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Dissertação orientada pelo Professor Doutor Nuno Miguel Silva Conceição

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Abstract

In psychotherapy, it is not uncommon for therapists to leave certain domains of personality functioning untouched (Gross, 1992, 2020). In the present study, participants were allocated to one of four conditions, in which two aim to influence consideration of Gross' approach and principles ("Gross-influencing") and two others did not ("Not-Gross-influencing"). Our goal was to contrast clinicians' preferences when prompted explicitly to influence personality change, by evaluating two principles/action styles of Gross' approach to facilitate characterological change: habit validation (HV), which strengthens the therapeutic relationship but potentially reinforces the habit; and habit interruption (HI), whose goal is to disrupt the maladaptive habit. Previous studies (Lopes, 2018; Vale, 2019) found that clinicians preferred HV to HI. In the present dissertation, clinicians were asked to choose an intervention in reaction to a segment of a real therapy session with a client with a particular maladaptive pattern or habit. Two of the options portray HV, two portray HI, and one novel option that integrates both components is offered as a middle route choice (HVHI). Afterward rating scales were included to understand clinicians' representations of the choice they made, according to five criteria. Participants preferred HVHI over all other options, and we theorize that when HI is embedded in HV, HI is better well-received. Also, participants that chose HI options seemed to be more considerate of the importance of aspects of Gross' approach and there seemed to exist an influence of condition on choice. Possible explanations for these and other findings are discussed and directions for future studies are suggested.

Keywords: personality: process; clinical decision making; psychotherapy integration

Resumo

Em psicoterapia, não é incomum os terapeutas deixarem por abordar determinados domínios do funcionamento da personalidade (Gross, 1992, 2020). Os participantes do presente estudo foram distribuídos por quatro condições experimentais, duas das quais têm como objetivo promover a consideração da abordagem e princípios de Gross ("Gross-influencing") e as restantes duas não ("Not-Gross-influencing"). O nosso objetivo foi contrastar as preferências dos clínicos quando explicitamente incitados a influenciar a mudança de personalidade, avaliando dois princípios/estilos de acção da abordagem de Gross para facilitação de mudança caracterológica: validação do hábito (HV), que fortalece a relação terapêutica, mas possivelmente reforça o hábito; e interrupção do hábito (HI), cujo objetivo é interromper o hábito. Estudos anteriores (Lopes, 2018; Vale, 2019) revelaram uma preferência por HV em detrimento de HI. Na presente dissertação, foi pedido aos participantes que escolhessem uma intervenção, como resposta a um segmento de uma sessão de psicoterapia real com um cliente com um padrão ou hábito maladaptativo. Duas das intervenções representam HV, duas HI, e uma com ambos os componentes (HVHI). Seguiram-se questões para compreender as representações dos clínicos quanto à decisão tomada, de acordo com cinco parâmetros. Os participantes preferiram HVHI em detrimento das restantes opções, e postulámos que, quando a intervenção HI está integrada com HV, a componente HI é mais bem recebida. Ademais, os participantes que optaram por HI parecem considerar a importância de aspectos da abordagem de Gross e parece haver uma influência da condição na escolha. São discutidas explicações possíveis para estes e outros resultados e são feitas sugestões para estudos futuros.

Palavras-chave: personalidade; processo; tomada de decisão clínica; integração em psicoterapia

Resumo alargado

O trabalho com foco na mudança de personalidade e, em particular, com clientes com perturbações de personalidade (PDs), parece apresentar desafios adicionais. Johnson et al. (2018) afirmam que os sintomas e comportamentos comuns nos indivíduos com PDs podem dificultar um envolvimento em terapia colaborativo e eficaz entre terapeutas e clientes, sendo que, segundo Gross (1992, 2020), em psicoterapia, não é incomum os terapeutas deixarem por abordar determinados domínios do funcionamento da personalidade.

Com estes desafios em mente, diversos autores desenvolveram princípios de mudança em personalidade (Clarkin & Livesley, 2016; Critchfield & Benjamin, 2006; Livesley, 2003, 2017, 2018; Livesley & Clarkin, 2016) com o intuito de ajudar os clínicos, orientando-os nos seus processos psicoterapêuticos. Houve também progressos no sentido de identificar processos, como é o caso do processo de reconsolidação de memórias emocionais (Ecker, 2020; Lane, 2018, 2020; Lane et al., 2015), e mecanismos de mudança sugeridos para o trabalho com foco na personalidade (Kramer, 2017, 2018; Kramer et al., 2020).

Subjacente aos princípios, processos e mecanismos de mudança em personalidade, Kramer (2020) identifica a responsividade como um princípio fundamental de mudança em psicoterapia no geral e em clientes com PDs em particular. Por outro lado, a responsividade impõe-se também como um desafio no trabalho com esta população em particular. Um dos motivos prende-se com o impacto dos padrões recorrentes maladaptativos (RMPs) na relação terapêutica (Livesley, 2007) e com o próprio desafio de formar e manter uma boa aliança terapêutica (Johnson et al., 2018; Livesley, 2003).

Ainda, outra razão para o desafio do trabalho do terapeuta com clientes com PDs, é o risco de o terapeuta agir em conformidade com o estilo de comunicação a que o cliente está habituado, em vez de agir como facilitador da mudança em personalidade, RMPs e emoção. O que acontece com as experiências emocionais corretivas (CEEs) é exemplo disso: uma das

explicações para a sua ocorrência é o facto de o terapeuta assumir uma atitude/postura diferente de outras pessoas na vida do cliente (Lane et al., 2015).

Assim, conclui-se que a necessidade do cliente pode não corresponder ao que o cliente perceciona, o que nos leva ao trabalho desenvolvido por diversos autores, que se referiram à psicoterapia como exigindo um balancear de duas possibilidades ou dialéticas, de que são exemplo as seguintes: validação-mudança (Linehan, 1993), suporte empático-mudança (Critchfield & Benjamin, 2006), familiaridade-novidade (Mahoney, 2004), e experiência-significado (Goldman & Greenberg, 2014).

Gross (1992, 2020) contribui para este corpo de conhecimento ao propor uma variação potencialmente relevante destes princípios gerais de mudança, capazes de influenciar a personalidade e adequados ao trabalho com clientes com PDs: validação do hábito (HV) e interrupção do hábito (HI).

A HV é uma ação necessária ao fortalecimento da relação terapêutica, que satisfaz o cliente e mantém a homeostase do seu sistema, mas que pode reforçar o hábito. A HI, pelo contrário, tem como objetivo a interrupção do hábito, e com ela a promoção de CEEs e a facilitação de mudança caracterológica. A HI destabiliza o cliente, algo que Linehan (1993) sugeriu ser necessário, para que, de acordo com Gross (1992, 2020), padrões emocionais mais adaptativos possam tomar o lugar de padrões emocionais maladaptativos.

Esta ação remete para uma distinção importante na teoria de Gross: “texto” e “subtexto”. Estes são dois componentes ou canais de comunicação que ocorrem simultaneamente na interação diádica terapeuta-cliente. O texto é mais explícito e está geralmente no centro da atenção da díade. O subtexto refere-se a aspectos mais frágeis e centrais, que estão ligados à forma emocional como o texto é comunicado. Aceder ao subtexto e explorá-lo torna o diálogo mais útil para o processo terapêutico e permite uma interrupção com a qual o cliente não está familiarizado.

Pretende-se com o presente estudo averiguar as preferências dos clínicos quando explicitamente incitados a influenciar a mudança de personalidade, avaliando os dois princípios/estilos de acção da abordagem de Gross para facilitação de mudança caracterológica: HV e HI.

Os participantes foram distribuídos por quatro condições experimentais, duas das quais tiveram como propósito promover a consideração da abordagem e princípios de Gross (Gross-influencing") e as restantes duas não ("Not-Gross-influencing").

Foi apresentado aos participantes um segmento de uma sessão de psicoterapia real com uma cliente com um padrão ou hábito maladaptativo.

Foram apresentadas aos participantes cinco opções de intervenção consideradas válidas e responsivas à necessidade apresentada pela cliente. Duas das intervenções apresentadas representam HV, duas representam HI e uma representa ambos os estilos de acção integrados (HVHI). O resultado foi um conjunto de cinco opções baseadas em diferentes abordagens que integram diferentes tipos de intervenções complementares: (A) HI Gross, (B) HI AEDP, (C) HVHI EFT, (D) HV CBT, e (D) HV Dynamic. Com base em estudos anteriores (Lopes, 2018; Vale, 2019) que revelaram uma preferência por intervenções HV em detrimento de HI, no presente estudo, foi hipotetizado que os participantes optariam mais frequentemente por uma intervenção HV (Opções D e E), do que intervenções HI (Opções A e B), sendo que HVHI (Opção C) seria preferida às HI e preterida às HV.

Seguiram-se questões de carácter exploratório para compreender as representações dos clínicos quanto à decisão tomada, de acordo com cinco parâmetros: (a) mudança do RMP; (b) mudança emocional; (c) mudança caracterológica; (d) distinção texto/subtexto; e (e) desafiar além da validação.

No presente estudo, mantivemos em mente uma questão empírica: será o não reconhecimento das vantagens de intervir de acordo com a HI na mudança de personalidade e

em clientes com PDs, que deixa os terapeutas relutantes em escolher opções que representem HI; e/ou deve-se esta relutância a um desconforto com a aplicação de HI que pode ser compensado ao associar HV e HI? Os resultados sugerem que se trata de ambos. Por um lado, parece que os terapeutas foram capazes de reconhecer vantagens da HI – os participantes que escolheram HI, parecem considerar a importância de lidar com a emocionalidade subjacente do cliente e de desafiar o cliente de forma responsiva. Além disso, parece ter havido influência da promoção da consideração da abordagem de Gross na escolha tomada quanto à Opção A (HI Gross). Por outro lado, conjugar HV com HI gerou respostas positivas, sendo que o feedback que recebemos foi de maior preferência por esta opção (Opção C), o que pode sugerir uma maior aceitação do componente HI quando está integrado com HV.

As escolhas tomadas são contextualizadas em relação às condições de que provêm os participantes, bem como abordagens que estes referem como sendo influenciadoras da sua prática clínica.

São apresentadas limitações relativamente a alguns aspectos do presente estudo.

Face à preferência pela Opção C (HVHI EFT), sugerimos que estudos futuros investiguem se diferentes abordagens mistas deste estilo de ação terapêutica se traduzem em resultados semelhantes ou diferentes aos encontrados no presente estudo.

Apesar de o conhecimento existente acerca de intervenções adequadas para mudança de personalidade ser significativo, ainda há necessidade de o expandir, de forma a melhorar a resposta dada a clientes que necessitem de algum tipo de mudança na personalidade, como é o caso de indivíduos com PDs. As intervenções HI proporcionam uma oportunidade de mudar padrões profundos e enraizados da personalidade de uma pessoa. No entanto, como constatado em estudos anteriores (Lopes, 2018; Vale, 2019), estas intervenções não são tão bem aceites como intervenções de HV. Como tal, pode ser necessário instruir aspectos da teoria de Gross de forma a possibilitar a aplicação da HI e desafiar o cliente de forma segura e responsiva,

reduzindo a probabilidade de que esta abordagem seja experienciada pelos clientes como contendo julgamento ou como sendo uma tentativa de controlo por parte do terapeuta. Diversas formas são sugeridas para alcançar este objectivo em estudos futuros, nomeadamente, (a) simplificar e tornar mais acessível e compreensível a teoria de Gross, um objetivo praticado por Ferreira (em preparação); (b) treinar os terapeutas em aspectos essenciais da teoria de Gross, como concretizado por Oliveira (2020); (c) promover e influenciar o raciocínio por detrás da conceptualização de caso focada na personalidade e mudança de personalidade, como realizado por Dias (2021), incluindo a teoria de Gross e os seus estilos de ação; e (d) continuar a explorar o processo de tomada de decisão dos participantes clínicos, de forma semelhante à do presente estudo e estudos de Lopes (2018) e Vale (2019), eventualmente incluindo questões relativas aos princípios e processos de mudança em personalidade que os participantes possam identificar.

Visto já ter sido sugerido no estudo de Simões (2018) que a abordagem de Gross é um modelo de psicoterapia eficaz, abonamos a que estas formas de estimular os terapeutas, possivelmente recorrendo a manipulações experimentais, continuem a ser exploradas, não só para aumentar o conhecimento sobre esta abordagem na prática psicoterapêutica, como para testá-la.

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Theoretical Framework

The benefits of psychotherapy have gradually ceased to be an issue to researchers, as it has been shown that psychotherapy produces clinically meaningful changes (Lambert, 2013).

Promoting adaptation and influencing change is the general goal of psychotherapy and it is a hard enough task. Influencing change in personality, particularly in clients with personality disorders (PDs), seems to come with additional challenges, as, according to Johnson et al. (2018), the symptoms and behaviors common to individuals with PDs may make it more difficult for therapists and clients to engage collaboratively and effectively in treatment. To better understand these challenges and how they may be overcome, we must first understand what personality and PDs are, and how they connect to other concepts important to psychotherapy, such as recurrent maladaptive patterns (RMP) and emotion.

Personality, Recurrent Maladaptive Patterns, and Emotion

Caprara and Cervone (2000) have identified several aspects of personality that seem to converge across definitions, one of them being that personality is characterized by a complex system organized by enduring characteristic patterns of thoughts, feelings, and behaviors. A PD reflects an impairment in this organization. American Psychiatric Association (2013) defined it as "an enduring pattern of inner experience and behavior that deviates markedly from expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" (p. 645).

As we can tell, "enduring" and "pattern" are words present in both personality and PD descriptions. These enduring patterns result in personality traits whose definition, according to Roberts (2009), can be captured by repetitions in states, in a circular traits-states causality (Schöller et al., 2018). As Roberts (2009) asserted, this implies that long-term shifts in states have implications for personality trait change. Livesley (2003) related traits to personality pointing out that "Traits form the basic scaffolding of personality. They influence the

development and functioning of most parts of the personality system and shape reactions to most situations." (p. 305). In PDs, these "parts of the personality system" are not integrated, and there may be maladaptive cognitive-affective structures involved (Livesley, 2007). The concept of RMP comes from the Psychodynamic Therapy (PDT) and Psychoanalysis tradition, but it is similar to concepts of other theoretical orientations (e.g., *schemas* in Cognitive-Behavioral Therapy (CBT), or *schemes* in Emotion-Focused Therapy (EFT)) (Lane, 2020b).

RMPs are the product of the patterns encountered in three interpersonal contexts: those found in relationships with the person's family of origin (where the RMPs are originated), their current adult relationships, and the transference relationship with the therapist (Lane, 2020b) – three contexts Malan (1995) has called the "triangle of the person" (p. 90), which were originally developed by Menninger (1958). Because RMPs are expressed in the transference relationship with the therapist, they may impact the therapy relationship itself. This means that RMPs are amenable to change in the context of the therapeutic interaction (Lane, 2020b).

RMPs relate to emotion, as they have a mutual influence on each other. Understanding RMPs can work as a guide to promote emotional change and corrective emotional experiences (CEE) (Lane, 2020a). According to Alexander & French (1946), CEEs happen because more favorable circumstances to experience past emotional situations are provided in psychotherapy, which allows the client to face these experiences differently. These new positive experiences challenge past automatic behaviors (Lane, 2018, 2020b).

Emotional change also promotes change in RMPs, in that it helps update schematic models that determine the client's mental representation of their world (Lane, 2020a). Greenberg (2015a) summed up key findings in emotion research and stated that they become problematic when they are based on a maladaptive emotion schematic memory. Emotional change, then, happens when the access to an alternate emotion transforms the original maladaptive state, and, thus, a new state is born. A premise of Greenberg (2015a) sums up this

process – “emotion changes emotion” (p. 60). This means that the access to an alternate emotion transforms the original maladaptive state, and, thus, a new state is born.

Both RMP and emotional change can be considered key ingredients to enduring change in personality. Thus, in the following section, we turn our attention to personality change and discuss how it may come about, by exploring principles, processes, and mechanisms of personality change.

Principles, Processes, and Mechanisms of Change in Personality

The notion that personality is stable and unchanging has been challenged, and authors such as Clark (2009), defended that personality is more malleable than previously believed, with various authors (e.g., Allemand & Flückiger, 2017; Roberts & Mroczek, 2008) suggesting that change in personality traits can result from specific life experiences and its interpretation.

Also, as Hudson and Roberts (2014) stated, there is now a promising prognosis for attempts at volitional trait change. Hennecke et al. (2014) have dedicated to the study of autonomous personality development and suggested three preconditions for the occurrence of self-regulated personality change. The authors refer that the process is set in action after a person has decided that change is both desirable (Precondition 1) and feasible (Precondition 2). These two preconditions are necessary for self-regulated behavioral changes to occur, after which Precondition 3, “Self-regulated changes become habitual”, is required for behavioral change to be maintained and turn into a stable trait. In psychotherapy, preconditions 1 and 2 require an engagement on part of the client that is not always easy to attain. Resistance is frequently found with clients with PDs (Aafjes-van Doorn & Barber, 2018) and interferes with making progress towards desired changes (Engle & Arkowitz, 2006). Precondition 3 resonates with research on RMPs and PDs (e.g., Allemand & Flückiger, 2017; Ecker, 2020; Gross, 2020), which maintains that changes in personality and RMPs can only become enduring if the new

behaviors are practiced and repeated. Psychotherapy can be a powerful facilitator of this process.

Rogers' (1957) well-known necessary and sufficient preconditions for change in general, and personality change in particular (congruence, unconditional positive regard, and empathy), were an important step to stimulate discussion of how personality may be influenced. They refer to the quality of therapist-client *rapport*, an integral part of the quality of the working alliance introduced by Bordin (1979) which has been supported as a "moderate *causal facilitative factor*" (Flückiger et al., 2018, p. 330, italics in original) for therapy outcomes.

To make sure that psychotherapy indeed facilitates change in RMPs, emotion, and personality, principles of change, described by Levitt et al. (2005) as standards or guidelines whose goal is to regulate conduct in a particular domain, should be considered. Principles of change's utility has to do with them being common to most forms of therapy, which, according to Goldfried's (1980, 2019) view, contribute to overcoming an existing unconformity/disagreement between theoretical and technique levels of intervention. In this sense, they can be considered a form to integrate and reach a common ground. We will now be discussing principles of personality change.

As mentioned earlier, clients with PDs have been known to be resistant to change (Aafjes-van Doorn & Barber, 2018). The challenges of working with clients with PDs led Critchfield and Benjamin (2006) to work on identifying guidelines on how to act therapeutically with these clients. The authors call for a treatment that is tailored to the client, and a setting that conveys safety, which entails establishing a strong alliance, that the therapist is aware of his inner experience, adopts an open-minded flexible and creative approach, and applies a comprehensive treatment to the client by considering the client's recurrent themes and problems.

Livesley and Clarkin (Clarkin & Livesley, 2016; Livesley, 2003, 2017, 2018; Livesley & Clarkin, 2016a, 2016b) also proposed treatment principles to aid in interventions with clients with PDs and developed a transtheoretical approach named Integrated Modular Treatment. In this approach, within therapy conditions for change include a structured treatment process, building and maintaining a collaborative treatment relationship, maintaining a consistent treatment process, and promotion and validation. Patient-related conditions include increasing self-knowledge and self-reflection and building motivation for change. The authors propose an integrative approach in which more structured methods are gradually followed by less structured methods, as domains shift from most amenable to change to less amenable to change. To tackle these intervention modules, different goals are presented in a sequential but nonlinear manner, namely, (1) safety, (2) containment, (3) regulation and modulation, (4) exploration and change, and (5) integration and synthesis.

Implicit in these principles are the needs for the therapist to attain a comprehensive understanding of the client and to adapt and be responsive to the client. In practice, they also reflect a need to follow the client's rhythm, which may require some back and forth movement on the focus of intervention.

Principles are also useful due to their contribution to the understanding of change processes, which usually occur in the treatment session and are considered active ingredients of a treatment that lead to changes in the client (Doss, 2004). Reconsolidation of emotional memories is pointed by authors (Ecker, 2020; Lane, 2018, 2020b; Lane et al., 2015), as the core process of enduring change. The authors propose an integrated memory model which encompasses three inextricably linked components – autobiographical (event) memories, semantic structures, and emotional responses. Lane et al. (2015) explain that, because of these components' link, they allow access to the integrated memory structure by different cues. Any of these elements can activate the memory structure and have the potential of updating other

components via reconsolidation. To use this process can be a guideline, i.e., a principle of change, that should be fostered in psychotherapy to influence personality change.

As we have just seen, principles of change inform change processes. In turn, change processes impact mechanisms of change, which are intermediate changes that have generalized to clients' life outside of therapy (Doss, 2004). Mechanisms of change reflect the processes by which therapy unfolds and produces change (Kazdin, 2009), and are now briefly discussed.

Kramer and colleagues (Kramer, 2017, 2018; Kramer et al., 2020) comprise emotional change (regulation and transformation), socio-cognitive change (mentalizing, meta-cognition, and interpersonal patterns), increases in insight, and change in defense mechanisms as key mechanisms of change in clients with PDs. To detail these mechanisms is beyond the scope of the present study, and, thus, for more information on these dynamic, situation-dependent, and fluid states, we recommend starting with studies by Kramer and colleagues.

A main theme underlying change in personality structures seems to be responsiveness – referred to by Kramer (2020) as being one of the primary principles of change in psychotherapy in clients with PDs. In an effort to adapt interventions and interconnecting them with principles and variables (of the therapist, the patient, and the relationship between both), a chain of reaction can be identified, in which responsiveness impacts processes of change, which impact mechanism, which influence therapy outcomes. Because of its relevance to clinical decision-making, we explore its meaning and usefulness in the next section.

Responsiveness in Psychotherapy

As Caspar (1997) pointed out the kind of therapy by which a patient is treated does make a difference, as certain techniques may be found to be more effective than others depending on the client's characteristics and the clinical problems he/she presents (Goldfried, 2019). As Wampold (2019) puts it, "how a treatment is delivered is more important than which treatment is delivered" (p. 121). "Appropriate responsiveness" is the term used by Stiles and colleagues

(Kramer & Stiles, 2015; Stiles, 2013; Stiles et al., 1998; Stiles & Horvath, 2017) to refer to consistently doing "the right thing at the right time" (Kramer & Stiles, 2015, p. 279).

Responsiveness translates into different actions, and context markers may hint at what the therapist must pay attention to. These markers work within an "if-then framework" (Boswell et al., 2020, p. 3), wherein *if* a marker is observed, *then* the clinician may act in a specific manner. They are client statements or behaviors that alert therapists to aspects of clients' functioning that may need attention (Elliott et al., 2005). Several authors have identified complementary types of intervention to guide therapists' decisions. Goldman (1997) and Kramer (2017) differentiate the internal from the interpersonal world; Kramer (2017) also mentions focus on skills building vs. focus on insight-oriented therapy; and Goldman and Greenberg (2014), too, have contributed with some other formulation decisions: (a) relational vs. task mode, (b) exploring underlying emotions vs. encouraging experience of expressed emotions, and (c) focusing on meaning vs. focusing on emotion.

As addressed, in psychotherapy, therapist and client adapt to each other, and the therapist determines the best way to respond to fit the client's needs. This interaction is essential to the work with clients that present interpersonal issues, such as those exhibited by clients with PDs. Responsiveness can be considered a core principle of change central in working with clients with PDs (Kramer, 2020; Kramer et al., 2020), as work with this population may pose a significant challenge to therapist responsiveness. One of the reasons for this difficulty may be the fact that RMPs can impact the therapeutic relationship itself (Livesley, 2007). As various authors (e.g., Johnson et al., 2018; Livesley, 2003) affirm, one of the most common challenges in working with clients with PDs refers to forming and maintaining the therapeutic alliance and collaborating on treatment.

Another reason for the difficulty may be the risk that the therapist will follow the client's preferred and accustomed style of communication instead of acting in a way that is needed to

facilitate change in personality, RMPs, and emotion. Indeed, one of the explanations given for the important role of CEEs in altering integrated memories is that the therapist assumes a different attitude than the ones from others in the client's life (Lane et al., 2015). Instead of acting in conformity with the client's expectation, the therapist notices the client's invitation to behave as others did, and, through reflection and understanding of the client's past experience, tries to identify what the client needs (Lane, 2020b).

Thus, what the client needs may not be what the client is expecting, and several authors have referred to the work of psychotherapy as demanding a balance between two possibilities, or two dialectics, for change to happen. Linehan's (1993) main dialectic consists of validation-change. Similarly, Critchfield and Benjamin (2006) have called for a balance between empathic support and change. Other authors have also provided their input and called to attention familiarity-novelty (Mahoney, 2004), and experience-meaning (Goldman & Greenberg, 2014). These are some examples of dialectics with the potential to influence personality change and clients with PDs that are part of more habitual and consensual literature. Gross (1992, 2020) contributes to this body of knowledge by bringing to the table a potentially relevant variation of these general principles of change, capable of influencing personality and suitable to the work with clients with PDs: Habit Validation (HV) and Habit Interruption (HI). These general principles arise from a need for responsiveness. In this sense, in certain situations, to challenge can mean to be responsive. Linehan (1993) has stated that it is important to push the client off balance, so that the rebalancing movement that follows is enabled. Gross' (2020) brain-based theory of the mind and personality points to the same process, conveyed in terms of homeostasis. HI has the power of destabilizing the client, so that more adaptable ways of being gradually take the place of maladaptive emotional patterns. This principles of action and Gross' (2020) approach will be elaborated in more detail in the next section.

Zoltan Gross' Approach to Facilitating Characterological Change in Clients with Personality Disorders

Gross (1992, 2020) understands psychological phenomena as a homeostatic process and presents a metatheory encompassing a paradigmatic shift, framed within an Interpersonal/Relational approach, in which personality is seen as the experience of the brain engaged in the process of stabilizing itself.

To maintain equilibrium and sustaining the integrity of neurological systems, validating feedback is needed. If humans are deprived of validating feedback, the brain suffers from what Gross (1992, 2020) called "affect hunger", which is experienced as a feeling of loneliness, and guides moment-to-moment dynamics of all interpersonal relationships, including the therapeutic relationship. In an attempt to satisfy affect hunger, self-presentations are repeated in a non-conscious way. Self-presentations are a set of behaviors a person displays to elicit a validating response from others (Gross, 1992, 2020). Kramer (2020) has also pointed out this tendency in clients with PDs and states that these displayed aspects correspond to less central and less fragile contents and processes.

Although these displayed behaviors are important, more central and fragile aspects should be focused on if we wish to better access and influence personality. To find a balance between both, as therapist and client interact, the therapist must attend to two simultaneous communication channels that occur in their dyadic interaction, which Gross (2020) named these channels "text" and "subtext", or, in Safran and Segal's (1996) words, "content" and "process", respectively.

Typically, the text is more explicit, it sits at the center of the dyad's awareness, and refers to the discussion of non-emotional facts or ideas – it is often experienced with ease. On the other hand, the subtext is attached to the emotional way by which the text is communicated – it is usually in the background of awareness, and it is more difficult to engage in. Text and

subtext may not always match. However, the subtext may be more active/conscious and can be explored, if brought to awareness by the therapist. Doing this may require a skill that entails that the therapist acknowledges and accepts his/her own feelings in the therapeutic interaction to, in Safran and Segal's (1996) words "simultaneously participate in the interaction with the patient and observe the interaction in which one participates" (p. 144), that is, to take a stance of "participant-observer". When subtext is uncovered and explored, the dialogue becomes more therapeutically useful. This is especially important in interventions aimed at personality change, as it implies an interruption that the individual is unfamiliar with.

Given the persistent nature of RMPs, interruption must be a repeated process, to ensure that the resulting changes are enduring (Allemand & Flückiger, 2017; Ecker, 2020; Gross, 2020; Hennecke et al., 2014). Ecker (2020) underlines the need to update previous learnings, through a brain's innate mechanism already mentioned named "memory reconsolidation". In this mechanism, repeated destabilization of a given unwanted learning/RMP, and provision of a counter-learning experience, give way to a newly acquired pattern that can become automatic with practice. Greenberg (2015a) links emotions to memories, arguing that every time a memory is retrieved, the underlying memory trace becomes fragile, allowing for the reconsolidation process to occur.

Both these authors and Gross (1992, 2020) see psychotherapy as a key to interrupt such processes and create more adaptive personality structures. Gross distinguishes between two types of therapeutic actions with clients that require personality change: Habit Validation (HV) and Habit Interruption (HI). HV refers to an action that feeds the client's affect hunger but does not address the person's underlying habit. HI interventions, on the other hand, aim to interrupt the automaticity of self-perpetuating emotionally dysfunctional habits, thus promoting a CEE and facilitating characterological change. Therapists should consider that HI is a riskier action when it is not done in the context of a good enough therapeutic alliance – thus the need for

validating interventions such as HV. HI's utility lies on its capability to better influence change in personality.

Critchfield and Benjamin (2006) found that a focus on empathic support alone could reinforce maladaptive personality patterns. HI offers an opportunity not to reinforce these patterns, but rather to change them. Additionally, as Wu and Levitt (2020) found in their review, challenging the client may be beneficial "when growth is obstructed or when clients are more self-aware" (p. 168). As the authors pointed out, clients may be more open to challenges if certain conditions are provided, viz., if they are emotionally involved in therapy, and if they are becoming increasingly aware of their negative patterns and are more vulnerable in sharing their negative experiences. Gross (2020) considers such conditions and explains that HI happens when the therapist draws attention to something the client is unaware of doing or when the therapist gets emotionally involved with the client. Thus, performing a HI is not a blind action, but rather an action that contemplates factors that allow for the risks of HI to be minimized, and for the potential to influence RMPs and personality to be increased.

Five previous studies were carried out to study Zoltan Gross' approach to psychotherapy. A study from Lopes (2018), that centered on clinical decision-making, showed a preference of therapists to intervene according to HV interventions when compared to HI interventions, even when participants were informed that HI would be the more effective intervention in what concerns characterological change. Vale's (2019) study results seem to be in agreement with Lopes' (2018) and have also shown that therapists tend to lean more on HV interventions, rather than HI interventions.

Simões' (2018) qualitative study aimed to identify processes and mechanisms of change in this approach, through clients' perspectives. The results showed categories of Gross' approach that are present in other therapeutic models, already considered effective, thus suggesting that Gross' approach is also an effective model of psychotherapy. Furthermore,

results showed that, as Gross himself had warned, clients revealed an initial disturbance with Gross' intervention but ended up appreciating the transformation they got from it.

Oliveira (2020) sought to experimentally train therapists to be more open to HI interventions, with a focus on raising awareness of the specific text/subtext distinction component. Results showed no significant association between the "Basic Training Condition" and the "Intermediate Training Condition", and the clinical decision, as Option A, associated with Gross' approach, was not more frequently chosen than the other options. There were also no significant differences between the two experimental groups when it came to participants' perceived usefulness of the exercise to the text/subtext distinction.

Dias (2021) sought to experimentally stimulate clinicians to formulate a case according to approaches that place a bigger focus on personality, one of them being Gross' approach. This approach was not chosen more frequently than the other options.

The Present Study

Even though responsiveness is a core operating principle for clinicians, it remains a problem for researchers, as it stands in the way of the straightforward answers searched (Kramer & Stiles, 2015). Goldfried (2019) identified a gap between research and practice that limits both parties' work. Taking this into consideration, it becomes clear that there is a need for further investigation on how therapists make appropriate choices of interventions in specific circumstances (Stiles & Horvath, 2017), and for research in larger quantitative studies on responsiveness (Wu & Levitt, 2020).

As we have seen, there are possible focus points that can be pursued by the therapist during the psychotherapy process, to provide the client with the most responsive and helpful intervention. Also, based on the model proposed by Lane and collaborators (Lane, 2018, 2020b; Lane et al., 2015), different modalities can access the integrated memory structure through different cues, and, then, the component accessed can update the other ones via reconsolidation.

With this in mind, we sought to understand participants' clinical decision-making processes, when faced with different valid and responsive options of intervention. To that effect, and given that, different techniques, linked to different approaches, can end up affecting the client in similar ways, we came up with five diverse answers, constituted by different complementary types of intervention, all considered to be responsive to the client's presented need.

As we also noted, applying a comprehensive treatment to the client is an essential principle of personality change in the work of psychotherapy (Clarkin & Livesley, 2016; Critchfield & Benjamin, 2006; Livesley, 2003, 2017, 2018; Livesley & Clarkin, 2016a, 2016b), as well as balancing possibilities of action such as acceptance and change (Linehan, 1993), empathic support and change (Critchfield & Benjamin, 2006), familiarity-novelty (Mahoney, 2004), experience-meaning (Goldman & Greenberg, 2014), and validating or interrupting habits (HV and HI, respectively) (Gross, 2020).

Our goal was to identify participants' likelihood to proceed according to the five approaches developed. Two of them pertain to a HV approach, that had a bigger focus on acceptance, empathic support, and strengthening of the therapeutic alliance, but does not address the client's underlying habit. Two others refer to the HI approach, which was aimed at changing emotionally dysfunctional habits and facilitating characterological change. Finally, another option presented to participants consisted of a mix of these two kinds of interventions. Afterward, we determined the preferred approach among the five. We sought to assess participants' decision-making and asked them to base their choice on the client's complaint.

Based on the results of Lopes (2018) and Vale (2019), we hypothesized (H1) that participants would more frequently opt for an HV intervention (options D and E) than for an HI approach (options A and B). We further predicted that option C, which represents a mix of HV and HI interventions, would be preferred to HI interventions, and less preferred than HV interventions.

In the present study, participants were allocated to one of four conditions. We sought to explore if there were differences in the choice made by the participants, according to these conditions. In two of the conditions (Conditions 2 and 3), there was an attempt to familiarize participants with Zoltan Gross' approach, and to influence their decision, choosing more often an intervention that fitted the author's framework. In two others (Conditions 1 and 4) there was not such an influence. We sought to determine whether participants' choice was influenced by the conditions.

Another goal was to examine participants' degree of conviction in the ability of the choice made to respond to five parameters: the perceived effectiveness of their chosen intervention to answer to different aspects that require change or facilitation – (1) RMP change, (2) emotional change, and (3) characterological change –, (4) the degree to which the choice was responsive to the distinction *text/subtext*, as defined by Gross (2020), and (5) the capacity of the choice made to allow to go beyond validation and judiciously challenge the client. We sought to explore how the elements of each group (i.e., participants clustered into the choice of intervention made) appraised the choice they made, according to these same parameters.

We further aimed to a better understanding of the decision-making process of therapists, specifically regarding Zoltan Gross' approach to psychotherapy. For this purpose, additional exploratory analyses were carried out.

Method

Participants

The participants were mental health professionals from any clinical orientation or approach, the majority being psychotherapists (60%) and psychologists (58%). Of a total of 100 respondents, 61% were female and 39% were male. 32% of individuals were from the USA, 27% were from the UK and the remaining sample was constituted by participants from diverse countries.

The mean age of the participants was 56,95 (SD=15,083) ranging from 23 to 86 years old. The participants' clinical experience ranged from 1 to 56, with a mean of 24,808 (SD = 14,101) and a weekly caseload ranged from 1 to 40, with a mean of 16,654 (SD = 8,979).

From 1 to 6, the mean rate for eclectic or integrative orientation was 4,458 (SD = 1,436). Participants had the option of identifying models that influence them in their clinical practice. Out of the 69 participants who answered this question, 50 identified more than one approach. Psychodynamic/Psychoanalytic was the most reported (N = 28), followed by CBT (N = 27), Existential/Humanistic/Experiential/Client-centered (N = 15), Relational/Interpersonal (N = 9), EFT (N = 7), systemic (N = 7), and others.

Procedures and Materials

Data collection was conducted through a Qualtrics Survey Software online platform and was carried out over the course of 12 days. The recruitment of participants was made via an e-mail invitation, using lists from International and European societies of mental health professionals.

Firstly, it was presented to the participants an informed consent (Appendix A), after which the participants received instructions on the task in which they would participate (Appendix B).

It was presented to the participants some information about the client, namely biographic information, complaint, family history, and previous experience with psychotherapeutic intervention (Appendix C). It followed a video that depicted a segment of a session with the client (Appendix D).

The participants were then randomly allocated to one of four conditions. Two conditions focused on a deliberate practice exercise, that gave rise to the dissertation thesis of Oliveira (2020) (Condition 1 refers to a "Basic Training Exercise" and Condition 2 refers to an "Intermediate Training Exercise"; see Appendix E). The other two pertained to an exercise on

case formulation and were the focus of the thesis dissertation of Dias (2021) (Condition 3 refers to a Manipulation Condition, and Condition 4 refers to a Control Condition; see Appendix F). Conditions 2 and 3 had a goal to influence participants to consider Zoltan Gross' approach to psychotherapy.

Afterward, the first video was replayed, and participants of all conditions answered some questions regarding clinical decision-making (Appendix G).

After finishing the tasks, participants were asked to fill in some biographic information and to (optionally) leave a comment concerning their experience with the exercise (Appendix H).

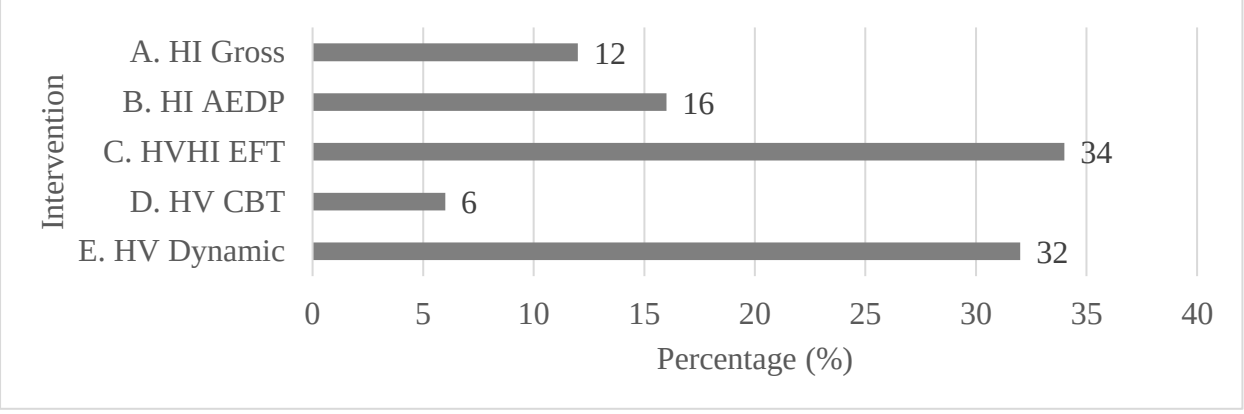
Results

First, normality tests were performed, to determine which tests were more suitable to the data and which to conduct. All variables significantly deviated from a normal distribution.

Regarding H1, which predicts that HV interventions would be chosen more frequently than HI interventions and that the HV and HI mixed intervention would be less preferred than HV but more preferred than HI approaches, Figure 1 shows the distribution of interventions chosen by the participants.

Figure 1

Percentages of Interventions Chosen by Participants



The results show that Option C, relative to the HI and HV mixed intervention, was the preferred among the five (34%), receiving a greater preference than both HV and HI interventions. Unexpectedly, Option D, which was hypothesized to be one of the preferred for being an HV intervention, is the least preferred (6%), with HI interventions surpassing it. Of the two HI interventions, Option A, the one that most resembles a Zoltan Gross intervention, is chosen less frequently than Option B. The other HV option, Option E (32%), on the other hand, was preferred to HI interventions, which goes in the direction of H1. Thus, H1 was only partially supported by the data.

We also explored whether there were differences between the choice made by participants, according to the conditions to which they were allocated: conditions that aimed to dare participants to practice HI or to address the underlying parts of communication as postulated in Zoltan Gross' approach (Conditions 2 and 3, N = 51, labeled "Gross-influencing"), and conditions in which there was no such tentative influence (Conditions 1 and 4, N = 49, labeled "Not-Gross-influencing"). First, we tested whether "Gross-influencing" and "Not-Gross-influencing" conditions were related to the choice made, through the calculation of the Chi-square Test of Independence. As results showed a violation of the assumption that the expected number of frequencies is more than 5, we performed Fisher-Freeman-Halton Exact Test instead. Results showed that there is a statistically significant association between Conditions and choice made (p = ,034). The distribution of participants in percentages is shown in Table 1.

Table 1

Distribution in percentages of the options regarding the choice of intervention made in "Gross-influencing" vs. "Not-Gross-influencing" conditions.

Options	Gross-influencing	Not-Gross-influencing	Total
Option A (HI Gross)	8	4	12
Option B (HI AEDP)	9	7	16
Option C (HVHI EFT)	21	13	34
Option D (HV CBT)	4	2	6
Option E (HV Dynamic)	9	23	32
Total	51	49	100

The percentage of participants that passed through Gross-influencing and Not-Gross-influencing is balanced (N=51 and N=49 respectively). As can be seen in Figure 1 and Table 1, 12 participants chose as their preferred intervention option A, which depicts an approach that most resembles Gross' style of intervening. Option A was chosen by participants from the Gross-influencing condition twice as many times (N = 8) as from participants from the Not-Gross-influencing condition (N = 4).

Option C showed the same tendency, whereas Option E showed an inverted tendency (more frequently chosen by participants from the Gross-influencing condition than the Not-Gross-influencing condition). Option B showed balanced results, and, as for Option D, even though there are twice as many participants choosing Gross-influencing conditions, the number of participants that chose that option is small, and, thus, differences may not be possible to be analyzed.

We created a new variable in which the two HI interventions (Options A and B) were grouped, along with the two HV interventions (Options D and E), resulting in a variable constituted by three groups: (1) HI; (2) HVHI; and (3) HV. Descriptive data of each group

according to parameters “RMP change”, “Emotional change”, “Characterological change”, “Distinction text/subtext”, and “Challenge beyond validation” are presented in Table 2.

Table 2

Mean, SD, and Median for variables “RMP change”, “Emotional change”, “Characterological change”, “Distinction text/subtext”, and “Challenge beyond validation”, according to groups of intervention.

Variables	Groups of intervention								
	HI			HVHI			HV		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
RMP change	3,32	,670	3	3,41	,609	3	3,32	,525	3
Emotional change	2,96	,744	3	3,26	,618	3	2,89	,649	3
Characterological change	2,93	,663	3	2,97	,758	3	2,76	,590	3
Distinction text/subtext	3,36	,826	4	3,21	,687	3	2,76	,820	3
Challenge beyond validation	3,44	,847	4	3,15	,784	3	3,16	,547	3

A Kruskal-Wallis H test was conducted to test whether there were differences between the three groups on each variable measured (i.e., “RMP change”, “Emotional change”, “Characterological change”, “Text/subtext distinction”, and “Challenging beyond validation”). The results of this analysis can be seen in Table 3.

Table 3

Kruskal-Wallis H results for different variables.

Variables	N	Kruskal-Wallis H	df	*p*
RMP change	100	0,719	2	0,698
Emotional change	100	5,661	2	0,059
Characterological change	100	2,049	2	0,359
Distinction text/subtext	100	9,627*	2	0,008
Challenge beyond validation	100	5,491	2	0,064

*$p < 0,05$

The Kruskal-Wallis H test revealed at least one statistically significant difference in the degree to which participants consider the answer chosen to be responsive to the distinction text/subtext differed across groups of interventions (H (2) = 9,627, p = ,008). The group HI recorded a higher mean rank (60,18), followed by the HVHI group (54,10), and, finally, the HV group (40,14). To determine which pair(s) of comparisons yielded significant differences, a pairwise comparisons analysis was carried out. A statistically significant difference between HI and HV (p = ,009[1]) was found. There were no statistically significant differences between HV and HVHI (p = ,090[1]), nor between HI and HVHI (p = 1,000[1]).

The Kruskal-Wallis H test revealed no statistically significant difference across the three groups in the variables “RMP change”, “Emotional change”, “Characterological change”, and “Challenging beyond validation”. However, the difference was marginal for the variables “Emotional change” (p = 0,059) and “Challenging beyond validation” (p = 0,064). As can be seen in Table 1, the highest mean in “Emotional change” belongs to group HVHI (M = 3,26), followed by group HI (M = 2,96), and group HV (M = 2,89). In “Challenging beyond

[1] Values adjusted using the Bonferroni correction.

validation", the highest mean pertains to HI (M = 3,44), followed by HV (M = 3,16) and HVHI (M = 3,15).

Since the three types of change subject to analysis are related, correlations were carried out to analyze shared variance, through Spearman's Rank Order Correlation. The correlation of RMP change and emotional change shows a medium positive statistically significant association (r_s = ,350, p = ,000). A statistically significant medium positive association was found for RMP change and characterological change (r_s = ,394, p = ,000). Finally, the association of emotional change and characterological change is a large, positive, and statistically significant association (r_s = ,654, p = ,000).

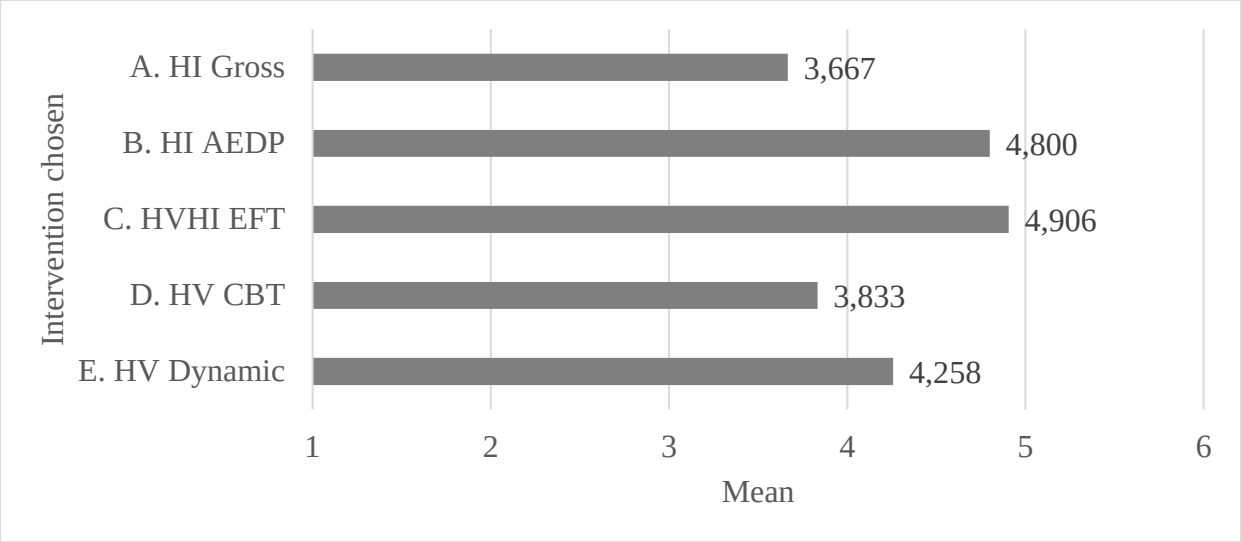
The correlation between "Text/subtext distinction" and "Challenging beyond validation" was also the subject of analysis. A large positive and statistically significant association was found between these two variables (r_s = ,505, p = ,000).

Given the exploratory nature of the present study, more analyses were carried out to investigate the characteristics of the participants that chose each option (see Appendix I for Mean and SD of age, clinical experience, and weekly caseload).

Additionally, means of the extent to which participants, grouped into choice made, consider their orientation as eclectic or integrative were calculated and are represented in Figure 2.

Figure 2

Mean of the extent to which participants consider their orientation as eclectic or integrative, for each choice of intervention made.



As evidenced, overall, participants who chose Option A consider themselves less integrative (M = 3,667) than participants that chose other approaches. Participants who chose Option C, on the other hand, had the highest mean of eclectic/integrative approach, as reported by themselves (M = 4,906), followed by Option B, then Option E, Option D, and, finally, Option A.

As previously mentioned, the participants had the option of identifying models that influence them in their clinical practice. Out of the participants that chose Option A (HI Gross), 9 replied to this question. 7 of them reported having their work influenced by a Psychodynamic or Psychoanalytic approach, 3 of them referred Relational/Interpersonal influence, 2 referred Emotion-Focused Therapy (EFT), 2 referred Transactional Analysis (TA), 2 mentioned Constructivism, and 2 follow an Existential-Humanistic or Client-centered approach.

As for Option B (HI AEDP), the dominant approaches, as with Option A, were Psychodynamic or Psychoanalytic approach (N=4), closely followed by Relational/ Interpersonal approach (N=3).

As for the HV options (Option D (HV CBT) and Option E (HV dynamic)), an influence of Psychodynamic or Psychoanalytic approach is also prominent. In Option D (HV CBT), in addition to Psychodynamic/Psychoanalytic, an equal preference for CBT was observed, but with only 2 participants reporting these approaches influencing them in their work, it may be unreasonable to interpret this data. As for Option E (HV Dynamic), the Psychodynamic/Psychoanalytic approach (N=14) is followed by CBT (N=9) and Existential/Humanistic (N=6).

The most referred approach by participants that chose Option C (HVHI EFT) contrasts with the preference for Psychodynamic/Psychoanalytic present in the other options, with the most reported approach being some form of CBT (N=9), followed by Existential/Humanistic (N=6).

Other approaches were also mentioned by participants that chose each option, but in a lower number, and thus they were not reported here.

Discussion

The present study is the third of a bundle of three studies that were carried out with a common goal to study Zoltan Gross' psychotherapeutic approach, with the other two already completed (Dias, 2021; Oliveira, 2020). Before this bundle project was designed, as we have previously seen in the theoretical framework, another three studies had already studied Gross' approach, two also from an experimental quantitative perspective (Lopes, 2018; Vale, 2019) and one from a qualitative perspective (Simões, 2018). A theoretical study is also currently being developed (Ferreira, in preparation).

In the present study, it was possible to evaluate, once again, how participants reacted to Gross' approach by presenting options that convey a general principle, one drawing attention to a core aspect of Gross' theory of personality – HI. Previous studies have revealed what the author himself postulates, namely that many therapists may collide with clients' personality

styles or disorders, leaving certain domains of personality functioning untouched. He, therefore, calls attention to the importance of HI as a general principle of therapeutic action if one wants to better influence change in personality. He is aware of the risks of such intervention, nonetheless presents a brain-based theory of emotionality as a personality process to minimize those risks and reminds the reader that such risky activity needs to be done in the context of a good enough therapeutic alliance (Gross, 1992, 2020). Previous studies (Lopes, 2018; Vale, 2019) did in fact corroborate that therapists more frequently prefer other more validating, more consensual, and less risky interventions. In the qualitative study (Simões, 2018) listening to the voice of clients in such a therapy that follows this principle of occasional HI, they indeed acknowledged that there was something somewhat initially disturbing to them in some of the interventions by those therapists, but, in the end, they appreciated the transformative experience they got from it. The empirical question remained open: is it a matter of making therapists aware of a degree of freedom they may be lacking in terms of intervention in the realm of personality in general and PD in particular, and/or is it a matter of mixing or wrapping up HI with HV so therapists feel more comfortable in applying that degree of freedom of HI? With that double question in mind, we designed this study, again contrasting therapists' preferences in relation to HV interventions and HI interventions, when prompted explicitly to influence change in personality the most. Yet, this time we offered them a middle route choice where they could choose to do both at the same time, that is, we added a novel option that integrated the HI component with a more common style of intervening – HV.

We will now discuss results regarding H1, which predicted a preference for HV options over HVHI, and for HVHI over HI options, which was only partially supported. The preference for option C (HVHI intervention) when compared to options A and B (HI interventions), and the similar values to option E (a HV intervention), may suggest that, when the HI intervention is embedded in a HV intervention, the resistance/reluctance of clinician participants to the

intervention is smaller than with purely HI interventions, and it may be as well-received by therapists as a HV option. The existence of such an option in the present study is unlike previous studies dedicated to clinical decision making within Gross' approach to psychotherapy (Lopes, 2018; Vale, 2019), in that it combines two approaches that, up until now, could have been considered dichotomous. Thus, clinicians may be more open to an integrated approach, rather than a HI-only approach.

Of the two HI interventions, there is disfavor of option A, compared to option B, which again suggests less openness to the HI approach formulated by Zoltan Gross. This result is in line with previous studies (Lopes, 2018; Vale, 2019) supporting the notion that therapists are more reluctant to choose to intervene with HI, especially when this intervention is formulated in Gross' style. This may be due to what therapists have in mind concerning how responsiveness should look like, which does not include challenging the client in the way Gross does it. As Wu and Levitt (2020) pointed out, a look at the literature available has shown an overall tendency for not recommending challenges to the client because they were experienced as "judgmental or controlling" (p.168). Especially given that there is a high risk for the occurrence of ruptures with individuals with PDs and for the therapeutic process to end prematurely with this population (Boritz et al., 2018), Gross' style may be considered a riskier intervention.

A look at the preference of participants made us wonder why Option D (HV CBT) was the least preferred, even compared to the HI ones. It seems that, in this case, participants found HI interventions more responsive to the client's complaint than Option D.

The disfavor of Option D is not surprising when we recall that participants were prompted to focus their intervention on personality change. Even though both HV options have in common the fact that they answer to the "text" – the explicit –, and not the "subtext" – the implicit, they are based on very different approaches and there is a difference between the

skills-building/problem-solving based approach (Option D) and the psychodynamic (Option E). Option D's CBT base can mean that a bigger focus is put on symptom change, rather than personality change. By not focusing on personality aspects of the person, even though it is validating, it does not answer to what was asked of participants: to choose the option that they consider to be more facilitative of enduring change in the presented client's RMP.

Contrasting with both HV options are approaches that integrate HI (HI or HVHI), which address the "subtext". According to Gross (2020), helping the client "feel better" can help change some meaningful aspects of clients' personalities and behavior. This can be achieved when the client receives a "novel validating explanatory perspective on themselves" (p. 210), such as what happens when the therapist takes a validating approach. However, as Gross (2020) argues, the aspects of personality reached by HV approaches do not reach changes in habits that cause difficulties for many of those who seek psychotherapeutic help. Instead, he argues, it is by repeatedly engaging in intense emotional interaction that client and therapist enable profound characterological change.

Considering the conditions participants were allocated to, we found that the number of participants who chose Zoltan Gross' intervention (Option A) is twice more from participants coming from the Gross-influencing condition, than those who came from the Not-Gross-influencing condition. This opens the possibility, that, when stimulated to consider Gross' approach, the therapist may be more prone to accept it as a reliable approach to personality change in psychotherapy. Such results add information to previous studies (Lopes, 2018; Vale, 2019) and may help shed light on how manipulation in quantitative studies such as studies from the present bundle project may influence participants in their preference for HI approaches. Curiously, the same tendency is shown for Option C (HVHI EFT), which may suggest that sensibilization to HI may get participants to be more prone to an EFT approach, that not only encompasses an HV component, but also an HI element. As for Option B (HI AEDP), which,

as Option A, portrays a HI-only intervention, even though there was a difference with the same trend, this difference was small. Thus, it seems that Option A received a bigger influence for the manipulation than Option B, which is consistent with the fact that Option A more closely relates to the way Zoltan Gross would formulate his response following the HI principle. Given the small difference, it seems far-fetched to interpret an effect of the conditions on the choice of Option B. The same trend was verified for Option D (HV CBT), but with a small number of participants it is hardly reliable to analyze it. Option E (HV Dynamic) showed an opposite trend, suggesting a decrease in the inclination of participants to choose Option E when these participants came from Gross-influencing conditions.

It should be considered that the 4 conditions used in the present study are heterogenous in their structure and, thus, the effects detected in this analysis can also be due to other characteristics that distinguish them that were not controlled in this investigation. For example, the fact that the difference between the manipulation group and control group regarding case formulation (Conditions 3 and 4, respectively) are the absence of a part of the information, instead of a different set of information, can influence the results, in that they can be due to a different information overload between conditions, and not the content of the conditions itself.

Other variables that were not controlled for in this investigation include the presence of different videos from the therapy session in the different conditions (one video for Conditions 1 and 2, and another video for Conditions 3 and 4), in addition to the video that is presented in every condition and based on which participants were asked to make their decision. The presentation of different videos may have influenced clinicians' decision regarding which intervention to choose, as different information was presented to them regarding the client's case.

Even though these limitations are present, we should consider that statistical analysis found an association between conditions and choice. Future studies could continue to explore

a manipulation design that aims to influence participants to be more prone to HI interventions and Zoltan Gross' approach to personality change. Some suggestions are presented afterward.

Regarding the three-group variable (HI, HVHI, and HV), the fact that group HI registered a statistically significant higher mean rating than group HV concerning the variable "Text/subtext distinction" offers support to the ability of Zoltan Gross' approach to facilitating change to be sensitive to both these levels. This implies that the therapist becomes a "participant-observer", as previously mentioned by Safran and Segal (1996), which helps therapists integrate several sources of information, which include text/content and subtext/process.

As for the variable "Challenging beyond validation", a marginal effect was also found, with a higher mean rating for HI over HV and HVHI, which opens the possibility that a purely HI intervention would better allow the therapist to act in conformity with the client's need by judiciously challenging the client and going beyond validation when compared to HV and HVHI interventions.

The large positive and statistically significant association found between "Text/subtext distinction" and "Challenging beyond validation" makes sense when we consider that both are linked to HI interventions. It could be that participants in the present study choosing HI interventions appreciate essential elements of Gross' approach such as the need to access the subtext and to challenge the client when advised, whether they are aware of it or not. As for HVHI and HV interventions, the mean ratings for these groups are still relatively high for the variable "Challenging beyond validation". The high mean for HVHI is not surprising, given its HI element. Concerning HV interventions, this result is more unexpected, since HV is not considered by Gross (2020) to be an action that better accomplishes the goal of challenging the client. Further research could clarify this. As for "Text/subtext distinction", the HVHI option

is also still relatively high, which could be a reflex of a bigger consideration of the option's capability of going beyond the explicit, towards the subtext.

Going back to results regarding statistically significant differences between the three groups on options of intervention, it is important to consider the marginal effect, with a higher mean rating for HVHI over HI and HV, found for the variable "Emotional change". Thus, the hypothesis that an option that embodies both principles of action by Gross and that is rooted in an EFT framework was considered to better facilitate emotional change than single-component options (either HV or HI), with a bigger discrepancy for a HVHI–HV comparison, must not be ruled out. Also, it is worth reminding that EFT works directly and primarily with emotion. Thus, the higher mean rating for the HVHI option, based on an EFT framework, for this variable is not surprising and matches the approach's focus.

The presence of positive and statistically significant medium to large correlations among the three parameters that evaluated change based on the choice of intervention made may reflect a close connection between RMP change, emotional change, and characterological change, which goes according to research that links these three types of change.

Since characterological change and RMP change are best facilitated by HI interventions, which have a bigger focus on personality, and given that it was asked of participants to influence specifically personality and RMPs, the answer to the question raised from Lopes (2018) and Vale (2019) as to why it is, then, that HI options were not appraised as more able to influence characterological change and RMP change remains. It is worth mentioning that the present study presents a design in which participants did not rate each option's responsiveness to each of the five parameters evaluated. This makes it more difficult to make trustworthy comparisons, as the only information we have is of participants' perceptions and interpretations of the survey's contents.

Regarding participants' mentions of approaches that influence them in their practice, it cannot be ignored that not every participant mentioned any approaches and, thus, we may not be getting a look at the full picture. Even so, a look at participants' mention of approaches that influence them in their work shows that, as for the two HI options (Option A and Option B), there is a similar preference. Even though there were other approaches mentioned by participants, it is worth noting that the most referred approach was Psychodynamic or Psychoanalytic, followed by Relational/Interpersonal. This result can point to the possibility that clinicians who choose a HI approach may be more influenced by these two approaches. Note that the Relational/Interpersonal approach is an acknowledged influence of Gross' theory. However, given that participants that chose Option D and Option E – the two HV options – also show a preference for a Psychodynamic/Psychoanalytic approach, it cannot be substantiated that participants that have their work influenced by these approaches are more prone to choose an HI intervention.

As for the HVHI option (Option C), the preference for a Psychodynamic/Psychoanalytic approach does not apply. Instead, an influence of CBT and Existential/Humanistic approach is marked. Thus, it could be hypothesized that participants who are most influenced by CBT and Existential/Humanistic would choose the HVHI option. Participants that chose this option considered themselves to be more integrative/eclectic than participants that chose other options, which goes according to our goal with option C to formulate an option that embodies two complementary styles of intervention aimed to influence personality – HV and HI.

Nevertheless, overall, it seems there is not a relationship between each group of options (HI vs. HVHI vs. HV) and integration/eclecticism means.

One of the limitations of the present study is that the number of approaches represented in the options of interventions available to participants does not reflect the diversity of approaches that exist in clinical practice. Through an analysis of the open question made at the

end of the questionnaire (see Appendix H) it is possible to verify some dislike towards the options of intervention available, partly due precisely to the underrepresentation of interventions just described. An alternative way to request participants to answer this question could be through an open answer question, that would give them the freedom to generate their intervention – one that they deem more appropriate/responsive. In this method, however, a HI approach could have been underrepresented, for possibly being less conservative, and for participants' lack of knowledge of this intervention style.

It could also be informative to ask forced-choice follow-up questions that allow researchers to identify the degree to which certain processes/principles of change underlying the intervention(s) participants would consider to be more helpful and how likely it would be for them to act in conformity with said processes/principles. This addition to the components evaluated in the present study, in the survey, would provide more complete and rich information on clinical decision-making concerning personality change and PDs in alignment with Gross' approach and principles.

Offering an equal number of options of the type of intervention to choose from, by having another HVHI option, thereby providing the participants with a more diverse array of options for each type of approach (HV, HI, and HVHI), could prove useful to test whether the preference for this type of approach holds up in other response formulations. Another option, in favor of simplicity, is having only three options, one of each, instead of a six-option question. Although this could reduce the representativity of approaches in the options, it could be less demanding of participants, in terms of cognitive load. Opting for a three-option question could prove to be particularly useful if, in the future, it is asked of participants to rate, for each approach, the degree of conviction they have in the ability of the intervention to respond to several parameters. In the present study, this approach did not take place – participants could only respond with reference to the intervention chosen, not regarding others. A study in which

the parameters evaluated can be compared, by letting participants rate each response could provide more secure comparisons.

At the beginning of the present discussion, we raised a double question: Is it the unawareness of the advantages of intervening with HI for personality change and with clients with PDs, that makes therapists reluctant to choose options that portray HI? Is it discomfort with HI application that can be made up for by mixing HI with HV? Perhaps it is a little bit of both. On the one hand, it seems that therapists were able to see the advantages of HI: participants that chose HI options seemed to be more considerate of the importance of dealing with the underlying emotionality of the client and of judiciously challenging the client; plus, there seems to have been an influence of sensitization to Gross' approach on the choice made regarding Option A (HI Gross). On the other hand, it seems that blending HI and HV yielded some positive responses, as the feedback we had was of a greater preference for this option. This exhibits, contrary to results of previous studies (Lopes, 2018; Vale, 2019), a favor of an option that includes a HI action – Option C (HVHI).

The development and/or recognition of suitable personality change interventions, that attend to clients responsively, is still a need. HI interventions, as defined by Gross (2020), offer an opportunity to change profound and habituated aspects of a person's personality. Yet, to safely and judiciously intervene and challenge the client with a HI intervention, some knowledge of Gross' theory may be required, thus lessening the probability of therapists' approach being experienced by clients with judgment or control.

One way to do so is instructing clinicians on Gross' approach, by simplifying his theory, to make it more accessible and understandable to psychotherapists and other readers. Ferreira (in preparation) is making such an effort by contemplating key points as well as subtleties of Gross' brain-based theory and approach to personality change with a straightforward tactic.

A parallel option is to train therapists on certain essential aspects of his theory, such as accessing the subtext or underlying emotionality of the client (as depicted by Oliveira (2020)) or responsively challenging the client. It is important to keep in mind what Wu and Levitt (2020) suggested regarding the training of therapists: that interventions are taught from a process lens, that teaches therapists to reflect on therapy decisions guided by moment-to-moment markers and adjust interventions and relational dynamics accordingly. As such, the authors suggest that, in supervision, therapists guide trainees to reflect on therapy decisions and intentional moment-to-moment decisions.

Still, another possible and complementary path is to promote and influence case formulation reasoning focused on personality and personality change, as Dias (2021) studied, essential in guiding therapists' decisions and interventions. Presenting Gross' brain-based theory of personality and his view of the advantages of putting into practice a HI intervention, can be a step in the right direction, as it is a possible and suitable way of thinking about each client's case, and anchoring their HI intervention when deemed appropriate.

Future studies may further investigate whether different HVHI approaches yield the same or different results, like the ones found in the present study. The question of why HI interventions are less preferred than an HVHI intervention and some HV interventions can be explored further, perhaps by looking into different questions regarding the characteristics of the therapist and his/her approach to psychotherapy. Furthermore, participants' perceptions of the interaction observed in a psychotherapy session, in the case of similar stimuli as the ones shown in the present bundle study and in other studies alike (Lopes, 2018; Vale, 2019) may prove useful to this understanding.

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Appendix A – Informed Consent

"Dear Clinician,

Our research team at the Faculty of Psychology, University of Lisbon, invites you to participate in another research study on facilitating emotional change in pair with characterological change.

The participants of this study are clinicians of any theoretical approach. This experiment should take you 15/20 minutes.

We welcome and appreciate your interest and invite you to read the Informed Consent information below before taking part in the survey, which has been through the Ethics Committee and follows the American Psychological Association (APA) and Order of Portuguese Psychologists (OPP) guidelines.

You will watch excerpts from a real psychotherapy session and then be randomly allocated to one of four conditions, also with videos – two conditions slightly shorter and two slightly longer. You will be asked to adopt the stance of the therapist, so watch the videos carefully. If you have participated in a previous study with this client you will see this is a different one, so you are welcome anyway. Finally, we ask you to provide basic demographic information and share your experience while participating.

The responses to this questionnaire will be data for the four researchers' dissertation projects, in coordination with three other completed projects. The results could potentially be used at conferences and in relevant publications. Your participation is voluntary, and your answers will be anonymous and confidential. We do not know or anticipate risks to your physical or mental health.

If you move on by pressing the "forward" button, we assume that you have read and understood the previous information and have agreed to participate in this research.

You can quit at any time. If you have further questions or want to be later informed about the results of the study, please feel free to contact us.

We hope you appreciate the clinical material we prepared with care.

Thank you in advance!

If you have any questions, you can contact the student investigators:

Mariana Dias, Patrícia Oliveira, Raquel Terruta, and André Ferreira, at

paradigmaticcomplementaritylab@gmail.com

You may also contact the researcher supervisor:

Nuno Conceição, Ph.D., at:

Complementarity Lab

Faculty of Psychology, University of Lisbon

Alameda da Universidade

1649-013 Lisbon, Portugal

nconceicao@psicologia.ulisboa.pt”

Appendix B – Instructions

As mentioned earlier, your collaboration in this research involves adopting the therapist's stance.

We request you to be in a quiet and comfortable place, mostly free from interruptions and distractions.

Headphones are advised but not compulsory. Make sure **the sound of your computer or device is turned** on and balanced to your hearing needs.

The following video will be an excerpt from a therapy session. Please put yourself in your therapist stance and mindset and pay attention to this client.

Appendix C – Background of the client

Joaquina is a 21-year-old Portuguese female who already had a first therapeutic process of three years with a psychodynamic psychotherapist and is currently having therapy with an integrative psychotherapist. The excerpts you are about to watch are from a recent session with her therapist.

When the client was 7, her mother left the country, and she started living only with her father. According to her, before this happened, her mother was the one that mostly took care of her. Her mother was supposed to only go for a masters' degree, but she ended up getting together with a man and traveling around the world. She came back when Joaquina was 17. A couple of months after, Joaquina went to Holland, where she is still currently living. The client says that her relationship with her mother is still complicated because her mother is unstable and very dependent on men. She also mentions that after her mother left, her father became very much focused on Joaquina and that he was a lonely man with very strong ideals of how people should live their lives.

In the next excerpts, Joaquina brings her main complaint to this session. In previous sessions, therapist and client have agreed to work on a recurrent maladaptive pattern she experiences in situations of emotional closeness with female friends."

Appendix D – Initial Stimulus: Excerpt Transcription

J: Joaquina

T: Therapist

J: Still, this difficulty I have sometimes with my women friends. Because now, the women I have around me in Holland, they are very caring for me and they love me a lot.

T: Ah, that's good.

J: Although I still feel this nervousness when I try to get closer to them especially physically. Like when I try to hug them or if we are, for example, watching a movie together and we get very close in the couch. I love it a lot and I want more closeness. But I start feeling so nervous, like in a first date or something, like a little baby.

J: And I have a very close friend, for example, and she cuddles me a lot, we give hugs…

T: That is nice.

J: And we know how much we mean to each other. But instead of feeling, like, when I see girls like friends of mine and they hug, and they are so playful in the way they do it.

T: Yup.

J: And for me, when I get a hug I still get somehow uncomfortable because I am so afraid that will end or that they won't like me or that if they get close enough to me they discover something about me and they'll just disappear.

Appendix E – Conditions 1 and 2

Condition 1. Basic Training Level	Condition 2. Intermediate Training Level

Introduction

(you can skip the grey text if you want to save time)

Usually, therapists know how important a good working alliance is to facilitate change, be it emotional, cognitive, or behavioral. Part of any good training in psychotherapy implies learning to validate what their clients are sharing with them. As any other human beings that appreciate being well received by others, it is also natural that therapists have a desire to feel that themselves and their interventions are well received by their client.

These two natural inclinations to be validating to the client and to seek assent or validation from the client can, at times, lead to strains in the therapeutic alliance, with therapists being hooked under the umbrella of a nice therapist who has a good therapeutic relationship with their client. This can present problems, especially among clients with longstanding habits of mind or maladaptive patterns of functioning automatically repeating themselves.

Facilitating characterological change can thus imply specific levels of expertise and inner work by the therapist. When and how does facilitating emotional, cognitive, and behavioral change also foster characterological change, and when and how it does not, are interesting questions for us. We are interested in ways that expand the psychotherapist's perspective, exploring the important links between an integrated theory of emotion and personality and effective clinical practice capable of influencing that same personality for the better.

Interrupting habituated, automatic processes of the client's functioning can be a useful step towards facilitation characterological change. Thus, disentangling content/text from

process/subtext in the client's message might be skills worth learning, to, later on, judiciously choosing to address and engage the client at the subtext level and thus interrupt some of the automaticity.

We prepared a small training exercise about a process aiming at interrupting the automaticity of the self-presentation of the client, as usually delivered at the text-level.

Depending on the condition you will randomly be assigned to, you will have a quick opportunity to practice some intrapersonal or/and interpersonal technical micro-skills, aimed at that strategic goal.

We also developed a set of skill criteria that might help you get through the exercise. Guidelines are on the next page.

	Skill Criteria At this level, you are supposed to <u>practice just 1st and 2nd criteria</u> 1. Therapist receives the content of what the client is sharing and tries to capture the process that comes with it. While the client is delivering the text, the therapist also pays attention to any subtext, or to any emotionality arising in the here and now, in a non-reactive, receptive, and present way. The therapist imagines text and subtext as coming from two separate parts of the client.

	2. The therapist notices the opportunity to provide a verbal empathic engagement to the part of the client delivering the text message. The therapist imagines a possible validating answer but suppresses the inclination to deliver just that. The therapist exercises letting go of a) any automatic tendency to be a nice therapist and b) any need for the client's assent. The therapist holds in mind the other part delivering the subtext, which might also need attention. 3. Therapists thus bypass the self-presentation of the client and sets the stage to directly address and engage also with the part that carries the subtext. The therapist judiciously moves forward and risks offering an incoherent, counter-intuitive, potentially surprising, or apparently unemphatic answer designed to answer the part carrying the subtext. 4. The therapist remains present and fosters attention and contact with the client as a

	whole again. The therapist tries to endure the possible discomfort of the client associated with the surprising challenge that interrupted the seamless flow of the dyadic interaction. The therapist explicitly and engagingly processes the therapeutic relationship with the client fostering integration.
Stimulus J: Still, this difficulty I have sometimes with my women friends. Because now, the women I have around me in Holland, they are very caring for me and they love me a lot. T: Ah, that's good. J: Although I still feel this nervousness when I try to get closer to them especially physically. Like when I try to hug them or if we are, for example, watching a movie together and we get very close in the couch. I love it a lot and I want more closeness. But I start feeling so nervous, like in a first date or something, like a little baby.	
Now it's your turn, bring all your empathy and caring attitude and say this verbal response in your imagination, 3 times, <u>before pressing the blue >> button to proceed</u> ***"That's really difficult. I don't think that they recognize what it is like to have a friend who wants to be their loving daughter."***	
Great work! Thank you for your willingness to practice our micro-skill.	Great work! Thank you for your willingness to practice our micro-skill.

Training micro-skills, attending to instructions, staying present, and dealing with eventual internal struggles from experience arising in the moment is not easy and can create discomfort. We ask you to do the exercise just one more time.	Training micro-skills, attending to instructions, staying present, and dealing with eventual internal struggles from experience arising in the moment is not easy and can create discomfort. Now we ask you to do the exercise just one more time, and this time we have prepared some prompts.
	In order to better capture any subtext message, other than just the textual message Joaquina delivered, we invite you to explore what is your internal experience in this little moment with her. What do you notice in yourself and her, when she presents her pattern of relating with her female friends? What nuances and subtleties can you find in Joaquina's experience? **Check if any of the following prompts help you grasping useful information.** - Which feelings and sensations does she evoke in me? - What is the client trying to achieve in me, or in any other? Where does she want to

	bring us? Which action tendencies are activated in me? - Which presentation of the self does the client give to me/to any other? - Which presentation of the self does the client try to give/maintain facing herself? - Which behavior may not be appropriate in the current situation? Which behavior is the client trying to prevent?
	Skill Criteria At this level, you are supposed to <u>practice just 1st and 2nd criteria.</u> 1. Therapist receives the content of what the client is sharing and tries to capture the process that comes with it. While the client is delivering the text, the therapist also pays attention to any subtext, or any emotionality arising in the here and now, in a non-reactive, receptive, and present way. The therapist imagines text and subtext as coming from two separate parts of the client. 2. The therapist notices the opportunity to provide a verbal empathic engagement to the

	part of the client delivering the text message. The therapist imagines a possible validating answer but suppresses the inclination to deliver just that. The therapist exercises letting go of a) any automatic tendency to be a nice therapist and b) any need for the client's assent. The therapist holds in mind the other part delivering the subtext, which might also need attention. 3. Therapists thus bypass the self-presentation of the client and sets the stage to directly address and engage also with the part that carries the subtext. The therapist judiciously moves forward and risks offering an incoherent, counter-intuitive, potentially surprising, or apparently unemphatic answer designed to answer the part carrying the subtext. 4. The therapist remains present and fosters attention and contact with the client as a whole again. The therapist tries to endure the possible discomfort of the client associated with the surprising challenge that interrupted

	the seamless flow of the dyadic interaction. The therapist explicitly and engagingly processes the therapeutic relationship with the client fostering integration.

Same Stimulus

J: Still, this difficulty I have sometimes with my women friends. Because now, the women I have around me in Holland, they are very caring for me and they love me a lot.

T: Ah, that's good.

J: Although I still feel this nervousness when I try to get closer to them especially physically. Like when I try to hug them or if we are, for example, watching a movie together and we get very close in the couch. I love it a lot and I want more closeness. But I start feeling so nervous, like in a first date or something, like a little baby.

Now it's your turn, bring all your empathy and caring attitude and say this verbal response out loud, **3 times**, before pressing the blue >> button to proceed.

"That's really difficult. I don't think that they recognize what it is like to have a friend who wants to be their loving daughter."

Questions

Now we ask you to rate your trainee experience, from (1) not at all to (4) completely.

- Considering the level of internal, emotional fit, and congruence with your experience, during the verbal rehearsals, how challenging was the overall exercise for you?
- How well do you think you grasped the subtext, i.e., some underlying emotionality of the client's textual message?
- How useful do you feel the exercise was to alert you to text/subtext distinction?

- Would you agree this distinction can be useful to help bring about enduring, personality change in psychotherapy?
- Would you consider attending a proper training module about these skills?

Appendix F – Conditions 3 and 4

Case Formulation: Manipulation Condition (Condition 3)	Case Formulation: Control Condition (Condition 4)
Small Lecture *Introduction* "We prepared a very small lecture on the repetition of recurrent maladaptive patterns that we hope will be useful. Please stay with us and enjoy the following 5 slides. In the end, we will ask you to critically appraise the (consolidating) learning moment." *Slide 1* "Different treatment modalities conceptualize recurrent maladaptive patterns in different ways, yet sharing common features. By using terms like cognitive schema, emotional scheme, mode, core self-organization, part of the self, structurally dissociated part, little one inside, inner child, … many approaches are somehow formulating underlying personality	

structures, traits, giving rise to client's complaints, symptoms or emotional states." *Slide 2* "Addressing both the underlying personality structures and the symptoms, presumed to be interconnected, makes it more likely to produce enduring change. Many approaches, however, are bringing a Homuncular perspective to this experiential work, which has its caveats. And it might not be about deep-seated structures, but about processes, personality processes occurring at a deep or profound level, which become visible if one captures them in operation and sees emotionality as personality process." *Slide 3* "Personality is this brain-led system developed early in childhood and personality processes are continually reinforced, become overlearned, highly stable, automated and change-resistant. They become habituated – functionally autonomous and self-	

perpetuating, and keep being practiced in the present moment, today, also in session." *Slide 4* "Clients and therapists may or may not be aware of what is going on, of what is being repeated, rehearsed, or practiced, in the session, in the moment. By its very nature, the repetition or enduring practice of habituated emotionality is usually not face evident. When therapists are not trained to identify and formulate about the presence of these hidden underlying processes, they often do not look for it. This contributes to therapeutic sins of omission and commission, making it difficult to bring about enduring change." *Slide 5* "Theorizing emotion as personality process in pair with some type of a parts-based formulation approach can help clinicians recognize these patterns. Even when the subject is discussed in an emotional way, therapists may miss the underlying	

personality processes because the client presents them in the background of awareness. Looking for the nonsensory process of the brain, the one that structures the emotional response and regulates the personality processes opens access to the habituated and automatic patterns of emotional responses. Somehow formulating at least **two different parts of the client, one delivering text/content and another holding subtext/process**, can help therapists to better grasp these subtle cues to personality processes enmeshed with emotional messages." "The lecture is over!" "On a scale of 1 (not at all) to 4 (Completely), please rate how much you appreciated this lecture"	
"Now you will watch two small excerpts of the session, with a therapist's intervention/formulation.	

Please refrain from interrupting your viewing if possible”. *video excerpt:* J: Joaquina T: Therapist “**Z**: Again you are smiling at me! Why would you smile at me when you are feeling so sad? I am talking to you about these very sad things. And you have a very pretty smile, but it doesn’t fit.” “**Z**: It was a hard time. And those hard times continue to live inside of people even though they don’t know it, and it comes out in strange ways. In different ways. And I think in your case, the loss of your mother continues to operate in your current relationships. The tragedy of her loss makes you very sensitive to being rejected by your friends. **J**: Hm-hm. **Z**: What is going on, what are you feeling? **J**: [tearing up] A little bit – hum – sad.	

Z: Yeah? **J**: Hm-hm. **Z**: I hope you'll forgive me."	
"We have shown you part of this therapist's formulation, but we are most interested in how YOU would formulate her recurrent maladaptive pattern with her female friends. Please rate how the following options fit your formulation perspective, from extremely unlikely (1) to extremely likely (5)"	"We are interested in how you would formulate Joaquina's recurrent maladaptive pattern with her female friends. Please rate how the following options fit your formulation perspective, from extremely unlikely (1) to extremely likely (5)."

"Formulation A

The longing of her mother when she abandoned her at age 7 (an early age where the foundational parts of her personality were still developing) created an automatic pattern of her brain's functioning, making a part of her still feel afraid of rejection by female figures when they get physically closer. This part still lives in Joaquina, operating automatically in her brain and causing her to experience imminent rejection/abandonment, especially in a context where a female friend is increasingly closer.

Formulation B

When the client was abandoned by her mother at age 7, the inability to integrate the trauma evolved into a structural dissociation of her personality into two parts. A part was able to go on with her normal life, while another part was desperately longing for her mother. Today, the client feels two conflicting first-person perspectives from these two parts of her personality. When in contexts of meeting attachment/closeness needs, the part that goes on with normal life is intruded by the fragile part that is hurt and afraid of painful rejection.

Formulation C

After being left by her mother at age 7 for several years, the client experienced ongoing unbearable aloneness and developed a defensive pattern to retain her from being abandoned again. Being close to female friends makes her conflicted about such interactions, where she wants more closeness, yet at the same time, anticipates painful rejecting abandonment, resulting in worry and anxious feelings around them.

Formulation D

Joaquina's abandonment by her mother lead to the development of painful maladaptive emotion schematic memories of fear, shame, and sadness. She developed a negative core self-organization characterized by a sense of self as vulnerable, alone, and/or defective. This core self-organization, based on an automatic synthesis of activated emotion schemes, is activated in situations of increasing closeness with her female friends. In this state, she feels threatened and distressed and begins to worry to protect against sensed danger in an attempt to defend against it."

"Which of the previous formulations would you be more likely to choose for facilitating characterological change?"

A

B

C

D

"Which of the previous formulations would you be more likely to choose for facilitating emotional change?"

A

B C D

Appendix G – Clinical Decision Making

You will now be presented with the initial video of the session with Joaquina once again.

excerpt from the first video

J: Still, this difficulty I have sometimes with my women friends. Because now, the women I have around me in Holland, they are very caring for me and they love me a lot.

T: Ah, that's good.

J: Although I still feel this nervousness when I try to get closer to them especially physically. Like when I try to hug them or if we are, for example, watching a movie together and we get very close in the couch. I love it a lot and I want more closeness. But I start feeling so nervous, like in a first date or something, like a little baby.

J: And I have a very close friend, for example, and she cuddles me a lot, we give hugs…

T: That is nice.

J: And we know how much we mean to each other. But instead of feeling, like, when I see girls like friends of mine and they hug, and they are so playful in the way they do it.

T: Yup.

J: And for me, when I get a hug I still get somehow uncomfortable because I am so afraid that will end or that they won't like me or that if they get close enough to me they discover something about me and they'll just disappear.

post video instructions

Several options will be presented to you, regarding how to reply to the client. All of them were considered appropriate enough interventions according to a panel of diverse clinicians. We ask that you rate them in terms of fit to your likely stance, and then select the one that you trust you would feel comfortable with and confident about in offering just after what Joaquina said.

Imagine yourselves on a structured, consistent, and collaborative treatment process with an established good therapeutic alliance and you really want to facilitate enduring change in her recurrent maladaptive pattern!

From 0 to 9, please rate how likely you are to proceed according to each intervention.

Option A:

"That's really difficult. My guess is that when you are with your loving female friends in Holland, you enjoy the warmth that you are getting from them, and you probably want to have more. And sometimes, I don't think they understand what it is that you want. They might feel uncomfortable about you wanting to be closer to them than they are used to being close. I don't think they recognize what it is like to have a friend who wants to be their loving daughter. …(allow reaction)… What am I doing to you, just now?"

Option B:

"I see this adorable little baby and how fragile and vulnerable she is feeling inside. She wants more closeness, wants to be loved and cared for, and definitely does not want to be left alone for so long. It must have been very painful to be abandoned by your mother, and that pain still lingers on. Can you see her? Is she hearing me? What can we say to this part that would be soothing, that makes her feel safe, that makes her feel stronger and loved? She deserves our utmost care and attention! …(allow reaction)… How does she react to me saying this?"

Option C:

There is a part of you that wants more closeness, that wants to be loved and cared for. And there is another part that is afraid to get close and let others in. Like a part of you wants the warmth and another part that fears or gets uncomfortable with it. I wonder if we could have a dialogue between these two, and I could coach you into that conversation to fully explore what is going on within you, that might be interfering with your ability to fully and safely enjoy closeness with your female friends."

Option D:

"It must be hard to want the warmth you get from your friends and worrying that negative consequences might follow. You're afraid to expose yourself, that it will go wrong and that you'll end up abandoned or rejected by them. This context makes you feel insecure, makes you self-conscious. Would you be open to planning some kind of gradual exposure interweaved with some skills training for you to have some learning opportunity to gradually transform your fears and your anxious thoughts?"

Option E:

"After being left by your mother at age 7 for several years, it is understandable that you anticipate some kind of painful rejection again. I guess it is only natural you keep some barriers to retain yourself from being abandoned again. Being close to female friends, makes you conflicted and distressed about such interactions. It is nice to see you did not give up on

closeness but the road is not yet free and safe. Does it make sense to you? What does this roadblock mean to you? What might lie under it?”

If you had to choose one of the presented interventions in light of the client’s complaint, namely, bring about enduring change to her recurrent maladaptive pattern, which one would it be?

- Option A
- Option B
- Option C
- Option D
- Option E

From not at all (1) to a lot (4), please answer the following questions regarding the choice you just made.

- To which degree do you believe this choice is responsive to the client’s need to change her recurrent maladaptive pattern?
- How confident are you that your choice is the best among others to facilitate emotional change, assuming it could be delivered in a responsive way?
- How confident are you that your choice is the best among others to facilitate characterological change, assuming it could be delivered in a responsive way?
- To which degree do you consider that this choice is responsive to the distinction text/subtext, that is, the self-presentation part of the client and the other part holding the underlying emotionality?

- To which degree do you consider that making this choice would allow you to go beyond validation and judiciously challenge the client without needing to be just a nice therapist, in need of the client's assent?

Appendix H – Participants' Information

"Please fill in some information about yourself.

Gender

- Male
- Female
- Other

Age: ___

Nationality: ___

Race/Ethnicity (check as many as apply):

- White/Caucasian (Europe)
- African
- Asian/Pacific Islander
- Indigenous Australians
- Hispanic
- Middle Eastern
- Native American/Alaska Native
- Multiethnic (please specify) (…)
- International (please specify) (…)
- Other (…)

Profession (Check as many as apply):

- Psychiatrist
- Psychologist

- Psychotherapist
- Counselor
- Social worker
- Other (…)

To what extent do you regard your orientation as eclectic or integrative?

- 1 – Nothing
- 2
- 3
- 4
- 5
- 6 – Totally

In your practice which models or approaches do you follow?

- ___
- ___
- ___
- ___

Years of clinical experience: ___

Estimate most frequent weekly caseload: ___

Lastly, we are interested to know about your experience of participating in our study. What was your motivation when you decided to participate? What was it like for you to answer all these questions? How is it like for you now that you have participated?

_____

_____

Appendix I – Descriptive Characteristics of Participants, According to Choice of Intervention

Table 4

Mean and SD of "Age", "Clinical Experience" and "Weekly Caseload", for each choice of intervention made.

	Age		Clinical Experience		Weekly Caseload	
	Mean	SD	Mean	SD	Mean	SD
A. HI Zoltan	55,417	15,565	24,083	14,158	20,545	9,3098
B. HI Experiential	54,063	12,375	19,438	9,529	17,462	9,955
C. HVHI EFT	56,912	14,796	24,647	14,165	15,767	8,460
D. HV CBT	58,167	20,488	28,833	17,566	19	8,216
E. HV Dynamic	58,806	16,055	27,258	15,280	15,862	8,348

Table 5

Mean and SD of "Age", "Clinical Experience" and "Weekly Caseload", for each category of choice of intervention made.

	Age		Clinical Experience		Weekly Caseload	
	Mean	SD	Mean	SD	Mean	SD
HI	54,643	13,573	21,429	11,730	18,875	9,584
HVHI	56,912	14,796	24,647	14,165	15,767	8,460
HV	58,703	16,528	27,514	15,419	16,324	8,282