated: their main strategy was to isolate themselves from social situations, which may refer to avoidant personality disorder. Social phobia has many overlapping features with this disorder and it is notable limitation of the study that clients' possible other diagnoses were not assessed in the beginning of the study. On the other hand, as the cognitive-constructive philosophy of the treatment was to discover what was problematic for each individual

client and to work therapeutically with these individual issues, the diagnostic labels were secondary, and the individual therapeutic goals primary issues. Still, this kind of diagnostic comorbidity would be important to evaluate as it may affect the effectiveness and suitability of the group treatment model used. Although diagnostic categorizing manuals have some deficiencies, as mentioned in the introduction, they are still the most practical tools to categorize and describe mental disorders. In the Isolated subgroup there was also one client who discontinued the treatment after ninth session, and it would have been interesting to evaluate what kinds of other problematic experiences this particular client possibly had, along with social phobia.

4.4 Group as a therapy context: limitations and advantages

According to Norcross and Wampold (2011), decades of scientific research now support what psychotherapists have long known: different types of clients require different types of treatment and relationships. Indeed, the diversity of group-therapy members may pose challenges to a psychotherapist, despite the fact that these kinds of therapy groups are often composed of clients with some particular concordant factor, such as a joint diagnosis. In a group-treatment format, clients in the group always have different kinds of therapeutic needs, depending on, for example, the individual stages of their psychological change. Since several clients participate in the group, it restricts the degree to which the therapist can customize his or her actions to the clients' individual therapeutic needs and readiness to benefit from the therapeutic interventions. In addition, there are time limitations, as each client has less time to express his or her issues, and the therapist has less time to pay attention to each individual client. This may put limits on how sensitive the therapist can be in regard to different clients, even though group treatment usually allows for each client to have his or her own time of interaction with the therapist.

As Study II showed, there was variance in clients' change processes during the therapy: in the Isolated subgroup, there were two clients who only reached level 2 in their assimilation process, which could suggest that the therapeutic progress was not successful in these particular themes with these clients. In the Isolated subgroup was also one client who didn't attend to the last three sessions, thus missing the last, fifth therapeutic strategy, although she progressed in her two problematic themes from level 1 to level 3 and from level 2 to level 4. This result may reflect the challenges and restrictions that semi-structured group therapy places on the therapist, especially when considering customization of the treatment in accordance with every client's individual needs.

As is the case with all diagnostic categories, the category of social phobia also refers to a heterogeneous group of individuals who differ, for example, in their compensatory strategies (as discovered in Study I) and in their stage of change process. Attention to the individual is essential in cognitive-

constructivist therapy, as individual, subjective structuring and restructuring processes are special targets of therapeutic exploration. Lacking any universal taxonomy of disorders that define the way in which our attempts at meaning-making may go awry, constructivist therapists seek to discover what is at issue or what is problematic for each client they serve (Neimeyer, 1995b). Taking into account this individual attention and even critiques concerning diagnostic categories being based on the constructivist philosophy the treatment was based on, it is interesting that this kind of cognitive-constructivist philosophy of treatment was connected with a semi-structured group format, and with the groups that were formed on the basis of the diagnosis that participants share.

On the other hand, constructivist approaches situate the self firmly in a social context and emphasize the meaning of the surrounding people vis-à-vis the individual. According to Feixas (1995), a family context is always part of the conceptualization of the problem and individual behavior is understood primarily as a function of a larger system. This systemic perspective differs from the viewpoint of cognitive-constructivist group treatment, as clients are placed in a group away from their natural social contexts. A natural context of clients is still paid attention to in the fourth and fifth therapeutic strategies, where clients explored how their problematic experiences, related to social phobia, appeared in their respective present adulthood relationships and early attachments to parents and other significant adults.

As mentioned earlier, Study II showed that most of the clients who progressed least in the therapeutic change process belonged to the Isolated subgroup. This might indicate that when a person uses social isolation as a compensatory strategy for social phobia, the group format applied in this study might not be the most suitable form of therapy. Stangier et al. (2003) also found in their randomized controlled trial that individual cognitive therapy was superior to group cognitive therapy when treating socially phobic clients. Mavranezouli et. al. (2015) constructed a decision-analytic model to compare costs and quality adjusted life years of 28 interventions for social anxiety disorder from the perspective of the British National Health Service and personal social services, deriving efficacy data from a systematic review and network meta-analysis. According to their study individual cognitive therapy was the most cost-effective intervention for adults with social anxiety disorder, being also superior to pharmacological interventions.

In group therapy, clients are expected to expose personal and possible painful experiences to others, yet this is precisely what clients using isolation as a coping strategy seek to avoid. But then again, there were also clients belonging to this particular subgroup who benefitted from this kind of therapy, such as the case of Miia, whose therapeutic change process was closely examined in Study III. On the basis of Study III, it can be assumed that in these successful cases, the therapist managed to be appropriately responsive for the particular individual clients whose main compensatory strategy was isolation. This kind of appropriate responsiveness requires, of course, that a client contributes enough to the treatment and talks enough that the therapist has something to

seize onto. This kind of involvement with the treatment also demands emotional investment in the therapeutic relationship, which may be especially difficult for persons with social phobia (see Alden & Aueung, 2014).

If this kind of group treatment is not suitable for some socially phobic clients belonging to this particular Isolated subgroup, should there be an explicit selection process and assignment to a proper treatment? It would be a good practice to consider, especially if there is the possibility of sending particular clients to individual therapy, if needed. But in some cases, could the group-treatment format be even more suitable for a person with social phobia than individual therapy? This might be the case if a person finds it frightening when he or she is supposed to share difficult issues with the therapist, between just the two of them. In particular, this can be the case when a person is emotionally very wary and finds face-to-face situations even more frightening than group situations, where people's attention is divided among more persons. In these cases, the group-therapy format might be more suitable for the person, as the group may bring safety and allow the client to observe and follow others' contemplation of issues that are central to him/herself. This can be a really meaningful thing to clients with difficulties in taking active part in therapeutic conversations.

Indeed, it is true that we don't know in what different ways group therapy provides advantages to clients, and in this study it was a noteworthy limitation that there were no other indicators of therapeutic change other than the spoken material in the therapy sessions. When analysis and results depend solely on spoken material in therapy, we lack information concerning experiences of the advantages of therapy from those clients who were quieter in the group and followed conversations mainly on the side, instead of participating in them. With these clients, it would have been informative if there had been used, for example, some questionnaires concerning possible changes in problematic symptoms. Also, a more explicit diagnostic evaluation would have been important so that there would have been information about each client's possible diagnostic comorbidity and about the magnitude and strength of social anxiety disorder. Also, it is important to remember that all the clients in this study entered treatment after themselves contacting the clinic on the basis of a notification in the local newspaper about the possibility of group therapy for persons with social phobia. Thus, it was their own conscious decision to ask to be treated in a group-therapy format.

Since some clients may find it difficult to share their personal issues in a group-treatment format, it is important for a therapist to pay attention to creating a safe and trustful atmosphere in the group. There are means to work in a group setting with individuals with an isolative stance; for example, in system-centered therapy (Agazarian, 2001) clients are encouraged to bond with one another in their wariness toward exploring problems. Also important are a clear description and negotiation of the goals and strategies of the treatment.

In addition to wary clients' possibility of observing other's clients contemplation, there are also other advantages that clients have when treated in a peer

group. A group of this type offers all clients many-sided possibilities to see alternatives and to construct and reconstruct their problematic experiences. As clients contemplate their negative and problematic self-identities, their differences offer them possibilities to reconstruct the self and accept earlier problematic sides in the self. Thus, it would not be advisable to form treatment groups for socially phobic clients on the basis of the subgroups found in Study I, for example.

The group format also offers for the therapist the possibility of crucial interventions which are not available in individual therapy. For example, a therapist may use one particular client to illustrate for the rest of the group the specific occurrence of an essential issue. Observing how other's issues are dealt with gives group members the opportunity to take a reflexive stance towards their own problematic experiences and how they relate to them. This may be especially important for those clients who tend to withdraw and follow conversations from the side instead of actively participating. Also, possible support and compassion from the group when sharing difficult feelings and experiences may be precious, and these can also encourage insecure clients to share their experiences. According to Guidano (1995), the interpersonal and relational domains play a crucial role in the development of self-knowledge.

Another possible benefit of the group format includes the therapist being able to use members' mentalization abilities; in mentalization-based group therapy (MBT), the group provides a training ground for mentalization (Karterud & Bateman, 2012). Everyone now and then experiences loss of their mentalizing capacities in the group, and in MBT the aim is to try to identify these instances, to explore them, to understand them, and to restore the ability to think and feel. In MBT, when patients lose the mentalizing ability and become victims of psychic equivalence thinking during the group process, "fellow patients may not lose mentalizing simultaneously and, preserving their capacities, may act as responsible group members in concert with the therapist to alleviate the pain and restore the mentalizing abilities of the protagonist" (Karterud & Bateman, 2012, 89). On a group level, the therapist thus strives for a good interactive mentalizing group in MBT. Indeed, this kind of active exploration by clients and their offering of alternative perspectives to each other also happened in the group treatment of this study, which may have increased fellow clients' mentalization, as well as reflexivity.

It is a fact that in a group-therapy format, there are multiple emerging contingencies, since there are many different clients with differing needs and at different stages in their therapeutic processes. Considering this, some sort of predefined structure may be an important element in group treatment, although it also reduces, to some degree, the therapist's flexibility to respond to a single client's needs. A predefined structure helps the therapist to focus on essential issues when there are many differing clients' needs at the same time. In a group-treatment format, during each moment the therapist has to evaluate and decide what are the issues to contemplate and whose issues to deal with and when. Thus, it is important that the group have a shared agreement about the

course and goals of therapy, and it is important that clients have information about these at the very beginning of the treatment.

It is important to acknowledge that the treatment model was a result of experimentation when developing a working group-treatment model. As such, it was probably a result of some compromises as well. Indeed, the treatment model which ended up being adopted was a combination of such good features as recognizing individuals, but also the good features of group treatment. As such, it is inevitable that the work of the therapist is quite challenging.

4.5 Mechanisms of psychotherapeutic change

Although there are various empirically supported treatments for social phobia, including cognitive-behavioral therapy (CBT), cognitive psychotherapy and mindfulness and acceptance-based approaches, each form of treatment may involve shared (as well as distinct) mechanisms of change. On the basis of Study III, important components of successful change were the therapist's emphatic attunement, responsiveness, and ability to work inside the client's therapeutic zone of proximal development (Leiman & Stiles, 2001; Mendes et al., 2016).

4.5.1 Reflexivity

In the cognitive-constructivist treatment model in question, reflexive processes were particularly targeted by the therapist, as they were regarded as essential processes in successful therapeutic change. It is an interesting question how directly a particular process needs to be targeted, and how essential those processes are, in the end, in the successful therapeutic change. Some processes may be important even when they are not explicitly discussed in a particular treatment model, as was the case in the study of Kocovski, Fleming, Hawley, Ho and Antony (2015). They found that mindfulness (present-moment, non-judgmental awareness) was associated with subsequent change for both cognitive-behavioral group therapy and mindfulness and acceptance-based group therapy, even though the precepts of mindfulness are not explicitly discussed in CBT. Actually, there are techniques in many different treatments that actively and systematically (if not deliberately) promote reflexivity; for example, in Clark's (2006) cognitive psychotherapy, there is the intervention of drawing the client's attention to automatic negative and irrational self-statements which exemplify reflexivity. Also, in mentalization-based group therapy (MBT), the primary task of the group is to provide a training ground for mentalization so that clients' group experiences can be further explored in individual sessions.

In the treatment model in question, reflexivity was seen as a process where one directs attention at one's own immediate experience; recognizes experience; symbolizes and interprets experience; creates a new kind of attitude and meaning related to experience; owns experience and integrates within one-

self; and aims to create a regulatory and agentic relationship with this experience. When studying reflexivity in Study III, this process-based viewpoint was not a starting point in the analysis, but rather that what the data and the text under analysis presented.

When looking in detail at some episodes of exchanges between the client and the therapist, it appeared that the client's reflexivity was indeed the aim in many therapist's interventions, and it was also possible to recognize different levels in the client's reflexive talking. In assimilation model, reflexivity has been identified as one marker of stage 3 (problem statement/clarification; Honos-Webb et al., 2003). As the definition of reflexivity in the APES model is not detailed it could not be fully compared with the definition made in Study III. In Study III there was one passage where the client showed reflexivity and was at stage 2, and the assimilation process did not appreciably progress. One explanation for this finding was that the client's first-level reflexivity, that is, taking an observational stance and turning onto the self and recognizing one's own inner processes, might be a requirement for him or her to be able to form a clarification of the problem and to move to stage 3.

It is an interesting question how meaningful these therapeutic actions, targeted at inducing clients' reflexivity, actually were in the end. On the basis of the results, I would claim that these therapeutic actions helped to achieve the client's reflexivity, but only when the timing was right. Reflexivity, self-reflection and agency have been noted as important factors in successful therapeutic change (e.g., Angus & Kagan, 2007; Rennie, 1992; 2007; 2010), and thus inducing clients' reflexivity can be seen as a relevant therapeutic intervention. But, again, the meaning of the therapist's responsiveness and timing – in other words, working inside the client's therapeutic ZPD – must be emphasized when inducing client's reflexivity.

Rennie's (1992, 1994) research on reflexivity positioned therapy as a product of self-aware clients engaging in behaviors in order to elicit responses from therapists, being broadly typical of human interactions (see also Levitt et al., 2015). In this way, clients may passively resist particular ways of treatment and avenues of exploration or engage in power struggles over the focus of therapy as therapists and clients negotiate it in the session. Rennie (1992, 1994) described reflexivity as the central function of psychotherapy, in that clients not only become aware of their desires but also assign worth to different desires (Levitt et al., 2015). In this way, the client is more a participant of the treatment, who makes decisions, instead of a patient who is only receiving treatment. Considering this, when I interpreted in Study III that the client was not yet ready to perceive the therapist's point of view of taking a reflexive stance, it can also be seen that the client passively resisted this kind of intervention, because she wanted something else before that, thus eliciting different kinds of responses she needed from the therapist.

Angus and Kagan (2013) state that reflexive inquiry into emotionally salient personal stories heightens the client's sense of personal agency for the purpose of constructing new personal meanings and self-narrative representations.

Indeed, with an increased sense of personal agency it becomes possible for clients to make some crucial changes in their lives when they are unhappy and dissatisfied. Increased agency also helps them to understand more broadly their own ways of interpreting situations and other people's meanings and motives. Reflexivity can be seen as an essential process in therapy, because it enables some other crucial processes, such as agency, that are necessary in the successful change process. It can be said that actually all psychotherapies pursue the development of self-reflection, which gradually allows for formation of a new kind of relationship with the original problem (Leiman, 2012).

4.5.2 Empathy

In Study III, it was noted that the therapist's expression of empathy for the client is important, especially in the early phases of therapy. Greenberg, Watson, Elliot and Bohart (2001) stated that empathy serves as a positive relationship function. Feeling understood increases a client's satisfaction with therapy and thereby increases compliance and feelings of safety in the relationship and makes it easier to self-disclosure (Greenberg et al., 2001). On the basis of study III, I would like to suggest that the client needs empathy from the therapist before she or he can take advantage of other interventions, such as clarifications, by the therapist.

Furthermore, Malin and Pos (2015) found in their study that a therapist's expression of empathy in the initial sessions affected the outcome indirectly. This indirect effect occurred through strengthening the early therapy alliance and contributing to an environment in which clients could turn their inward attention towards processing emotional experiencing. Malin and Pos (2015) concluded that the therapist's empathy may be a necessary "ingredient" for other therapy processes; this is an interesting point, because it was also concluded in this dissertation's case study that the client needed empathy from the therapist before she was ready to take a reflexive stance toward her inner processes.

Indeed, empathy on the part of the therapist can be seen as an essential factor, as it helps the client to get in touch with his/her feelings (see, e.g., Angus & Kagan, 2007). According to Greenberg and Paivio (1997), it is important to reach primary feelings, which are usually hidden behind secondary feelings at the beginning of therapy. In social phobia, primary maladaptive shame is usually the main problematic feeling. When dealing with shame, the therapist's empathic attitude is especially important.

In emotion-focused therapy (EFT), the withdrawal tendencies of primary maladaptive shame are transformed by activating the approach tendencies in anger or comfort seeking, and also by accessing pride and self-worth (Greenberg, 2010). When a client finds the therapist to be emphatic and understanding, it becomes easier and safer for him/her to express painful feelings in therapy, and this advances the therapeutic change process. When confronting shame in therapy, it is important that a therapist emphatically shares the vulnerability and pain connected to it (Greenberg & Paivio, 1997). In EFT, a number of ways

are outlined for a therapist to help the client access new emotions to change emotion (such as shame), such as shifting attention to different aspects of the situation or to emotions that are currently being expressed but are only on the periphery of a client's awareness (Greenberg, 2010).

4.5.3 Therapist's responsiveness

It is important to understand how therapist activities affect the psychological change process, because then it is possible to inform therapists how to be appropriately responsive. According to Caro Gabalda, Stiles and Ruiz (2015), setbacks in psychotherapeutic change can sometimes be an intentional consequence of the therapist's work, by directing attention to a level where work needs to be and can be done. In their case study, they also concluded that setbacks sometimes seemed to show that the client was not ready to explore difficult material and the therapist was pushing him above his current limit, exceeding the therapeutic ZPD (Caro Gabalda, Stiles & Ruiz, 2015).

In Study III, it was recognized that sometimes the therapist incorrectly evaluated the client's ability to accept the point of view that was offered and the psychotherapeutic change did not proceed, at least when viewing the assimilation process. Here the therapist was working outside the client's therapeutic ZPD, in which premature exposure to the therapist's conclusions could be counterproductive. In this particular case, the client was at the beginning of her change process, at a quite low stage (stage 2) of her assimilation. It was concluded that such a mismatch can happen more easily during the early phases of therapy when the client is aware of a problem but cannot formulate it clearly or reflect on it, as is the case at assimilation stage 2.

Furthermore, in a case study by Caro Gabalda, Stiles and Ruiz (2015), the setbacks in psychotherapeutic change also happened more often at lower stages of assimilation, where the problem was unformulated. Here the therapist was more often actively listening and the setbacks were attributable to pushing a theme beyond the client's working zone. Preceding setbacks to later assimilation stages, where the problem was at least formulated, the therapist was more likely to be directing clients to consider alternatives, and the setbacks were more often attributable to the client following these directives, shifting attention to less assimilated (but nevertheless formulated) aspects of the problem (Caro Gabalda, Stiles & Ruiz, 2015). If a client is not yet ready to proceed in his/her therapeutic change process, it is important that a therapist notices and respects it with patience and offers something that client needs at the moment, such as empathy. If the therapist succeeds in creating an emphatic and understanding atmosphere in a group, it becomes possible for a single client to integrate his or her problematic sides in the acceptable self. This kind of successful integration requires possibilities to reconstruct the self gradually, at the appropriate time, so that the dynamic balance of consistency and feeling of coherency of self remains.

According to Guidano (1995), the search for consistency is the basic procedure for the structuring and stabilizing of self-identity and self-awareness,

and emotional perturbations aroused by the perceptions of discrepancies are the main regulators eliciting and restructuring more integrated levels of self-identity and self-awareness. To allow any consistent degree of modification in the concepts of self and the world, the individual must gradually elaborate an alternative self-image without experiencing unmanageable interruptions in his or her structured sense of subjective continuity. It is important that the therapist acknowledges and pays attention to this, because any substantial interruptions would represent a loss of the sense of reality for the client. In a group treatment, if a client's sense of coherence was threatened, he or she would presumably withdraw from the therapeutic interplay as to protect his or her coherence of self. Maintenance and change processes, rather than being opposite polarities, are to be considered as interdependent and overlapping processes. Whereas maintenance processes are continuous, change processes are continuous only as challenges or possibilities but are discontinuous in their occurrence (Guidano, 1995).

How do we know, and how could a therapist know, what helps a particular client to effect change in each particular moment or phase of therapy? In the context of the assimilation model (APES), the client's emerging requirements are represented by the moment-by-moment level of assimilation with respect to his/her problematic voice. If one follows a client's specific requirement for each APES level, some hypothetical sub-goals can be identified, which are meant to help the client move forward to the next APES level (Honos-Webb & Stiles, 2002).

At the lowest APES stages (0–2), the therapist's sub-goal may be to help a client increase his or her awareness of the presenting problematic experience. At the middle stages (3–4), a therapist may help a client gain some understanding and elaborate insight. At the last stages of psychological change (stages 5–7), a therapist will encourage the client to put into practice new behaviors and then to generalize them (Meystre et al., 2015). Also, in emotion-focused therapy (EFT), intervention is marker-guided and process-directive; EFT therapists are trained to identify markers of different types of problematic emotional processing problems and intervene in a specific way that best suits these problems (Greenberg, 2010).

Norcross, Krebs and Prochaska (2011) in their transtheoretical model also posit that the processes of change are differentially effective in certain stages of change. In general terms, change processes traditionally associated with the experiential, cognitive, and psychoanalytic persuasions are most useful during the earlier stages of change (i.e., the precontemplation and contemplation stages). More precisely, with patients in the first stage (precontemplation), the therapist's role is like that of a nurturing parent, who joins with a resistant and defensive youngster who is both drawn to and repelled by the prospects of becoming more independent. At this stage as well, I assume that the therapist's emphatic attunement is essential. With clients in the second stage of change (contemplation), the role is akin to a Socratic teacher, who encourages clients to achieve their own insights into their condition. Here the reflexive stance of a

client would seem to be important. Change processes traditionally associated with the existential and behavioral traditions, by contrast, are most useful during action and maintenance, as the psychotherapist becomes more of a consultant, who is available to provide expert advice and support when action is not progressing smoothly (Norcross, Krebs & Prochaska, 2011).

The therapist's responsiveness is always present in therapy. As part of a good practice, it requires sensitivity and flexibility from a therapist, whether the therapy is structured or manual or in a group format. Interaction always happens in the here and now, and when relating with another one cannot know what will happen in the next moment. According to Rennie (2010), thinking of the client as an agent working with the therapist as an agent, each operating intentionally, implies that if each could learn what the other's intentions are, it would be easier for them to get along. Rennie suggests that the client and the therapist could symmetrically disclose the intentions behind their communication and invite the other to disclose the intentions behind their communication, in order to establish a real encounter. This is not easy for either member of the therapeutic dyad, and even more challenging in group therapy, but if it is possible, the door to reflexive, bi-lateral meta-communication is opened.

Although Rennie (2010) refers especially to moment-to-moment disclosure, this kind of transparency regarding the intentions and interventions used is especially important in a group-treatment format which follows predefined strategies and goals. In the cognitive-constructivist treatment model of the study, clients had information about the course of the treatment already during their first individual meeting with the therapist, before entering treatment even. They were also given a brief set of written material concerning the strategy of particular sessions before they started.

Indeed, clients should have enough information about the goals and strategies of the treatment they are entering, be it individual or group treatment, before it begins. In this way, an individual client can evaluate and decide if that particular treatment is suitable for him or her.

4.6 Evaluation of the research

In this research, the therapy setting was naturalistic; clients entered into the treatment themselves by contacting the clinic following an announcement in the local newspaper. Because of this, the subgroups were not identical in their sizes, and different clients used compensatory strategies in various ways. Also, it is important to pay attention to the small amount of participants (17), as well as the small and unequal sizes of the subgroups. In the smallest subgroup, the Self-demanding one, there were only three clients, so it is reasonable to ask how representative this result is. In other words, how reliably can it be said that there are many socially phobic people who mainly use self-demanding compensatory strategies to compensate for their social phobia? Furthermore, there were no controls group of any kind and, for example in Study I, it cannot be

determined if the subgroups identified are particular to socially phobic clients. The naturalistic therapy setting may have also had an effect on generalization of the results; for example, most of the participants (15 of the total of 17) were female.

On the other hand, the naturalistic therapy setting improved the clinical relevance and applicability of the study. For example, there was no randomized treatment selection. When contacting the clinic, clients knew that the treatment would be in a group-treatment format, so the basis for the choice of the treatment format was the client's own evaluation and wish, as is usually the case in a natural clinical setting. There were also individual meetings with the therapist before the beginning of the treatment, where clients were informed about the strategies of the treatment. Thus, they made their decision to participate in the treatment also on the basis of their feelings of the therapist and their knowledge of the treatment procedure, which is also usually the case in clinical settings. This might be related to the fact that most of the clients progressed well in therapy, since they themselves had asked to be treated in this kind of treatment format and with this particular therapist.

The small sample and amount of therapy groups are clear limitations in this study, although qualitative research allowed intensive study of self-descriptions (Study I), therapeutic progress (Study II) and change processes (Study III) in a scientifically rigorous way. Indeed, there are some clear advantages when having small group sizes; for example, in Study II, this allowed clearer identification of deviant cases and the formation of conclusions concerning their specific pattern of progress.

One clear limitation of the research was that there were no other indicators of therapeutic progress or change than videos and transcriptions of the therapy sessions. Thus, I had a very incomplete view of how individual clients benefitted from the treatment. It would have been useful if there had been different kinds of indicators of therapeutic progress, such as symptom indicators and questionnaires measuring clients' conditions.

The assessment interview brings some essential limitations to the study. It would have been important to know more specifically about the severity of symptoms, possible comorbidity (did some client possibly have some other primary disorder?), and about the extent of symptoms of social anxiety in different situations. In this way it would have been possible to evaluate for example subgroups found in relation to the type of social phobia (e.g., generalized type or performance related type of social phobia). Changes in clients' performance and for example in their isolative behavior would have been crucial to measure. Also, separate individual interviews clarifying possible advantages and discomforts of the treatment that clients experienced would have been informative.

When considering the analysis of reflexivity and responsiveness in Study III, a qualitative description of them has obvious advantages with respect to actual reality, but it encounters more problems than quantitative and statistical approaches with respect to precision and generality. According to Kramer and

Stiles (2015), the responsiveness critique is that a psychotherapeutic intervention (the "what") is not a coherent entity but a fluid, adaptive process that stands in the way of the straightforward answers everyone would like. Thus a detailed process research, such as intensive case studies, are important as we try to understand the therapeutic change process; even though they offer only a limited picture of the process, it is still an explicit one.

A cognitive-constructivist treatment model for social phobia has been introduced in this dissertation. It offers a useful and economical group-therapy model for clinicians working with clients with social phobia, and this is definitely an advantage in the public healthcare system, where resources are often limited. The strategies of the treatment model can be adapted to individual therapy as well, which has more flexibility to take into account the client's individual therapeutic needs.

As the research pointed out, clients with isolative coping strategies may require special sensitivity from a therapist in a group-therapy format, and when a therapist manages to be responsive enough, isolative clients can also benefit from group treatment. Overall, the therapist's responsiveness and attunement to clients' ZPD are essential in successful therapy process, and in a group-therapy format it is a greater challenge than in individual therapy. On the other hand, in a group-therapy format some sort of predefined structure helps the therapist with multiple contingencies, but it is important that the course and the goals of the treatment are shared with the group, and in spite of predefined structure, the therapist is able to be flexible and responsive enough when needed.

In the future, more research is needed concerning factors related to the therapeutic change of clients with social phobia. In particular, qualitative, intensive case studies are valuable as they expose more specifically the interplay between therapist and client. Also, more information concerning socially phobic clients' reflexivity is needed; for example, have they any typical difficulties with self-reflective skills? Here the Reflexive Functioning Scale, for example, could be a useful method.

YHTEENVETO (SUMMARY)

Tässä tutkimuksessa tutkittiin sosiaalisesti foobisten terapia-asiakkaiden erilaisia minän kuvailuja sekä heidän terapeuttista edistymistään lyhytkestoisessa, ryhmämuotoisessa kognitiivis-konstruktiivisessa psykoterapiassa. Tavoitteena oli saada myös kliinisesti hyödynnettävissä olevaa tietoa siitä, miten terapeutit voisivat edesauttaa sosiaalisten jännittäjien onnistunutta terapiaprosessia etenkin terapiaprosessin alkuvaiheessa, jossa asiakkaat alkavat muodostaa refleksiivistä suhdetta omaan ongelmalliseen kokemukseensa. Refleksiivisyydellä viitataan kykyyn tarkkailla omia sisäisiä mielentiloja, kuten omia tunteita, ajatuksia ja tapaa ajatella ja toimia erilaisissa tilanteissa. Tutkimuksen aineisto koostui kahden eri terapiaryhmän (n = 7 ja n = 10) videonauhoitetuista istunnoista ja näistä transkriptoidusta tekstiaineistosta. Molemmat terapiaryhmät kokoontuivat viikoittain 12 kertaa. Aineisto analysoitiin laadullisesti.

Ensimmäisessä osatutkimuksessa terapia-aineistosta eroteltiin kunkin asiakkaan itseä kuvailevat puheotteet, jotka luokiteltiin teemoittain niiden erojen ja yhtäläisyyksien perusteella. Tuloksena oli seitsemän erilaista minäkuvailun kategoriaa, joista kolme oli luonteeltaan kokemuksellisia (”surkea minä”, ”riittämätön minä” ja ”läpinäkyvä minä”) ja neljä luonteeltaan kompensatorisia, kuvaten jännittäjien keinoja selviytyä ongelmallisen jännittämisensä kanssa (”muita miellyttävä ja mukaileva minä”, ”itseä kohtaan vaativa minä”, ”ulkopuolinen, erilainen, eristäytyvä minä” ja ”joitain tunteita ja itsen puolia piilotteleva ja kontrolloiva minä”). Tulokset vahvistivat käsitystä siitä, että sosiaaliseen fobiaan liittyy keskeisesti kielteinen minäkuva, joka kuitenkin vaihtelee totaalisesta itsensä surkeaksi kokemisesta lievempiin negatiivisiin tunteisiin omasta riittämättömyydestä. Osatutkimuksessa muodostettiin lopulta kolme erillistä alaryhmää, joihin kukin asiakas sijoitettiin hänen pääasiallisesti käyttämänsä kompensointikeinon perusteella: muihin ihmisiin suuntautuneet (n= 7), eristäytyneet (n= 7) ja itseä kohtaan vaativat (*n*= 3). Nämä alaryhmät kuvastavat erilaisia keinoja, joilla sosiaaliset jännittäjät pyrkivät kompensoimaan sosiaalista jännittämistään, toisin sanoen selviytymään tämän vaikean jännittämiskokemuksensa kanssa.

Toisessa osatutkimuksessa tutkittiin näihin kolmeen eri alaryhmään kuuluvien asiakkaiden terapiassa edistymistä käyttäen tutkimusmetodina laadullista assimilaatioanalyysia. Assimilaatioanalyysi on tutkimusmenetelmä, jolla voidaan laadullisesti tutkia terapiassa tapahtuvaa psykologista muutosprosessia ja sen etenemistä. Jokaiselta asiakkaalta tunnistettiin yksi tai kaksi sosiaaliseen jännittämiseen liittyvää ongelmallista teemaa, joka kuvattiin assimilaatioanalyysin mukaisesti dominoivana ja ei-dominoivana sisäisenä äänenä (esimerkiksi: ”minun täytyy aina olla itsevarma, vahva enkä saa pelätä mitään / voin olla myös epävarma ja heikko”). Ongelmallisten teemojen valinnan jälkeen niihin liittyvät puheotteet luokiteltiin assimilaatioanalyysin mukaisesti asteikolla 0–7. Alaryhmien välillä todettiin joitain yhtäläisyyksiä ja eroja, kun asiakkaat edistyivät eriasteisesti assimilaatioprosesseissaan. Kaikkein yhdenmukaisin edistymisessään oli itseä kohtaan vaativat -ryhmä, kun kaikki kolme asiakasta

tässä alaryhmässä saavuttivat assimilaatiovaiheen 6 ainakin yhden ongelmallisen teemansa suhteen. Suurin vaihtelu oli eristäytyneiden alaryhmässä, jossa oli sekä onnistuneita muutosprosesseja, mutta myös prosesseja joissa terapeuttista muutosta ei juurikaan tapahtunut.

Kolmas osatutkimus oli tapaustutkimus, jossa tarkasteltiin yhden asiakkaan edistymistä assimilaatiovaiheesta 2 vaiheeseen 3. Erityisesti tarkasteltiin sitä, miten tämän vaiheen muutos on yhteydessä asiakkaan lisääntyvään refleksiivisyyteen suhteessa omaa ongelmallista kokemustaan kohtaan. Kyseinen asiakas oli eristäytyvien alaryhmästä, ja hänen muutosprosessinsa kyseisen ongelmallisen teeman suhteen oli onnistunut hänen saavuttaessa lopulta assimilaatiovaiheen 6. Yksityiskohtaisen analyysin kohteeksi valikoitui 13 tekstiotetta asiakkaan ja terapeutin välisestä keskustelusta. Tutkimuksen mukaan asiakkaan refleksiivisyys näyttäisi olevan välttämätön edellytys terapiassa edistymiselle tässä terapiaprosessin alkuvaiheessa, mutta on tärkeää huomioida, että refleksiivisyys voi ilmetä eri tavoin ja eri asteisena. Terapeutin työskentely asiakkaan terapeuttisen lähikehityksen vyöhykkeellä osoittautui terapian onnistumisen kannalta välttämättömäksi, sillä terapeutin liian aikaiset johtopäätökset ja interventiot, joiden tarkoitus oli kasvattaa asiakkaan refleksiivisyyttä, saattoivat viedä terapeuttista prosessia taaksepäin. Tässä assimilatioprosessin alkuvaiheessa asiakas tarvitsee empatiaa ennen muita terapeuttisia interventioita.

Kaiken kaikkiaan tutkimus nostaa esiin haasteita, joita terapeutti kohtaa hoitaessaan ryhmämuotoisesti erilaisia tarpeita omaavia sosiaalisten tilanteiden jännittäjiä. Sosiaalisesti foobiset asiakkaat saattavat olla monella tapaa keskenään erilaisia ja eroavat toisistaan esimerkiksi käyttämiensä jännityksen kompensaatiokeinojen suhteen. Täten terapeutin herkkyys ja kyky työskennellä kunkin asiakkaan terapeuttisen lähikehityksen vyöhykkeellä on välttämätön edellytys asiakkaan terapiassa edistymiselle.

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ORIGINAL PAPERS

I

SELF-DESCRIPTIONS OF SOCIALLY PHOBIC PERSONS IN SHORT-TERM GROUP PSYCHOTHERAPY

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RESEARCH ARTICLE

Self-descriptions of socially phobic persons in short-term group psychotherapy

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Abstract

This paper explores how socially phobic persons exhibit their self-images through self-descriptions expressed in a naturalistic group therapy context. The data, which is analysed qualitatively, consists of videotaped therapy sessions, transcribed verbatim, from two groups of individuals (n=17, mainly women) attending short cognitive-constructive psychotherapy. Seven categories of self-descriptions are found. Three categories, 'self as miserable,' 'self as insufficient,' and 'self as transparent,' relate to experiential self-images. Four categories, 'self as adjusting and pleasing others,' 'self as demanding toward self,' 'self as outsider, different, isolated,' and 'self as hiding and controlling some feelings and features in oneself' describe strategies of dealing with negative self-images. Three client subgroups are also identifiable; namely, 'other-oriented,' 'isolated,' and 'self-demanding,' terms that represent participants according to their use of coping strategy. The results of this study support the view that a negative self-image is central to social phobia, and highlight the diversity of manifestations of a negative self-image in group therapy conversations.

Keywords: social phobia, self-description, self-image, cognitive-constructive group psychotherapy

Introduction

Social phobia or social anxiety disorder has been defined as an intense, irrational fear of embarrassment, humiliation, or scrutiny by others in social situations (DSM-IV). Many researchers and theorists of cognitive psychotherapy link social phobia closely to public self-consciousness (see for example Rapee & Heimberg, 1997; Toskala, 1997, 2001; Saboonchi et al. 1999; Schlenker, & Leary, 1982; Stangier et al. 2003) and to a negative self-image (Clark & Wells, 1995; Wells, 1997, Rapee & Heimberg, 1997), which are considered the basic features of social phobia, connected strongly to social situations and to seeing the self as an object. In that light, it is surprising that the self-descriptions of socially phobic persons have not been studied more extensively, particularly considering that clients' self-descriptions are a therapist's main source of information. This study examines the problematic self images of socially phobic individuals—fifteen men and two women aged twenty-four to fifty—as manifested in self-descriptions elicited in group therapy situations.

Cognitive models of social phobia have emphasised self-related processes in particular (Hofmann et al, 2004). Toskala and Hartikainen (2005, see also Clark & Wells, 1995; Wells, 1997; Rapee & Heimberg, 1997; Saboonchi et al. 1999; Stangier et al. 2003) stress that persons with social phobia experience as threatening the idea of being evaluated or the possibility of being misunderstood. Given that the central feature of social phobia is a strong desire to convey a favourable impression of oneself to others (Clark & Wells, 1995, Wells, 1997), phobic persons are afraid that their "hidden" negative self-image might be revealed (Toskala, 1997, 2001). Christensen et. al. (2003) found that persons with pathological levels of social anxiety exhibit a pervasive

negativity in how they regard themselves and how they think others see them. Clark and Wells (1995) discuss 'unconditional negative beliefs' that, they contend, socially phobic persons hold about themselves. Indeed, a negative self-image or negative representations of oneself in social situations have been seen as central to maintaining social phobia (see also Hackmann et al. 2000; Hirsch et. al. 2003; Hope et. al., 1990; Vassilopoulos, 2005).

The diagnostic criteria of DSM-IV and ICD-10 already recognise the avoidance of feared social situations as a central factor in social phobia. ICD-10 also states that, in extreme cases, avoidance may result in almost complete social isolation. Support for this statement can also be found in empirical studies; Olfson et. al. (2000) reported finding a significant association of social anxiety with feelings of social isolation, even after controlling for other symptoms of common anxiety and depression. The avoidance of feared social situations may be a way to cope with anxiety and can be seen as a 'compensatory rule,' a term used by J.S. Beck (1996), who describes the rule in this instance as follows: "If I avoid others, I can avoid rejection" (Beck, 1996, 14). Beck (1995) contends that a therapist must understand the cognitive, affective, and behavioural mechanisms, positive and negative, that an individual has developed to cope with his or her disorder. She terms those behavioural mechanisms 'compensatory strategies.'

Higgins (1987; see also Strauman, 1989; Weilage & Hope, 1999) has proposed that vulnerability to emotional distress is linked to discrepancies in self-representation that develop during a lifetime of social interactions. The theory defines self-discrepancies along two dimensions: the referent person or *self* versus *other*; and the view of self taken or *actual* versus *ideal* versus *should or ought*. Persons with social phobia have a high discrepancy between how they see their actual selves and how they believe others think

they should be. Self-discrepancy theory looks at aspects of the self that are available to conscious introspection, as is the case in therapy situations.

Kelly (1955) contends that every person has a system of personal constructs; that is, a personal lexicon of characteristics of the self and of the other. Core constructs are the constructs by which a person maintains his or her identity and existence. 'Personal Construct Therapy,' developed by Kelly (1955b), employs several creative methods including self-characterisation, in which a therapist requests that a client write a character sketch of himself or herself from the standpoint of an intimate and sympathetic other, or requests that the client undergo a repertory test in which relevant people or situations from that client's life are compared and contrasted so as to yield a fuller portrayal of his or her personal construct system for construing self and situation. Diaz, Feixas, Pellungrini, and Saul (2001) examine the role of cognitive conflicts in social phobia using Kelly's (1955) repertory grid technique. Diaz et. al. discuss in particular cases in which a subject associates symptoms of social phobia with positive personality characteristics to the extent that abandoning those symptoms may threaten the subject's sense of identity. Diaz et. al. found implicative dilemmas more often and in a greater number in subjects with social phobia than in subjects without (Diaz et. al., 2001).

Many studies suggest that high self-consciousness (Hofmann et al, 2004), particularly public self-consciousness (see for example Hackmann et al., 1998, Hope & Heimberg, 1988, Ruiperez & Belloch, 2003, Schlenker & Leary,1982)—in other words, the awareness of oneself as a social object (Fenigstein et. al., 1975), is an important maintaining variable of social anxiety. Individuals with social phobia, particularly when believing themselves negatively evaluated by others, shift their attention to detailed

monitoring and observation of themselves (Clark & Wells, 1995); they then use the internal information resulting from this monitoring and observation to infer how they appear to others and what others are thinking about them. Clark (2001) stresses that many patients with social phobia experience, to an increasing extent, spontaneously occurring images in which they see themselves as if from an observer's perspective. Unfortunately, they do not see in those images not what an observer would see, but their own fears visualised.

Some studies suggest that socially phobic individuals overestimate the extent to which other people notice and attend to their internal states. Heinrichs and Hofmann (2001) refer to a specific interpretational bias toward self-relevant social information. Brown and Stopa (2007) suggest that some socially phobic individuals believe that other people can see or detect aspects of their internal selves; for example, their thoughts, images, or feelings.

The above cognitive-approach studies argue that the self-images of socially phobic individuals are frequently negative and distorted, and, yet, that those individuals consider their self-images accurate presentations. The self-images of socially phobic persons have been studied principally using experimental cognitive methods (for example, the Stroop colour naming test, Hope et. al., 1990; or the implicit association task, de Jong, 2002) and quantified questionnaires (see for example Hoffman, Moscovits, Kim & Taylor, 2004), with certain exceptions, such as the use of semi-structured interviews in studies by Hackmann et al. (1998) and Hackmann et al. (2000). Some studies of social phobia using a repertory grid technique also exist, but those studies have focused to a greater extent on case conceptualisation (Neimeyer, 2010) or on cognitive

conflicts (Diaz et al., 2001) than on actual self-images, although a grid may also be used as a measure of one's concept of self (Winter, 2003). To the best of our knowledge, no studies examine the self-images of socially phobic individuals in therapeutic conversational contexts. Group therapy situations are interesting contexts in which to consider private and public self-consciousness, because private thoughts and feelings concerning the self become public in conversation in therapy.

In this study, we examine how phenomena related to the self-image of socially phobic persons occur in a naturalistic group-therapy context; in particular, how those phenomena appear in the self-descriptions given in group therapy conversations shared with other socially phobic persons. What are the commonalities and differences of the self-images as those self-images appear in the self-descriptions? Is it possible to discover client subgroups based on the commonalities and differences observed? The self-descriptions of clients are usually the only information and tool a therapist has when working with clients; therefore, it is reasonable to study self-images as they naturally occur in conversations in therapy; specifically, in statements in which participants describe themselves.

Method

Participants

Fifteen female and two male clients aged twenty-four to fifty years of age, forming two separate therapy groups with seven and ten participants respectively, participated in this research. All seventeen participants were assessed individually before entering the treatment; were informed about the nature of the course of the group treatment; reported

anxiety in social situations and varying degrees of anxiety-related physiological symptoms, such as sweating, trembling hands, and dizziness; and met the DSM-IV diagnostic criteria for social phobia. All the participants gave informed consent to taking part in this study and to having their sessions videotaped.

Short cognitive-constructive group psychotherapy

The treatment in this study followed a model of short cognitive-constructive psychotherapy developed at the Jyväskylä University Psychotherapy Training and Research Centre. The therapist had a PhD and was a licensed advanced-level psychotherapist.

The therapy consisted of twelve weekly two-hour sessions, all of which were videotaped and later transcribed. The group treatment adopted five therapeutic strategies based on a cognitive-constructive model of the constitution of problematic experience and of the therapeutic development of reflexivity (Toskala & Hartikainen, 2005).

Data and analysis

The data for this study consists of twenty-four videotaped group therapy sessions and verbatim transcriptions of those tapes amounting to 665 pages of Microsoft Word document data files. We analysed the data qualitatively, using a generic data-driven approach (cf. McLeod, 2001), aiming to identify, describe, and classify the self-descriptions given by the client participants in the therapy sessions in question, and to find possible subgroups among those participants.

The analysis comprised five phases in total. In the first phase, the first author of this paper conducted an open reading of the material and highlighted all text segments that appeared to qualify as participant self-description or at least self-related statements. . The highlighted passages, five hundred in total, varied in length and structure from short statements to extensive paragraphs, and were coded as units of meaning using the ATLAS/ti software (cf. Seale, 2000).

In the second phase, we created individual registers of self-description for each participant, grouping the self-related statements by participant and naming, categorising, and coding each unit of meaning according to its content. Whenever possible, we gave identical category labels to units of meaning in different individual registers. When the individual registers of each participant were complete, the first author of this study compared and grouped the participants on the basis of similarities and differences between their registers. Since the participants offered quite different quantities of self-description, the grouping—resulting in five subgroups—was conducted on qualitative rather than quantitative grounds.

In the third phase of the analysis, in order to test the reliability of the grouping, selected self-related statements by each participant were given to a clinical psychologist, who classified the participants according to subgroups the first author formulated previously on the basis of the total data. Only two of seventeen cases were grouped differently, meaning that agreement between the two classifications was eighty-eight percent. As a result of this cross-checking, the first author decided to reconsider the subgroup assignment of the two participants.

In the fourth phase of the analysis, the original 500 self-related meaning units were re-inspected and 178 statements judged to qualify as actual self-descriptions. Two co-researchers categorised the statements independently, with no knowledge of the participants, and the categories formed by those co-researchers were then compared to one another and to the categories formulated previously by the first author. A consensus on the categorisation regarding 141 of the 178 self-descriptions was reached, as a result of which seven categories of self-descriptions were formed and definitions and criteria for each category were specified.

In the final phase of the analysis, we examined the self descriptions of the seventeen participants in the light of the seven categories. The original grouping conducted by the first author on the basis of the total data was reconsidered, and, because the quantity of data per participant varied considerably, we used clinical judgements when comparing participants' predominant modes of self-image. A consensus was reached that three different subgroups of varieties of self-description were identifiable among the seventeen participants.

Results

Descriptive categories

As described in the 'Method' section, 141 statements of self-description were classified according to seven categories.

1. The self as adjusting and pleasing others (26 units). This category included descriptions of oneself as adjusting to or pleasing others; it also contained descriptions of

oneself as other-oriented, as overly sensitive to the evaluations and expectations of others, or as dependent on others. Expressions such as “I then have to behave in a way that is expected of me,” “I have a strange need to sort of please others and I am, like, dependant on others,” or, “Holding one’s ground is terribly difficult; I adjust and I adjust beyond limits” were detected.

2. The self as miserable (26 units). This category consisted of descriptions of the self as miserable, pitiful, helpless, or poor. All such descriptions were characterised by seeing the self in a totally negative light, without any hope of anything better. In this category, participants used expressions such as “So I’m so bad: such rubbish,” “I’m no good; I’m the worst of all,” or, “There’s nothing good about me.”

3. The self as insufficient (24 units). This category also included negative descriptions of the self, but those descriptions were not as strongly negative as those in the previous category. The self was depicted as insufficient, not-valued, and the description given by participants revealed feelings of inferiority or low self-esteem. It was often stated that one does not fulfil the demands one should or that one is simply not enough. Examples of descriptions in this category were: “Whatever I do, or however I do it, it’s sort of, it’s not good enough for me, or I fear it’s not good enough for others,” “My self esteem is terribly low and inadequate,” or, “I have a terrible feeling of inferiority.”

4. The self as demanding toward self (24 units). In this category, self-descriptions revealed a strong tendency to be a particular type, something other than what one actually

feels one truly is. It is essential here that a person have a self-created image of what type of person he or she should be. This category was characterised by perfectionism, by the need to be excellent, and by a strictness toward the self. Expressions such as "I sort of don't accept it if I don't know something," "I have such a strong need to be the number one," or, "I kind of always have to sort of like be better than I am" were noted.

5. The self as outsider, different, isolated (16 units). This category included extracts where participants described themselves as outsiders, as notably different from others, or as isolated. Descriptions such as "I have always been shy and avoided company to some extent," "I'm abnormal in some ways," or, "Our society is like a jigsaw puzzle but I just don't somehow seem to fit; like, all other pieces go well together but there's this one piece that just doesn't go in the right place" were prominent in this category.

6. The self as transparent and a fear of being exposed (14 units). The essential feature in this category was describing oneself as transparent, or expressing fears that unwanted features of the self would be exposed to others. This was noted in expressions such as "A kind of transparency, sort of like there'd be sort of glass and everyone can sort of see through, or I unwillingly reveal more than I'm prepared to."

7. The self as hiding and controlling some feelings and features in oneself (11 units). Central to this category was a disapproval of some features of the self or feelings towards the self, as well as descriptions of attempts to hide these unacceptable features and feelings from others and to control or disintegrate them and disconnect them from the

self. This category included extracts such as, “I do get angry but I try to hide it in every way,” “I hide everything; I shut out the dark or the negative side of me,” “I am seldom who I really am; usually I’m someone else and I put on a role,” or, “I’m sort of not allowed to feel those feelings; I have to, kind of, withhold.”

It can be seen that three of these categories, the self as miserable (2), insufficient (3), and transparent (6), are experiential descriptions, and the four others are descriptions of how one deals with a ‘basic’ negative feeling towards oneself or how one tries to compensate for that feeling.

Client subgroups

Our attempt to identify subgroups among the participants—according to how their self-images were manifested in self-related statements and self-descriptions during the group therapy conversations—underwent several phases, as described in the ‘Method’ section. Finally, we decided that a division into three subgroups best fit the data, taking into account both the 500 self-related meaning units and the individual registers of self-description emerging from those units, as well as the 141 actual self-descriptions and their distributions of frequencies among the participants. These three subgroups were labelled “the other-oriented,” “the isolated,” and “the self-demanding.”

The other-oriented (n=7). Most clients in this subgroup described themselves negatively and as dependent on other people. The most essential feature was their overemphasised tendency to adjust their own behaviour to the wishes and expectations of others, using

self-descriptions from the "self as adjusting and pleasing others" category, even when their own wishes were contradictory. Two participants in this subgroup also described themselves as demanding toward themselves but—unlike the participants in the self-demanding subgroup—the other-oriented participants sought their "ought self" mainly in other people's assumed expectations, meaning that their sought self varied with different situations and with the people in those situations.

Two participants in this subgroup expressed difficulty describing their true self, such as difficulty describing their own feelings, desires and features. The two participants related those difficulties to uncertainty in social situations. As a consequence of this, they sought their way of being and acting from the people around them.

Unlike other participants in this or any other subgroup, two participants talked about themselves in a mainly positive manner. It seemed as if they might almost accept themselves, if only they had no anxiety problem in social situations. However, despite a positive attitude, the two participants tried to accommodate other people's assumed expectations. They described it as particularly important to maintain the positive image they had of themselves, and said that social anxiety was something that did not match that image.

The isolated (n=7). Typical also of this second subgroup was a negative self-image; more commonly, a "self as miserable" category of but also "self as insufficient." The other descriptive feature of this subgroup was their tendency to give up trying and to avoid anxiety provoking situations. As they avoided social situations, their typical experience

was loneliness and isolation from others. Those descriptions of loneliness reflected both actual isolation and feelings of loneliness, even when with other people.

Two participants in this subgroup offered very few self-related statements in group conversation. The shared features in their self-related speech were narrow, minimal descriptions on the whole, expressing negative self-images and control related to the self. Altogether, their shyness showed itself as a withdrawal from the therapy group. Withdrawal from the therapy group and minimal talking was also a distinguishing characteristic of other participants in this subgroup; therefore, self-descriptions of the "self as outsider, different, or isolated" were not always present in the speech of the clients described here, for the simple reason that they only produced a few self-descriptions related to compensatory categories.

The self-demanding (n=3). The prevalent feature of the self-descriptions of the third subgroup was their expression of an overemphasised demanding attitude toward the self. The participants in question possessed a self-created image of the type of person they should be, and this "ought self" was clear and saturated with perfectionism. Participants in this subgroup frequently used self-descriptions from the "self as demanding toward self" category. Also characteristic of participants in this subgroup was a rigid and negative image of their actual self. To hide this negative self and prevent it from being revealed, they attempted to compensate for the gap between their actual and "ought self" by demanding more and always better performances from themselves. Nonetheless, these participants' self-images remained negative. Some clients in this subgroup also described

an aching need to be accepted by others, acceptance they assumed was to be attained by being perfect in the eyes of others.

Discussion

This study aimed to explore self-descriptions of socially phobic persons in group therapy situations. We found seven categories of self-description, three of which were experiential and four compensatory in nature. Three meaningful client subgroups were identified on the basis of how participants compensated for their social anxiety and negative self-images that emerged strongly in the descriptive categories.

Many theorists stress that socially phobic persons have a negative self-image (see for example Clark & Welles, 1995). Our study also confirms this phenomenon: two of our descriptive categories were 'miserable' and 'insufficient' and all but two participants exhibited the behaviour described in those categories. However, this study also shows that such negativity varies from total piteousness to fewer negative notions of insufficiency. Some participants exhibited behaviour described by one category only, while others showed both types of negativity in their self-descriptions.

The third experiential self-descriptive category was the self as transparent and a fear of being exposed, or both. This is in accordance with the findings of Brown and Stopa (2007), who suggest that some socially phobic individuals believe that other people can see or detect aspects of their internal selves, such as thoughts, images, or feelings. Most participants used this descriptive category.

The other four descriptive categories described ways in which participants tried to manage their negative self-images: *one*, trying to fulfil expectations and demands of

others; *two*, aspiring to be perfect; *three*, resorting to withdrawal and isolation; or *four*, hiding and controlling some feelings and features in oneself. These can be seen as compensatory strategies, a term used by J.S. Beck (1995); they are behavioural strategies that patients have developed to cope with a problem, in this case social phobia. Beck (1995) links the use of compensatory strategies to painful core beliefs; the individual assumes—a core belief—that engaging in the compensatory strategy will prevent the feared situation from actualising. Beck (1995) contends that different individuals can develop different strategies even if the problem, or core belief, is the same. Interacting with an environment, different individuals develop different intermediate beliefs that reinforce their particular strategies. The three subgroups found in this study seem to describe the different strategies certain socially phobic persons habitually use.

The 'self as outsider, different, isolated' descriptive category was exhibited by only a few participants, and not by all the participants in the 'isolated' subgroup. This finding is due partly to the fact that this subgroup included most of the participants who talked the least; some of those participants did not exhibit any of the compensatory strategies described. The shyness and withdrawal in question was, we presume, actualised by the group context. In this study, only some participants described themselves as outsiders or isolated, while others exhibited actual isolating behaviour in the therapy group.

The category 'self as demanding toward self' was exhibited to some extent by participants from all three subgroups, but in particular by participants from the 'self-demanding' subgroup, who described such demands upon the self as present not only in social situations, but in almost all performances and activities. This finding conforms to

earlier results stating that persons with social phobia are more likely to report elevated levels of perfectionism than persons without social phobia (Anthony et. al., 1998; Ashbaugh et. al., 2007). Also, Clark and Welles (1995) stress that socially phobic persons have excessively high standards for social performance.

The descriptive category 'self as hiding and controlling some feelings and features in oneself' can also be seen as a manifestation of perfectionism in which a person cannot accept an experienced weakness, such as insecurity or social anxiety, as part of himself or herself. However, although perfectionism may be characteristic of persons with social phobia, its quantity varied as experienced and narrated by the participants in this study. In our 'self-demanding' subgroup, perfectionism was a significant element of self-image, but in the 'isolated' subgroup, perfectionism was not proliferated because the participants in questions compensated for their negative self-image through isolation rather than by being perfect.

Considering the three client subgroups we identified—other-oriented, isolated, and self-demanding—one should notice that while certain typical cases fit one of those groups very well, some cases raised issues of variance, even incongruities, in the participants' self-related statements and self-descriptions. It appears that some socially phobic individuals apply diverse coping and compensatory strategies, at times conforming themselves to others' wishes and expectations, sometimes isolating themselves from others and sometimes attempting to be perfect, while others habitually adopt one particular compensatory strategy.

Other possible explanations for this considerable variance of descriptions exist. Clark and Wells (1995) suggest that unstable self-schemata are typical of many individuals with

social phobia. Wilson and Rapee (2005) suggest that socially phobic individuals—as compared to individual takings part in non-clinical control studies—show less certainty in their views of themselves with regard to whether they possess negative personality characteristics or lack positive personality characteristics. As descriptions of self by the participants in this study also varied significantly, the constructions of self of individuals with social phobia may indeed be unstable to some degree, a phenomenon that might also explain the difficulty of describing themselves that two participants in the 'other-oriented' subgroup expressed.

This variance of descriptions may also relate to the group situation in which many types of descriptions were brought up, affording participants the possibility to consider the applicability of those descriptions to their own personal self-experience. From a constructivist vantage point, psychotherapy can be defined as the variegated and subtle interchange and negotiation of inter-personal meanings (Neimeyer, 1995), including self-related meanings. Indeed, we cannot underestimate the powerful effect of a group therapy context.

It is also important to note that participants were not in their usual relational context: rather, they were in the context of a group therapy consisting specifically of persons with a problem of social phobia and all the discourse that goes with that problem. From a systemic perspective, the conceptualisation of a problem always includes a family context, and individual behaviour is understood primarily as a function of the larger system (Feixas, 1995). DSM diagnosis places the problem inside the person, and in this therapy model also, no treatment occurred in the participants' usual contexts, such as family and workplace. Indeed, it is important to consider whether it is actually reasonable

to place clients in a group in which all participants have the same diagnosis. On the other hand, we should not forget the support clients have when treated in a peer group. Also, a group of this type offers a client many-sided possibilities to see alternatives and to construct and re-construct his or her problematic self-identity. The personal construct theory formulated by Kelly (1955) views a person as a scientist actively formulating personal hypotheses and revising or elaborating on those hypotheses in the course of their ongoing experience. In a peer group context, there are many more ongoing experiences than in individual therapy and many more possibilities to share, compare, and change one's constructs.

In our material, Higgins' (1987) discrepancy theory obtained partial support. The 'other-oriented' and 'self-demanding' subgroups differed most with regards to how participants described the extent to which they take into account demands from themselves or others. Participants from the 'other-oriented' subgroup conformed most closely to the model, frequently using the descriptive category 'self as adjusting and pleasing others.' Persons in the 'other-oriented' subgroup appear to have a high discrepancy between how they see their actual selves and how they believe they ought to be in the eyes of others; this discrepancy may urge them to attempt to please others. Interestingly, participants in the 'self-demanding' subgroup did not conform to discrepancy theory: they described defining their self-related demands mainly on their own. Also, Weilage and Hope (1999) found that although a high discrepancy between actual and ideal self was related to self-reported social anxiety, a group with non-generalised social phobia did not display an abnormal discrepancy between how they perceived their actual self and self as expected by significant others.

Some limitations should be acknowledged with regards to this study and its overall findings. Firstly, it is important to note that most of our participants, fifteen of the total seventeen, were females, which may affect the results. The effects of gender should be taken into consideration in future research. Secondly, as we were interested in the self-descriptions exhibited in a group situation, considerable differences were observable between participants in the amount of self-descriptions produced, which also affected the results. Also, it can be seen as a limitation that we could not arrange a control group of any kind: strictly speaking, without a control group it cannot be determined if the subgroups identified in this study are particular to socially phobic patients. Nonetheless, we contend that these results concern social phobia in particular as so much evidence in former research supports our results.

Researchers and clinicians are increasingly recognising the heterogeneity of presentations of social phobia. For example, Hoffman, Heinrichs, and Moscovitch (2004) suggest in their review that the DSM-IV "social phobia" category refers to a heterogeneous group of individuals who may differ in a number of dimensions, including fearfulness, anxiousness, shyness, self-consciousness, submissiveness, and anger. The findings of our study, we contend, are clinically relevant in demonstrating how this multitude of self-experiences and compensatory strategies may show themselves in clients' descriptions of self in a group therapy context. The self-descriptions that emerged here have commonalities with observations from other studies, but some important novelties in our findings concern representations of compensatory strategies in particular. Our descriptive categories and subgroups offer a useful tool for therapists to adopt and utilise this information directly in their therapeutic work.

We suggest that, in addition to exhibiting shared descriptions of self, socially phobic individuals also differ in how they describe themselves as coping with their anxiety; those differences should be taken into account when considering proper therapeutic strategies. Cognitive restructuring of self-organisation is seen as valuable therapeutic focus particularly in constructive cognitive treatment (see for example Mahoney, 1991; Guidano, 1991), and it is important to recognise the self-organisation of each particular client behind a diagnostic label. A client's own descriptions of himself or herself during therapy offer a practical, unique avenue for the therapist to recognise and appreciate his or her constructions of self-image. Social phobia, we contend, is not just a discrete symptom but an element of a holistic, complex self-organisation, which, despite common features, differs from one client to another. The three client subgroups that this study identifies may act as a useful opening to appreciating the diversity of the disorder. Hopefully, this description will also prove clinically useful and helpful in designing appropriate treatment.

A substantial research agenda still remains to be pursued before the scope of the self-images and self-descriptions of socially phobic persons is understood fully. To appreciate the clinical utility of the present findings, we intend to examine how clients from the three different subgroups progress in therapy. We assume that clients with differing self-descriptions—and therefore, most likely, differing self-constructions—have different aptitudes for therapeutic intervention. In addition, we plan to focus on some clinically interesting cases with the purpose of micro-analysing their therapeutic process. We will evaluate the processes of those cases in relation to different therapeutic strategies, examining in more detail how the present results relate to the therapy process

itself. It would also be interesting to study how individuals from the three subgroups differ in their past experiences. Research suggests that socially anxious individuals have childhood experiences such as parental hostility (see for example Taylor & Alden, 2005) that influence how they process contemporary social information (see for example Neal & Edelmann, 2003; Rapee & Heimberg, 1997). It may be possible that clients from the same subgroup share childhood experiences associated with certain self-images and coping strategies, which manifest themselves as particular types of self-description in therapy.

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II

PROGRESS IN ASSIMILATION OF PROBLEMATIC EXPERIENCE IN GROUP THERAPY FOR SOCIAL PHOBIA: A SUBGROUP ANALYSIS

by

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Progress in assimilation of problematic experience in group therapy for social phobia – a subgroup analysis

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Abstract

This study examined the progress of assimilation of problematic experience during group psychotherapy of seventeen clients presenting with social phobia. The data comprised of videotaped and verbatim transcribed sessions from two therapy groups (n=10 and n=7) of time-limited cognitive-constructive psychotherapy, and was examined using qualitative assimilation analysis. The clients were divided into three subgroups on the basis of their self-descriptions as reported in an earlier study: (1) the other-oriented, (2) the isolated and (3) the self-demanding. The aim of the study was to discover possible similarities within these subgroups and differences between them with respect to their assimilation process. The results showed that all clients progressed in their assimilation process but to different degrees. Some similarities and some differences between the subgroups could be noted. Clients from the self-demanding subgroup reached the highest assimilation levels and this group was the most homogeneous in the progress of assimilation. The groups of the other-oriented and the isolated were more heterogeneous, with some clients in these groups advancing less and some further in their assimilation processes.

Keywords: Social phobia, therapy process, assimilation analysis, cognitive-constructive group psychotherapy

Progress in assimilation of problematic experience in group therapy for social phobia – a subgroup analysis

Social phobia (or social anxiety disorder) is the most common anxiety disorder, and has a disproportionately higher risk of persistence compared to other anxiety disorders (Wittchen & Fehm, 2003). There are many specific therapeutic approaches that have been effective, for example many cognitive-behavioral approaches (Hofmann, 2010; McEvoy, Nathan, Rapee & Campbell, 2012). However, though the efficacy of a particular therapeutic approach may be demonstrated, this does not automatically provide evidence of its suitability for all individuals within the same diagnostic group. Thus, an analysis of the individual progress in treatment of different kinds of clients with social phobia may serve to evaluate more precisely the aptitude of individuals from client subgroups for different kinds of interventions.

In a meta-analysis of the effectiveness of psychological treatments for social anxiety disorder, Acarturk, Cuijpers, van Straten and de Graaf (2009) concluded that psychological treatments of social anxiety disorder are effective in adults, but may be less effective in more severe cases. They found no indication that the inclusion of specific techniques such as cognitive restructuring, exposure, social skill training or applied relaxation resulted in higher effect sizes. The authors concluded that because most of the studies in their meta-analysis utilized a mix of several of these methods, more research and in particular dismantling studies are needed to explore the specific effect of each of these techniques in further detail.

In addition to possible differential effects of therapeutic techniques, it is important to note the differences between patients with social phobia and the eventual

consequence of these on suitability for psychotherapy. Researchers and clinicians are increasingly recognizing the heterogeneity of presentations of social phobia. For example, Hofmann, Heinrichs and Moscovitch (2004) suggest in their review that the DSM-IV (American Psychiatric Association, 1994) category "social phobia" refers to a heterogeneous group of individuals that may differ in a number of dimensions, including fearfulness, anxiousness, shyness, self-consciousness, submissiveness and anger. The authors state that despite over 25 years of investigation into the nature of social phobia, little research has explored the validity and clinical utility of defining clients using other variables than the number and types of feared social situations. There has been no attempts to categorize social phobic clients into subgroups, until recently (see e.g., Moscovitch, 2009; Authors' own, 2012).

The current study is part of a larger research project focused on uncovering therapeutic change processes and their variations in different kinds of clients with social phobia. As a first step in this research we explored self-descriptions given by socially phobic clients in group therapy situations and identified three meaningful client subgroups based on how the participants compensated for their social anxiety and negative self-images (Authors' own, 2012). Here, the term subgroup refers to members who use similar compensatory strategies, not members who somehow coalesce with one another during the sessions, as the term is used in the group psychotherapy literature (see e.g., Agazarian, 2001). These three subgroups were named "the other-oriented", "the isolated" and "the self-demanding". Clients in the other-oriented subgroup dealt with their social anxiety mainly by trying to fulfill the expectations and demands of others, while those in the isolated subgroup resorted to withdrawal and isolation. Clients in the

self-demanding group aspired to perfection and in that way compensate for their negative self-image. It also appeared that some of the socially phobic clients applied diverse coping and compensatory strategies, sometimes conforming themselves to others' wishes and expectations, sometimes isolating themselves from others, and sometimes trying to be perfect, while others habitually adopted one particular compensatory strategy.

The particular treatment applied in the present and the earlier studies was cognitive-constructive, short-term group psychotherapy for social phobic patients. The treatment rationale is based on constructivist views, thus differing from traditional cognitive psychotherapies. The therapy model developed at the University of Jyväskylä Psychotherapy Training and Research Centre (Finland) emphasizes the exploration of individual meanings that patients give to their problematic experience. In this model persons are seen as active subjects as they organize their experiences of themselves and their world (Toskala & Hartikainen, 2005). Reflexivity, defined by Rennie (2004) as self-awareness and agency within that self-awareness, is seen as a central tool for therapeutic change. The client's growing ability to connect diverse experiences within the self; to gain a sense that the self can regulate these experiences; and to be reassured that the disturbing experiences do not threaten the self's sense of coherence; are emphasized as a key elements of therapeutic change. The group setting gives clients, among other things, opportunities to see that they are not alone in experiencing these kinds of problems (Dies, 2003).

As we (Authors' own, 2012) had previously found that social phobic individuals differ in how they describe themselves and how they cope with their anxiety, it seemed appropriate to ask whether these differences should be taken into account when

considering proper therapeutic strategies. Therefore, in the present study, we explored the therapeutic change processes of clients from the earlier identified three different subgroups. We decided to use qualitative assimilation analysis (see e.g., Stiles, 2011; Mosher & Stiles, 2009; Osatuke & Stiles, 2011), based on the assimilation model and the Assimilation of Problematic Experiences Scale (APES), as it offers a useful tool for studying therapeutic processes and outcome from recorded sessions. Also, it is not tied to any particular therapeutic approach or model.

In the assimilation model (Stiles, 2011; Osatuke & Stiles, 2011), the psychotherapy outcome is understood as a change in relation to particular problematic experiences, such as painful memories, threatening feelings or destructive relationships. The model suggests that in successful psychotherapy, clients follow a regular developmental sequence of recognizing, reformulating, understanding and eventually resolving the problematic experiences that brought them into treatment. As the meaning of the problematic experience changes it is assimilated into a community of voices that constitutes the self. The problematic experience is considered to be a separate, active voice within a person, rather than an abstract memory or a passive packet of information. Theoretically, voices of unproblematic experiences are easily assimilated into the community, but voices representing problematic experiences may be avoided, and are therefore nondominant voices (Honos-Webb, Stiles & Greenberg, 2003). . Assimilation is hypothesized to proceed along an eight-level sequence (stages 0-7) described in the Assimilation of Problematic Experiences Scale, or APES (Stiles & Greenberg, 2003; Stiles, Osatuke, Glick & Mackay, 2004). The level the client holds in respect to a particular problematic theme, and movements from lower to higher stages appear in the

client's utterances as he or she talks about issues related to the problematic experience. At stage 1, the client does not make reference directly to the problematic experience and attempts to avoid discussing contents associated with the disturbing voice, while at stage 2 the client is capable of discussing the problematic experience at length, without being kept on the topic by the therapist, although he or she is still distressed and not able to clarify the problem. At stage 3, again, the client explicitly recognizes the problem but only at stage 4 there arises a dialog and an emphatic understanding between the separate voices. At stage 5 the understanding is used to work on a problem and voices work together to address problems of living. At stage 6 the formerly problematic experience has become a resource and is used for solving problems, and at stage 7 the client is less likely to focus on the problematic experience as he or she has incorporated the change into daily living. It seems that assimilation does not progress rigidly and systematically; rather, there can be regressions to earlier levels and sudden gains that need further research (Honos-Webb, Stiles & Greenberg, 2003).

The purpose of the present study was to examine the possible similarities within and differences between three subgroups of patients with social phobia in their progression of assimilation of problematic experience. The setting of the study was naturalistic in the sense that clients entered the therapy group by contacting the therapy clinic themselves. The three subgroups were formed according to the main compensatory coping strategies used by the patients and were named (1) the other-oriented (n=7), (2) the isolated (n=7) and (3) the self-demanding (n=3).The treatment used in this study, short-term cognitive-constructive group therapy, is a mixture of prescriptive and

exploratory approaches. It is prescriptive in that it is time-limited and structured, but exploratory in its basic philosophical approach.

Method

Subjects

The two therapy groups were carried out in two subsequent years, one group at a time. Clients entered treatment by contacting the University of Jyväskylä Psychotherapy Training and Research Centre after there had been a notification in the local newspaper about the group therapy possibility for persons with social anxiety. Fifteen female and two male clients (aged 24–50) – forming two separate therapy groups with seven (first year) and ten participants (second year), respectively – participated in the research. As mentioned earlier, the three client subgroups were identified post-treatment, and group membership was not used as an assignment criterion to the treatment groups. In the treatment group with seven participants, there were four clients belonging to the group of other-oriented and three clients belonging to the group of isolated. In the treatment group with ten participants, three clients belonged to the group of other-oriented, four to isolated, and all three self-demanding clients were in this group.

All seventeen clients were assessed individually before entering the treatment, and were informed about the course of the group treatment: its duration, schedules and the five cognitive-constructive strategies to be used during treatment. All clients reported anxiety in social situations and anxiety-related physiological symptoms to varying degrees (e.g., sweating, trembling hands, and dizziness), and met the DSM-IV diagnostic criteria for social phobia (American Psychiatric Association, 1994). All clients gave informed consent to participate in the study and to have the sessions videotaped.

The treatment

The treatment followed a model of short cognitive-constructive psychotherapy developed at the University of Jyväskylä Psychotherapy Training and Research Centre (Finland). The male therapist held a PhD and was a licensed advanced-level psychotherapist, and had also developed the therapy model in question. The same therapist carried out both therapy groups. The therapist participated in this study only by conducting the therapy groups.

The therapy was time-limited, consisting of 12 weekly two-hour sessions, all of which were videotaped and later transcribed. Five therapeutic strategies based on a cognitive-constructive model of the constitution of problematic experiences, and of the therapeutic development of reflexivity (Toskala & Hartikainen, 2005), were adopted in the group treatment. The development of the clients' reflexivity was a central therapeutic principle. The therapist's goal was to increase the clients' ability to reflect on their inner states and individual ways of experiencing and interpreting these experiences. The clients were given a brief written material concerning every strategy, before the particular sessions. The first strategy (sessions 2 and 3) was to recognize the internal, mental process – such as feelings, thoughts, bodily sensations, images – related to the problematic experience of each individual participant. This was done by processing situations in which social anxiety was experienced. Reformulation, the second strategy (sessions 4 and 5), included reconstruction of the problem on the basis of the individual's own inner process. At this point, both the client and therapist concentrated on the way in which the problem was constructed and what was most essential in the problematic experience, including possible explanations for it. In the third strategy (sessions 6 and 7),

the idea was to reconstruct an alternative relation to the individual's problematic experience. The goal was a more allowing and accepting attitude toward oneself and to one's own inner experience, which would enable the integration of the problematic experience with the self.

The fourth strategy (sessions 8 and 9) was to explore and clarify how the problematic social phobic experience appears in present adulthood attachment relations. In the last, fifth, strategy (sessions 10 and 11), the group contemplated the problematic experience in each client's early attachments to parents and other significant adults. This was done by recalling significant experiences related to childhood and youth, and having an emotional connection to these memories.

The therapist was mainly action-oriented, embracing strategies such as reframing and fostering generalization (Dies, 2003). The focus of interventions was mainly on each individual client, not targeted on the group as a whole: each client was invited to deal with his or her own feelings and experiences relating to the issues in question. There was also a psychoeducational component in every meeting when the therapist clarified the strategy in question, and outlined the clients' experiences relating to it, summarizing them on a flipchart. Although the therapy was structured and monitored by the therapist, the clients could also talk spontaneously to one another within the group context. The purpose of the five strategies was to offer the clients mental tools to work on their problematic experiences in social situations, not only in the therapy meetings, but also between sessions and after the therapy was over.

Assimilation analysis

As mentioned earlier, the Assimilation of Problematic Experience Scale (APES) (Honos-Webb, Stiles & Greenberg, 2003; Stiles, 2011) is an eight-point fully anchored rating scale from 0 to 7. Although the scale has been used as a continuum that allows for mid-point ratings (e.g., 2.5), only whole-point ratings were used in this study.

Six students majoring in psychology were trained to perform an assimilation analysis on a part of the data (260 APES ratings of a total of 590). As the students had no prior knowledge of the assimilation model, the analytic procedure was undertaken in pairs. Parallel to a general course in qualitative methods the students familiarized themselves with the literature on assimilation analysis (mainly research articles) and were supervised by the first author. The students met with her every two weeks for six months, to discuss the method and the data. The analysis was carried out by the first author and the students during this six months period.

The analytic procedure used was an adaptation of a four-step assimilation analysis described previously (Honos-Webb et al., 2003; Honos-Webb et al., 1999):

Step 1: Familiarization and indexing. The analysis began by watching all the videotapes, which comprised 24 group therapy sessions. Next, the first author read the verbatim transcriptions of these tapes, amounting to 665 pages in Word. She identified the speech segments of each client participant and read several times the transcripts of all sessions one client at a time, listing the topics that each client addressed in the order in which they were discussed. The first author went through all 17 clients in this way. As a reliability check, the students went in pairs – independent of the first author – through this same procedure for six clients, two clients per pair.

Step 2: Identifying themes. Based on her understanding and notes, the first author identified and described one or two emerging central themes related to social anxiety for each client. For eight clients, two separate themes were identified and formulated, and for nine clients only one. Again, in the case of six clients, this step was undertaken independently by the undergraduate students and finally for these six clients the themes were identified and described in agreement. In the case of these six clients, two separate themes were identified for five clients, and one theme for one client. Each theme was cast in terms of a dominant and nondominant voice (see Table 2). The dominant community of voices represents accepted experiences, and voices representing problematic experiences may be avoided, and are therefore nondominant voices (Honos-Webb, Stiles & Greenberg, 2003).

Step 3: Selecting passages. The parts of the data that were associated with the identified themes were collected from the transcripts. The first author selected the passages of all 17 clients and the three student pairs independently selected the passages of two clients each, altogether the passages of six clients. Next, the first author compared with each student pair the selection of passages. When a particular passage was selected both by the first author and the student pair, it was included in the final data. If a passage had been selected by only one (i.e., the first author or the student pair), its inclusion or exclusion was based on agreement. The selection of passages for the remaining 11 clients was made by the first author alone. All selected passages (n=590*)* ranged in length from 3 lines to 2 pages.

Step 4: Assigning assimilation ratings. The first author rated the selected passages of all 17 clients on the APES (Table 1), guided by her understanding of the

whole case, problematic experience and knowledge of the passages' context. To check reliability, altogether 260 selected passages from six clients were independently rated by three student pairs, two clients per pair.

Reliability of APES Ratings

As mentioned earlier, the reliability was checked for 6 of the 17 clients (11 of the 25 themes), each student pair together analyzing two clients. Two student pairs encountered rating problems with a few passages' APES ratings. These problematic passages (altogether 11) were rated together with the first author and were excluded when counting the reliability. The inter rater reliability was estimated by counting the Intraclass Correlation Coefficient (ICC) (Fleiss, 1981, Shrout & Fleiss, 1979).

$$ICC = \frac{\sigma_\alpha^2}{\sigma_\alpha^2 + \sigma_r^2}$$

The ICC of the student pairs' ratings with those by the first author were .769 (21 ratings, theme 3a), .673 (29 ratings, theme 3b), .874 (41 ratings, theme 5), .654 (20 ratings, theme 6a), .811 (24 ratings, theme 6b), .846 (24 ratings, theme 7a), .824 (18 ratings, theme 7b), .865 (17 ratings, theme 12a), .947 (15 ratings, theme 12b), .874 (25 ratings, theme 13a), and .824 (15 ratings, theme 13b). Fleiss (1981) provide references to the magnitude of standard estimates of ICC, in the following ranges: < .40 = poor, .40 - .59 = fair, .60 - .74 good, and > .74 excellent. Thus, in 9 of 11 themes the ICC signified excellent agreement and in 2 themes good agreement.

Results

Altogether 25 themes from 17 clients were identified and described (two themes from eight clients and one theme from nine clients). The themes are described in terms of their dominant and nondominant voices in Tables 1, 2 and 3. Four of the clients for whom two different themes were identified belonged to the other-oriented group (4/7), three to the isolated group (3/7) and one to the self-demanding group (1/3). All themes were related to the issue of social anxiety, but they were also quite personal in nature. Many of them seemed logically related to the subgroup membership of the client, but there were also some obvious overlap. These overlaps are in accord with the observation from the previous study that some of the clients applied diverse coping and compensatory strategies.

[Insert table 1 about here]

[Insert table 2 about here]

[Insert table 3 about here]

Changes in APES levels within different subgroups

The highest APES level reached during the therapy process was not always the same as the level of the last passage of the last session. Because of this the changes in APES levels are reported in two parts: first, we report on the highest gained advantage for each client at some point in the treatment, and secondly Figures 1 to 3 show more precisely the change process in APES levels during the 12 sessions. These results were analyzed by visual inspection only, i.e. no statistical analysis of the trends was performed because of the small number and uneven distribution of measurement points.

All clients but one in the other-oriented subgroup had an initial assimilation level of 2 or 3. In this group the clients progressed in varying degrees. One client reached level 3, progressing only one APES level, while the six other clients reached level 5 or 6 in at least one personal theme, progressing two to four levels in all of their themes. Within this group, at its maximum, two clients reached level 5 (application/working through) and four clients reached level 6 (problem solution) in one or both personal themes.

In the isolated subgroup, both the initial assimilation levels and the highest levels reached were the lowest compared to the other subgroups, and the gained advantage differed between one to four levels of progression. For three clients the process began at level 1, for two clients at level 2 and for the remaining two at both levels 1 and 2 as they had two different themes. The highest level obtained in this subgroup was also 6, which was reached by three clients. One client reached level 5, one level 4 (understanding/insight), whereas two progressed no further than level 2 (vague awareness) in their change process.

In the self-demanding subgroup, two clients had an initial assimilation level of 2 and one client of level 3. This group benefitted most from the treatment as all reached level 6 in one or two themes, gaining three to four APES levels during their treatment.

The progress in APES levels over the course of the 12 group sessions for each client within each subgroup are shown in Figures 1 through 3. In these figures the APES levels shown on the y-axis are averages of the level ratings for each session, and for those clients who had two themes they are also averages of the two themes.

[Insert figure 1 about here]

[Insert figure 2 about here]

[Insert figure 3 about here]

In the other-oriented subgroup, there was a fairly even progress throughout the sequence of sessions, except for one client whose progress was very slow (Figure 1). In the isolated subgroup the progression in assimilation levels was the most heterogeneous (Figure 2), while in the self-demanding subgroup it was the most homogeneous (Figure 3). Comparing Figures 1 through 3, it can be noted that in most of the cases – particularly

in the other-oriented and isolated subgroups – the change processes followed a sawtooth pattern, as movement toward greater assimilation through repeated sequences of a rapid advance were followed by falling back to an earlier level. In addition, in the isolated subgroup there were two clients whose APES levels were not higher in the last session compared to their initial levels: the level of one was the same as her initial level, and the other's level at the end of the therapy was even lower compared to her initial level. The change process progressed the most smoothly in the self-demanding group, except in the 8th and 9th sessions, in which the strategy was to consider the reconstructed, problematic experience in one's adulthood attachment relations.

Discussion

The aim of the present study was to examine the possible similarities within and differences between three subgroups of clients with social phobia in the progress of their assimilation process during time-limited, cognitive-constructive group psychotherapy. We studied the assimilation processes of three different subgroups, defined on the basis of their main coping and compensatory strategies: (1) the other-oriented (n=7), (2) the isolated (n=7) and (3) the self-demanding (n=3). Some similarities and some differences between the subgroups could be noted. The self-demanding subgroup was the most homogeneous, as all clients within this subgroup progressed well in their assimilation process during the treatment, reaching APES level 6. The two other subgroups, the other-oriented and the isolated, were more heterogeneous as the change processes of the clients varied. The largest variance in the progress of assimilation was in the isolated subgroup, in which two clients reached only level 2, but three clients progressed to level 6 in at least

one of their problematic themes. Thus, although most of the clients who benefitted least from the treatment were in the isolated subgroup, belonging to this particular subgroup did not automatically mean that the client could not benefit from the treatment.

The highest and the last levels were nearly the same in all cases except in two. When considering the progress in APES levels as an indicator of outcome, we chose to use the highest level reached, instead of the level in the final passage related to theme in question. This was because we noticed that the five therapeutic strategies directed which themes the clients brought up, causing sometimes step-downs in APES levels. Because of this, despite these occasional step-downs in APES levels, we consider the highest levels to be most appropriate as indicators of the gained therapeutic benefit.

When considering the progress of different clients in this part-prescriptive, part-exploratory treatment, a central observation is that 19 of the 25 themes of problematic experiences presented by the 17 participating clients progressed to assimilation levels 5 or 6, and 13 of the 17 clients progressed to levels 5 or 6 in at least one of the presented themes. At level 5 the client uses his or her new understanding of the problem to work on it and the voices work together to address problems of living. We venture to state that when gaining this level, the client has evidently benefitted from therapy. Thus it can be concluded that, overall, this treatment model yielded at least reasonable effectiveness.

When looking at the four clients who progressed to lower than level 5, it can be noted that three of them belonged to the isolated subgroup, and that the initial APES level for these three clients in at least one theme was 1. This would indicate that using social isolation as a compensatory strategy for social anxiety and having a poor level of assimilation for problematic experience would be contraindicative for the kind of group

therapy applied in this study, particularly as one client's progression in APES levels went downwards at the end of the therapy. But then again, one client from the same subgroup with the same initial levels progressed to levels 5 and 6. The fourth client who did not benefit from the treatment (despite an initial level of 2) belonged to the other-oriented subgroup in which all other clients reached level 5 or 6. It would be worthwhile in further studies to look in more detail at the individual progress of these positive and negative deviant cases.

The fact that all the clients from the self-demanding subgroup clearly benefitted from treatment could be a coincidence, as there were only three participants in this group. Also, no one in this group had an initial level of 1, and consequently the good outcome may be partly related to this. However, this finding could also be related to the compensatory strategy used by the clients from this subgroup. When the main strategy used to manage social anxiety is to aspire for ever-better achievements, this strategy may also affect the client's performance in treatment. This could be seen as beneficial for treatment outcome as long as it does not approach perfectionism, but rather helps the client to recognize his or her personal way of relating to the self and the world.

When considering the session-by-session progress in assimilation, we noted in the data yielded from this study that most clients within the general ascending trend exhibited a sawtooth pattern with occasional step-downs in APES levels. This kind of sawtooth pattern has been reported by several investigators (e.g., Caro Gabalda, 2008; Osatuke, et. al., 2005). In two case studies, Stiles (2001) observed that a client-centered case made smooth but gradual progress along the APES continuum, whereas a cognitive-behavioral case followed a sawtooth pattern progressing toward greater assimilation though repeated

sequences of a rapid advance followed by a fall-back to an earlier level (Stiles, 2001). The observation that this kind of sawtooth pattern also occurred in most of our cases may be related to the fact that the therapy was partly prescriptive and was carried out in a group setting. The five therapeutic strategies significantly directed which themes the clients would bring up. Thus, a client who had developed his or her theme at a higher assimilation level earlier may have processed it at a lower level in the context of the next therapeutic strategy. This may have been the case for example in the self-demanding group for sessions 8 and 9, in which the strategy was to work on the problematic experience in early attachments to parents (5th strategy). Before those particular sessions one of three clients was already at the problem solution stage (APES 6) and the other two at the working-through stage (APES 5), but during these sessions the level ratings went down to the understanding stage (APES 4). Also, vice versa, the strategy used might have pulled some clients a little more quickly to assimilation levels that they otherwise, without the input of the therapist, would not yet have reached, thus causing a regression in later sessions. This may have also been the case with the two clients in the isolated subgroup, as in the last session one's APES level returned to her initial level and the other's APES level went downwards compared to her initial level. As Stiles (2001) considers, each "tooth" in the pattern could represent a different narrow topic or domain, opened by the therapist's strategy of focusing on issues one by one, and actively leading the client to the crux of each issue.

When considering the possible specific effect of the group format of the treatment on the results, it is notable that the two clients who benefitted least (progressing only from APES level 1 to 2) were both in the isolated subgroup. For clients whose social

anxiety management strategy is to withdraw from other people, the group format applied in this study might not be the most suitable form of therapy. In group therapy, clients are expected to expose personal and possibly painful experiences to others, and this is precisely what clients using social isolation as a coping strategy seek to avoid. Thus an explicit selection process and a proper assignment to a treatment would be important. There are, however, means to work in group settings with individuals with an isolative stance; in System-Centered Therapy (Agazarian 2001) clients with an isolative stance are encouraged to bond with one another in their wariness toward exploring problems and Burlingame, McClendon and Alonso (2011), in their meta-analysis, concluded that all group leaders should actively engage in interventions that cultivate and maintain cohesion. Enhancing group cohesion, using means such as emphasizing member interaction (see e.g., Agazarian, 2001; Burlingame, McClendon & Alonso, 2011; Yalom, 2005), would be especially important for clients adopting a strategy of isolation.

When considering the limitations of this study, we recognize that our small group sizes in the three different subgroups can only slightly highlight their possible similarities and differences concerning progress in the therapy process. There was also a considerable variation within the subgroups regarding how exclusive the use of the particular compensatory strategy defining group membership was for different clients. On the other hand, we see that there are also some clear advantages when having small group sizes: for example, it allows one to identify more clearly deviant cases and make conclusions concerning their specific pattern of progress. Also, qualitative research allows intensive study of individuals in a scientifically rigorous way and for these reasons bridges the research-practice divide (Kazdin, 2008). It is also important to pay attention to the fact

that the therapy setting was naturalistic. Because of this, the subgroups were not identical in their sizes and different clients used compensatory strategies differently. Still, we see that small group size and naturalistic setting, on the other hand, improve the clinical relevance and applicability of our study.

Also, as the identification of themes and rating of APES levels include interpretation, it is probable that at least some parts of the data would be interpreted differently by different researchers. We took this into account by using multiple observers, thus improving the reliability both of theme identification and selection of passages, and ratings of assimilation levels.

As Norcross and Wampold (2011) state, decades of research now scientifically support what psychotherapists have long known: different types of clients require different treatments and relationships. We also, on the basis of our findings, conclude that the factors contributing to a successful treatment of clients with social anxiety are more complex than simply the confirmed diagnosis of social phobia or the use of certain therapeutic techniques. In the next stage of our research, as we further explore the psychotherapeutic process of clients with social phobia, we intend to look in more detail at the deviant cases found in this study, especially those in the isolated subgroup whose initial assimilation level was 1. With these cases, we will try to find those moments that were significant in making the treatment successful or unsuccessful. What did the therapist do or say during these moments? What did the client or the rest of the therapy group do? We hope that by understanding these factors at so precise a level we can highlight the way to more client-tailored and more effective treatments for social phobia.

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Table 1.

Personal themes in the subgroup of other-oriented

The other-oriented
Client 1. a) Dominant: I must succeed and excel, I'm not allowed to make mistakes or to be unsure Nondominant: I'm allowed to be unsure, to be incompetent b) Dominant: I must be sensitive to the moods of others, must help others, prevent conflicts and be a mainstay for others Nondominant: I'm allowed to be helpless, to not have enough strength and to need support from others Client 2. Dominant: I must be cheerful and invulnerable Nondominant: I can also be vulnerable, down, melancholic Client 3. a) Dominant: I must be competent and successful, and able to meet the demands of others Nondominant: I can also be weak, unable, I sometimes need support and help from others b) Dominant: I must be kind, must please and adapt to others, must like everybody Nondominant: I'm not allowed to think negatively about others, not allowed to experience feelings that are in conflict with pleasing others Client 4. Dominant: I must avoid challenges, I am not allowed to fail, and no one can get angry Nondominant: I can be experimental, curious and I'm brave enough to fail also Client 5. Dominant: I must be a good worker, competent and confident in every situation Nondominant: I can also be shy sometimes, fearful and unable to fulfill responsibilities Client 6. a) Dominant: I must be successful, flawless Nondominant: I can also be weak and unsure b) Dominant: I must please and adapt to others, must forget my own needs Nondominant: I have the courage to act with self-determination, take into account and/or express my own feelings and opinions Client 7. a) Dominant: I demand a lot from myself: competence, know-how, intelligence Nondominant: I'm allowed to be unsure, incompetent weak b) Dominant: I must adapt to and please others Nondominant: I dare to act according to my own will

Table 2.

Personal themes in the subgroup of isolated

The isolated
Client 8. Dominant: I must appear as self-confident Nondominant: I'm allowed to be tense and unsure Client 9. Dominant: I'm not allowed to be tense, I must be self-confident Nondominant: I'm allowed to be unsure and shy Client 10. Dominant: I must succeed in front of others Nondominant: I'm allowed to be unsure Client 11. a) Dominant: I must think only good things of others, must be kind and a good person Nondominant: I can sometimes get angry and disagree with others b) Dominant: I must succeed, be competent, self-confident Nondominant: I'm allowed to be unsure and incompetent Client 12. a) Dominant: I must be open, kind and conscientious Nondominant: I can be angry and act with self-determination b) Dominant: I must be strong and confident Nondominant: I'm allowed to be weak, unsure and be tense Client 13. a) Dominant: I must be independent, hard and manage without others Nondominant: I want to be confronted as I am – also with regard to my sensitive side and idiosyncrasies. I need support and approval from others b) Dominant: I must reach great achievements in my life and look distinguished and competent in the eyes of others Nondominant: I can be unsure, incompetent, uninformed Client 14. Dominant: I must manage alone, without help from others Nondominant: I'm allowed to be weak, helpless and need support or other people

Table 3.

Personal themes in the subgroup of self-demanding

The self-demanding
Client 15. Dominant: I must succeed, be self-confident and clever Nondominant: I can be unsure, incompetent Client 16. Dominant: I must be able to do things perfectly, must always pursue better performance, must not reveal weakness nor uncertainty Nondominant: I'm allowed to be unsure, incompetent Client 17. a) Dominant: I must be strong, competent and accomplished Nondominant: I'm allowed to be unsure, incompetent b) Dominant: I must please others, keep them in a good mood Nondominant: I can be angry and act according to my own feelings and needs

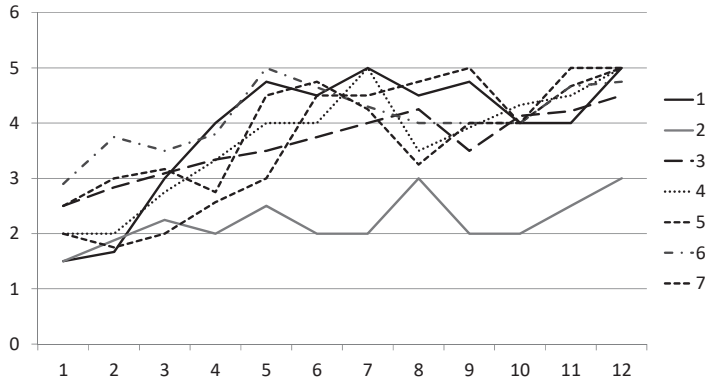

Figure 1. Changes in APES over the course of the 12 group sessions within the group of other-oriented. The Y axis shows the level of assimilation for each client (1-7). The X axis shows the number of the sessions.

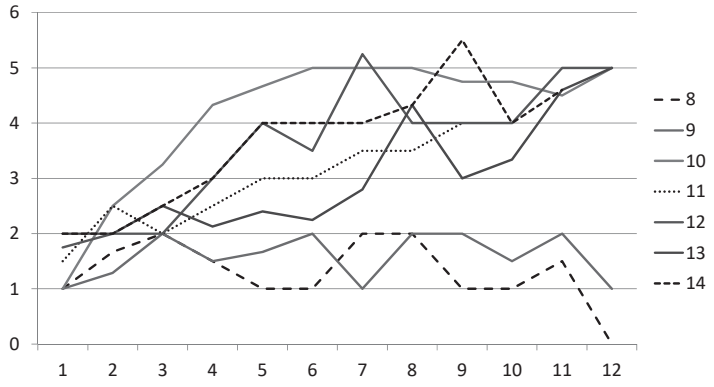

Figure 2. Changes in APES over the course of the 12 group sessions within the group of the isolated. The Y axis shows the level of assimilation for each client (8-14). The X axis shows the number of the sessions.

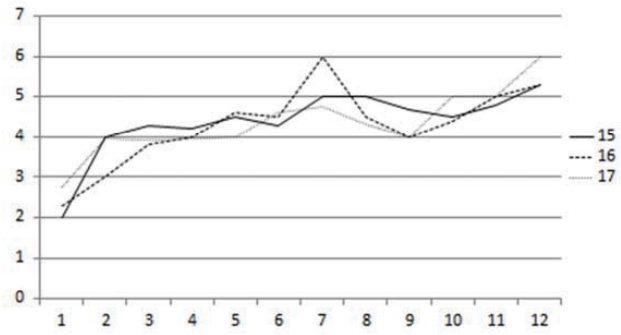

Figure 3. Changes in APES over the course of the 12 group sessions within the group of the self-demanding. The Y axis shows the level of assimilation for each client (15-17). The X axis shows the number of the sessions.

III

ASSIMILATION, REFLEXIVITY, AND THERAPIST RESPONSIVENESS IN GROUP PSYCHOTHERAPY FOR SOCIAL PHOBIA: A CASE STUDY

by

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Assimilation, Reflexivity, and Therapist Responsiveness in Group Psychotherapy for Social Phobia: A Case Study

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Abstract

Objective: This case study examined reflexivity and the assimilation of problematic experiences, especially its progress within and between the Assimilation of Problematic Experiences Scale (APES) Stages 2 to 3, in group psychotherapy for social phobia.

Method: The data consisted of all of one client's turns expressing the two voices of her main problematic experience in 12 sessions, and all replies by the therapist in direct connection to them. The client's utterances were rated on the APES.

Results: A detailed analysis of 13 conversational passages revealed that progress in assimilation happened only when the client took a reflexive stance towards her inner experience or outer actions. There were a few instances when she took a reflexive stance, but no progress in assimilation could be noted. A qualitative analysis of three conversational episodes showed how therapist responsiveness facilitated the client's increased reflexivity and progress in assimilation.

Conclusions: Reflexivity appears to be a necessary condition for progress in assimilation both at APES Stages 2 and 3, but the model should recognize that reflexivity can appear in diverse forms and at different levels. Therapist responsiveness and sensitivity to the client's assimilation process is crucial for a successful transition from Stage 2 to Stage 3.

Keywords: assimilation, reflexivity, social phobia, group psychotherapy, case study.

Assimilation, Reflexivity, and Therapist responsiveness in Group Psychotherapy for Social Phobia: A Case Study

Despite the common diagnostic criteria for social phobia included in DSM-IV, such as an intense and irrational fear of embarrassment, humiliation, or scrutiny by others in social situations (American Psychiatric Association, 1994), the category of "social phobia" refers to a heterogeneous group of individuals who may differ in a number of dimensions (Hofmann, Heinrichs, & Moscovitch, 2004). Taking such individual variability—which is not restricted to this diagnostic category alone—into account is a challenge for therapists. This is especially true in structured methods of group psychotherapy for particular target categories. One important difference between clients is their readiness to take a reflective stance on their problems and experiences. This calls for sensitivity and responsiveness towards the individual client's ways of processing his or her problematic experiences and inclination to appreciate and benefit from the therapist's interventions (Leiman & Stiles, 2001; Stiles, Honos-Webb, & Surko, 1998).

The Concept of Reflexivity

One of the qualities in which clients differ is in their capacity to assume a self-reflexive stance, a positioning seen as central to progress in psychotherapy (see Levitt, Butler, & Hill, 2006; Rennie, 1992, 2000, 2004). In this case study, we address these issues by examining how, in short-term group psychotherapy for clients presenting with

social phobia, the therapist's responsiveness, or lack of it, contributed to, or hindered, one client's increasing reflexivity, and how this related to progress in the assimilation of her problematic experiences (Stiles et al., 1991; Stiles, 2001, 2002, 2011).

The current case study is part of a larger research project on therapeutic change processes and their variations in cognitive-constructive group psychotherapy for social phobia (Penttinen & Wahlström, 2013; Penttinen, Wahlström & Kuusinen, 2013). In the treatment model applied, increased reflexivity is seen as a central element of therapeutic change. Self-reflexive examination is presumed to have a number of effects for the client: It enhances his or her ability to connect diverse experiences within the self, helps gain a sense that the self can regulate these experiences, and reassures that the disturbing experiences do not threaten the self's sense of coherence (Toskala & Hartikainen, 2005).

The concept of reflexivity is manifold and has been used in psychotherapy research more or less synonymously with such concepts as metacognition, agency, reflectivity, self-monitoring, recursiveness, and self-consciousness (Dimaggio & Lysaker, 2010; Rennie, 1992). Rennie refers to Lawson (1985), who describes reflexivity as turning back on oneself, a form of self-awareness. In Rennie's (2004) definition, reflexivity is taken to mean the formation of intentions within self-awareness which results from turning one's attention to oneself. Reflexivity has also been paralleled with the notion of employing a metaposition. According to Hermans (2004), a well-developed metaposition allows one to stand above the ongoing stream of perception. In other words, the person takes the perspective of an author watching his or her voiced positions and how they function as actors in specific circumstances. As a result of such an increased level of self-awareness, the person is able to strengthen his or her capacity for seeing

relevant connections in life experiences. Hermans (2004) emphasizes that a metaposition is always connected to one or more internal or external positions (e.g., one represented by the psychotherapist), which are actualized at a particular moment and in a particular situation. Accordingly, the meta-position is a dialogical phenomenon, including both the outer dialogue with the therapist and the client's internal dialogue. This also implies that, depending on time and situation, different metapositions can emerge.

From our reading of the literature and the data from this study we contend that different levels of reflexivity can be observed in therapeutic discourse. The first level, forming a basis for assuming a reflexive stance, is achieved when a person turns onto the self and recognizes his or her own internal processes, such as feelings and thoughts. On the second level, such a turning onto the self may allow the person to address and eventually analyze his or her interpretations based on these processes. Reflexivity on the first level can be defined as an observable utterance in the therapeutic discourse where the client takes an observational stance towards her own experiences or internal processes (e.g., "then I get this feeling of uncertainty"), and on the second level as an utterance where he or she indicates making observations on her own way of interpreting her experiences (e.g., "then this feeling of uncertainty makes me think that everybody else is critical of me"). Taking such a metaobservation stance expresses, at least implicitly, an understanding of people having their own personal perspectives, differing from the speaker's image of those perspectives.

The Assimilation of Problematic Experiences Model

In this study we used the Assimilation of Problematic Experiences model to assess therapeutic change. The model is a theory of psychological change that depicts the self as a community of internal voices, composed of traces of the person's experiences (Honos-Webb et al., 1999; Stiles et al., 1991; Stiles, 2001, 2002, 2011). These internal voices may embody other people's activities, events, or any other interlinked complex set of experiences (Mosher & Stiles, 2009; Stiles, 2011). External persons, especially therapists, may sometimes act as real-world representatives of inner voices. In a healthy, functioning community, voices are easily accessed and can be called upon as needed. Voices are considered problematic when they represent foreign, discrepant, or traumatic experiences (Brinegar, Salvi, & Stiles, 2008).

The assimilation model strives to depict how a problematic voice becomes accepted and integrated into the dominant community of voices. Assimilation is hypothesized to proceed according to an eight-level sequence described in the Assimilation of Problematic Experiences Scale (APES; Stiles et al., 1991; Stiles, 2001; Honos-Webb & Stiles, 1998). Problematic or nondominant voices are more or less rejected by the community. In the extreme, problematic voices may be denied awareness or avoided (APES Stages 0 or 1), in which case the therapeutic work entails bringing the voice into awareness (Honos-Webb et. al., 1999). Theoretically, as an unwanted voice emerges into awareness, a voice that opposes it is called forth from the dominant community of voices (Honos-Webb & Stiles, 1998). At Stage 2 (vague awareness), the client acknowledges the problematic experiences and describes distressing associated thoughts but cannot formulate the problem clearly. At Stage 3 (problem statement/clarification), the client is able to state the problem in words and/or give

expression to both the nondominant and the dominant voice. Then, at Stage 4 (understanding/insight), with the development of new understandings, both the dominant and problematic voices change and accommodate each other, and are understood to develop so-called meaning bridges between them. Potentially, this enables the client to progress to the higher assimilation levels.

The transition from Stage 3 to Stage 4 is seen as central to the therapeutic change process, and reaching Stage 4 is considered to be the minimum criterion for a good therapy outcome. Hence, a considerable amount of research has been devoted to that transition (Brinegar, Salvi, & Stiles, 2008; Brinegar, Salvi, Greenberg, & Stiles, 2006; Detert, Llewlyn, Hardy, Barkham, & Stiles, 2006). Much less consideration has been given to the transition from Stage 2 to Stage 3, which is the interest of our study. In the assimilation model, reflexivity is given as one marker of Stage 3 (Honos-Webb, Stiles, & Greenberg, 2003). Theoretically, it is a well-founded notion that for the client to become aware of the dialogical processes between different parts of the self, a required criterion for reaching Stage 3 (problem statement/clarification) is second-level reflexivity (as defined above). Then again, some previous research indicates reflexivity appearing already at Stage 2 (vague awareness). Gonçalves et al. (2014) showed that low APES levels (< 4) were associated with so-called low innovative moment (IM) levels, including reflection. In Leiman's (2012) metamodel of the psychotherapy process, which is presented as a modification of the APES scale, the notion of an observer position is given a central place. In Leiman's reading of the assimilation model, an observational stance is reached already at Stages 2 (vague awareness) and 3 (problem formulation), which then creates the potential for Stage 4 (insight).

The assimilation model does not, however, elaborate on the definition of reflexivity and within research on the model there is limited investigation into the development of reflexivity. Our supposition is that first-level reflexivity (as defined above) needs to be generated already at Stage 2 for a transition to Stage 3 to be possible. We would not expect reflexivity in this sense to be present at the outset of Stage 2 or to be a defining feature of that stage, but we are asking how the processing of problematic experiences in Stage 2 paves the way for a transition to Stage 3. Should reflexivity as a marker of Stage 3 be explicated as presenting the kind of metaobservational stance outlined above as a feature of second-level reflexivity? In addition, should turning onto oneself be seen as an important goal for therapeutic work with clients entering therapy at Stage 2? The main feature of this stage is that the client feels badly but has only a vague sense of why. Reaching a clearer formulation of the problem (Stage 3) would seem to ask for an increased emotional preparedness to look at those bad feelings as parts of the self.

Progress in Assimilation and Therapist Responsiveness

Research shows that the assimilation process does not progress in a fixed or systematic manner; rather, there can be regressions to earlier levels alongside sudden gains (Honos-Webb, Stiles, & Greenberg, 2003). According to Caro Gabalda and Stiles (2013), the causes of setbacks in assimilation appear theoretically and clinically sensible, and can be seen as expected consequences of active therapist interventions, often characteristic of directive therapies. Stiles, Honos-Webb, and Surko (1998) already showed that the therapist's responsiveness and sensitivity to the client's readiness to

utilize the interventions used is vital for the therapeutic change process. In line with this, Leiman and Stiles (2001) have proposed that the dialogical space in which the positions of therapist and client appropriately meet, and in a manner that advances the client's self-awareness, could be defined in terms of the Vygotskian concept of a zone of proximal development (ZPD). The therapeutic ZPD can be understood as a region between the client's present APES level and the level that the client can achieve in collaboration with the therapist. Thus, the therapist's responsiveness to the client's ZPD is thought to be essential in a successful therapeutic process (Caro Gabalda & Stiles, 2013), and therapy is most likely to be effective when working within the therapeutic ZPD (Ribeiro et al., 2014).

In spite of the theoretical significance of reflexivity, empirical studies examining its meaning and specific connection to the assimilation are scarce. Research particularly on the progress of assimilation within Stages 2 and 3 or on the transition from Stage 2 to Stage 3 is very rare, with certain exceptions (e.g. Caro Gabalda, Stiles & Ruiz, 2015; Gonçalves et al, 2014; Meystre, Kramer, De Roten, Despland & Stiles, 2014). Accordingly, in this case study we asked how, for one participant in a therapy group, progress in assimilation at Stage 2 and if progressing to Stage 3 was connected to increasing reflexivity, and how the connection between the two could be seen in the context of a semistructured model of group psychotherapy. The group format did restrict the degree of customization the therapist could achieve for each client's therapeutic ZPD. Hence we expected to find both matches and mismatches in client–therapist positions, in other words, a variation in therapist responsiveness, even in successful cases. We looked at more and less successful therapeutic actions, and asked how these functioned in respect

to enhancing reflexivity and assimilation of problematic experiences within this particular group therapy setting.

Method

Participants

Miia (a pseudonym) was chosen from among our original 17 participants from two therapy groups (n = 10 and n = 7). The two groups were carried out in two subsequent years, one group at a time. In this naturalistic study setting, all clients referred themselves for treatment in response to an announcement in a local newspaper. All clients met the DSM-IV (American Psychiatric Association, 1994) diagnostic criteria for social phobia and gave informed consent for participation in the study. The therapy group in which Miia participated had seven members, and they were all females. Miia was an interesting case, because her particular management strategy for social anxiety was to withdraw from other people, which made the group format of treatment challenging for her. Miia was also an informative subject, because she spoke enough in the group conversations to allow for a detailed analysis, which was not the case with all the clients. These were the grounds for choosing her as the client-participant of this case study.

Miia was a woman in her forties who presented with social phobia related especially to performance situations. She had dreamed of a career as a violinist when she was younger, but she eventually pursued another line of work. At the time of therapy, she played the violin in an orchestra as a hobby, which included regular rehearsals and

performances. Miia was single, childless, and lived with her elderly mother, whom she took care of.

The therapist was a male Ph.D. in his fifties, a licensed and experienced psychotherapist. He had developed the particular treatment model used here.

Treatment model

The treatment model applied in the present study was developed at the University of Jyväskylä Psychotherapy Training and Research Centre (Finland). It is a cognitive-constructive, short-term form of group psychotherapy for socially phobic patients. The treatment rationale is based on constructive views, and thus it differs from traditional forms of cognitive psychotherapy. The constructive perspective emphasizes the operation of tacit (unconscious) ordering processes, the complexity of human experience, and the merits of a developmental, process-focused approach to knowing (Mahoney, 1995). Based on an understanding of persons as active subjects organizing their experiences of themselves and their world (Toskala & Hartikainen, 2005), the treatment model highlights the exploration of the individual meanings given by clients to their problematic experiences. Accordingly, the development of client reflexivity is seen as an essential element of the treatment model; one of the therapist's essential goals was to increase the clients' ability to reflect on their inner states and individual ways of experiencing and interpreting these experiences.

The therapy was time-limited, consisting of 12 weekly two-hour sessions. Five therapeutic strategies based on the aforementioned cognitive-constructive model of the constitution of problematic experience and on the therapeutic development of reflexivity

were adopted for the group treatment. The clients were given brief written material concerning the strategy to be used before the particular sessions in question. The first strategy (Sessions 2 and 3) was to recognize the internal, mental process—such as feelings, thoughts, bodily sensations, images—related to the problematic experience of each individual participant. This was accomplished by processing situations in which social anxiety was experienced. Reformulation, the second strategy (Sessions 4 and 5), included reconstruction of the problem on the basis of the individual's own inner process. At this point, both the client and therapist concentrated on the way in which the problem was constructed and what was most essential in the problematic experience, including possible explanations for it. In the third strategy (Sessions 6 and 7), the idea was to reconstruct an alternative relation to the individual's problematic experience. The goal was a more permissive and accepting attitude towards oneself and towards one's own inner experience, which would enable the integration of the problematic experience with the self.

The fourth strategy (Sessions 8 and 9) was to explore and clarify how the problematic social phobic experience appears in present adulthood attachment relations. With the fifth strategy (Sessions 10 and 11), the group contemplated the problematic experience in each client's early attachments to parents and other significant adults. Clients recalled significant experiences from their childhood and youth to which they had an emotional connection.

The treatment could be characterized as individual therapy offered in a group setting, because the clients were invited in turns to deal with their feelings and experiences related to the issues in question, mainly in dialogue with the therapist.

Occasionally the clients did comment on each other's talking in the group. There was also a psychoeducational component in every meeting, in which the therapist clarified the strategy in question and outlined the clients' experiences related to it, making a summary of them on a flipchart.

Data

The data consisted of all of the client-participant Miia's turns expressing the voices of her main problematic experience in 12 sessions, all videotaped and transcribed, along with all replies by the therapist in direct connection to them. In all, these constituted 25 pages (out of 42 pages in total—all of Miia's turns in the discussion). All analyses were made from the original Finnish transcripts. Extracts from the data have been translated into English for presentation in this article.

Analysis

The analysis consisted of three parts. The first part followed the steps of assimilation analysis (Honos-Webb et al., 2003). Two particular voices were identified in Miia's conversational turns related to her problematic experience with social anxiety, which involved feelings of inferiority, indifference, and a need for support from others. The voices reflected Miia's efforts to cope with her social anxiety by showing seeming autonomy and self-sufficiency, a typical pattern for people with social phobia. All passages of speech relevant to the expression of the voices were extracted from the text. In these passages she spoke about her feelings of inferiority and indifference, her need for support, and her efforts to manage with those feelings. Twenty-five such passages were identified.

Voices can be recognized by their content, their verbal and vocal characteristics, and also by the dialogical patterns that they establish towards the other mental states, for example, by their response or attitude towards the other voices in that same individual (Osatuke et al., 2004). In this study, the dimensions used in distinguishing the two voices were partly taken from Osatuke, Stiles, Barkham, Hardy, and Shapiro (2011), also depending on the evidence available in the transcript. The first author distinguished the two voices by their content (what the voice talked about), intentionality (the voice's apparent reason for speaking), affect (specific emotions associated with the voice), and triggering characteristics (contextual events that seemed to elicit the expression of the voice). The two voices were named and characterized as follows:

The Detracting Voice (dominant): "I am unworthy. I must not imagine that I would matter to anyone, and I have to manage on my own."

The Needy Voice (nondominant): "I am worthy of love. I want to be accepted as I am, including my sensitive side and idiosyncrasies. I need support and approval from others. It's okay to have my needs met."

How Miia assimilated these voices throughout the therapy process was assessed by the first author and two students majoring in psychology. This assessment included APES ratings of all 25 conversational passages in which Miia processed her problematic experience as expressed by the voices.

As a second part of the analysis, we concentrated specifically on a sequence of 13 consecutive passages where the assimilation process was mainly at APES Stages 2 (vague awareness/emergence) and 3 (problem statement/clarification), with two exceptions where Stage 4 was reached. The length of the passages varied from 15 to 106 lines.

Progress in assimilation within and from Stage 2 to Stage 3 was found in passages from Sessions 4 to 7. After that, from Session 8 onwards, Miia mainly processed her problematic experience at APES Stage 4 or higher. There was, however, one regression to Stage 2 in a later session.

In this second part of the analysis, performed jointly by the three authors, two questions were asked in regard to each of the 13 passages:

(1) Does the assimilation process progress in this particular passage?

An affirmative answer to this question included both progress within the APES stage as well as progression to a higher APES stage. Progress within a stage was defined as processing which moved towards the next stage of assimilation without fulfilling the criteria of the next stage in the APES scale.

(2) Is the client taking a reflexive stance in this particular passage?

The criteria for a reflexive stance was that the client turned onto the self in her speech, recognizing her own inner processes and analyzing the representations based on these processes. For an affirmative answer to Question 2 it was sufficient that the first part of the criteria, turning onto the self (i.e., first-level reflexivity) could be recognized in her speech.

On the basis of the aforementioned observations, in the third part of the analysis the first and the second author performed a detailed consensual qualitative analysis of how the therapist's interventions in three representative instances the therapist's responsiveness facilitated or failed to facilitate the assimilation process of the client and her growing reflexivity. We focused especially on the therapist's role, focusing on how he tried to help the client to take a reflexive stance. We also focused on which voices were

addressed by the therapist and how these particular voices responded to the therapist's attention.

Reliability

As a reliability check for the assimilation analysis, the assimilation levels for the client's two voices were determined by the first author and independently two additional judges: two master's students psychology working in tandem. The students familiarized themselves with the literature on assimilation analysis and were supervised by the first author. The students met with her every two weeks for six months to discuss the method and the data. It was during this six-month period that the first author and the students conducted the analysis. The intraclass correlations coefficient (ICC), for all 25 passages, between judges was 0.874, signifying excellent agreement (see Fleiss, 1981).

As a credibility check for the rating of the 13 passages concerning the assimilation process and reflexivity, the three authors separately answered Questions 1 and 2 from above for each passage. Then, in a consensus meeting, all ratings were discussed. The ratings are presented in Table 1. For the ratings of whether the client showed reflexivity 9 out of 13 were unanimous. For the ratings of whether the passage showed progress in assimilation, only 5 out of 13 were unanimous. This greater discrepancy was mainly due to differences in the definition of progress: whether it should be understood as movement to the next stage of assimilation or as progress within a stage. In the consensus meeting, the latter definition was adopted. After this, the raters had no difficulty in agreeing on the final ratings when they jointly reviewed all the passages for which they had earlier shown discrepancies. The final ratings were reached consensually.

[insert Table 1 about here]

For the third part of the analysis, the first two authors looked at the contributions of the therapist to the client's progress in assimilation and increasing reflexivity (or the lack thereof). Detailed accounts of three conversational episodes are included in this article. The inclusion of extracts from the original data, although translated into English, gives the reader the possibility to appraise the trustworthiness of the analysis.

Results

Assimilation of problematic experiences

Miia's problematic experience of social anxiety took its expression in the restricted assimilation of two voices. One dominant voice, the Detracting Voice, defended against and aimed to exclude a nondominant and problematic one, the Needy Voice. The Needy Voice conveyed Miia's wish to be accepted as well as to receive support and approval from others, even when perceived as being weak and sensitive. When using this voice, she expressed that she wanted to feel that she belonged with other people and that someone would take care of her. The Needy Voice was problematic because it represented a part of Miia's self that was different from the dominant community represented by the Detracting Voice, which conveyed her feelings of unworthiness. Miia's solution for these difficult feelings of unworthiness had led to her trying to manage on her own, which also reflected her Detracting Voice. The Needy Voice expressed Miia's feelings of loneliness

and sometimes even her experiences of being abandoned, when her Detracting Voice dominated the internal community.

Miia's assimilation of the two voices was rated at APES Stage 2 in Session 2, and it gradually progressed to APES Stage 6 by Session 11 (see Figure 1), and was rated as Stages 6 and 5 in the last two sessions. In Sessions 4 to 7, she worked towards a clearer statement of her problematic experiences, and then, from Session 8 onwards where the assimilation level was mainly on Stage 4 or higher, the dominant and the nondominant voices built meaning bridges and started to understand each other. She could see the connection between her neediness and her detracting attitude towards herself as grounded in her mother's dismissive stance and expressed her belief that she could only be accepted by others as highly competent.

[insert Figure 1 about here]

In the second part of this section we show how taking a reflexive stance was connected to progress in assimilation from vague awareness (Stage 2) to clarification of the problem (Stage 3). In the third part we present selected extracts from the conversations in the therapy sessions in order to show in detail how the dialogue between the therapist either hindered or allowed for reflexivity and progress in assimilation to occur within Stage 2 and during the transition from Stage 2 to Stage 3.

Reflexivity and progress in assimilation

To assess the connection between reflexivity and progress in assimilation, we looked at the 13 passages from Sessions 4 to 8 in which Miia expressed her Detracting and Needy voices while mainly at Stages 2 or 3. We did not include the first appearance of the voices at Stage 2 in Session 2, because the actual processing of them did not start until Session 4, nor the one drawback from Stage 4 to Stage 2 in a later session (see Figure 1). Looking at the selected sequence in Sessions 4 to 8, it is noteworthy that Miia reached Stage 3 by Passage 3, from Session 5 (see Table 1; the numbering of the passages corresponds to those in Figure 1), but regressed to Stage 2 in Passage 4 from Session 5 and stayed there during the next three passages (Passages 5, 6, and 7 from Session 5).

Table 1 shows whether each of the 13 passages included reflexivity on the part of the client and/or progress in assimilation. As mentioned in the method section, both a movement towards higher assimilation within a stage and a transition to the next stage were rated as progress. In 10 of the passages, reflexivity and progress in assimilation either were both present or were both lacking concurrently. This was the case for 8 of the 11 passages were the level of assimilation was at APES Stages 2 or 3. There were three (3) exceptions: Passages 9, 11, and 13. In these, Miia took a reflexive stance towards the issues at hand, but the assimilation process did not progress. In these passages, Miia's processing was at Stage 2 (Passage 11) and Stage 3 (Passages 9 and 13)**.** There were no passages (0) in which the assimilation process progressed but no reflexivity was shown.

Therapist-client positions and therapeutic change

The three episodes from the therapeutic dialogue between the therapist and Miia that we consider below were chosen in order to show different approaches taken by the therapist

to promote Miia's readiness to take a reflexive stance, as well as her responses to them.

Episode 1 is from Session 4, in which the clients' task was to contemplate why they experienced tension in social situations or what particular factors made the experiences so problematic for them. In the passage below (Passage 2 in Table 1), it is Miia's turn to consider the issue in question. Here she is at Stage 2 (vague awareness), and the problem is not yet clearly defined. In this and all subsequent passages, utterances identified as representing the Detracting Voice are marked with (DV) at the end of the sentence and those representing the Needy Voice are marked with (NV). Utterances showing reflexivity are written in bold.

Miia: I would like to belong to a totally different kind of group, to which I don't belong (NV).

Therapist: Mm-m.

Miia: A kind of a little better crowd (NV).

Therapist: Mm.

Miia: A crowd of more intelligent and capable people, like one would really feel that here I belong (NV), and then one always realizes that I don't belong here because they know much more (DV), and when somebody says something…

Therapist: Mm.

Miia: …they quickly understand what he says. I still ponder things too much on my own.

Therapist: Mm-m, mm. M-hm.

Miia: Well.

At the opening of the passage, Miia in her Needy Voice told about her wish to belong to a "different kind of group," a group of people she considered to better than she

herself was. The intentionality of the Needy Voice was apparent in the expression “like one would really feel that here I belong.” Immediately after that, the Detracting Voice reminded her how she always realizes that she does not belong, because those others know and understand so much more. The therapist reflected on this as follows:

Therapist: So that is connected to these kinds of demands that are unconditional, strict, and severe. It’s not just a kind of creative wish that it would be nice to grow in this or that respect, but it’s as you, as you really, you define even your basic quality as a human being through such things. And that is an endless path. There is no end. Because when you would be there in the other, the better crowd, there would be upon it yet another crowd, and you would have to aspire for it and so on.

Miia: Yeah, but one couldn’t get there (DV).

Therapist: Mm.

Miia: And not to the previous one either (DV).

Therapist: Mm. OK, that’s why you are anxious or feel distressing anxiety, when you, in your own opinion, don’t meet these kinds of standards and these kinds of very strict, absolute standards. OK.

The therapist in his response commented on how Miia, when talking about others as “better” and “more intelligent,” expresses unconditional and severe demands on herself. He highlighted his point of view by saying that Miia even defines her quality as a human being in this way. The therapist accentuated the futility of such an endeavor by saying how it is an endless path of always wanting to be in better and better crowds. In this way, the therapist articulated and challenged the way of thinking represented by Miia’s Detracting Voice. It is noteworthy that the therapist in no way, however, addressed

the actual wish of her Needy Voice to "really" belong to a group of people.

As can be seen, Miia did not comment at all on the perspective offered by the therapist. She only responded by saying "but one couldn't get there," a statement that represented her Detracting Voice. The therapist's confrontation of the severity of Miia's Detracting Voice did not help Miia to achieve a reflexive position. She stayed in a nonreflexive stance, experiencing herself as unworthy, not fitting into "the better group of people". The confrontation appeared to work for the therapist as a conclusion about Miia's particular way of relating to social situations, but it did not help Miia to recognize the demands stemming from the Detracting Voice. Nor did it lead to progress in the assimilation process; she remained at APES Stage 2.

In the episode 2, taken from Session 5 (Passage 3 in Table 1), Miia describes her feelings of being rejected and worthless and eventually makes a problem formulation. When talking about "coming to a standstill," Miia refers to an expression that the therapist had used earlier when encouraging clients to adopt a reflexive, observational position in problematic situations:

Miia: Well, I could, considering my coming to a standstill… I was wondering here by myself about it. Well, I thought like this that if one starts to, well, think about the situation and tries then in that way somehow to get over it, **then at least I feel like that, that I should then feel that I am an accepted person**, **and the kind that I could hold that, that I am somehow a proper person, and… (NV)**

Therapist: Yeah.

Miia: …somehow good (NV). **But if I feel as I feel, that I'm a little bit odd and strange in people's opinion, and that if I were to die then no one would even notice it**

for the next six months that I'm dead (DV), and like that, then there is not really any kind of support where one would get strength then. Then, well, to get rid of this kind of, because…

Therapist: Aha.

Miia: …nevertheless **this anxiety is based on a kind of, I guess, that one feels that one is not an accepted person**.

Miia stated that her social anxiety is based on her experience of not being approved by others. She reflexively recognized her Needy Voice, but in the demanding manner ("I should then feel that I am an accepted person"). Then Miia expressed her wish "that I could hold that I am somehow a proper person and somehow good," conveyed by her Needy Voice, now lacking the former demanding manner. Here the dominant and the nondominant voices are almost talking to each other, sharing each other's points of view: The former takes the approval of others as a condition (that cannot be reached), while the latter sees it as a wish. Then Miia continued by describing her feelings of being "a little bit odd and strange in people's opinion, and that if I were to die then no one would even notice it for the next six months," which represented the Detracting Voice's feelings of unworthiness, the reason why Miia thought one should manage without needing others. Miia's assimilation reached Stage 3 as she formulated her problem by recognizing her painful feeling that was now understood by both voices: "This anxiety is based on a kind of, I guess, that one feels that one is not an accepted person." The problem, at this point, was formulated from the point of view of the Detracting Voice expressing the thought that she is not accepted.

Then she continued as follows:

Miia: And then when one goes to that kind of, even to a pleasant situation, well, well **then, there comes this kind of thought that one is in the wrong place and it would be better that one wouldn't be there, and maybe even better that one wouldn't even exist, that one would have died already as a baby (DV), then one would have, well. So these kinds of feelings I have. So one feels that it's terribly hard to struggle then against that kind of feeling. That it, it's kind of natural, so it just comes.**

Therapist: Mm-m

Miia: And it's, if it's this kind of special… In just the kind of ordinary grey situations I manage, but if there's even a little of that kind of, more lively and more interesting, and that kind of where one would like to be along (NV), well then, **one feels how boring and unpleasant a person one is, and that kind which people would rather like to move aside so that they would have more fun (DV).**

Therapist: A-haa

Miia: Or I don't know if that's it, but anyway **this is how I feel on my part**.

Therapist: Yeah, that sounds terribly sad.

Miia: Well, it is.

Therapist: Mm.

Miia: **But that is how I feel**.

Here it is noteworthy that Miia further described, without any interruption or questioning by the therapist, the Detracting Voice's side of the experience, especially the experience of being a little bit odd and weird and, because of this, not approved of by others. The therapist was empathic to Miia, mainly listening, but saying finally how sad it sounded when Miia described her experience and feelings. Miia accepted this formulation

and actually used the word “sadness” many times in later therapy sessions when describing her feeling in the Detracting Voice. She had not used that word in earlier sessions. Through these descriptions and by giving words to her feelings, in this passage Miia reached a reflexive stance as she turned her attention towards her own way of experiencing and recognized her painful feelings. This particular reflexivity was an instance of first-level reflexivity.

The last conversational episode we present (Passage 8 in Table 1) is from Session 6. Here Miia continued dealing with her sense of being ignored as she and the therapist talked about Miia’s experience that other people despised her. Miia was telling how she lived, surrounded by people who judged and disapproved of her. Here she is referring to the therapist’s former psychoeducational talk, where he had emphasized the clients’ possibilities to form an alternative, less troublesome relation to their own problematic experience.

Miia: **But I think like this, that if one all the time lives in that kind of negative atmosphere… (DV)**

Therapist: Mm.

Miia: …**that you are being disapproved of, evaluated, and people are that kind of negative (DV), then it’s terribly hard to start to think in that way.** You really have to make an effort that you try to think that it isn’t so anyway, that I’m not that kind of what that one implies, but if one then would live in that kind of atmosphere, that one is being approved of, and so then…(NV)

T: Mm.

Miia: …then it would seem that it’s much easier to experience oneself that, oh, I’m quite

that kind of decent person. (NV)

Therapist: Mm.

Miia: And I'm not so bad and guilty as…(NV)

Therapist: M-hm.

Miia: …or in a blaming atmosphere.

Therapist: Yeah.

Miia: I don't know.

Therapist: But how do you, Miia, think? Isn't partly this atmosphere of blame, isn't it maybe partly, however, something that we ourselves construe?

Miia: Well, it could be so also, that one construes that…

Therapist: Yes.

Miia: …one is being blamed, though one isn't.

Therapist: Yes, we, we have a kind of sensitivity to notice these kinds of things then, if we have inside this kind of, have a negative relation to ourselves.

Miia: Mm.

Therapist: So then we kind of think that those others also, when I'm in this way in relation to, I don't approve of myself, others don't either approve of me. And you don't know what those other people are in relation to you.

Miia: Mm.

Here Miia's Detracting Voice expressed that being despised by other people made her feel herself to be an insignificant person. The therapist responded to this, inviting Miia to adopt a second-level reflexive stance, by implying that it was primarily Miia herself who was despising herself, not other people, and that she herself interpreted how

other people related to her. However, he formulated his comment as a question and in a softened mode by using the inclusive word *we* (e.g., "something that we ourselves construe"). Miia responded to this by admitting that this could be true, but she did not yet apply the idea directly to herself. She stated more generally: "One construes that one is being blamed though one isn't." The therapist continued to gently offer Miia a reflexive stance by talking about our "sensitivity to notice these kinds of things." It is noteworthy that he did not ask about Miia's possible actual experiences of being despised, but right away offered the idea of it being a subjective interpretation.

As the conversation went on, the therapist brought up alternative ways in which other people might relate to Miia. When Miia considered these alternative positive ways, the Needy Voice could emerge:

Therapist: They (other people) have a very, as I said, they have surely very different kinds of attitudes towards you, as towards anyone of us any other person has.

Miia: Mm. **But still I think so, that when you have met sometimes some person, whom you have, who has been that kind of a person whom you… (NV)**

Therapist: Mm.

Miia: …**yourself appreciate…(NV)**

Therapist: Yeah.

Miia: …**then that person has treated you quite as…(NV)**

Therapist: Mm.

Miia: …**you would be somehow nice, and kind of, like personal, and like that kind of person who can be approved…(NV)**

Therapist: Mm.

Miia: …**then it immediately feels like that you would have enough strength to do whatsoever after that.(NV)**

Therapist: That's right.

Miia: For a while…

Therapist: Yeah, yeah.

Miia: …after that kind of encounter.

Therapist: Yeah, yeah, yeah, yeah. So you are kind of talking about that, that you have a kind of an enormous, this, this kind of hunger for encounter.

Miia: **Apparently I need some approval…(NV)**

Therapist: Mm.

Miia: …**and this kind of friendly treating…(NV)**

Therapist: Mm.

Miia: …**that**…

Therapist: Mm.

Miia: …and kind of just like that, that it comes kind of spontaneously, that I see that it comes from, came from that person quite really truly, and then these kind of a little bit stranger people, who probably…

Therapist: Yeah.

Miia: …don't know, that **there is like a need to be approved of (NV)**, that they just approve just like that, straight away.

Miia's Needy Voice emerged as she thought of situations in which she had felt approval. She described how meaningful these kinds of encounters had been for her, and how afterwards she had felt she had enough strength to do anything. After this, the

therapist responded to Miia's Needy Voice. He reflected and commented with empathy on Miia's hunger for meeting with other people. At this point, working within Miia's therapeutic ZPD, the therapist offered reflexivity on the first level. Miia could benefit from this intervention and then defined her problematic experience more clearly, and in her own words; it was all about her need for other people's approval. Here Miia became aware of her need for support as a problematic voice in her community of internal voices, and the occurrence of the problematic voice was more visible in this passage. Her dominant Detracting Voice could not approve of this need, since it contradicted the voice's conviction that she was unworthy. Now Miia was able to formulate and express this need aloud, after the therapist had reflected on it. At this point, Miia reached APES Stage 3 again and now more firmly. Except for two regressions to Stage 2, she now started to process her difficulties on APES Stage 3 and higher (see Figure 1).

Discussion

In this study, we looked at how progress in assimilation was connected to increasing reflexivity in the case of one client with social phobia who participated in short-term, semistructured group therapy. We also had a special interest in the contribution of the therapist's actions to the change process, keeping in mind that the group format puts restrictions on the degree to which the therapist can customize his or her interventions.

From the point of view of assimilation, this was a successful case in which the client progressed from APES Stage 2 to Stage 6 during the course of the treatment. A

detailed analysis of all passages in the therapy conversations where she mainly processed her problematic experiences at Stages 2 to 3, before reaching a more stable level of assimilation at Stage 4 or higher, revealed that progress in assimilation happened only when the client took a reflexive stance towards her inner experiences or outer actions. There were a few instances in which she took a reflexive stance, but no progress in assimilation could be noted. Thus, in the sense of taking an observational position in respect to the self, reflexivity appears to be a necessary condition for progress in assimilation at those stages. This finding supports the claim that the client's reflexivity is generally a central factor in successful therapy (Rennie, 2004; Toskala & Hartikainen, 2005) The finding by Goncalves et al. (2014) that innovative moments identified as reflection occurred in both good and poor outcome cases indicates though that occurrence of reflexivity in the client's utterances is not sufficient to enhance assimilation beyond APES Stage 3.

It should be noted, however, that in the particular case of this study, the close connection between increased reflexivity and progress in assimilation could be attributed to the structure and the strategy of the treatment model. In the model the development of client reflexivity was seen as an essential active element of the intervention strategy. It is possible that the emergence of client reflexivity already at stage 2 happened because it was targeted at by the therapist, and would not appear in some other therapeutic modality. This is a question that we cannot answer in this study.

We looked in detail at three episodes of exchanges between the client and the therapist. In the first one, in which the client was at APES Stage 2, the therapist offered a formulation of her problematic experience which was relevant to the intention of her

dominant voice, but did not in any way address the feelings behind the dominant voice or her nondominant, problematic voice. This did not lead to any increase in reflexivity or to progress in assimilation. In the second episode, the client herself formulated in an experiential way her dominant self-detracting voice, especially its feelings of unworthiness. The therapist responded by listening empathically and expressing his sympathetic reaction. This appeared to help the client adopt a new emotional relationship to her dominant voice and to formulate her problematic experience in a manner that allowed the nondominant voice to also be heard. In the third episode, the therapist, in a rather confronting but simultaneously softened mode, pointed to the significance of the client's own construction of her problematic experience. This led the client to formulate her nondominant voice more vividly and to take a reflexive stance towards the discrepancy between the two voices.

When considering these episodes, one can notice the importance of the therapist's responsiveness (Stiles, Honos-Webb, & Surko, 1998) and sensitivity to the client's readiness to receive his or her perspective. When the therapist incorrectly evaluated the client's ability to accept the point of view that was offered, as happened in the first episode, the assimilation process did not proceed. This was a clear example of working outside the client's therapeutic zone of proximal development (ZPD; Leiman & Stiles, 2001; Ribeiro et al., 2014), in which premature exposure to the therapist's conclusion, meant to increase the client's reflexivity, can actually be counterproductive. It is possible that such a mismatch can happen more easily at Stage 2, where the client is aware of the problem but cannot formulate it clearly or reflect on it. Accordingly, this presents a special challenge to therapists in terms of how they receive the material that the client is

offering at this particular assimilation stage.

At this early assimilation stage, when directly prompting the client to take a reflexive stance is premature, what the client actually needs is empathy. In the second episode, simply naming a feeling turned out to be productive. Expressing empathy is indeed important and has been recognized in many theories. For example, in the process-experiental approach (Greenberg, Rice & Elliot, 1993) empathic understanding serves to enhance the client-therapist relationship, to offer prizing and support to the client, and to underline emerging issues. According to Toskala and Hartikainen (2005) construing a new meaning is easier when emotionally charged experiences are activated. In our case, however, showing empathy alone led only to temporary progress from Stage 2 to Stage 3. Advancing to Stage 3 in a more stable way took place after more work on clarification and reconstruction had been done, as shown in the third episode. To enable the client to move from Stage 2 to Stages 3 and 4, it was important that the therapist and the client shared the expression of all the voices, both the dominant and the nondominant, problematic ones. Tikkanen, Stiles, and Leiman (2013) also stated that an observer position allows a flexible exchange between the perspectives of self and other. Their findings demonstrated the parallel development of intrapersonal and interpersonal empathy, the former being significant in our case. Our results seem to support Kramer and Meystre's (2010) observation that taking sides is not helpful for the client. They suggested that supporting marginal voices unilaterally, without supporting the other communities of voices, does not encourage assimilation but tends to trigger only the specific voice. Brinegar et al. (2006) and Osatuke et al. (2007) also observed that the therapist has to honor and reflect all voices.

According to Georgaca (2001), the encouragement of a reflexive position entails the danger that this might silence and dominate the other voices. This would produce an essentially monological self, in which all other positions would be voiced through and mediated by an overarching observer. Georgaca suggests that therapy should perhaps aim not at the replacement of a variety of "I"s with an overviewing reflexive I, but at an interplay between all of these positions, including the reflexive I, in a fluent narrative of self. On the basis of our study, we agree with this view and emphasize the importance of timing in encouraging clients' reflexivity. In addition, the reflexive or observational stance should not be seen as a goal in and of itself, but as one alternative stance that can be adaptively adopted when needed.

The processes of reflexivity and of assimilation at Stages 2 to 3 seemed to appear largely at the same time and alongside one another, although there were a few exceptions. These exceptions appeared in three passages where Miia showed reflexivity, but the assimilation process did not appreciably progress. In one of these three passages, the client was at Stage 2. This is an interesting phenomenon, because reflexivity has been identified as one marker of Stage 3 (problem statement/clarification; Honos-Webb, Stiles, & Greenberg, 2003). In our study, the client had reached Stage 3 earlier, so this can be seen as a temporary regression. Then again, as the definition of reflexivity in the APES model is not detailedit could not be fully compared with our definition. One explanation for our finding could be that the client's first-level reflexivity, that is, taking an observational stance and turning onto the self and recognizing one's own inner processes, might actually be a requirement for him or her to be able to form a clarification of the problem and to move to Stage 3. This would mean that a client may be able to be

reflexive even if she is still at Stage 2 or on her way to Stage 3. Indeed, assimilation is considered as a continuum, and intermediate levels are allowed. For example, 2.5 represents a level of assimilation halfway between vague awareness/emergence (2.0) and problem statement/clarification (3.0). This notion is in line with Leiman's (2012) metamodel of the psychotherapy process, in which an observational stance is regarded as being reached throughout the progression within and between APES Stages 2 and 3 (vague awareness and problem formulation, respectively).

It has been observed that although formulations that lead to building a meaning bridge are frequently offered by therapists, clients often find accurate expressions themselves (Stiles, 2011). This was also evident in our case: The client formulated the final problem statements herself, and the therapist's earlier formulation, although in accord with the client's statements, was not helpful for her assimilation process. This aligns with Rennie's (2000) findings that clients actively lead therapeutic interactions in order to pursue their own goals for the session, often implicitly and without the therapist being aware of it. As Rennie (2007, p. 56) states: "It is reassuring to learn that the clients in good relationships evidently take from the therapist what is useful and transform or ignore the rest, in a spirit of goodwill." Also in our case, although the therapist made an important contribution to the change process, it was eventually the client who relentlessly brought her central issues into the therapeutic conversation, thus giving the therapist a chance to notice them, even after he had initially failed to do that.

There are some relevant aspects of the group treatment format that need to be addressed. Since several clients participate in the group, it restricts the degree to which the therapist can customize his or her actions to the clients' individual therapeutic needs

and readiness to benefit from therapeutic interventions. In addition, there are time limitations, because each client has less time to express his or her issues, and the therapist has less time to pay attention to each individual client. This may put limits on how sensitive the therapist can be in regard to different clients, even though the group format, as was the case in this study, allows for each client to have his or her own interaction time with the therapist.

On the other hand, the group format offers the therapist the possibility for some crucial interventions that are not available in individual therapy. For example, the therapist may use one particular client to illustrate a specific occurrence of an essential issue for the rest of the group. This seemed to happen in episode 1 where the therapist defined the demands that Miia set upon herself as unconditional and too strict. Using Miia as an example, he pointed out a theme common to all the group members, but this then precluded showing sensitivity towards her Needy Voice. Nonetheless, observing how others' issues are dealt with gives group members the opportunity to take a reflexive stance towards their own problematic experiences and how they relate to them.

Our primary conclusion from this case study is that client reflexivity plays a crucial role in the assimilation of problematic experiences, building from problem awareness, through clarification, to understanding and insight based on the emergence of meaning bridges between internal voices. We feel that reflexivity should be given an even more central role in the assimilation model than is the case at present, and conclude that it would be useful to take into account the diversity of the concept, as we have done by specifying the two levels of reflexivity. This would be a suggestion for further research. Second, we noticed the importance of finding a match between the therapist's actions and

the client's stage of assimilation, especially in terms of showing empathic acceptance before working on clarification and understanding. Third, we conclude that the group format of psychotherapy presents some particular challenges to the customization of therapist actions to the clients' process of individual change.

While we recognize the limitations put on conclusions and generalizations derived from a single qualitative case study, and from data based on a limited amount of conversational passages, we look forward to further intensive studies of the moment-by-moment change processes in psychotherapy. In particular, we would welcome further examination of the interrelationship between reflexivity and assimilation, especially in different modalities of psychotherapy and with clients presenting with different problems.

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Table 1. Assimilation Stage, occurrence of reflexivity, and progress in assimilation in 13 conversational passages from sessions 4 to 8

Passage number (cf. Figure 1)	Session number	Assi-milation Stage:	The passage with respect to:	Author 1	Author 2	Author 3	Final:
2	4	2	Reflexivity: Progress in assimilation:	No No	No No	No No	No No
3	5	3	Reflexivity: Progress in assimilation:	Yes Yes	Yes No	Yes Yes	Yes Yes
4	5	2	Reflexivity: Progress in assimilation:	Yes No	Yes Yes	No No	No No
5	5	2	Reflexivity: Progress in assimilation:	No No	No No	No No	No No
6	5	2	Reflexivity: Progress in assimilation:	No Yes	Yes No	No No	No No
7	5	2	Reflexivity: Progress in assimilation:	No No	No No	No No	No No
8	6	3	Reflexivity: Progress in assimilation:	Yes Yes	No No	Yes Yes	Yes Yes
9	6	3	Reflexivity: Progress in assimilation:	Yes No	Yes No	Yes No	Yes No
10	6	3	Reflexivity: Progress in assimilation:	Yes Yes	Yes Yes	No No	Yes Yes
11	7	2	Reflexivity: Progress in assimilation:	Yes Yes	Yes Yes	Yes No	Yes No
12	7	4	Reflexivity: Progress in assimilation:	Yes Yes	Yes No	Yes No	Yes Yes
13	7	3	Reflexivity: Progress in assimilation:	Yes Yes	Yes Yes	Yes No	Yes No
14	8	4	Reflexivity: Progress in assimilation:	Yes Yes	Yes Yes	Yes Yes	Yes Yes

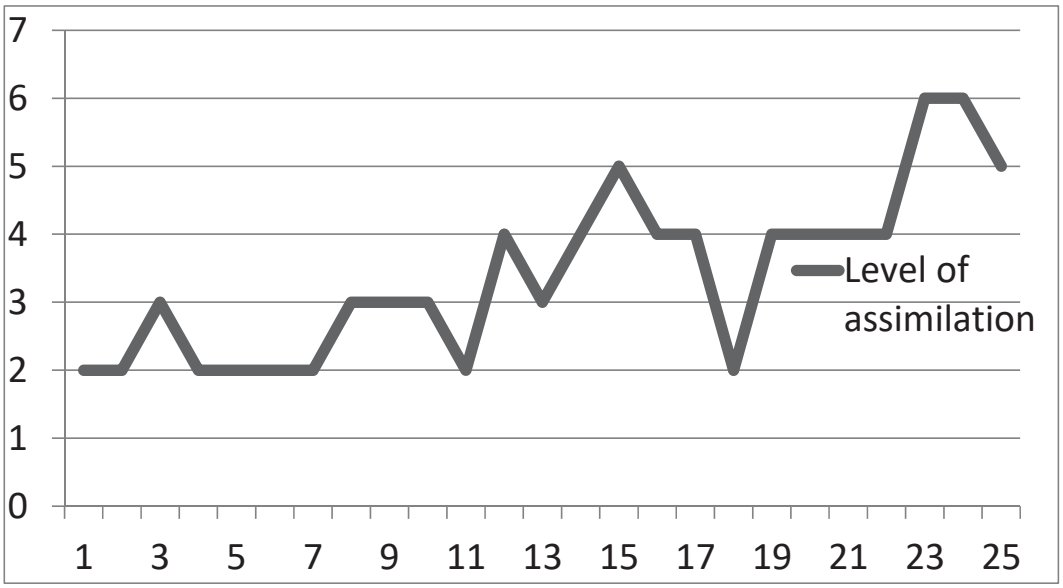

Figure 1. Progress of assimilation through 25 conversational passages. The X axis shows the number of passage and the Y axis the Stage of assimilation.