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Affect-focused Body Psychotherapy for patients with Generalised Anxiety Disorder

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AFFECT-FOCUSED BODY PSYCHOTHERAPY FOR
PATIENTS WITH GENERALISED ANXIETY DISORDER

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That if real success is to attend the effort to bring a man to a definite position, one must first of all take pains to find him where he is and begin there. This is the secret of the art of helping others (Kierkegaard [1848] 1962, p.27.)

ABSTRACT

Introduction and aims: This thesis investigates Affect-focused Body Psychotherapy (ABP) for patients with Generalised Anxiety Disorder (GAD). ABP has demonstrated good results in patients with chronic pain, but its effect has not been empirically tested in psychiatric disorders. The aim of the present thesis was to evaluate ABP for GAD from several angles. Study I was an outcome trial comparing ABP to Psychiatric treatment as usual (TAU). Study II investigated whether ABP influenced affect consciousness (AC), and how AC was related to psychiatric symptoms. Study III explored the relationship of treatment preferences and experiences to outcome. Study IV investigated how patients with GAD experienced ABP.

Methods: A group of 61 consecutive referrals with GAD, 21-55 years old, were randomised to ABP (n=33) or TAU (n= 28). Patients were assessed before treatment and followed-up one and two years after inclusion. ABP patients received treatment once a week for one year. Five self-report questionnaires were administered to both groups: SCL-90, Beck Anxiety Inventory, WHO (Ten) Well-Being Index, SCID screen, and Treatment Preferences and Experiences Questionnaire (TPEX). Patients in ABP were interviewed at the end of treatment and one year afterwards concerning their treatment experiences. ABP patients were also assessed with the Affect Consciousness Interview prior to and at termination of treatment.

Results: Both groups showed significant clinical improvement. At termination ABP had improved significantly more on the SCL-90 Global Symptom Index than TAU, whereas differences were non-significant on the BAI and WWBI. Affect consciousness increased after ABP, and patients with high levels of anxiety at treatment start as measured with the BAI increased their affect-consciousness most. However, it was not possible to conclude that affect consciousness had an effect on outcome, directly or as a mediator. ABP patients reported being helped by supportive and reflective treatment interventions to a greater extent than controls, but it was found that differences in outcome were considerably more marked for patients who had mainly positive treatment experiences compared to those who had mainly negative ones independent of treatment form. Treatment expectations appeared to be based on patients' perception of their bodies. A key aspect concerning shame and control emerged in the interview material. Patients who approached the body with curiosity and interest tended to reformulate anxiety, and could see such reactions as conveying meaningful information about their life situation.

Conclusions: The integration of body-based techniques and a focus on affects into a body psychotherapy framework, such as ABP, may constitute an effective treatment for GAD, especially among patients who are interested in exploring the questions of mind-body unity. However, the results indicate that interpersonal aspects of therapy need to be more fully explored. Paying closer attention to treatment preferences and body attitudes may increase the potential of ABP and improve outcome.

Key words: Affect-focused Body Psychotherapy, affect consciousness, Generalised Anxiety Disorder, lived body, physiotherapy, preferences

SAMMANFATTNING

Introduktion och syfte: I denna avhandling presenteras data om Affektfokuserad kropppsykoterapi (ABP) för patienter med generaliserad ångest (GAD). ABP har utvärderats med goda resultat för patienter med kronisk smärta. Emellertid har metoden inte testats för patienter med psykiska störningar. Syftet med denna avhandling var att utvärdera ABP från olika perspektiv. I studie I som är en utfallsstudie, jämfördes ABP med sedvanlig psykiatrisk behandling (TAU) inom öppenvårdspsykiatri. I studie II var syftet att utvärdera om affektmedvetenheten (AM) påverkades av ett års behandling med ABP och hur AM var relaterat till symptom nivå. I studie III jämfördes patienternas behandlingspreferenser och erfarenheter med behandlings resultatet. I studie IV undersöktes hur patienterna upplevde ABP behandlingen.

Metod: 61 konsekutiva patienter med GAD, 21-55 år gamla, randomiserades till ABP (n=33) och TAU (n=29). Data för utvärdering samlades in vid tre tidpunkter; före behandlingen samt ett och två år efter behandlingsstart. Patienterna i ABP gruppen erhöll behandling en gång per vecka under ett år. Fem självskattningsformulär användes; SCL-90, Becks ångest skala (BAI), WHO's välbefinnande index (WWBI), SCID screen, och frågeformulär om patienternas behandlings förväntningar och erfarenheter (TPEX). Patienterna i ABP intervjuades vid avslutad behandling samt efter ytterligare ett år rörande deras upplevelser av behandlingen. Vidare deltog patienterna i en affektmedvetenhetsintervju före och direkt efter ABP behandlingen.

Resultat: Patienterna i båda grupperna förbättrades signifikant över tid. Emellertid var förbättringen i ABP gruppen signifikant större beträffande symptomreduktion mätt med SCL-90, däremot var skillnaderna inte signifikanta beträffande BAI och WWBI. I studie II framkom att Affektmedvetenheten ökade signifikant, det var patienter med hög ångest, mätt med BAI, som ökade sin affektmedvetenhet mest. Det var dock ej möjligt att visa att affektmedvetenheten påverkade utfallet varken direkt eller indirekt. I studie III framkom att ABP patienter, i högre grad än kontrollgruppens patienter, upplevde att de hade fått hjälp av interventioner som var inriktad på stöd och reflektion. Skillnader i behandlingsresultatet var mer beroende på patienternas upplevelse av behandlingen än behandlingsformen, d.v.s de som huvudsakligen hade positiva behandlingserfarenheter förbättrades mer än de som huvudsakligen hade negativa erfarenheter, oberoende av interventionsmodell. I studie IV framkom att patienternas förväntningar på terapin var relaterade till hur de uppfattade sin kropp. Skam och kontroll var viktiga faktorer som trädde fram vid analysen av intervjumaterialet. Patienter som förmådde möta sin kropp med nyfikenhet och intresse lyckades omformulera ångest signalerna. Dessa kunde då förändras från att vara skrämmande till att förmedla meningsfull information om den egna livssituationen.

Konklusion: Integrationen av kroppsliga tekniker och fokus på affekter i en kropppsykoterapeutisk metod så som i ABP tycks vara ett möjligt behandlingsalternativ för patienter med GAD, i synnerhet för patienter som är intresserade av att närmare undersöka enheten kropp-psyke. Emellertid tyder resultaten på att de interpersonella aspekterna i terapin måste studeras närmare. En ökad uppmärksamhet på patienters behandlingspreferenser och inställning till den egna kroppen kan höja behandlingspotentialen och förbättra resultatet.

Nyckelord: Affektfokuserad kropppsykoterapi, affektmedvetenhet, den levda kroppen, Generaliserad ångest, sjukgymnastik, psykoterapi, preferenser

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LIST OF ABBREVIATIONS

ABP	Affect-focused body psychotherapy
AC	Affect consciousness
ACI	Affect consciousness interview
ANOVA	Analysis of variance
Anx	The anxiety subscale of SCL-90
BAI	Beck's anxiety inventory
DSM IV	Diagnostic and Statistical Manual of Mental Disorders, fourth edition
GAD	Generalised Anxiety Disorder
GSI	Global Severity Index (the mean across the 90 items on the SCL-90)
GSI-anx	Global Severity Index without the anxiety scale
GSI_anx	Global Severity Index without the anxiety scale
MANCOVA	Multivariate analysis of co-variance
MANOVA	Multivariate analysis of variance
PD	Personality Disorder
RCI	Reliable Change Index
SCL-90	Symptom check list 90
SCLAnx	The anxiety subscale of SCL-90
SCID	Structured Clinical Interview for DSM disorders
TAU	Treatment as usual
TPEX	Treatment Preferences and Experiences scale
WWBI	WHO's Well Being Index

1 INTRODUCTION

The affect-focused body psychotherapy (ABP) is a method that was created by Monsen in the end of the 80's (Psychodynamic body therapy, 1989) and so far its effect has not been tested regarding patients suffering from Generalised Anxiety Disorder (GAD).

In ABP anxiety is considered a natural emotion, it is the persons way of avoiding anxiety signals that may become neurotic (Malan, 1999; McCullough & Andrews, 2001). Affects, which are not accepted, or play a much too prominent role (such as shame and fear), will cause anxiety problems for the individual. The patient uses conscious or unconscious mental and bodily manoeuvres to defend him/herself from experiencing the unwanted emotions, thus worsening the problem by getting secondary difficulties such as muscular stiffness, pain, vertigo, nausea, sleeplessness, and phobias.

GAD is characterized by uncontrollable worry (Appendix 1; APA, 1994) and is associated with a wide range of somatic symptoms as well as impaired social functioning (Kubzansky et al., 1997). GAD is also associated with cardiac events (Shen et al. 2008), poor glycemic control in diabetes (Frasure-Smith & Lespérance, 2008), as well as chronic obstructive pulmonary disease (Brenes, 2003). Furthermore, patients with muscle pain, headache, or stomach pain are likely to have GAD, panic anxiety, or depression (Anderson et al., 2002). High rate of psychiatric co-morbidity, primarily depressive episodes, social anxiety, and sometimes self-medication with alcohol is also associated with GAD (Dyck et al., 2001; Wittchen, Zhao, Kessler, & Eaton, 1994). In a review of 34 studies, it was found that impairment in quality of life from GAD was of similar magnitude to that seen in depression. Substantial costs were incurred as a result of GAD, due to reduced work capacity (Hoffman, Dukes, & Wittchen, 2008).

Patients with GAD often seek primary health care because of muscular pain caused by anxiety-provoked tension. This is one reason why patients with GAD are often referred to physiotherapeutic treatment. However, this patient group is a challenge to physiotherapists because symptomatic treatment generally only achieves short-term relief. The patients tend to seek help because of their physical problems over and over again, with a high risk of becoming frustrated and disappointed. This pattern also causes high costs in the health care system. Therefore we wanted to explore if the ABP method that integrates bodily interventions with a focus on affect awareness could be a viable way of dealing with the problems presented by patients suffering from GAD.

1.1 MIND-BODY RELATIONSHIP IN PSYCHOTHERAPY

Freud stated in the *Ego and the Id* (1927) that the ego is “*first and foremost a body-ego* (p 26)”...“*the ego is ultimately derived from bodily sensations, chiefly from those springing from the surface of the body*” (p 27). Freud fought throughout his earlier career with the integration or lack of integration between body and mind. As Freud’s psychoanalytic theory and technique developed it became more trapped in the mind-body dualism prevalent in European culture of the time. One of Freud’s associates, Wilhelm Reich, has contributed to our understanding of the body’s role in psychotherapy. He developed a theory of muscular armour, which sought to understand the ways in which we inhibit our “libidinal flow” by means of muscular defences mostly seen in the thorax. Reich’s (1948) work is the basis for many approaches to body psychotherapy that exist today, and it has influenced the ABP. Reich used touch to accompany the talking cure, taking an active role in sessions, feeling his patients’ chests to check their breathing, repositioning their bodies and sometimes requiring them to remove their clothes, so that men were treated wearing shorts and women in bra and panties.

Another of Freud’s associates was Franz Alexander, a Hungarian psychoanalyst and physician, who investigated the dynamic interrelation between mind and body. Alexander observed that patients with certain illnesses had corresponding personality styles. He concluded that addressing the personal style of the patient could pave the way to healing. Alexander is considered one of the founders of psychosomatic medicine (Alexander, 1962). Alexander’s work was a continuation and realization of ideas first proposed by Ferenczi and Rank (1925). Ferenczi opposed to the touch taboo and was not comfortable with the distant and neutral position of the psychoanalyst. He wished for a more genuine relationship and included bodily techniques to reach a deeper level of contact with the client. He believed that through physical contact he was addressing early developmental needs in his clients (Eiden, 2002).

Winnicott, emphasized the relational aspect in therapeutic work. He regarded the ‘holding environment’ as essential for the emotional development of the child (Winnicott, 1960). The needs of the emotional body self were taken more into account. Sensual and tactile needs were no longer seen as sexual needs; instead it was considered as vital for the individual to have joy in bodily activity and tactile experiences. These were seen as necessary to build an embodied sense of self – the body as a container of the self. Winnicott (1962) stated that: “*the ego is based on a body-ego but it is only when all goes well that the person of the baby starts to be linked with the body and the body functions, with the skin as the limiting membrane*” (p 59).

It is through the sensations from the skin that we can reach the twofold experience of both having a body and being a body (Anzieu, 1989). Anzieu argues that the functions of the skin serve as a rudimentary model for the primitive ego, what he calls the skin ego. Aron (1998) proposes that the term skin ego may be better termed

the skin self and may then be viewed as one aspect of what Stern (1985) calls the “core self”. Aron (1998) states: *“Our bodies, our sensations, particularly the sensations of our skin surface are critical in shaping our images of our selves. In infancy, our bodily sensations are greatly affected by the qualities of the “holding” and “handling” that we receive from caretakers, and so it is not much of an extension to suggest that our self is foremost a body-as experiences-being-handled-and-held-by-other-self, in other words, our self is foremost a body-in-relation-self”* (p.20).

Both Lowen (1958) and Reich (1948) suggested that there was a close connection between the inhibition of breath and inhibition of feelings. Lowen (1976) has developed bioenergetics based on Reich’s structure model, a theoretical system and a practical approach concerned with raising consciousness about how we use our ‘life energy’. In bioenergetics focus is directed towards facilitating breathing and body exercise to facilitate emotional expression. Keleman (1992) developed another system of body structures based on anatomical structures with focus on parts where ‘energy’ is constricted or suppressed. He would emphasize the body work and requested his patients to listen to what the body could tell (Eiden, 2002).

During Reich’s stay in Norway in the 1930s he came to influence the psychotherapy of the time. The Norwegian physician and psychoanalyst Braatøy was greatly influenced by the work of Reich. Braatøy (1947/1965) discovered the interplay between tense muscles, respiration and nervousness as he worked closely together with the physiotherapist Bülow Hansen. Their joint work laid the foundation to the now widely recognized *Norwegian psychomotor physiotherapy*, developed by Thornquist and Bunkan (1990). This is considered the first cornerstone of the Affect-focused body psychotherapy (ABP).

1.2 PSYCHOMOTOR PHYSIOTHERAPY

In Psychomotor Physiotherapy (Bunkan, Thornquist & Radøy, 1982) the body is seen as a functional unit. This signifies that local symptoms are viewed in the context of the whole person as a social, psychological and physiological being. In Psychomotor Physiotherapy the aim is not to break the defence mechanism but to offer a possibility for new experiences and facilitate the ability to get in touch with earlier experiences. The treatment in psychomotor physiotherapy is partly based on findings from the physical examination, performed following the Resource Oriented Body Examination (ROBE) developed by Bunkan (1996). This type of body examination represents a qualitatively different approach than the objective, biomedical oriented body examination. In the ROBE communication, subjective experiences and the relation between the patient and the therapist are crucial elements. The body examination gives important information concerning the patient’s way of relating towards himself as well as his resources. (Bunkan, 1996; Bunkan, Ljunggren, Opjordsmoen, Moen, & Friis, 2001; Bunkan, Opjordsmoen, Moen, Ljunggren, & Friis, 1999; Friis, Bunkan,

Ljunggren, Moen, & Opjordsmoen, 1998). The body examination comprises four distinct parts: observation of the patient's body posture, reactions to passive movements, palpatory examination of skeletal muscles, and observation of respiration. The patients overall reactions, during and after the physical examination, also helps the physiotherapist understand the patient's specific needs and resources.

1.3 BODY AWARENESS

There are many techniques that aim at improving body awareness. One of the first in Europe might have been Gindler. From her personal experience of recovering from tuberculosis, she helped establish an entire school of bodywork. Her efforts in this field have later led to the Esalen institute. At the same time Feldenkrais and Frederick Matthias Alexander established techniques named by their family names. They have different backgrounds; Feldenkrais from engineering and Alexander (1932) from being an actor. Both created different ways of altering bodily difficulties and (re)learning new ways of acting and relating to ones body. The Feldenkrais method (Feldenkrais, 1977) has been evaluated in patients with shoulder pain (Lundblad, Elert, Gerdle, 1999) and along with Basic body awareness therapy in patients with chronic pain (Malmgren-Olsson, Armelius, & Armelius, 2001) and as a means to reduce anxiety (Kolt, & McConville, 2000).

Amongst Swedish physiotherapists the far most known bodily intervention is the Basic Body Awareness Therapy introduced by Roxendal (1985) with great influence from the French movement teacher Dropsy (1975, 1988, 1999). He combined Eastern meditation with western influences. The Body Awareness Therapy has been evaluated in patients with psychiatric disorders with good results (Friis, Skatteboe, Kvamsdal Hope, & Vaglum, 1989; Gyllensten, Hansson, & Ekdahl, 2003; Mattsson, 1998; Roxendal, 1985) and in patients with experiences of childhood sexual abuse (Mattsson, Wikman, Dahlgren, Mattsson, & Armelius, 1998) as well as in patients with irritable bowel syndrome (Eriksson, Nordwall, Kurlberg, Rydholm, & Eriksson, 2002).

1.4 AFFECT-FOCUSED BODY PSYCHOTHERAPY

The ABP stems from the combination of bodily intervention developed in the Psychomotor Physiotherapy and the focus on affect exploration. The treatment model is named Psychodynamic Body Therapy by Monsen (1989). In order to emphasize the focus on affects, rather than transference issues, the method is referred to in this thesis as Affect-Focused Body Psychotherapy (ABP). It is essentially the same method as PBT. In ABP the focus is on understanding the information latent in affects and to increase the tolerance for affects in general and anxiety in particular (Monsen & Monsen, 2000).

The Psychodynamic Body Therapy has been tried out in two controlled outcome studies. In the first one, 28 patients with fibromyalgia received PBT treatment or ordinary physiotherapy (Monsen, et al., 1994). The therapy was conducted by eight therapists with three years of learning this specific approach. The PBT group changed significantly more on subjective experience of pain, somatisation and general symptoms (MMPI and SCL-90) than did the control group (Monsen, et al., 1994). The second study included 40 patients with long lasting pain; half of the patients were treated with PBT for 33 sessions, and the other half received treatment as usual (TAU) or no treatment. At the end of therapy the pain was significantly reduced in the PBT group compared to the controls, and 50% of the PBT patients reported no pain. The findings further showed a significant and substantial change in somatisation, depression, anxiety, denial, assertiveness, social withdrawal and increased affect consciousness. The results remained stable at one year follow up, and the PBT patients even continued their improvement concerning depression, anxiety and assertiveness during follow up (Monsen & Monsen, 2000).

1.4.1 ABP according to Wampold's levels of abstraction of psychotherapy

Treatments can be described from different view points. Wampold (2001) has depicted four levels of abstraction of psychotherapy: theoretical approach, technique, strategies, and meta-theory. This model of analysis will be used to further describe ABP. In the following text the therapist will be addressed as “she” and the patient as “he”.

1.4.1.1 Theoretical approach

The ABP has several roots; stemming from existentialism, self psychology and affect theory as well as Psychomotor Physiotherapy.

The existentialist part can be traced back to Buber and his I-Thou relationship. It has also been outlined by Rogers (1942) in his client-centred therapy: The focus is on the interaction; the therapist does not only function as an alter ego but also as an independent pole of interaction. At times the therapist expresses, to the client, her own feelings about the situation. On account of this transparency, the process becomes more a dialogue, an I-thou encounter (Buber, 1923/1958). In the I-Thou dialogue the therapist attempts to be fully present in the moment, attending to the patient's inner experience, regularly checking her understanding with him, letting the patient know that she understands how he feels on the inside, and attempting to focus his attention on what is merely becoming conscious. This has more recently been described by Greenberg (2002). The therapist might not be aware of the patients affect experience through what he is communicating verbally but rather in the way he is saying it, his vocal tone, and her bodily experience. The therapist's role is to contribute to making these experiences verbally explicit (Greenberg, 2002). This is also in line with other

therapists working with affect awareness such as Fosha (2005) and Mc Cullough & Andrews (2001).

Both Rogers and later on self psychologists such as Kohut stressed that the cure comes along with the therapist's way of being empathic. Kohut (1977) described it as a "consistent empathetic stance" and his followers as "sustained empathic inquiry" (Stolorow, Brandshaft & Atwood, 1987).

The *Affect Consciousness Treatment* model developed by Monsen & Monsen (1999) is the second cornerstone in ABP. Affects, feelings and emotions are concepts that are not easily defined and they have different connotations depending on the researcher. Many researchers (Basch, 1976; Damasio, 2002; Nathanson, 1992) distinguish between affect, emotion and feeling, where affect refers to the biological activation- and signal system, and feeling corresponds to the mental experience of the affect, whereas emotion corresponds to the cognitive evaluation of the affect i.e. including previous experiences attached to the affect. Nathanson (1992, p. 50) concisely summarises the relations among these three concepts: "*Affect is biology, feeling is psychology and emotion is biography*". However, the literature on affect consciousness seldom makes this distinction. When we talk about affects we usually talk about them in relation to a specific situation, and from that point of view it is not really possible to separate affects from emotions and feelings.

Darwin (1872) was the first to describe different patterns of behaviour in differing situations of danger, victory, or defeat delineating patterns of emotional reactions with motor and somatic components. He treated them as components of successful or unsuccessful ways to adapt to certain demands of the surroundings. Fundamental in ABP is the view, launched by Tomkins (1962), that affects, and not our drives, are the primary motivators of behaviour.

Each affect has a biologically inherited program controlling facial muscle responses, blood flow-, respiratory-, and vocal responses (Tomkins, 1963). Affects are obviously bodily experiences, although interpreted and named by the mind (Damasio, 2002). Ekman (1992) has demonstrated that each affect is characterized by a discrete pattern of skeletal muscle contraction visible on the face and in body posture. Each affect also feels different on the inside of the body, however the ability to observe these bodily sensations vary between individuals. This is one, of four, aspect of the ability that has been called affect consciousness (AC; Monsen, Ødegård & Melgård, 1989). The four aspects of affect consciousness are; awareness, tolerance, emotional expression, and conceptual expression. A basic belief in ABP is that a general low degree of affect consciousness is likely to hinder the adaptive functions of affect in the organisation of personality functioning. It can be expected to influence the capacity to form mutual relationships, and if severely inhibited, it can also contribute to a loss of contact with a basic sense of self (Stern, 1985). It has been demonstrated that a low

degree of AC is significantly correlated to high distress in a psychiatric population (Monsen, Ødegård & Melgård, 1989; Monsen, Eilertsen, Melgård, & Ødegård, 1996; Monsen, Odland, Faugli, Dae, & Eilertsen, 1995).

Reich's theory concerning the body armour, supported by Lowen's hypothesis that there is a close connection between the inhibition of breath and inhibition of feelings, has also influenced ABP.

1.4.1.2 Technique

Awareness of body and affect is at the core of ABP. The bodily part of the therapy will focus on helping the patient to gain a better stability through exercises and massage grips that will enhance the patient's contact with his legs, thus emphasizing the importance of having a firm base. Bodily techniques such as massage grips and specific exercises are performed in different ways, depending on the patient's resources as they appear during the inquiry of anamnesis and physical examination (Monsen & Monsen, 2000). It is necessary that the patient gains the feeling of stability and control before the therapy is furthered. The use of massage and touch will generally have an anxiety-reducing effect and pave the way for self-reflection and mentalization processes. Special massage grips are used to loosen the stiff muscles around the thorax, aiming at a less controlled and deeper respiration. It is believed that loosening of muscular stiffness and/or restricted respiratory patterns may allow the patient to be emotionally moved and let affects have an impact on him. The bodily interventions may also help the patient to become more aware of affect signals and habitual ways of responding to them. Exercises can be used to stimulate new ways of acting; for instance, instead of withdrawal and silence when experiencing pain, the patient can discover ways of expressing pain and demonstrating rejection of the pain-provoking stimuli (Monsen, 2002).

Affect awareness is fundamentally a bodily experience. The therapist tries to understand the patients' affect information; may it be verbal or nonverbal (breathing, body posture and body reactions) and also by being observant of her own reactions using them as a way of sensing what the patient may be feeling. The affect exploration is focused on how the affects are organised concerning the four self-functions: awareness, tolerance, emotional expression and conceptual expression. The interventions are aimed at helping the patient to become more aware of the affect signal, to tolerate and let the affect influence him, which is necessary if the affect is to become a meaningful signal and not a mere anxiety provoking state. And finally to evolve the ability to express the affect emotionally and conceptually in a way that is appropriate and meaningful (Monsen & Monsen, 1999, 2000). This procedure is repeated while working directly with the body – with massage grips or movements – or while in the therapeutic dialogue focusing on bodily and verbal processes. The affect exploration focuses on how affects are experienced and expressed in the treatment room as well as in relation to other people - thereby identifying maladaptive organizing patterns

(Monsen & Monsen, 1999). By repeating this process, the patient may be able to reorganize his view of emotionally important other persons as well as his self-image. ABP can be viewed as a learning process, starting with stimulating the patient's interest and curiosity about exploring their affects and aiming at the patient adopting the affect exploration process and being able to continue it on his own (Johansson, Levy Berg, Biguet & Clinton, 2002; Monsen & Monsen, 1999). This way, the patients will learn to perceive affects as meaningful self-signals (Monsen & Monsen, 1999).

1.4.1.3 Strategies - the therapist's role

In ABP the focus is on external relationships and scenes from daily life that may activate maladaptive ways of functioning. There is no focus on the transference process; (i.e. the repetition in the present of a relationship that was important in a person's childhood) which is the core of psychodynamic psychotherapy. In this sense it differs quite substantially from the body-therapy by Downing (1994) who stresses the importance of working with the transference. In ABP there is a fundamental belief that the therapist and the patient mutually affect one another. The curative part of the treatment is considered to be the therapist's way of catching and identifying the patients' emotional experience. The therapists affect attunement and deep understanding of the patients experience is crucial in ABP. The patients' curiosity about the therapist plays a subordinated role. The therapist's role is to be empathic; to see, recognize, acknowledge and validate the patient's emotional state.

The therapist's role is active and supportive, encouraging and assisting the patient to explore his own feelings and to tolerate and express them adequately and directly (Johansson, Levy Berg, Biguet & Clinton, 2002; Monsen & Monsen, 1999; Monsen & Monsen, 2000).

1.4.1.4 Meta-theory

Wampold (2001) describes two different meta-theories in psychotherapy research; the contextual and the medical. In the contextual model it is emphasized that common factors are of fundamental importance, and it is argued that there is no evidence for specific intervention effects. Adherence to a specific technique is supposed to be of less importance but on the other hand coherence and the role of the therapist is underscored. In the medical model, common factors are regarded of less interest for research, according to Wampold. Instead the variation in efficacy between different psychotherapy techniques and the adherence to them are stressed.

The medical model in psychotherapy differs from the medical model in medicine in the following ways "*(a) disorders, problems, or complaints are held to have psychological rather than physiochemical etiology; (b) explanations for disorders, problems, or complaints and rationale for change are psychological rather than medical*"(Wampold, 2001, pp16). Considering these facts, the point of departure when initiating this study was to study ABP from the medical perspective. In the following section I will describe how ABP could be viewed that way:

Following Wampold, the medical model has five components:

- *Client disorder*

In the present material we have been treating patients with the GAD diagnosis following the DSM-IV manual (APA, 1994). Thus attributing an importance to the medical diagnosis.

- *Psychological explanation for the disorder*

In ABP it is a basic belief that the patients' difficulties can be related to a deficiency in affect awareness, tolerance and expressivity. Our presumptions are that the patients care givers not have been able to create a safe enough environment thus impeding a proper affect development in line with suggestions from other researchers (Crits-Christoph, Connolly, Azarian, Crits-Christoph, & Shappell, 1996) who state: *The emerging research literature on GAD and worry suggests that GAD is linked to both insecure/conflicted attachment in childhood and to a history of past traumas (pp 421).*

Abel (1991) has shown that GAD patients report difficulties identifying what they feel and describing their affects, therefore it has been suggested that GAD patients may avoid emotional experiences in general and not just anxious feelings (Borkovec, Newman, & Castonguay, 2003). In ABP it is suggested that affects that are not being accepted are being withheld presumably by tightening muscles especially around the thorax thus impeding the free breathing (Bunkan, 1996; Bunkan, Ljunggren, Opjordsmoen, Moen, & Friis, 2001; Bunkan, Opjordsmoen, Moen, Ljunggren, & Friis, 1999; Friis, Bunkan, Ljunggren, Moen, & Opjordsmoen, 1998; Havik et al., 1991; Lowen, 1958; Meurle-Hallberg, Armelius, & von Koch, 2004; Reich, 1948). In that way the muscular armour is supposed to defend the individual against unwanted or unacceptable feelings. Affects can also be held back by lack of muscular tonus similar to the acting dead described by Rothschild (2000).

- *The mechanisms of change* offered in ABP are increased affect consciousness and improved bodily awareness

- *Specific therapeutic ingredients* are the focus on the body and the affects as they are experienced within the body. ABP, as all body psychotherapies, addresses the meaning of bodily expressions and in doing so works against the fundamental split between the mind and the body (Eiden, 2002) that is prevalent in patients suffering from GAD.

- *Specificity*

Special intervention methods in ABP are the therapists acknowledging and accepting attitude, the interest that the therapist shows towards the patient, his body and bodily reactions, and the therapist's way of actually letting herself be moved by the patients affects, thus helping the patient to get access to his affect states. In ABP there is a belief that the specific therapeutic ingredients, such as the affect exploration process and

bodily focus, are remedial, and that the specific ingredients are assumed to be responsible for client change or progress toward therapeutic goals. Specificity implies that specific effects will be overwhelmingly larger than general effects (Wampold, 2001).

1.5 GENERALISED ANXIETY DISORDER

GAD in the DSM-IV nosology is defined by the key features of excessive, uncontrollable worry of at least 6 months' duration about a number of life events or activities, accompanied by at least 3 of 6 associated symptoms of negative affect or tension such as restlessness or feeling keyed up or on edge, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension and sleep disturbance (Appendix 1; APA, 1994).

A person with GAD thus experiences anxiety most of the time, with a cognitive dysfunction that is prospective rather than retrospective as in depression. The worry content deals with prospective themes concerning safety and harm issues for oneself and the immediate family. In general, people with anxiety, have a low tolerance for experiencing their anxiety and do whatever possible to oppress it and try to hide it from others. They are actually afraid of their anxiety and are thus caught in a negative spiral where they become anxious of fear from getting into a situation where they believe that they will feel anxious (Wells, 1995). The more the person tries to solve the problem by avoiding it, the more it persists and even gets stronger (Malan, 1999; McCullough, 1998). People with GAD frequently have been hindered in their working life and in their spare time due to their reluctance of taking risks and their vulnerability to stress.

1.5.1 Prevalence and incidence

Generalized Anxiety Disorder (GAD) is the most prevalent anxiety disorder in the general population and in primary care, with lifetime prevalence rates of about 6 per cent, mostly presenting in middle age (Hoyer, Beesdo, Becker & Wittchen, 2003). In a population sample drawn from the Swedish Twin registry, women were diagnosed with GAD twice as often as men (3.95 % versus 1.74 %; Mackintosh, Gatz, Loebach Wetherell, & Pedersen, 2006).

In a screening of 14000 patients seeking primary health care in Belgium and Luxemburg, 8.3 % were given a GAD diagnosis (Ansseau, Fischler, Dierick, Mignon & Leyman, 2005). In a Scandinavian study, the prevalence of GAD in patients consulting their general practitioner was studied (Munk-Jørgensen et al., 2006). Among the Swedish 1300 patients in that study, 5% were diagnosed with pure GAD and an additional 1.5 % of the males, and 3% of the women had comorbid GAD and major depression.

GAD is associated with a wide spectrum of somatic disorders, such as pulmonary and heart disease (Kubzansky et al., 1997) as well as depression (Allgulander, 1994; Andersson, Noyes & Crowe, 1984; Wittchen, Zhao, Kessler & Eaton, 1994). Researchers conclude that comorbidity between anxiety and depressive disorders may represent the rule rather than the exception, especially within clinical samples (Belzer, & Schneier, 2004). Researchers have also found high rates of PD diagnoses (Dyck et al., 2001; Sanderson & Barlow, 1990; Sanderson, Wetzler, Beck & Betz, 1994 a). Once diagnosed, patients tend to describe their cognitive dysfunction and worrying style for having persisted for as long as they can remember, while the social consequences tend to become apparent in their middle ages, thus analogous with a personality disorder rather than an axis I disorder (Allgulander, personal communication).

1.5.2 Etiology

The underlying causes of generalized anxiety disorder are unknown. This might be due to the difficulty to delineate GAD from other co-occurring disorders such as depression, panic attacks and social phobia, and a shared genetic substrate shown in women (Allgulander, 1998). It thus involves a combination of hereditary and predisposing childhood experiences (Angst & Vollrath, 1991).

1.5.2.1 Genetic explications

Some researchers have through twin studies found evidence for a heritability of psychological traits, thus supporting the genetic risk contribution for developing GAD (Bouchard. 2004; Woodman, 1993). Kendler's study of female twins provides support for the concept that in women, major depression and GAD are based on a shared vulnerability. Environmental risk factors then determine whether a woman will develop GAD or major depression (Kendler, 1996). In the Swedish twin registry cited above, 10,566 same-sexed twins aged 55-74 were interviewed to determine the genetic contribution to GAD. It was estimated at 27%, while individual environmental factors were 72% and shared environmental risk factors 1% or less (Mackintosh et al., 2006).

1.5.2.2 Childhood experiences

GAD is a persisting, perhaps life-long disorder with many studies indicating an age of onset as far back as an individual can remember (Barlow, Blanchard, Vermilyea, Vermilyea, & DiNardo, 1986; Rapee, 1987). Some researchers have retrospectively examined childhood factors in GAD and compared them with patients suffering from panic attacks (Raskin, Pecke, Dickman, & Pinsker, 1982). Raskin et al. (1982) found that the GAD patients reported a less "grossly disturbed childhood environment" than did the panic patients. Angst and Vollrath (1991) showed that distressing conditions in the family, such as conflict between parents or with parents, lack of attention, or sexual trauma, were more prevalent among subjects with anxiety disorders than among controls.

Wolfe (2005) has proposed a psychodynamic theory of the etiology of GAD. He suggests there are three processes involved in the acquisition of GAD: 1) *A failure to learn specific social and life-care skills*; 2) *Internalization of toxic opinions of significant others regarding one's basic worth*; and 3) *The development of unconscious conflicts centering on the expression of one's feelings* (pp. 146-147)

1.5.3 Understanding the worry in GAD

Deficient regulation of affect is often seen in patients with psychiatric and/or psychosomatic disorders and is a main feature in Generalized Anxiety Disorder (GAD). Significant in GAD worry is that the focus of worry seems to change over time, only the worry persists. Worry in GAD can be viewed as a defensive manoeuvre. Wolfe (2005) suggests that patients with GAD are fearful of their emotional reactions, and worry in GAD can be viewed as a form of avoidance (Borkovec, Alcaine & Behar, 2004). Studies have also revealed that GAD worry is characterized by meta- worry, i.e. worry about worry (Wells & Carter, 2001). There are at least two possible ways to understand the worry as avoidance:

- Considering that worry might reduce the probability of a future negative incident and thereby reducing the sense of uncertainty (Craske & Hazlett-Stevens, 2002; Freeston, Rhéaume, Letarte, Dugas, & Ladouceur, 1994; Dugas, Gagnon. Ladouceu, & Freeston, 1998).
- Worrying about trivial matters may reduce thoughts and feelings about one's sense of worthlessness (i.e. shame) or other unpleasant internal experiences (Roemer & Orsillo, 2002). Eventually worry itself becomes an unwanted internal experience, which triggers attempts to avoid it, which may increase its frequency (Wells, 1995; Roemer & Borkovec, 1994).

The hypothesis that worry serves as an avoidance of internal distress is supported by findings that GAD is associated with chronic tension, as well as vigilance and scanning symptoms rather than the increased sympathetic activation seen with all the other anxiety disorders (Brown, Barlow, & Liebowitz, 1994; Marten et al., 1993).

1.5.4 Therapeutic treatment

Cognitive-behavioural therapy has been shown in controlled studies to be effective in reducing symptoms of GAD (Ballenger et al., 2001; Borkovec & Costello, 1993; Butler, Fennel, Robson & Gelder, 1991; Durham, Murphy, Allan, & Rickard, 1994; Falsetti & Davis, 2001). Cognitive therapy and cognitive-behavioural therapy and applied relaxation have been compared (Arntz, 2003; Borkovec, Newman, Pincus, & Lytle, 2002; Öst & Breitholtz, 2000) and all methods were found equally effective, with recovery rates about 50-60%. Some authors conclude that it may be necessary to also develop methods that address the interpersonal problems that patients with GAD often present (Borkovec et al., 2002). Thus it seems to be essential to integrate methods of

different kinds to meet the multifaceted needs of patients with GAD. Several attempts to apply theoretical integration (Stricker & Gold, 1996) in the treatment of patients with GAD have been presented. Crits-Christoph (2002) suggested a treatment package that integrates cognitive, behavioural, psychodynamic/inter-personal and acceptance-based models for patients with GAD (Crits-Christoph, Connolly, Azarian, Crits-Christoph, & Shappell, 1996; Crits-Christoph, Connolly Gibbons, Narducci, Schamberger, & Gallop, 2005). Likewise, Roemer and Orsillo (2002) have described a model for treating GAD integrating mindfulness/acceptance-based approaches with existing CBT models.

Wolfe has developed an integrative psychotherapy especially suited for patients with anxiety disorders that incorporates psychodynamic, behavioural, cognitive-behavioural, humanistic-experiential, and biomedical perspectives on anxiety disorders. He also emphasizes the need to treat both the symptoms and the associated underlying issues and thus has developed a four-stage treatment; first establishing the therapeutic alliance, then ameliorating the anxiety symptoms, uncovering the deficiencies in immediate self-experiencing, and finally repairing underlying self pathology (Wolfe, 1989, 1992, 1995, 2005; Wolfe & Sigl, 1998). His model is consistent with the “three-tier” model of personality structure and change, developed by Gold & Stricker (1993). Tier one refers to overt behaviour, tier two to conscious cognition, affect, perception and sensation and tier three to unconscious mental processes, motives, conflicts, images, and representations of significant others. Gold and Stricker (1993) have developed an integrative method that addresses pathology on all three tiers.

1.6 PATIENT’S PREFERENCES AND EXPERIENCES RELATED TO OUTCOME

The medical model predicts that differences among therapies are obscured by various patient characteristics and that it might be necessary to match therapies to fit the patient’s specific characteristics such as psychiatric diagnosis, illness etiology or treatment preferences. Various terms have been associated with designs that test for differential interactions between patients’ characteristics and therapy content, such as: matching studies, aptitude x treatment interactions, and moderating variables (Wampold, 2001).

Thus, patient’s preferences for particular treatment strategies could be a possibly important mediating factor in the treatment of GAD. It has been demonstrated that beliefs or attitudes that patients bring to therapy have an important influence on the process and outcome of treatment (Frank, 1959; Joyce & Piper, 1998). It has also been shown that initial treatment preferences were significantly related to treatment satisfaction at follow-up in patients with eating disorders (Clinton, Björck, Sohlberg & Norring, 2004). Several researchers have demonstrated that the congruence between a patient’s treatment assignment and his/her preference for a particular form of treatment was significantly related to whether the patient remained in treatment (Clinton, 1996;

Elkin et al., 1999). Preferences of treatment may be related to patients' coping styles, since patients may tend to prefer and expect to be helped by interventions that reflect their own characteristic coping styles. Some authors suggest that coping style may interact with treatment form as an important predictor of treatment response (Dance & Neufeld, 1988; Blatt & Felsen, 1993). Some coping styles may be particularly important, such as: a) active and independent versus passive and dependent, b) introspective versus focused on external solutions, and c) confrontative versus avoidant. In the case of GAD, greater knowledge of patients' preferences and experiences of treatment may help to improve treatment efficacy and outcome by contributing to improved treatment planning, since patients may initially be motivated for treatment that is compatible with their own preferences, yet unmotivated for methods that conflict with their preferences. Better knowledge of preferences of treatment interventions in GAD may also help therapists to engage patients in treatment. By alerting therapists to sources of potential conflict when preferences are discrepant or inappropriate, it may be possible to reduce the risk of dropout and improve screening procedures for better matching of patient to treatment, as well as facilitating the working alliance (Clinton, 2001).

1.7 LOCATING MYSELF

In my view there are many ways of knowing and no single truth, thus I adhere to epistemological relativism. This signifies that there are multiple realities and that they are socially constructed (Lincoln, & Guba, 1989). Furthermore realities are experienced differently depending on the person experiencing and judging them (Öhman, 2005). Therefore it is valuable to use different perspectives to try and capture various aspects of the problem in focus. Restricting oneself to a single way of knowing can result in a limitation to the depth of knowledge that can be applied to a given problem situation (Shepard, Jensen, Schmoll, Hack, & Gwyer, 1993).

Therefore I will describe my own role and preconceptions with regard to the research area. I have had a twofold role; being one of the four clinicians in this study as well as the researcher. When starting this study, my colleagues and I were all working in psychiatry. We had just finished the training in the ABP method, named Psychodynamic Body Therapy (PBT). We were trained and examined in PBT by Kirsti Monsen, who had created the method (Monsen, K., 1989, Monsen & Monsen, 1999). Another of our teachers was Berit Bunkan (1996), who together with Thornquist and Radøy had established the psychomotor physiotherapy method, one of the cornerstones in PBT. We were also trained in affect theory and affect interviewing by Jon Monsen (Monsen, Melgård, & Ødegård, 1986).

Since the start of this thesis in 1998, I have completed psychodynamic psychotherapy training. In my work as a body psychotherapist, in psychiatry and psychosomatics, I am constantly engaged in how to integrate different techniques to

enhance the patient's ability to experience the mind-body unity. I am inspired by experiential psychotherapy such as Fosha (2001) and McCullough (1998), the relational perspective (Aron & Anderson, 1998) as well as trauma treatment (Rothschild, 2000).

My knowledge in the ABP method gave me the possibility to pose questions to the patients who had been in treatment and it helped me understand their descriptions and experiences. This could be viewed as a clear advantage. However, there is always a danger in this procedure that the researcher will "go native", as it is described in action research. This signifies that the researcher is far too involved to see clearly and thus loses the necessary distance to critically examine data. Others say that it is necessary to "go native" to be able to: *"pick it to pieces, deconstruct, reconstruct and transform it with its tensions, tacit assumptions and practical preconditions exposed"* (Eikland, 2001, pp. 154). My intention was to strive in that direction in order to explore and articulate some of the ingredients in the ABP method for patients with GAD.

My understanding of worry in GAD corresponds to the view presented by Wolfe (2005); worrying is a cognitive process that protects the person from experiencing painful emotions. It can be viewed as an escape from one's direct, in-the-moment experiencing. This study is based on the view that the worrying behaviour can function as a defence blocking more adaptive forms of responding. The conflicted feelings can be any of the full range of feelings that the person is not capable of accepting (McCullough, 1998).

1.8 RATIONALE

GAD is an incapacitating illness and the impairment from GAD can be compared to that seen in depression (Hoffman, Dukes, & Wittchen, 2008). Although CBT for GAD has been listed as an empirically-supported treatment by the Task Force for the Dissemination and Promotion of Empirically Supported treatments (Chambless, & Ollendick, 2001) some methods of assessing clinically significant change suggest that only about 50% of GAD patients receiving CBT return to normal levels of anxiety (Borkovec, & Whisman, 1996). The focus on affect-exploration and bodily interventions are expected to help the patient to get in touch with his/her feelings, thoughts and behaviour in the physically felt, bodily experience. The wish to develop an alternative and integrative treatment for patients suffering from GAD has been the impetus to the present study.

1.9 AIM OF THE THESIS

The overall aim of this thesis was to evaluate and explore the Affect-focused body psychotherapy for patients with Generalised anxiety disorder

The specific aims were:

- I. To study the long-term effects of Affect-focused body psychotherapy in comparison with psychiatric treatment as usual.
- II. To investigate if affect consciousness is influenced by Affect-focused body psychotherapy. To explore if there is a relationship between affect consciousness and psychiatric distress, and if so, to describe the relationship between affect consciousness and distress.
- III. To explore preferences for particular sorts of treatment interventions, (i.e. support, inward reflection, concrete and directive problem solving, and affective expression), how patients experience such interventions, and the relationship between treatment preferences and experiences to outcome.
- IV. To gain knowledge in how patients experience the ABP and if/how the treatment enhances the patients' capacity to redefine their anxiety symptoms.

2 METHOD

2.1 RESEARCH DESIGN

The research design in study I-III corresponds to the medical model, described above (1.4.1.4 *Meta- theory*). The four levels of abstraction served as a guide to the research design utilized.

In **study I** the *specific approach* in ABP was investigated. The corresponding research question was if ABP was as effective as another treatment intervention. Thus a randomized clinical trial was chosen.

In **study II** the *specific technique* with affect exploration was investigated. The research questions concerned if the method actually could influence the affect consciousness and if there was a link between affect consciousness and outcome. The research design that I used to answer these questions was a clinical trial without control group.

In **study III** the focus was to investigate if the patients' *treatment preferences* were related to outcome and how their experiences were related to initial preferences and outcome and if it differed between the treatment modalities. The research design that I used to answer these questions was a clinical trial with a control group.

The research design in **study IV** is rooted in the life-world perspective. The research question was still concerned with the ABP treatment but the focus was on what participation in ABP meant to the patients, their life-world perspective was central. The life-world perspective was initially formulated by Edmund Husserl (1970). He stated that we in phenomenology are interested in the persons' lived experiences rather than objectivistic descriptions. The basic methodological question for Husserl was how to study subjectivity (Husserl, 1970). The life-world is thus the world as we perceive it, and it is constituted of our memories, our experiences of the everyday world and expectations about the future. A hermeneutic approach has been used to interpret the interviews, with the aim of acquiring a valid understanding of the meaning that the patients attributed to participating in ABP. In this thesis the purpose of the qualitative work was to extend the understanding of the ABP process from the patients' perspective. Therefore it was natural to have the qualitative part at the end of the thesis. However, the different approaches have the same importance.

There is no unbiased interpretation of a text, because the interpreter cannot leave the tradition of understanding the reality he or she lives in (Kvale, 1996). I would like to add that there is no unbiased interpretation of numbers/statistics either.

2.2 PATIENTS

The patients were recruited consecutively through six first-line psychiatric out-patient clinics south of Stockholm. They were examined by a medical doctor or a team member. The following **inclusion criteria** were applied: GAD according to DSM-IV (APA, 1994); age 18-55 years; ability to understand and speak Swedish well enough to be able to answer the questionnaires. **Exclusion criteria** were: Major Depressive Disorder and Bipolar Disorder according to DSM-IV, with or without severe suicidal risk; organic brain damage; psychotic syndrome; ongoing drug or alcohol abuse and current pregnancy.

Table 1.			
Patients characteristics		Treatment groups	
		ABP n=33	TAU n=28
Age	Age mean (range)	38 (25-55)	37 (21-53)
Sex	Female/male	24 / 9	18 / 10
Martial status	Married or cohabiting	24	17
	Single/divorced	4 / 5	5 / 6
Working capacity	Working full time	8	13
	Working part time	9	2
	Sick leave/pension	10/1	6 / 3
	Unemployed	3	1
	Parental leave/studying	1/1	1 / 2
Education ^a	High	5 (15%)	7 (25 %)
	Medium	22 (67%)	14 (50%)
	Low	6 (18%)	7 (25%)
Medication ^b		24 (73%)	20 (71%)
Personality disorders	No personality disorder	6 (18%)	6 (21%)
	1-3 diagnoses	17 (52%)	14 (50%)
	4-8 diagnoses	10 (30%)	8 (29%)

^a High: > 12 years. Medium: 10-12 years. Low: 9 years or less

^b Anxiolytics and/or antidepressants and/or sleeping pills

The total patient group consisted of 61 individuals. There were 42 women and 19 men; the mean age was 37 years (range 21-55); 70 % were married or living with a partner; more than half of the group were working at least part time. About 60 % had 10-12 years in school, 20 % had less and 20 % had some form of higher education (see Table 1).

According to a self-report instrument, SCID screen (Ekselius, Lindström, von Knorring, Bodlund & Kullgren, 1994), 49 (80 %) patients met the DSM-IV Axis II criteria for at least one personality disorder (PD). This is an important observation in its own right. However, we did not use PD as an exclusion criterion. More than half of the group had 1-3 self-reported PDs and one fourth had 4-8 (see Table 1). Slightly more than 70 % of the patients were on medication (anxiolytics and/or antidepressants and/or sleeping pills). More than 50 % of the patients had had their first contact with psychiatry more than three years prior to the study.

2.3 PROCEDURES

Prospective participants diagnosed with GAD were given both written and verbal information about the trial, and written consent was obtained from all participants. The study was approved by relevant professional ethics committees.

A flow chart of the study is presented in Figure 1. The patients were recruited from six different psychiatric clinics. All participating patients had a doctor in charge at the psychiatric clinic, and if needed the patients received medication. Consenting patients were then referred to physiotherapists who administered assessment measures prior to randomisation and treatment (T0). Patients were subsequently assessed one and two years after initial assessment (T1 and T2).

Sixty-four patients met the GAD criteria in the screening. However, three of the patients fulfilled exclusion criteria, and were therefore not included in the study. Of the 61 patients 33 were randomized to ABP and 28 to TAU, using a random number table. Twenty-seven patients completed the one-year ABP, and six patients dropped out. During the second year 18 patients in the ABP group (including three from the drop-out group) had no further treatment in psychiatry, but 15 continued with some other kind of treatment. One patient had a few booster sessions of ABP and another patient had counselling due to a traumatic event, two had a few sessions of family therapy and three from the dropouts continued in therapy other than ABP. Eight patients had regular but scarce medical contact (see Figure 1).

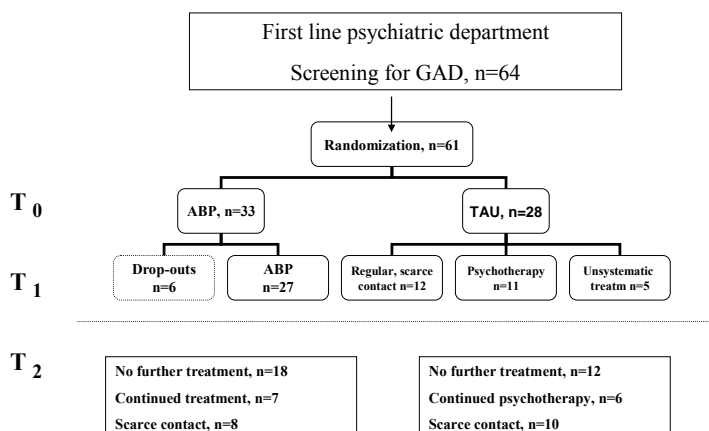


Figure 1. Flow chart of the study

2.4 INSTRUMENTS AND MEASURES

Various quantitative and qualitative instruments were used in the studies in this dissertation (Table 2).

2.4.1 Self-rated instruments

2.4.1.1 Socio-demographic data

Background and Treatment Inventory; a questionnaire constructed, by the author and co-workers regarding different socio-demographic data and previous illness and treatment history.

2.4.1.2 Severity of psychiatric symptoms

The Symptom Check List (SCL-90; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974) was used to measure patients' subjective experience of psychiatric symptoms. The degree of distress was rated on a 5-point scale ranging from 0 (not at all) to 4 (extremely) for each item. Besides 10 subscales, the Global Severity Index (GSI) is constituted by the mean across all 90 items. In a Swedish standardization the mean GSI for psychiatric patients was 1.02 ($SD = .69$) for men and 1.21 ($SD = .73$) for women (Fridell, 2002).

In paper I and III we separated changes in anxiety from changes in distress in other respects, hence we calculated two separate scores:

- Anxiety as the mean across the 10 anxiety items (named Anx in paper I and SCLAnx in paper III).
- Global Severity minus Anxiety as the mean across the remaining 80 items (named GSI–Anx in paper I and GSI_anx in paper III).

In paper II we used the Global Severity Index (GSI), constituted by the mean across all 90 items, to measure general distress. The GSI has high internal consistency and high test-retest reliability in a Swedish translation (Fridell, 1998). In our material Cronbach's alpha was .96 on the GSI, .98 on the GSI without the anxiety scale, and .91 on the Anxiety scale.

2.4.1.3 Severity of anxiety symptoms

Beck's Anxiety Inventory (BAI; Beck, Epstein Brown & Steer, 1988; Beck & Steer, 1993) is a 21-item self-report scale that assesses common features of anxiety, with a focus on body symptoms and cognitions on a 4-point severity scale. It has been widely used in studies of psychological treatments for anxiety. The BAI has high internal consistency and test-retest reliability over one week and it can discriminate anxiety disorders from non-anxiety disorders. In our sample Cronbach's alpha was .91.

Table 2. Review of instruments and methods used in the dissertation

Variable	Instrument	Presentation
Baseline data		
Self rated personality disorder	SCID screen	Paper I, II, III
Background data concerning socio-demographic facts and previous illness and treatment history	Background and Treatment Inventory	Paper I, II, III, IV
Outcome		
Psychiatric symptoms	Symptom Checklist -90 (SCL-90)	Paper I, II, III
Anxiety symptoms	Beck's anxiety inventory (BAI)	Paper I, II, III
Well being	WHO's well being index	Paper I, II
Patients treatment preferences and experiences	Treatment preferences and experiences scale (TPEX)	Paper III
Affect-consciousness	Affect-consciousness interview, semi-structured	Paper II
Patients experiences of participating in ABP	Interviews directly after treatment and one year later, semi-structured	Paper IV

2.4.1.4 Well being

The WHO (Ten) Well Being Index (WWBI; Bech, Gudex & Staehr Johansen, 1996) includes negative and positive aspects of well-being in a single scale. The 10-item scale has been found to constitute a valid index of well-being, being derived from the 28-item WHO Well-Being Questionnaire. After reversing one item the scale measures positive well-being. In our material Cronbach's alpha was .95.

2.4.1.5 SCID II screen

This is a self-report instrument including questions for all items in the DSM-IV axis II. (Ekselius, Lindström, von Knorring, Bodlund & Kullgren, 1994). The 97 items can be answered by a 'yes' or a 'no'. Compared to the SCID interview the SCID screen is over-inclusive. Ekselius has therefore suggested raising the cut-off point so that one more criterion has to be fulfilled for each of the PDs. It has been demonstrated that the SCID screen questionnaire with raised cut-off levels can be used to give a rough estimate of the frequency of PD in a population. The overall kappa for the agreement between the SCID interviews and the SCID screen questionnaire with adjusted cut-off has been found as high as .78 (Ekselius et al., 1994). We have used the number of PD's as a rough indication of the severity of the patients' personality problems.

2.4.1.6 Treatment preferences and experiences

Assessment of initial preferences and subsequent experiences of treatment interventions was made using the Treatment Preferences and Experiences Questionnaire (TPEX; Clinton, & Sandell, 2007), a 29-item questionnaire being developed in an on-going project looking at the relationship of treatment preferences and experiences to outcome in different forms of psychotherapy. The TPEX has two forms, one for assessing preferences and the other for assessing experiences. Prior to treatment subjects were asked to rate the extent to which they believed they would be helped by specific interventions and therapist characteristics; at follow-up patients were asked to rate the extent to which they believed they been helped by these interventions. TPEX uses a six-point Likert scale, with items grouped according to four subscales: Outward Orientation (interventions focusing on concrete and directive problem solving), Inward Orientation (interventions focusing on reflection and inner mental processes such as fantasies, memories and dreams), Catharsis (focusing on expressive interventions and affect) and Support (focusing on active advice, encouragement and sympathy from the therapist).

Psychometric properties of the TPEX subscales were satisfactory. Internal consistency using Cronbach's α in the present combined sample (ABP and TAU) ranged between α .77 and .95. Coefficients for individual subscales were: Catharsis α .82 (preferences), α .87 (experiences); Inward Orientation α .77 (preferences), α .89 (experiences); Outward Orientation α .78 (preferences); α .90 (experiences); Support α .81 (preferences); α .93 (experiences).

2.4.2 Interviews

2.4.2.1 *Affect Consciousness interview*

The Affect Consciousness Interview (ACI; Monsen et al., 1996), used in study II, is a semi-structured interview designed to assess a person's capacity to cope with his or her feelings, across nine basic affect categories; Interest-Excitement, Enjoyment-Joy, Fear-Terror, Anger-Rage, Shame-Humiliation, Sadness-Despair, Envy-Jealousy, Guilt-Remorse and Tenderness-Devotion (Monsen et al., 1996). For each of these affects the interviewer attempts to assess and rate the interviewee's capacity to (a) be aware of, (b) tolerate, and express, (c) emotionally and (d) conceptually, inner emotional states. The assessment is based on the interviewee's free accounts of affect-laden life experiences. Monsen et al. (1996) have shown that ratings have satisfactory inter-rater reliability and high levels of internal consistency.

In this study five affects were assessed in the affect consciousness interview: Enjoyment-Joy, Fear-Terror, Anger-Rage, Shame-Humiliation and Sadness-Despair. These five affects are the ones that both Tomkins (1963) and Monsen et al. (1996) suggest as the primary affects, besides Interest-Excitement. However, pilot tests revealed that Interest-Excitement could not be scored with sufficient reliability, so it was not further covered in the analysis.

For each affect the following four aspects of affect consciousness were explored according to Monsen et al. (1996, pp 242).

- *Awareness*: The ability to feel, sense, become aware of, recognize or notice when experiencing a particular affect.
- *Tolerance*: The ability to be influenced by the affect; physically and mentally without acting out or becoming overwhelmed.
- *Emotional expression*: The ability to express the affect nonverbally in different kinds of object relations in a clear and appropriate way according to the circumstances.
- *Conceptual expression*: The ability to articulate the affect experiences in different interpersonal settings in a clear and appropriate way according to the circumstances.

The interviews were performed by physiotherapists, who were trained, by J. and K. Monsen to perform the interviews and apply the scoring method. Pre-treatment interviews were made by the physiotherapist who was going to treat the patient; post-treatment interviews by another physiotherapist previously unfamiliar to the patient. The interviews lasted for 90-120 minutes and were video- and tape recorded.

Subsequently, the interviews were analysed according to Monsen et al. (1986) using a 5-point scale, where 5 stands for the highest possible degree of affect

consciousness. A scoring manual developed by Monsen et al. (1986) was used and further developed by the author and co-workers in 2004 (unpublished, can be sent on request to the author).

The following ten scores were computed for each interview: The mean score for each affect across the four aspects of affect consciousness; the mean score of each aspect across all affects; and a global score as the mean of all the 20 ratings. Following Monsen et al. (1996) we have analysed the scores parametrically.

Additional analysis

In order to give a description of how changes in affect consciousness could be manifested, I also conducted a minor qualitative study concerning the patients who showed reliable change in affect consciousness regarding the specific affects.

1.1.1.1 Qualitative interviews

In study IV, a qualitative, semi-structured interview was undertaken directly after treatment termination and once again after a year. The interviews aimed at addressing all relevant aspects of the ABP interventions and the patients' life situation before and after therapy. Specifically, the interview entails a collaborative process between patient and interviewer, by which the patient is engaged in reflecting on the experiences of therapy and the interviewer extracts information relevant to specific research questions regarding the therapy process.

The interview directly after treatment termination focused on the patients' situation before therapy start, their initial attitude towards being offered the ABP treatment, their understanding of the treatment and the treatment impact on symptoms, relations and self image. The patients' relationship towards the therapist and memories of turning points in therapy were also elucidated.

The interview at one year follow up focused mainly on the patients' present situation in comparison to before therapy. The main themes were, the present trouble/pains/symptoms and how it was understood by the patient, the social situation, the patients view of themselves and experience of and attribution to change

The interviews lasted for between 45 minutes to 90 minutes and were audio taped and transcribed verbatim. The patients could choose place for the interview, either at their home or at the clinic where they were treated. The interviews were conducted by a physiotherapist previously unknown to the patient.

1.2 TREATMENT AND THERAPISTS

Four female physiotherapists, the author being one of them, administered the ABP once weekly during one year. Their professional experience in psychosomatics or psychiatry

varied from ten to twenty years. The treatment was guided by a manual (Monsen, 1989). Before the study, the physiotherapists were trained and examined in the ABP method by its author. During the treatment period all therapists had supervision twice monthly by another ABP teacher to ensure the quality of the ABP treatment and adherence to the manual.

2.6 PATIENTS AND METHODS OF ANALYSIS

The various methods of analyses that have been used are displayed in table 3. Data analysis was conducted by means of the Statistical package for Social Sciences (SPSS, 16.0)

2.6.1 Paper I-III

In paper I, data is presented on the entire intent-to-treat sample (ABP, $n = 33$; TAU, $n = 28$), with the last observation carried forward for all persons with incomplete data. The intent-to-treat approach is a conservative way to evaluate treatment effects for those patients for whom the treatment was intended, regardless of whether they completed treatment or not. Six patients (18%) dropped-out from ABP. The number of patients that did not return outcome data in the ABP group was two at T1 (6%) and three at T2 (9%). In the TAU group there were seven non-responders at T1 (28%) and three at T2 (10%).

Statistical analysis, paper I

Repeated measures multivariate analysis of covariance (MANCOVA) was performed on the SCL-90, BAI and WWBI. Effect sizes, d , on the raw scores on each outcome variable were also calculated. The raw score differences between the first measurement (baseline) and each of the two follow-up measurements for each scale in each group were divided by the standard deviation at baseline (Cohen, 1988; Leichsenring & Leibing, 2003). Between-groups effect sizes, Δ , were calculated using Becker's (1988) method, that is, computing the difference between the within-group d 's.

In paper II, a sub sample consisting of 22 patients from the first study was used. For inclusion in this study patients were required to have completed the one year ABP treatment and to have participated in the affect-consciousness interview before treatment start and after treatment termination. Sixteen women and six men were included in this study. Mean age was 41 years (range: 26-55 years).

Statistical analysis, paper II

The scoring of all interviews was performed by the author. In order to estimate the reliability of the ratings another physiotherapist scored nine randomly chosen interviews. Intraclass correlations (ICC) ranged between .65 (for shame) and .95 (for awareness) with a median of .88.

Multivariate analysis of variance (MANOVA) was used to evaluate the affect scores. Furthermore, within-group effect sizes, d (Cohen, 1988) and the Reliable Change Index (RCI) according to Evans, Margison and Barkham (1998) were calculated.

Reliable Change (RC) is about whether patients changed sufficiently that the change is unlikely to be due to simple measurement unreliability. The formula for criterion level, based on change that would happen less than 5% of the time by unreliability of measurement alone, is: $1.96 * SD_1 * \sqrt{2} * \sqrt{(1 - \text{reliability})}$.

In order to analyse the interaction between AC and outcome measures over time we ran a descriptive path analysis on an autoregressive cross-lagged model with standardized variables, using the LISREL 8.80 software. It is in the nature of this kind of model that each path is estimated with all other independent variables constant, making the dependent variables correspond to a standardized residual.

Qualitative analysis, paper II. Interviews that showed a positive reliable change were analysed qualitatively using the method of content analysis (Krippendorff, 2004). The number of interviews varied between 3 (shame and fear) and 13 (sadness). The software ATLAS.ti was used as an aid to the analysis (Graneheim, & Lundman, 2003). Before a statement was coded, it was first considered in its context to avoid using the patient's statement in a way that the patient might not have intended. Based on the aims of this study, the specific question put to the material was: How did the patient experience, tolerate and express the affect before and after therapy?

In paper III, a sub sample consisting of 43 patients from the first study was used. For inclusion in the study patients were required to have: a) either completed treatment in the ABP group or adhered to treatment in the control group; and b) completed all relevant measures at initial assessment (T0) and follow-up after one and two years (T1 and T2). In the ABP group T1 corresponded to the end of treatment. Twenty-six patients in ABP and seventeen in TAU fulfilled criteria. Mean age in both groups was 38 years (range: 21-55 years).

Statistical analysis, paper III

Independent-sample t-tests were used to compare ABP and controls on initial TPEX Preferences. In order to control for initial treatment preferences, univariate ANOVA was used, to examine between-group differences on TPEX Experiences. Paired-sample t-tests were used to compare scores on TPEX Preferences with scores on TPEX Experiences within each treatment group separately. In order to more fully explore patterns of treatment preferences and experiences we conducted a cluster analysis (Everitt, Landau & Leese, 2001). Cluster analysis is conceptually similar to factor analysis; however, while factor analysis reveals patterns among variables, cluster analysis focuses on groupings of individuals.

Table 3. Number of included patients, instruments, and methods of analysis in the four studies.

<i>Study</i>	<i>Treatment groups</i> <i>ABP TAU</i> <i>n n</i>		<i>Data collection method</i>	<i>Analyses</i>	<i>Secondary analyses of subgroups of patients</i>	<i>Analyses</i>
<i>I</i>	33	28	SCL-90 (GSI-Anx, Anx) BAI WWBI	MANCOVA Within-group effect sizes, <i>d</i> , Between group effect size, <i>d</i>	<i>Number of PD's:</i> 0 <i>n</i> = 12 1-3 <i>n</i> = 31 4-8 <i>n</i> = 18	MANCOVA
<i>II</i>	22 (<i>From study I</i>)		ACI SCL-90 BAI WWBI	MANOVA Within-group effect sizes, <i>d</i> Reliable Change Index (RCI) Descriptive path analysis	<i>Reliable change scores</i> ¹	Content analysis
<i>III</i>	26 (<i>From study I</i>)	17 (<i>From study I</i>)	TPEx SCL-90 (GSI_anx, SCL anx) BAI	Independent sample t-test ANOVA univariate Paired sample t-test Hierarchical cluster analysis	<i>Relative treatment experience</i> <i>Positive n=29</i> <i>Negative n=14</i>	MANCOVA Simultaneous multiple regression
<i>IV</i>	30 (<i>From study I</i>)		Follow up interviews	Hermeneutic approach		

¹ Additional analysis only in the frame of this thesis

Hierarchical cluster analysis was conducted using Ward's method on TPEX subscales for both preferences and experiences (i.e. 43 individuals clustered on 8 variables). By grouping ABP and controls together for cluster analysis it was possible to test whether either of the two treatment groups would be over- or under-represented in any of the resultant clusters. A two-cluster solution was judged to be the most meaningful, since it resulted in heuristically meaningful and conceptually distinct clusters

The relationship of treatment preferences and experiences to outcome was explored in two steps. In the first step we compared treatment groups and clusters in relation to the three outcome measures the Global Severity Index minus the anxiety scale (GSI_anx), the anxiety scale of SCL-90 (SCLAnx) and Beck's anxiety inventory (BAI). We used repeated measures multivariate analysis of covariance (MANCOVA) on the GSI_anx, SCLAnx and BAI with occasions (T0, T1, T2) as a within subjects factor, treatment group and cluster as between subjects factors, and number of treatment sessions as a covariate. In the second step we used a simultaneous multiple regression analysis to assess the ability of TPEX subscales to predict outcome across both samples of patients.

2.6.2 Paper IV

In paper IV, a sub sample consisting of 30 patients from the first study was used. For inclusion in this study patients were required to have started the ABP treatment and to have participated in an interview directly after treatment termination and/or at the follow up one year later. Thirty-three patients were randomised to the one year ABP treatment. There were twenty-seven completers and six drop-outs. Twenty-nine patients participated in the interview at treatment termination (T1) and twenty at the follow up interview (T2), one of them had not participated at T1. Only one of the completers and two of the dropouts did not participate in any interview.

Thus, 30 patients, 23 women and 7 men, were included in this study. Mean age was 38 years (range: 25-55 years). Eighteen patients (60%) were working at least part time or studying, 3 (10%) were unemployed and 9 (30%) were on full sick leave. Twenty-three patients (76%) were married or cohabiting and 7 (23%) were living alone.

Qualitative analysis was used as the research interest was to explore and extend knowledge about how the patients experienced the ABP. Qualitative inquiry and research methods are used to seek in-depth description and understanding of the qualities of given phenomena (Gubrium & Holstein, 1997). Qualitative methods usually address research questions such as what, how and why (Maxwell, 1996). The method of analysis was hermeneutical, as the meaning interpretation from the material was brought out. Other common techniques involved in qualitative

interpretative analysis such as condensation, coding, structuring, thematizing, hierarchically organizing, were the main methodological tools used (Ziebland & McPherson, 2006). Inevitably the researcher co-constructs data during the whole process from data gathering to analysis. In that sense meaning interpretation differs from a phenomenological analysis in that it is the researcher's reflection that brings out the meaning structure of the experience. Kvale (1996) has formulated three contexts of interpretation that were followed in the analysis process:

1) *Self-understanding*; the interviews were read as openly and non judgmental as possible, and statements were formulated according to the patients' way of expressing their experiences.

2) *Critical common sense understanding*; general knowledge was used as a frame for understanding. The aim was to go beyond the patients' self-understanding. The focus was to find out what the data revealed about the patients' way of relating towards their own body in the therapy process. In reading and analysing the text I followed the hermeneutic circle; my understanding of the text as a whole was established by reference to the individual parts and my understanding of each individual part by reference to the whole. Neither the whole text nor any individual part can be understood without reference to one another.

3) *Theoretical understanding*; the material was analysed in light of the mind-body unity and with the aim of relating the patients' experiences to concepts and discussions within the field of physiotherapy/body psychotherapy. This last process was a collaborative process between me and one of the co-authors.

3 RESULTS

3.1 PRIMARY OUTCOME STUDY (I)

Raw score means and standard deviations in the two groups at each measurement are displayed in Table 4, along with the within-groups \bar{d} s and between-groups Δ s.

The overall reduction in symptoms on all four indices over time was significant in both treatment groups. This was demonstrated in a MANCOVA with occasions as a within-subjects factor and groups as a between-subjects factor, using sex, age, and number of PD diagnoses as covariates, which gave a significant multivariate effect of occasions, [$F(8; 220) = 2.39, p = .017$]. There were significant univariate effects of occasions, showing reductions in symptoms on the GSI-Anx, [$F(2; 112) = 7.38, p = .001$, Anx, $F(2; 112) = 8.84, p = .000$, BAI, $F(2; 112) = 5.29, p = .006$], but not on the WWBI, [$F(2; 112) = 3.02, p = .053$]. However, the multivariate Group \times Occasion interaction was not significant, although univariate tests revealed a significant Group \times Occasion interaction on the GSI-Anx, [$F(2; 112) = 4.74, p = .011$, and Anx, $F(2; 112) = 3.99, p = .021$]. The differences were to the favour of the ABP group.

Neither sex nor age had any effect on treatment outcome. In contrast, PD was associated with high scores on the GSI and the BAI and low scores on the WWBI, indicating more distress at all occasions. When the patient group was divided into three subgroups according to number of PD diagnoses, 12 patients had no PD diagnosis on the SCID screen, 31 patients had 1-3, and 18 patients had 4-8 PD diagnoses. A MANCOVA with scores on the four outcome measures as dependent variables, occasions as a within-subjects factor, and the three-way sub-grouping based on number of PDs at treatment start as a between-subjects factor, using sex and age as covariates, gave a significant multivariate effect of number of PDs, [$F(8; 18) = 3.41, p = .002$], and significant univariate effects on all variables, [$F(2; 56) > 4.62, p < .015$]. The PD Group \times Occasion interaction was not multivariately significant, but there were significant univariate effects on Anx and WWBI. All comparisons showed higher levels of distress and lower rates of change the more PD diagnoses there were in the group.

Table 4.

Raw score means (*M*), standard deviations (*SD*), within-group effect sizes (*d*) and between-group effect sizes Δ for patients in affect-focused body psychotherapy(ABP) and psychiatric treatment as usual (TAU); all patients

Variable	ABP (<i>n</i> =33)			TAU (<i>n</i> = 28)			Δ Between groups
	<i>M</i>	<i>SD</i>	<i>d</i>	<i>M</i>	<i>SD</i>	<i>d</i>	
GSI-anx(SCL-90)							
Baseline	1,7	0.59		1.61	0.6		
T1	1.16	0.83	0.93	1.4	0.74	0.33	0.60
T2	1.1	0.87	1.17	1.27	0.84	0.55	0.62
Anxiety (SCL-90)							
Baseline	2.44	0.8		2.13	0.68		
T1	1.57	1.1	1.07	1.79	0.87	0.50	0.57
T2	1.44	1.1	1.23	1.64	0.98	0.72	0.51
BAI							
Baseline	29.5	13.2		25.4	10.5		
T1	17.7	12.3	0.89	18.6	12.2	0.65	0.24
T2	16.8	14.3	0.96	17.4	12.2	0.76	0.20
WWBI							
Baseline	7.9	5.3		7.8	3.7		
T1	11.6	7.8	0.71	9.7	6.2	0.51	0.20
T2	12.1	7.4	0.80	10.7	7.0	0.79	0.01

Note. GSI-anx = Global Severity Index, anxiety subscale not included; Anxiety = anxiety subscale on the SCL-90, BAI =Beck Anxiety Inventory; WWBI= WHO Ten Well-Being Index (the higher the score the better).

3.2 THE RELATIONSHIP BETWEEN AFFECT-CONSCIOUSNESS AND DISTRESS (II)

There was significant improvement in affect functions over time. This was shown in a MANOVA, with occasions as a within-subject factor, which gave a significant multivariate effect of occasions, [$F(4; 18) = 6.37, p = .002$]. There were significant univariate effects of occasions, showing improvement in all affect functions except awareness. In a corresponding analysis of the affect scores, there was no significant multivariate change although there was a univariate effect for Sadness. The raw score means and standard deviations concerning AC at treatment start and end of treatment are displayed in Table 5, along with effect sizes (d).

The number of patients with reliable change (RC), is given in Table 5. Ten patients showed a reliable positive change concerning the global AC. Furthermore, four patients had a reliable change concerning at least one affect and one affect function. However, six other patients showed reliable change in the negative direction. One of them deteriorated on global AC and five patients had at least one affect or affect function that was scored lower at end of treatment.

3.2.1 Additional analysis: Description of positive changes in affect consciousness

All interviews that showed a reliable positive change have been analysed, the number of interviews concerning each affect is stated in parentheses after the affect. The patients' statements are followed by an identification number in parentheses.

Enjoyment-Joy (n=6)

Before therapy, joy was considered a positive feeling but was viewed as absent or rarely present and, when experienced coupled with fear of its short-lived existence. Some of the patients seemed to express joy towards others as it seemed to be the only feeling that was considered legitimate to show to others, as a way to protect oneself against other more painful feelings.

I can't feel joy so easily now a days, I'm too occupied with the fear of getting an anxiety attack. I think that I'm blocking myself, I don't listen to those signals, I'm always observing myself, I can't concentrate, I can't relax, I'm always on guard because I fear that I will get a panic attack. (9)

In some cases it seemed as if the feeling and expression of joy tended to be exaggerated enough to render critique from others, which in turn made it difficult for the individual to express joy spontaneously.

Table 5. Reliability alpha (α), mean values (M) on affect consciousness (AC) at treatment start (T0) and end of treatment (T1), standard deviation (SD), p values from the MANOVA, and within group effect size d , and number of patients with reliable change (RC) in positive and negative direction.

<i>Affects</i>	<i>Reliability α</i>	<i>M_{T0} (SD)</i>	<i>M_{T1} (SD)</i>	<i>p</i>	<i>d</i>	<i>N of patients with RC</i>	
						<i>pos</i>	<i>neg</i>
Joy	.88	2.84 (0.54)	3.07 (0.58)	.08	0.43	6	2
Fear	.76	2.19 (0.39)	2.38 (0.57)	.24	0.49	3	1
Anger	.76	2.14 (0.46)	2.36 (0.65)	.10	0.48	6	2
Shame	.65	1.82 (0.44)	2.02 (0.61)	.09	0.45	3	1
Sadness	.88	2.05 (0.48)	2.51 (0.58)	.02	0.96	13	3
<u>Affect functions</u>							
Awareness	.95	3.02 (0.39)	3.08 (0.40)	.63	0.16	5	2
Tolerance	.91	2.07 (0.43)	2.55 (0.40)	.00	1.12	13	0
Emotional Expression	.90	1.80 (0.39)	2.05 (0.59)	.02	0.65	11	2
Conceptual Expression	.89	2.01 (0.62)	2.26 (0.56)	.01	0.40	5	0
Global AC	.92	2.23 (0.36)	2.49 (0.50)	.00	0.73	10	1

After therapy the description of joy was characterised by greater openness towards the feeling, towards oneself and towards others. Joy was viewed as a source from which to gain strength and power to fight difficulties. Enjoyment was recognized as a quiet, relaxed pleasurable feeling that enables oneself to think and enables contact and interest in others, enhances spontaneity and the ability to actually get pleasure from life. Joy was clearly linked to manifestations in the body, such as feeling light, having a more erect body posture, and feeling secure and approachable towards others.

I feel more open towards others than I did before, I don't have the shield as I had before, I'm able to touch people more than I used to do, I laugh more and I'm able to straighten myself up, I'm not afraid of showing myself (9).

Fear-Terror (n=3)

Before treatment patients described extremely low tolerance for fear. It was a dreaded feeling that they did not know how to cope with; the body signals of anxiety were experienced as taxing and unbearable. The unfounded worry was a feeling they wanted

to get rid of when it was present, i.e. running away from meetings. Much energy was also directed towards avoiding potentially anxiety provoking situations and not showing anxiety. None of the patients could share their feelings of anxiety with other people in a direct manner.

I never talk with anybody [about my fear], I don't tell anyone. I'm afraid that people would see me as weak, chicken. I told somebody once and was called wacko, since then I don't tell anybody. (6)

After treatment tolerance for anxiety had increased. The patients were also able to distinguish different types of worry and were able to see that the worry may signal important information. Strategies had also been developed to handle worries, and there was a tendency towards more openness.

I can talk about my fear with my wife but perhaps I don't tell here that I'm frightened, but I can say that I don't think that I'll manage. And at night, when I wake up with a scary feeling, then I wake my wife up and we can talk and slowly the fear vanishes. Sometimes I can talk with my son and daughter in-law. They have noticed that I have changed in a positive way. (6)

Anger-Rage (n=6)

The patients expressed that the feeling of anger was connected to childhood traumas such as parent's alcohol abuse and/or other types of neglect or punishments. Anger was provoked by the feeling of not getting through to other people, not being understood or listened to, being the victim of injustice or maltreated by superiors. All patients had severe problems with aggression, using violence as a means to protect themselves or acting out aggression verbally in a manner that would intimidate their families. Some of them made great efforts not to show any kind of aggression but directing it inwards instead, ultimately resulting in outbursts that were felt to be uncontrollable.

Anger makes me completely powerless to act, I loose interest in everything, I don't act as structured as I would like, I forget things, I get totally blocked. (9)

Most patients lacked the experience of expressing anger verbally because it was either totally controlled and neglected or acted out beyond control. In the latter case they did not see the point in expressing themselves verbally.

After therapy they acknowledged that the feeling of anger has an important message and, although they found it hard, they tried to communicate their feeling in a more appropriate way than before, increasing their chances to be understood.

I try to deal with the feeling in another way than I used before, I take the bully by the horns and I explain rather promptly that something is wrong instead of swallowing it as I used before. The feeling tells me something, but I think about it twice before I get it out of my chest. (9)

A fear of not being accepted when expressing angry feelings or deviant opinions, especially in working situation or outside the closest family, still persisted with many patients.

Shame-Humiliation (n=3)

The patients generally had great difficulties recognizing the shame feeling. Shame was considered extremely uncomfortable. The patients all recognized that shame made them want to sink into the ground and disappear. They were unsure about how they signal the shame feeling and they wanted to get rid of the feeling as fast as possible. This was done by laughing at themselves or changing subject to divert people's mind from the shame-provoking situation.

I get the shame feeling mostly when I feel a bit down. I try not to think about it because it has no sense, it's only something within me, and if I think about it, it only gets worse, I try not to hold on to it, just let it go, it may help to talk to someone about it. (14)

After therapy the patients seemed to be more aware of the shame feeling and analyzed it further than they had before. The shame feeling was connected to low self-esteem. The patients recognized different sorts of shame, the adequate feeling, like embarrassment, that helps people avoid passing the limits of what is socially and morally acceptable, and the kind of shame that they experienced as absolutely toxic and almost unbearable.

The feeling of shame is rather negative; it might be of use if one has acted inappropriate ...then I have to consider it and do something about it but in my case ... I do a reality testing and then the shame feeling usually disappears. (14)

Sadness-Despair (n=13)

Sadness was triggered by the feeling of not being able to fulfil one's obligations or one's goals. This was related to the loss of health; the long-lasting struggle with anxiety and the feeling of not being as strong and capable as before. The deep feeling of worthlessness was a fertile soil for experiencing other persons as being offensive. Sadness was described as losing power, energy and lust and thus sensing apathy, powerlessness, feeling tired or even dead inside.

When I feel sad I get a feeling of being paralysed inside, I feel sick, fade and loose my spirit, without power, it's like life vanishes in a couple of minutes. (10)

The sad feeling was described as a heavy downwards directed force. The ability to think was blurred because negative thoughts kept occupying ones mind only worsening the negative feeling. Not being able to tolerate sadness could result in panic attacks.

The patients found it difficult to show sadness and to express it verbally, as they did not want to be viewed as weak or needy or being a burden to the other person or even being rejected.

After therapy the sad feeling was a bit more accepted and they tried to understand why they felt it and what the sadness was all about. The effect of withholding sadness had become evident, with muscles getting tense and painful and the mind getting confused. The patients found that sharing their feeling of sadness with others helped them to overcome the feeling more easily and to find ways to cope with what actually caused their sadness.

I try to let it out, cry if I want to, and I try to sort out why I'm sad, talk about it and make it all right. (10)

For some of the patients it was still hard to tolerate and express their sadness, as they feared the reactions they assumed they would get.

3.2.2 Affect consciousness in relation to other variables

At intake, AC was not significantly correlated with any other variables but GSI, however at treatment termination there were significant correlations between intake AC and all outcome variables as well as number of PD diagnoses. Termination AC also correlated, negatively, with age, besides significant correlations with termination PD, GSI and WWBI (but not BAI). These correlations suggest that changes in AC might be associated with changes in the outcome variables. This was indeed the case with BAI ($-.49, p = .02$) but not with GSI ($-.36, p = .10$) or WWBI ($.25, p = .27$).

The interaction between AC and outcome measures over time was examined with a descriptive path analysis. The resulting path diagram concerning BAI is displayed in Figure 3a, b, c, where the thickness of a line is roughly proportional to the strength of the path and a negative path is indicated by a broken line.

Over the one year interval AC was highly stable (from .65 to .80 in the three models), whereas the stability of the outcome variables was lower, particularly so with BAI (.26). Keeping initial AC constant, BAI at intake significantly predicted AC one year later, such that patients with initially high BAI tended to increase their AC during treatment ($.49, p < .05$) more than patients with low BAI. No such effect was evident with GSI or WWBI. Reciprocally, AC at intake did not predict any of the outcome variables when initial scores and post-treatment AC were statistically controlled for. At termination, the link from AC to any of the outcome variables was not significant, varying between .24 and .33. Further, keeping AC at intake and termination constant only marginally reduced the correlations between intake and termination on the outcome variables, reducing it from .27 to .26 on the BAI, from .56 to .45 on the GSI, and from .54 to .48 on the WWBI. We concluded that AC had little effect on outcome, whether directly or as a mediator (Baron & Kenny, 1986; Whisman, 1993).

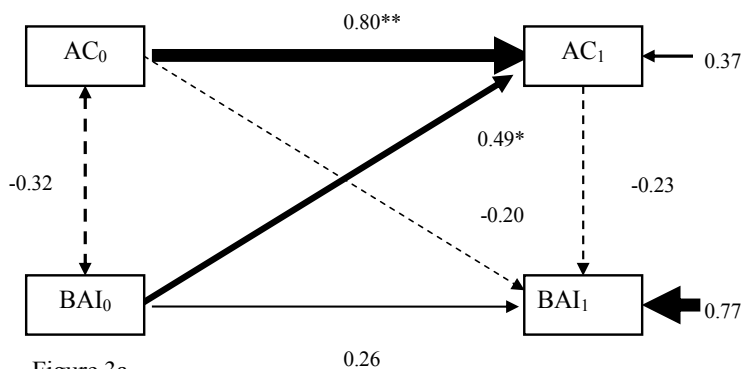


Figure 3a

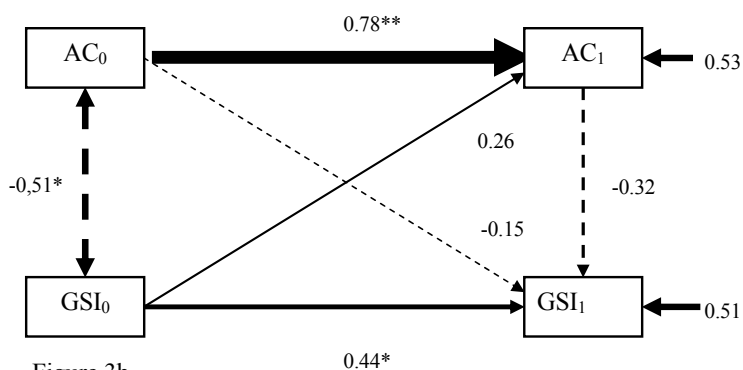


Figure 3b

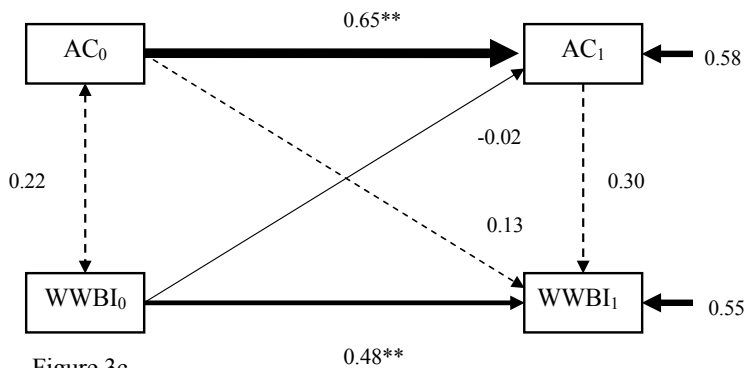


Figure 3c

Figure 3a, b, c. Path analysis between affect-consciousness (AC) and BAI, GSI and WWBI at baseline (T0) and follow-up (T1). Full lines signify positive and dotted lines negative relations. The thicker the line the higher the path coefficient. The arrows coming from the right symbolise the residual variance.

3.3 RELATIONSHIP OF PATIENTS PREFERENCES AND EXPERIENCES TO OUTCOME (III)

Initial treatment preferences did not differ between the two treatment groups. However, treatment experiences showed significant differences between the groups, controlling for preferences. ABP reported significantly more positive experiences than TAU on Support, Inward Orientation and Outward orientation. Results are presented in Table 6.

Table 6. Between-group comparisons using univariate ANOVA on TPEX treatment experiences controlling for initial preferences: means, (standard deviations), <i>F</i> (<i>df</i>) and <i>p</i> values.						
	Treatment Preferences		Treatment Experiences		ANOVA	
	ABP <i>M</i> (<i>SD</i>)	TAU <i>M</i> (<i>SD</i>)	ABP <i>M</i> (<i>SD</i>)	TAU <i>M</i> (<i>SD</i>)	<i>F</i>	<i>p</i>
Support	3.2 (0.8)	3.0 (1.1)	4.0 (0.9)	3.2 (1.2)	6.7 (2;42)	.01
Outward Orientation	3.0 (1.1)	3.2 (0.7)	2.8 (1.2)	2.2 (1.2)	4.7 (2;42)	.04
Inward Orientation	3.0 (0.9)	3.0 (0.9)	3.1 (1.1)	2.4 (1.0)	5.1 (2;42)	.03
Catharsis	2.6 (1.0)	2.6 (1.0)	2.9 (1.0)	2.4 (1.0)	3.1 (2;42)	.08

ABP patients appeared to have more positive experiences of supportive and emotionally expressive interventions than they had expected, while controls appeared to experience less help from treatment interventions focusing on concrete and directive problem solving than they had initially expected.

The cluster analysis on TPEX subscales for both preferences and experiences with all patients were grouped together rendered two distinctly separate groups. However, both clusters had roughly similar treatment preferences, but diverged in terms of their subsequent experiences. Cluster I was the largest cluster, comprising 29 patients (20 ABP and 9 controls). They tended to report positive experiences of treatment relative to their initial preferences and were accordingly labelled patients with “positive relative experiences”. Cluster II comprised 14 patients (6 ABP and 8 controls) who were characterised by significantly lower experiences relative to initial preferences and were accordingly labelled as patients with “negative relative experiences”. There was a statistically significant difference in number of treatments between the clusters. Patients in cluster I received an average of 34 sessions (range 12 - 47) and patients in cluster II received an average of 23 sessions (range 7 - 42). The main effects of cluster membership and treatment group in relation to outcome were tested. Number of treatments was controlled for and repeated measures multivariate analysis of covariance was used. Results were multivariately significant for treatment group but univariately significant for cluster on all three outcome variables, thus underlying the importance of patterns of treatment preferences and experiences for outcome.

Treatment preferences were not found to predict outcome for GAD patients in general. However, when Treatment Experiences were examined in relation to outcome (calculated as the difference between follow up score minus baseline) there was a significant relationship on the GSI_anx. The TPEX could explain 25% of the variance in GSI_anx ($R = .51$, $p = .02$), with Outward Orientation contributing to the greatest predictive power (standardized beta $-.465$, $p = .054$).

3.4 PATIENTS' PERSPECTIVE OF CHANGE PROCESSES IN ABP (IV)

The patients' expectations concerning therapy were influenced by how they experienced their body. If they related to their body as an object and had no interest in exploring the mind-body unity, they sought a way to health in the manner of a "quick fix" according to the "apparatus model" of the body. However, if they were open to explore their lived body as a mind-body unity, they had a desire to learn more about themselves in order to try to understand what the body was communicating.

Engaging successfully in body therapy was shown to require the capacity to surrender oneself to a state of uncertainty, being able to loosen control and having the courage to pursue what the body therapy might bring into focus. The healing process and the patients' way of understanding their symptoms after ABP could thus be described concerning aspects of control in the following way: loosing control, controlling the uncontrollable, gaining a constructive sense of control, feeling accepted as a whole person, seeing affects as meaningful signals about one self, making sense of bodily signals, finding new ways of acting and letting go of excessive control.

However, working through these stages can not be seen as climbing a stair but rather as a process that floats back and forth, where explicit and implicit knowledge evolve together aiming at giving the patients a deeper understanding of themselves and their anxiety symptoms (Lyons-Ruth et al., 1998). If uncertainty was accepted, it was seen as a viable way towards self exploration and self understanding. If, however, uncertainty was experienced as too anxiety provoking, the therapeutic process became obstructed and was experienced as meaningless to the patient.

The end result of therapy could be understood in terms of how the patients were able to integrate bodily feelings in their perception of themselves. Bodily feelings became re-conceptualized as meaningful signals rather than merely anxiety provoking. In this way, the patients attained a more integrated experience of the lived body.

4 DISCUSSION

This trial adds to the empirical evidence for ABP in a psychiatric setting. The main finding is that the ABP method seems to be a viable treatment alternative for patients with GAD. The patients' capacity to tolerate and express their affects raised and their symptom level was reduced after the one year ABP treatment. However, we could not demonstrate that affect consciousness had any measurable effect on outcome in this study, whether directly or as a mediator. ABP patients reported being helped by supportive and reflective treatment interventions to a greater extent than controls, but it was found that differences in outcome were considerably more marked for patients who had mainly positive treatment experiences compared to those who had mainly negative ones independent of treatment form. Treatment expectations appeared to be based on patients' perception of their bodies. The patients who could meet the body with curiosity and interest were benefiting more from the body therapy than those who felt insecure and therefore used defences to protect themselves from getting in touch with their body. Getting in touch with one's body, in a pace that one could endure, rendered bit by bit a feeling of being in control; e.g. noticing muscular tenseness and being able to influence it as well as understanding the connection between bodily manifestations, experiences and emotions. Thus anxiety signals turned from being fear provoking to become meaningful signals about one's life situation.

4.1 REFLECTIONS ON MAIN FINDINGS

In **study I**, significant changes between the two groups were detected on the SCL-90 but not on the other two scales. One possible explanation is the differences in the coefficient of variation (CV). It is defined as the ratio of the standard deviation to the mean ($100SD/M$) and it was clearly lower on the GSI compared to the other two measures; 34% on the GSI, 44% on BAI and 59% on WWBI. Another explanation would be that ABP could influence the patients' general distress level but not the fundamental experience of well being.

It is interesting to evaluate if the changes in the outcome measures corresponds to clinical significant changes. We have chosen the calculation proposed by Sandell et al. (2000) and Derogatis (Derogatis & Lazarus, 1994) to define the value that divides the 10% worst-scoring people in the norm group from the 90% best-scoring people. It is calculated by multiplying the norm group standard deviation with 1.28 and adding it to the norm-group mean. Using a Swedish norm-group with the mean .55 (SD .46; Fridell, 2002) gives the value 1.1. Thus values on GSI beneath 1.1 could be understood as clinically belonging to the normal population. Twenty-one patients (63%) in the ABP group and eleven patients (39%) in the TAU had scores that could be described as belonging to a non clinical sample at follow-up.

I have also compared the effect size concerning the BAI with effects reported in other treatment forms for GAD. Thus, Sanderson, Beck and McGinn (1994b) evaluated the effect of cognitive therapy for 32 adults with GAD. The effect size was 1.0 for the 16 subjects who were diagnosed with a comorbid PD and 1.63 for those without PD. Öst and Breitholtz (2000) reported an effect size of .83 at follow up (14 month) after 12 sessions of cognitive-behaviour therapy and 1.04 after 12 sessions of applied relaxation. The results in this thesis do match these magnitudes, although the treatment duration in the ABP group exceeded the short durations studied by Sanderson et al. (1994b) and Öst and Breitholtz (2000).

However, when analysing the number of patients with clinical significant change on the BAI, our results are rather modest. Following the calculation above, norm data from a Norwegian study (Nordhagen, 2001) composed of 869 persons selected randomly from the Norwegian register of telephone number, was used. The mean was 5.08 (*SD* 5.66) which would distinguish points below 12.3 as within the “normal”. Sixteen (48.5%) patients in the ABP group and twelve (42%) in the TAU group had reached a level that could be considered within the normal range. Before therapy only two in TAU and three in ABP had such low levels.

According to these values only half of the patient group reached a healthy level. A factor that can have contributed to the rather weak effects is the high amount of axis II co-morbidity in our sample. It might very well be that these patients would have needed a longer treatment period. Bateman and Fonagy (2001) have demonstrated that longer treatment produce larger gains in patients with personality disorders. Vinnars noted (2008), in a randomized controlled study evaluating time-limited dynamic psychotherapy for psychiatric outpatients with personality disorders, that a particularly difficult-to-treat subgroup was those with a co-occurrence of several PD diagnoses. In our sample there were about 25% who had 4-8 self evaluated PD's. This might be an overestimation according to the use of the self-report instrument but it gives a rough indication about the illness severity in the patient group. When we divided the patients in three groups according to number of PD's we found higher levels of distress and lower rates of change the more PD diagnoses there were in the group.

The results, in **paper II**, suggest that the ABP did influence AC in a positive direction, showing a medium effect size on global AC. This finding is in line with our expectations and indicates that the ABP has an impact on GAD patients' ability to cope with their affects. The greatest changes in AC concerned the affect functions, “tolerance” and “expression”. In ABP it is hypothesized that the ability to tolerate an affect is crucial to a person's capacity to reflect and understand the inherent message. According to this model the increased ability to express a feeling with body posture, facial expressions as well as having appropriate words to articulate the affect renders the person more apt to communicate with others in a manner that is clear and easily understood. In that way, a positive spiral is initiated; other people will find it easier to

communicate with them and this feedback may increase the patients' ability to trust themselves and their feelings. However, the only affect to show reliable change was sadness. This may be due to the fact that depressed mood was very common in the patient group to begin with and that work on sadness and mourning was crucial in most of the therapies. The patients' statements indicate that their ability to tolerate sadness improved and that they had been able to incorporate a weaker part of themselves, a part that they formally had not accepted.

Although there was no statistical significant correlation between anxiety level measured with BAI and AC at treatment start we found that the relatively greatest improvement in AC was seen amongst those who had the highest anxiety scores at entry. This patient group had come to therapy because of their anxiety; maybe their high anxiety level was also a substantially motivating factor, favouring the exploration of affects and thus enhancing the level of AC.

Our conclusions are that the ABP method had a positive impact on the patients' distress level and raised their ability to cope with affects. However, we could not demonstrate that AC influenced outcome, in terms of reduced symptom level, whether directly or as a mediator. What implications can we draw out of this finding? Maybe improved ability to experience, tolerate and express affects has a greater impact on the person's interpersonal relationships than on symptoms. Thus in a future study it would be interesting to compare affect-consciousness with values on the inventory of interpersonal problems (IIP; Horowitz, Rosenberg, Baer, Ureno, & Villaseñor, 1988).

Furthermore it might very well be that the greatest impact on the symptom level is not due to the changes regarding affect consciousness that are possible to evaluate in the ACI but rather to the affective interchange between patient and therapist that occurs through out the whole therapy procedure. This transaction occurs mainly on a non-verbal level and gives the patient a new experience of being with another person. This is in line with the concepts "procedural memory" and "implicit knowledge". According to Stern (1998) it is mainly within these domains that change occurs.

In paper III and IV, the need to address treatment preferences was stressed. This is in line with findings from other researchers (Addis & Jacobson, 1996; Clarke, Rees & Hardy, 2004) who have emphasized the relationship of the clients' belief about the reasons for their difficulties and what therapy might require of them to outcome. Philips (2005) has demonstrated that therapists who early in treatment confronted the patients with hindering aspects gained a better result than when these factors were not being addressed. Our results are in line with Philips. We suggest that the important question may not necessarily be how therapists use treatment preferences to match patients to treatment, but instead how therapists use treatment preferences in treatment. In effect, this puts the responsibility for successful treatment more squarely on the therapist rather than on treatment selection. Addressing patient preferences may help to

pave the way for successful interventions. In particular, when offering body therapy to patients with GAD, it may be important for therapists to explore patients' preferences of support and safety in such a way as to strengthen the therapeutic relationship. Thereby the therapist would be preparing the ground for the patient to make use of treatment strategies focusing on mind-body unity.

The results, in **paper IV**, shed some light on the patients' experiences of participating in body therapy and point to the necessity of letting the lived body take place in the therapy setting. The therapists' way of focusing on the body and what the body could tell helped the patient gain access to feelings, memories and experiences that hitherto had been hidden. The experience of a new understanding of symptoms; managing anxiety and recognizing bodily signals as important information about one's life situation helped the informants acquire a sense of control, which allowed them to use less self control in their communication with others. In therapy they experienced that they could be accepted as they were, which helped them to become more self assertive and confident in expressing their feelings and needs towards others. However, it should also be emphasized that initially the therapist should thoroughly explore the patient's attitude towards the lived-body in order to evaluate elements that may obstruct or facilitate change (Øyen, Råheim, Iversen & Steihaug, 2008). A question that has to be further elaborated is how to reach the patients who are too fearful to surrender to this type of treatment. Garfield (1992) described an eclectic way of dealing with this: *"In essence, procedures were selected for a given patient in terms of that client's problems instead of trying to make the client adhere to a particular form of therapy. An eclectic therapy thus allows the therapist potentially to use a wide range of techniques."* (p. 172). The freedom to choose interventions according to the individual patient and not necessarily cling to one method is a relief in the clinical setting. However, more important than the choice of particular interventions is the affect attunement. The therapist needs to refine her instrument i.e. listening to her own bodily signals, to be able to attune to the patients' affects, and thereby create a safe place for the joint task of exploring the patients' difficulties.

4.2 REVISED META THEORY

When the research project was designed a research paradigm in line with Wampold's (2001) description of the medical model, was used. However the conclusions in paper II, III and IV have demonstrated that the contextual model according to Wampold (ibid.) would be more appropriate in this case. The contextual model emphasizes a holistic common factors approach and provides an alternative meta-theory for psychotherapy.

In **paper II**, affect consciousness increased but we could not demonstrate that affect consciousness had any measurable effect on outcome, whether directly or as a mediator. Following the medical model one would argue that specificity requires that

the hypothesized change mechanism would mediate or directly influence treatment effects.

In **paper III**, we found that differences in outcome were considerably more marked for clusters - based on relative treatment experiences - than treatment groups. Patients who were having more positive treatment experiences than they had expected also had a better outcome. The distribution of ABP and controls in relation to clusters was not significant using a Chi-square test. Thus, it was not the therapy *per se* that was important, it was the relative treatment experience, regardless of type of therapy. This finding seems to be in line with Wampolds findings that *“the relationship between the client and therapist is related to outcome across various types of treatments and that this relationship is therapeutic (i.e., the relationship causes the outcomes rather than improvement in therapy causing a better relationship)”* p 39. This is supported by other researchers who suggest that the quality of the therapeutic relationship is a more important curative factor than the specific therapeutic technique (Lambert & Ogles, 2004; Norcross, 2002)

In **paper IV**, it was found that the patient's attitude towards the lived-body was central to if the therapy would evoke the patients' wish for and curiosity about the hidden body communication in symptoms. One of the key elements in the contextual model is that the treatment should be in accord with the beliefs of the client. The treatment must be performed in a way that corresponds to what the patient and the therapist conceive as meaningful and curative. This is especially important in the case of bodily treatments that need to take into account the patient's cultural and personal attitude towards touch and nakedness. The contextual model predicts interaction between treatments and various clients characteristics related to acceptance of or belief in various treatments.

There are other factors that are in support of viewing ABP from the contextual model: In ABP the patient is viewed according to his social and historical context, and the diagnosis is not of primary interest. Furthermore, in ABP there is no universal explanation or theory that can account for the patient's symptoms or psychological problem in general. The affect and body theory is a theoretical base but the unique patient can only be understood in view of his life history and life world (Merleau Ponty, 1997).

4.3 METHODOLOGICAL CONSIDERATIONS

The use of a combination of methods has been vividly discussed. The methods are often described as distinctively different paradigms, the positivistic and naturalistic paradigms. Instead of focusing on the philosophical differences Greene & Caracelli (1997) propose a shift to other characteristics of social inquiry traditions. They give examples of such features that represent characteristically different facets of knowledge

claims, such as: particularity and generality, closeness and distance, meaning and causality. These are different but not incompatible (Greene, & Caracelli, 1997) and a combination of methods may reinforce the results from one study to another (Casebeer & Verhoef, 1997; Öhman, 2005). I see the benefits by bringing together qualitative and quantitative methods. Malterud (2001) for example, points out how qualitative and quantitative methods can be combined in fruitful ways. One example is when a qualitative study is carried out after a quantitative one to gain a better understanding of the meaning and implication of the findings, as in this thesis.

The research questions, in this study, address different aspects of the ABP treatment model and in order to be able to elucidate the different angles both quantitative and qualitative research methods have been used. In the field of psychotherapy, and sometimes in physiotherapy, the vast majority of phenomena studied are essentially qualitative, since the research area mainly involves the domains of human experience and communication of meaning. These qualitative phenomena are often quantified, and data is transformed into numbers as I have done in study I-III. However, it is important to remember that these quantifications imply using numbers as metaphors for qualitative data (Philips, 2005). In spite of this, parametrical statistics have been used, thus adopting a “pragmatist” view of measurement rather than a “fundamentalist” view. Pragmatists, argue that measurement rules and classification into level are not clear cut, and emphasize that the use of statistical techniques is more optimally determined by the nature of the questions addressed, rather than by level of measurement alone (Waltz, Strickland, & Lenz, 1984). The reason for using a pragmatic view on data in this thesis was mainly to be able to compare with similar studies in the field.

Evaluating ones own treatment puts the researcher in a delicate position. On one hand it is an advantage to be familiar to the therapy model that one evaluates, on the other hand one might argue that I would not want to disclose negative or unfavourable information or statements about the ABP treatment. I have been clear about my position in this study and it is up to the reader to judge whether the results seem plausible and if they have a value in the context of clinical every-day physiotherapy/body psychotherapy praxis.

The primary outcome instruments used were chosen with the intention to capture general symptoms (SCL-90) as well as specific anxiety aspects (BAI) and furthermore to elucidate general aspects of well-being (WWBI). Unfortunately we did not have any specific GAD instruments because our study started in 1998 when they, to our knowledge, were not yet available in Swedish. However there were interviews that could have been used, such as Structural Clinical Interview for DSM IV (SCID; First, Spitzer, & Gibbon, 1997) and the Anxiety Disorders Interview Schedule-Revised (ADIS-R; DiNardo, Moras, Barlow, Rapee, & Brown, 1988). This would have

rendered more trustworthiness to the diagnostic procedure and maybe a less heterogeneous sample. A third person's evaluation would also have strengthened the credibility of the results.

The small sample size and the lack of a control group in study two are other obvious shortcomings. It took us about four years to recruit the 61 patients in the study. We were collaborating with first-line psychiatric out-patient clinics, which explain why we had a high percentage of patients suffering from Axis II co-morbidity. Maybe addressing patients who were treated by GP's in primary health care would have rendered more patients to the project and possibly less severely disturbed patients.

Another limitation is the heterogeneity of the patient group, with some patients seeking treatment for the first time and showing symptoms of GAD only and others with a severe illness history and heavy co-morbidity. Such heterogeneity is difficult to avoid without serious recruitment problems and considerable loss of external validity. That GAD often occurs simultaneously with other axis I diagnoses, such as depression and phobias, has been demonstrated by Ballenger et al. (2001), and researchers have also found high rates of PD diagnoses (Dyck et al., 2001; Sanderson & Barlow, 1990; Sanderson, Wetzler, Beck & Betz, 1994 a). The most frequent PDs appear to be obsessive-compulsive and avoidant PDs (Sanderson et al., 1994a). In our study the most frequent self-rated PD was borderline (n=36), followed by depressive (n=35) and obsessive-compulsive (n=34) PD. The rate of PD was higher than the 49 % reported by Sanderson et al. (1994a). This might have been an overestimation as a consequence of the self-screening instrument.

A further limitation of this study was the heterogeneity of treatment in the TAU group and - paradoxical as it may sound - its high quality. The TAU conditions in this study shed the light on the problems of undertaking randomized controlled studies in a clinical setting where clinicians have the freedom to determine the specific treatment approach and high-quality psychotherapy is offered quite freely (Vinnars, Barber, Norén, Gallop & Weinryb, 2005). Under such conditions psychotherapy researchers may need to consider and develop other control conditions. Future work, if one attempts to evaluate special therapy techniques in line with the medical model, should focus on comparing specifically defined forms of treatment and closely verify and assess control treatment methods.

Randomization is always a problem. In our material there were several patients who got the treatment they did not prefer and some of them also ended therapy in advance. Considering our finding in article III this is not the optimal way of testing a methods utility. As has been pointed out by Iacoviello et al. (2007) the alliance is likely to be negatively affected if the patient is not attaining the preferred treatment. Therefore in the future it would be wise to eliminate this potentially negative effect and leave the choice to the patient. One way of dealing with this problem has been described by Holmqvist (2007). He accounts for an ongoing

alliance study by Safran and Muran; patients with different psychiatric diagnosis are randomized to either cognitive therapy, dynamic-interpersonal or brief relational therapy. If there is a problem establishing or maintaining alliance the patient is offered to change to one of the other two therapy forms.

Furthermore there is a problem with the manualization. When research in psychotherapy is done in the same way as research concerning a new drug, i.e. using the medical model, inevitable there will be a problem. Furthermore, I would like to make a reference to Winnicott's statement "*there is no such thing as a baby*" and suggest that there is no such thing as a manualized therapy, there is always a relationship between the patient and the therapist no matter what the method might be. In our material it was quite evident that some patient-therapist couples worked well together and some did not. Of course this is not nor surprising nor new knowledge but it puts the light on the difficulties doing research in psychotherapy.

An observation is that the number of non-responders at the first follow-up assessment in the TAU group might have caused the intent-to-treat analysis to overestimate the between-groups differences.

Another issue that should be addressed was the patients' ability to feel free to talk about their APB experiences with the interviewer, knowing that she was a colleague to the physiotherapist who had been responsible for the treatment. This could have hindered some patients to articulate negative views. However, this was not the impression that I got, nor from doing, nor from reading and analysing the interviews.

The ACI in its original form is quite time consuming, which of course limits its usefulness in clinical practice. Its utility would increase if it was shortened, for instance using only three affects instead of the stipulated nine. Preliminary principal component analyses on different sets of ACI variables all yielded one general component accounting for between 55 and 72 % of the total variance. This suggests a very strong general factor. In view of this, exploring merely interest/excitement, anger, and fear, for instance might be sufficient.

The TPEX instrument has been further elaborated (PEX; Clinton & Sandell, 2007). It is a flexible instrument used to measure preferences and experiences of specific psychotherapy interventions among patients and their therapists prior to, during and after psychotherapy. The instrument can be used in several ways; most important in the clinical setting might be to use both the patient and therapists version prior to therapy and during therapy. Thereby it is possible to evaluate if both participants think about their joint undertaking in similar ways and if there are important differences to bridge. When marked discrepancies appear between patient and therapist before the start of therapy or during therapy this may serve as a warning signal of issues that need to be addressed.

4.4 CLINICAL IMPLICATIONS

In ABP the body examination usually takes place in the second session, as was the case in this study. This is of course neither necessary nor always appropriate, as some of the interviews revealed. Many informants considered it hard to appear in their underwear and also to perform certain movements. To stand undressed in front of another person and let her evaluate your stripped body was experienced as demanding and intimidating in line with findings from Ekerholt and Bergland (2004). Downing (1994) stresses the importance of building a solid ground before starting with bodily hands-on techniques. The therapist must first describe the body examination thoroughly, and it goes without saying that the patient needs to know that he or she can decline to participate without any negative consequences, as well as being able to participate wearing comfortable clothes instead of exposing themselves in their underwear. Choosing the right timing for suggesting the body examination acquires sensitivity from the therapist. Furthermore the therapist's ways of acting during the examination may be crucial to how the examination is experienced. Meeting the patient with genuine interest, focusing on the patient's perspective and seeking to direct the patient's attention to what he or she is feeling during the examination and how the patient is relating to his or her body will encourage the patient to become more interested in exploring themselves and less preoccupied with what impression they give. The examination is always an interaction and can give room for reflection and a good feeling of being acknowledged that may lay the ground for a positive therapeutic relationship (Ekerholt & Bergland, 2004). In some patients though, the examination was experienced as a violation of the personal boundaries and the therapist had to struggle to build up a trustworthy relationship. It must be emphasized that the therapist needs to be aware of the deep impact that the body examination can have and to use it carefully, with sensitivity towards the patient's resources. It is also important to see that in some cases it might even be contra indicated to use body-therapy because of the overwhelming affective discharge linked to the closeness to the therapist

The body examination in ABP contains both observation and direct hands on contact, and in the ABP treatment massage is generally included. The informants stated that to be touched by another person triggered emotional reactions in unexpected ways and evoked strong feelings encompassing the entire spectrum from sensing pleasure and relief to utmost vulnerability. One aim of massage in ABP is to promote the release of tension and many informants also stated that they felt suppler and more relaxed after the treatment and that it had an impact on their ability to get in touch with their feelings in line with findings by Ekerholt and Bergland (2006). There is a body of evidence considering the positive effects of massage (Field, 1996; Hanley, Stirling & Brown, 2003; Moyer, Rounds & Hannum, 2004) and how the release of tense muscles will promote deeper breathing and make it possible to get in touch with deep feelings (Braatøy, 1947; Ekerholt & Bergland, 2008). If, however, the release of muscular tension or the closeness to another person evokes memories of situations or emotional

conflicts that were too painful, the anxiety level rises and the defence mechanisms are put into place. This was found in some of the informants' experiences. Therefore it may be necessary to consider alternatives. "*There are many ways to work with the body, integrating important aspects of muscular, behavioural, and sensory input, without intruding on bodily integrity* (Rothschild, 2000, pp. xiv). However, when handled professionally, the touching part of the therapy can, for some patients, be profoundly intervening and favourable to the healing process. The informants felt that they were being accepted exactly as they were, in line with Stensland (2003), who states that to be touched by another person's hand may symbolize the experience of being taken seriously.

Critique against body therapy, from a verbal psychoanalytical view point, is that all sorts of bodily interventions may be a defensive activity away from the painful affect that the patient is about to get in contact with and the therapist does not feel apt to handle. This view has to be taken seriously and the therapist needs to keep in mind that there are twofold risks with bodily techniques; the patient may be overwhelmed by affects but it can also function as a defence against getting in touch with affects. Accordingly, the therapist needs to be well attuned towards the patient and herself to be able to choose the appropriate intervention. However, using or not using bodily techniques may have a subordinate importance in the light of the non-verbal communication that goes on in all therapies. Downing (2001) underlines that we still have a lot to learn about interactional movements.

4.5 SUGGESTIONS FOR FUTURE RESEARCH

In future it will be important to examine both affect consciousness and relationship of treatment preferences and experiences longer into the follow-up period. The comparison with other outcome measures could also be used. Furthermore it would be important to use measures of behaviour or ratings by independent clinicians to aid the assessment of outcome. It still has to be investigated in what way affect consciousness is related to psychopathology and specifically in the case of GAD how change might come about as we could not prove any causal pathway between affect consciousness and symptoms.

Our results have emphasized the possible importance of how the therapist deals with the patient's preferences therefore it will be important for future studies to examine the role of the therapist more directly. This could be done, for example, by examining the preferences and experiences of both patient and therapist over the course of treatment and into the follow-up period. Furthermore, the TPEX instrument could be elaborated to incorporate aspects of the bodily interventions.

Our findings support the intersubjective aspects in psychotherapy and highlight the necessity to further investigate and develop these aspects concerning ABP. It would be interesting to analyse the therapies that were ended prematurely as well as those who had mainly negative treatment experiences. In future studies one

way of exploring what causes drop-out or non cooperation in therapy would be to analyse video recordings of treatment sessions. Thus, in a future study the focus would shift from a one-person perspective to a two-person perspective or rather a two-body perspective (Southwood, 1974). The therapist-patient interaction has been studied in some previous physiotherapeutic studies (Ek, 1990; Engelsrud, 1990; Thornquist, 1994), and in a single case study concerning ABP (Henriques, 2008). However, more research focusing on the non-verbal communication can help clinicians become more aware of these subtle events.

4.6 CONCLUSIONS

The integration of body-based techniques and a focus on affects into a body psychotherapy framework, such as ABP, may constitute an effective treatment for GAD, especially among patients who are interested in exploring questions of mind-body unity. However, the results indicate that interpersonal aspects of therapy need to be more fully explored. Paying closer attention to treatment preferences and body attitudes may increase the potential of ABP and improve outcome.

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DSM IV Criteria for Generalized Anxiety Disorder

- Excessive anxiety and worry (apprehensive expectation) about a number of events or activities (i.e. work or school performance), occurring more days than not for at least six months
- Difficulty controlling the worry

At least three of the following symptoms associated with the anxiety:

1. Restlessness or feeling keyed up or on edge
 2. Being easily fatigued
 3. Difficulty concentrating or mind going blank
 4. Irritability
 5. Muscle tension
 6. Sleep disturbance (difficulty falling or staying asleep; restless, unsatisfying sleep)
- The focus of the worry and anxiety is not limited to the concerns associated with other mental disorders, such as the fear of having a panic attack associated with panic disorder or the fear of being contaminated that can occur in obsessive-compulsive disorder
 - Significant distress or impaired functioning socially, at work, or in other important ways because of the anxiety, worry or physical symptoms
 - This disorder is not due to the direct effects of a substance (a drug of abuse or a medication) or a general medical condition and does not occur only during a mood disorder, psychotic disorder, or pervasive developmental disorder

DSM IV; Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, 1994 American Psychiatric Association, Washington, DC.