UNIVERSIDADE DE LISBOA

FACULDADE DE PSICOLOGIA

DARING TO INFLUENCE PERSONALITY VIA ZOLTAN GROSS' APPROACH TO PSYCHOTHERAPY:

An Experimental Study on Therapist Clinical Decision Making

Filipe Bernardes Sintra Lopes

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Dissertação orientada pelo Prof. Doutor Nuno Miguel Silva Conceição

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Abstract

The goal of the present dissertation is to experimentally explore the preferences of clinicians when under stress to make a single clinical decision in reaction to a difficult client with a specific longstanding pattern or habit. Therapists were asked to choose one of four alternative clinical decisions in reaction to a video of that client. According to Zoltan Gross' principles, two of them were crafted to interrupt the habit (HI), while the other two to validate it (HV). The sample of 191 therapists was randomly distributed across 4 research conditions in which the stimuli shown before the client excerpt was manipulated (*Complex vs Plain* stimuli) as well as the instructions (*Symptom vs Personality* focus) before choosing an intervention.

It was hypothesized that participants in the *Complex Stimuli* condition would choose more HI interventions (H1), would feel more emotionally aroused by the client (H2) and would report more difficulty to attend to what the client said (H3). The last hypothesis was that participants in the *Personality Focus* conditions would prefer HI interventions when compared to their counterparts in the *Symptom Focus* conditions (H4).

H1, H2 and H4 were supported by the results. Additionally, the majority of participants (70%), opted for *Habit Validation* interventions even when the other ones were considered more effective personality wise, according to Gross' theory. Possible explanations are discussed highlighting a potential focus for future training and research.

Keywords: personality change; decision making; training; deliberate practice

Resumo

O objetivo da presente dissertação é o de, experimentalmente, explorar as preferências de terapeutas clínicos quando sob o stress de tomar uma única decisão clínica em reação a um cliente difícil que demonstra um padrão ou hábito de longa duração. Foi pedido aos terapeutas que escolhessem uma de quatro decisões clínicas em reação a um vídeo desse mesmo cliente. De acordo com os princípios de Zoltan Gross, duas das decisões clínicas foram desenvolvidas para interromper o hábito (HI), enquanto que as outras duas foram desenvolvidas para o validar (HV).

A amostra de 191 terapeutas foi distribuída aleatoriamente por 4 condições de investigação em que o estímulo apresentado antes do excerto era manipulado (*Complex vs Plain* stimuli) assim como as instruções (*Symptom vs Personality* focus) antes de ser escolhida uma intervenção.

Foi hipotetizado que os participantes na condição *Complex Stimuli* escolheriam mais intervenções HI (H1), se sentiriam mais ativados emocionalmente pelo cliente (H2) e que reportariam maior dificuldade em apreender tudo o que foi dito pelo cliente (H3). A última hipótese foi que os participantes na condição *Personality* Focus iriam preferir intervenções HI quando comparados com os participantes nas condições de *Symptom Focus* (H4).

H1, H2 e H4 foram apoiadas pelos resultados. Ademais, grande parte dos participantes (70%), optou por intervenções de *Validação de Hábito* mesmo quando as outras intervenções eram consideradas mais eficazes a nível da personalidade, de acordo com a teoria de Gross. Possíveis justificações são discutidas de modo a salientar potenciais futuros focos de treino e investigação.

Palavras-chave: mudança na personalidade; tomada de decisão; treino; prática deliberada

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Theoretical Framework

Therapist Challenges – Mismanaging and Avoiding Emotions

The journey of becoming a psychotherapist is not an easy one. As Halgin (2000) described it, this process is filled with many surprises and unexpected events, there is a lack of certainty sprouting from the fact that neither the questions or answers are clear nor precise. Pica (1998), presented us with an article covering the experiences trainees were faced with when starting their clinical practice. Going into session without the experience and knowledge needed for certain decision-making moments or wondering whether they made the right choices and asked the right questions were situations almost every trainee faced. Even though the article in question was written two decades ago, it still describes something that is very present in the life of many 2018's clinical trainees. As referred by Cartwright & Gardner (2016), jumping into practice with little to no experience is inevitable and it renders trainees fragile, hypersensitive and doubtful of their capabilities.

Central challenges trainees can face when starting their clinical practice include self-criticism, learning helping skills and putting them to practice, managing their reactions to clients and managing setting or session boundaries (Hill, Sullivan, Knox and Schlosser; 2007). Other aspects such as having difficulty in expressing themselves, lacking focus or direction, feeling ineffective and finding silences to be troublesome due to a heightened self-awareness should also be taken into account (see Pascual-Leone, Rodriguez-Rubio & Metler, 2013 for a more detailed and ample review).

How do these novice therapists cope with such varied challenges? In a study (Williams, Judge, Hill & Hoffman, 1997), a considerable number of trainees reported focusing on their clients to avoid anxiety and any feelings of self-awareness that could become too overpowering. Suppressing their emotions in session was therefore a common way to manage their reactions to clients and within themselves. This anxiety, however, does not only affect the less experienced practitioners and it is, in fact, something to be expected, especially when clients are challenging to the therapist as researched by Shamoon, Lappan, & Blow (2017). It is troublesome when therapists cannot properly manage their moments of emotional arousal, particularly when these moments generate discomfort or any other mental states that can hinder the therapeutic process, as it can lead to alliance breakdown or therapist burnout. Shamoon et al. (2017) point out the

importance of other variables contributing to less favourable therapy outcome but highlight how important it is for therapists to be able to manage emotional states that arise in session and how failing to do so compromises the chances of successful outcomes. Citing Lambert and Barley (2002): *"…work stressors could easily threaten the therapist's ability to empathize with the client, which in turn could impede the development of a positive alliance and undermine therapeutic progress."* (p.27).

Characterological Issues or/and Personality Disorders as a Stressor for Therapists

Clients with personality disorder (PD) are a recurrent population when considering challenging clients therapists assist (Aafjes-van Doorn & Barber, 2018; McCain, Boritz & Leybman, 2015). As noted by Critchfield and Benjamin (2006) in their review, PDs are chronic and, most often than not, severe conditions that encompass high levels of impairment and suffering as well as being considerably prevalent as pointed out by Greyner, Ng, Townsend & Rao (2017) and McCarthy, Carter & Greyner (2013). Due to their prevalence, it can be assumed that many therapists, irrespective of their experience levels, will find themselves working with a client suffering from PD or, more generically, longstanding characterological issues. If they are fully prepared to do so is a research question, but that this type of work puts an additional stressor to them as professionals seems to be a commonsense fact.

Dimaggio et al. (2012), describe several aspects that characterize PDs and make them an undeniable challenge to many professionals. Individuals with PD usually manifest metacognitive impairment resulting in their difficulty to recognize and process their inner experiences as well as their underlying motivations. When taken together with poor emotional awareness, an additional predominant characteristic, a poor outcome is to be expected. Another characteristic of PDs is related to the individual's attachment systems. According to Magnavita (2005), all psychopathology and mental dysfunction originates from trauma and this trauma is closely related to the individual's attachment system. Magnavita's review (2005) along with further research (Becker-Weidman, 2006; Haliburn, 2011; Marmarosh, Markin & Spiegel, 2013; Perez & Sundheim, 2015; Spiegel, 2016), there seems to be a consensus that trauma and attachment are deeply connected, as trauma operates through the attachment relationships of the individual and influences it to a very considerable degree. The client's attachment system thus plays a role and has a strong impact in the treatment process just as much as it contributed for the development

of symptoms, psychopathology and/or simply distress and dissatisfaction with life (Marmarosh et al, 2013; Perez & Sundheim, 2015; Spiegel, 2016).

In these situations, it is crucial to, above all, focus on the relationship between therapist and client. Attachment patterns will play a major role in establishing the therapeutic alliance. Citing Miller-Bottome, Talia, Safran & Muran (2017), *"…early attachments are the context in which we learn how to negotiate relationships and to express our emotions…"* (p.1). Considering that individuals with PD usually have an insecure attachment style, we can assume that their emotional expression and ability to negotiate relationships is compromised, as also suggested by DiMaggio at al. (2012).

Given this, the antidote least needed are therapists with compromised emotional expression and ability to negotiate relationships. Clients are as difficult as therapists can be. So the challenge is how to, from the perspective of the therapist, take the opportunity of seeing clients with personality longstanding issues, to both honor their emotional skills at the service of their profession and at the same time help their clients overcome the confinement of their habits, that are disallowing them from the cheerful struggle and joy of life.

Characterological issues or/and personality disorders could be considered the outputs of master minds performing the same old habits, and therapists are not necessarily better equipped to handle them simply accumulating the years of experience. If master therapists are to be eternal students, both master therapists and students alike face a challenge handling their own emotionality and even making professional use of them when in front of characterological issues or/and personality disorders. Here the therapist has a double challenge to focus on his and on the client's feelings, if they want to be free to choose which part of the conversation is more therapeutically meaningful (Gross, 1992; Gross, in press).

Personality Change and Challenges as Formulated by Zoltan Gross

Zoltan Gross (1992; in press) developed a personality and interpersonal theory whereby he asserts that at the core of therapeutic work lie the dynamics of dyadic interaction, which in turn rest on structures of personality, marked by a self-perpetuating nature, that function outside of awareness and conscious control of the individual, as they are habituated systems. Only by becoming conscious of these habits, can its automaticity be interrupted and, as the author defends, cortical structures have the possibility to

reorganize themselves in ways that are more adaptive and break away from behaviorally and emotionally dysfunctional habits.

Similar to what was previously mentioned (Magnavita, 2005; Marmarosh et al. 2013) regarding the origin of personality disorder, Gross (1992; in press), poses that these habits are structures that the individual developed in their childhood and its dominion over the personality system is seen as the result of their practice and rehearsal over extended periods of time. but defends that their presence isn't simply an expression of childhood trauma. The author defends that even though these habits are not functional, they act as a feedback system which reinforces "… *the stability of neural systems underlying their existence*." (p.205). Gross (1992; in press) stresses that the repeated interruption of these habits promotes personality change.

The therapist will have to carry out the task of interrupting these habits and promote a corrective emotional experience by not perpetuating dysfunctional interpersonal patterns and facilitating the client's experiencing of new or suppressed emotions. Habit Interruption interventions are grounded in this assumption and they require a high level of mastery regarding the handling of inner feelings and reactions as therapists.

The Importance of Making Professional use of Internal Reactions and Feelings

It is understandable why some therapists, trainees above all, try to avoid getting in contact with their own feelings. However, making use of self-awareness can be extremely productive in session in the sense that it can provide information concerning the therapist's own feelings and reactions to clients, consequently contributing to a more informed intervention as stressed by Gross (1992; in press), Stevens, Muran and Safran (2003) and Williams et al. (1997).

According to Elliot et al. (2004) content that emerges within a strong emotional context indicates something of emotional significance to the client. As Elliot et al. (2004) remind us, the therapist can only be truly responsive to the client's needs by actively listening to their present difficulties, attending to their styles of processing and being tuned in to their feelings as well as which feelings the client is arousing in the therapist. By doing so, the therapist can more easily comprehend what emotions and experiences are prominently represented and might need supplementary processing and additional focus. As noted by Gross (1992; in press) responding to the content presented by the client – what he described as "text"; the subject matter in hand - or responding to their

emotionality and the way they present the content – the “subtext”; the emotional way the subject is presented or discussed - will have different results. The latter often surprises clients and leaves them emotionally aroused.

For this matter, it is of extreme importance for the therapist to become skilled at monitoring his internal reactions and feelings towards the patient, because this monitoring also enables the therapist to be in contact with important clues regarding the nature of the relationship between client and himself as stressed by Safran (1984). Considering Sullivan’s (1953) perspective, in which he considers the therapist as a participant observer in the therapeutic interaction and the fact that the therapist will tend to respond to the client in a similar way as other people do (Safran, 1984), this monitoring can be a great tool at the professionals disposal in the sense that it can provide an overview of the clients interpersonal style and pull (for certain responses). This increased awareness helps the therapist to be more conscious of strains and/or fluctuations that occur in the therapeutic process as noted by Stevens et al. (2003). For example, according to Gross (in press), when a therapist’s attention is interrupted or distracted by a feeling, they can use that event to scan what is happening within themselves or in the background of their relationship with the client. The ability to detect and reflect on these strains will enable the therapist to unhook themselves from such interactions and consequently interrupt the interpersonal cycle that the client is promoting (usually unknowingly) (Safran. 1984). By becoming aware and unstuck from these cycles, the therapist can communicate his feelings and reactions to the patient for them to become informed of their impact on others, both participants can then step outside this interaction and explore it collaboratively (Safran, 1990). It is necessary to be aware of one’s own feelings and being able to recognize them, doing this is a step forward for the therapist to assume a recepting and feeling role in the therapeutic dyad (Binder, Holgersen, & Nielsen, 2008).

These moments of strain, deterioration or relationship quality fluctuation between the members of the therapeutic dyad are what Safran (1993) and Safran & Muran (1996), described as alliance ruptures, most often classified as withdrawal, confrontational or mixed. Such events are expected to occur during alliance development as this process is punctuated by episodes of rupture and repair, as investigated by Stevens, Muran, Safran, Gorman & Winston (2007).

As previously mentioned, it is supported by literature that alliance ruptures are expected and several authors (Safran & Muran, 2000; Stevens et al., 2003; Watson & Greenberg, 2000), defend that alliance ruptures present themselves as valuable

opportunity for deepening the alliance and promoting patient change. As shown by research (Rhodes, Hill, Thompson & Elliot, 1994), ruptures can, by nature, be threatening to the therapeutic process but their successful resolution is positively correlated to a good client outcome and suggests that resolving alliance ruptures could function as a mechanism of change intrinsically (Safran, Muran & Eubanks-Carter, 2011).

Failing to responsively tackle these strains (alliance ruptures) and client's feelings/reactions or by dismissing them in a non-accepting fashion can lead to unresolved misunderstandings that, if kept unattended in a proper way by the therapist, can result in early termination and failure of the process as shown by Rhodes et al. (1994). In this same study, authors found that therapists were not aware of clients' dissatisfaction unless it was explicitly shown by them, clients had to assert themselves first for the therapist to tackle the on-going rupture.

In a more recent study (Kline et al., 2018), trainees were found to be less aware of withdrawal ruptures than confrontational ruptures, which was something to be expected considering confrontational ruptures are a direct expression on the client's part. If experienced therapists are found to be less aware of withdrawal ruptures than confrontational ruptures is yet to be demonstrated, but it could well be the same case too, especially when working with characterological issues, in circumstances that look like good alliance, but the same old pattern or habit of the client persists (Gross, in press).

As argued by Kline et al. (2018), trainees – and other therapists – could benefit from additional knowledge about ruptures and how to better regulate their emotions (towards self and client) in the face of ruptures, as this could help them work towards repair, which has been shown positively influence client change, as previously mentioned. A study by Eubanks, Burckell & Goldfried (2018), indicated that when working towards alliance repair and rupture solving, therapists considered exploring the client's experience of the rupture and acknowledging/validating their perspective as the most effective strategies at their disposal.

Learning to be Skilled at Making Professional use of Internal Reactions and Feelings

Attaining a high level of skill/expertise can be especially hard considering the lack of resources therapists can resort to improve their skills and work out their deficits (Rousmaniere, 2017**).** Some resources do exist, such as Alliance-Focused Training (AFT) (Eubanks-Carter, Muran & Safran, 2014), but despite being a training focused on increasing therapists' crucial skills such as ability to navigate and handle ruptures through

the development of self-awareness and emotional regulation backed by a good amount of research, the availability of those resources to most therapists is arguable. Furthermore, in a recent study (Muran, Safran, Eubanks & Gorman, 2018), the authors argue that the AFT model presents potential gains for novice therapists but the impact on more experienced professionals is yet to be investigated.

This lack of tools/resources for continuous practice and improvement isn't exclusively a problem for trainees or less experienced therapists, but largely affects more experienced professionals. Despite a sizable focus on trainee/novice therapists' challenges and difficulties, Rønnestad & Orlinsky's (2005) findings suggest that therapists of all ranges of experience - least experienced therapists had less than 18 months of practice and most experienced therapists had on average 31 years of practice - are faced with what they considered to be challenging practice. Findings of the same study show a self-reported progressive and significant growth of technical expertise and relational skills, across years of experience. However, Rousmaniere, Goodyear, Miller & Wampold (2017), point out in their review that; *"...psychotherapy is a field in which practitioners' proficiency does not automatically increase with experience*." (p.4). This comes in line with a study (Goldberg et al. 2016), showing that, on average, therapists did not improve with more clinical practice time or caseload. Also, it is worth noting that, even though very small, there was a deterioration of therapist effectiveness over time.

These findings contradict the belief that years of experience directly reflect proficiency and support an interesting position, "A master is an eternal student", a stance that has been a hallmark of diverse areas in terms of their expertise, like elite musicians and high-performance athletes (Ericsson & Krampe, 1996; Rousmaniere, 2017). Deliberate Practice (DP) should be understood as the activity of setting aside some time for reflecting on one's performance especially weak points, making use of received feedback to improve one's skills and effectiveness (Ericsson & Krampe, 1996; Miller, Hubble, Chow & Seidel, 2013).

Even though DP feels challenging, less enjoyable than other types of learning and does not immediately reward the individual with palpable results, it does play an important role in the development of more effective therapists by possibly providing the required foundations for professionals to further develop their therapeutic skills and tackle their major difficulties and challenges (Chow et al., 2015; Rousmaniere et al., 2017). But, as Rousmaniere (2017) posed it, how come psychotherapists, who have an incredibly challenging job (personality disorders, anxiety, depression) with usually very

high consequences (preventing suicide, etc.), do not have at their disposal such means to strengthen their skills?

It goes without saying that the kind of practice required for psychotherapy professionals to improve their skills is quite different from the areas previously mentioned. Citing Rousmaniere, Goodyear, Miller and Wampold (2017); *"…our goal is to focus on the learning processes rather than any implied similarities between psychotherapy and functions of those other fields…*" (p.15). One cannot memorize a single specific client scenario and expect to become an effective therapist. These same authors, when describing deliberate practice, present a few examples of exercises such as reviewing therapy session videos with experts providing feedback and role-playing solutions to the mistakes pointed out, these exercises are in line with two of AFT's central supervisory tasks; videotape analysis of rupture moments and awareness-oriented roleplays (Eubanks-Carter et al., 2014). These shared similarities between what Rousmaniere et al. (2017) suggest and what is being proliferated by the AFT model (Eubanks-Carter et al., 2014; Muran et al., 2018), already make a good case for what therapists could gain from a kind of training/practice that enables them to focus specific weak points. Some goals are also presented by Rousmaniere et al. (2017), but overall, they consist in addressing knowledge deficits specific to each therapist, which could present itself as a problem when resorting to a single and more specific model of training/practice.

Present Study

The present study is grounded on Zoltan Gross' (1992; in press) personality and interpersonal theory and sets out with an ambitious goal of testing the decision making of therapists in a challenging potentially stressful condition where they are invited to answer to a client immersed in his characterological longstanding pattern. How do therapists decide to intervene at the level of personality change? A simple Deliberate Practice exercise/resource was designed in an attempt of priming participants to make better use of their internal reactions and also manipulated instructions with the objective of stimulating personality change interventions according to Gross' theory.

This study was designed to act as an exercise where therapists could practice and test their decision-making process as well as it aimed to explore therapists' decision making when faced with what could be considered a difficult client, exhibiting a characterological issue or a longstanding pattern even after much therapy. Irrespective of

experience level, it can be argued that the interventions informed by Gross' theory are difficult to embrace as they require a high level of emotional skill together with a theory-informed purpose that is usually not so present in training opportunities.

Drawing from Gross's (1992, in press) statement defending that human consciousness displayed information information both in the foreground and background of awareness, similarly to Gestalt's figure-ground illusion, we included a package of stimuli (Visual task and Instructions in the video – APENDIX B and C, respectively) in half of our conditions (A1 and A2) that was intended to promote alternation between what the client was communicating, how the client was communicating and how it made the therapist feel.

While the visual task was included in an exploratory fashion, it was hypothesized (H1) that participants in the *Complex Stimuli* conditions (A1 and A2) would benefit from being in contact with material that promoted alternation between coexisting instances when compared to the participants in the *Plain Stimuli* conditions (B1 and B2), from which we expected no benefits. The effects of these conditions (A1, A2) were expected to be seen by having participants choose more *Habit Interruption - HI* interventions (*interventions with the objective of interrupting the automaticity of self-perpetuating emotionally dysfunctional habits*) in detriment of *Habit Validation - HV* (*interventions that despite focusing the client's experience, would not focus their underlying habits*) ones. Participants would be influenced by the Figure/Ground visual task and the presence of instructions, enabling them to more easily alternate between what the client was saying and how the client was saying it, as well as the emotional context of their complaint. In turn, this would the participants to choose an intervention which focused more on the dyadic strains and potential emotional needs than it focused symptomatic complaints and problem solving.

It was also hypothesized (H2) that participants in the *Complex Stimuli* condition (A1 and A2) would feel more emotionally aroused by the client because the subtitle instructions would act as guiding line to facilitate the therapist alternation between client's complaints and their underlying emotionality, signs of dyadic strains and emotional needs.

Regarding the difficulty to attend to everything the client said, it was hypothesized (H3) that patients in the *Complex Stimuli* condition had more difficulty attending to everything the client said. This is due to research on visual and auditory attention that suggest that a visual stimulus can disrupt attentional processes responsible

for auditory stimulus apprehension (e.g. Regenbogen et al., 2012; Shrem & Deouell, 2016). In the present study's case, the subtitled instructions could unintentionally act as a distraction interrupting the participants attention and experience, therefore making it harder for them to apprehend the contents of the client's dialogue.

The last formulated hypothesis (H4) was that participants in *Personality Focus* conditions (A2 and B2) would pick more *Habit Interruption* interventions in detriment of *Habit Validation* ones, comparing with their counterparts in *Symptom Focus* conditions (A1 and B1) due to having an instruction after the excerpt asking them for an intervention that would best help the client with their recurring personality pattern.

Method

Participants

There were invited 8000 therapists randomly selected from membership directories of the American psychological Association's Division 29 (Psychotherapy) to voluntarily participate in the study. From the 191 participants that constitute the sample 59,2% are females (n=113).

Regarding their nationality, 63,4% participants were from the USA, 20,9% were from the UK, 2,6% were European-American (possessing double citizenship). The rest of the sample was constituted by individuals from diverse countries (Ireland, China, Italy). Relative to their country of practice, the majority of participants (70,7%) reported carrying out their clinical practice in the USA, 23% in the UK and the remaining participants carried out their practice in other countries, mostly from Europe (e.g. Portugal, Slovakia).

The participants ages ranged from 27 to 90 years old (M= 60,12; SD= 13.31). Their years of practice ranged from 0 to 60 years and had on average 25,2 years of practice (SD= 14,1). Regarding participants weekly caseload, it varied from 0h to 40h per week, on average therapists in this study did 15,18h (SD= 10,29) of weekly clinical work. Input from therapists of all ranges of experience was wanted, so the responses of participants that had either no experience yet or had already retired were accepted, their weekly caseload was registered as zero hours per week.

Participants were asked about their favoured theoretical orientation and how much it guided their clinical practice (Not at all, Somewhat, Greatly). Most participants (97,4%), considered themselves to be integrative to some extent.

Procedure and Materials

Data collection was carried out online through a Qualtrics Survey Software platform distributed via e-mail and it was carried out for 15 days.

The first part of the study was the same to every participant as it simply consisted in the informed consent (APPENDIX A). Afterwards, participants were randomly assigned to one of our four conditions. (see Table 1).

Table 1

2x2 experimental design.

	Reminder for Complaint/Symptom Change (n=98)	Reminder for Personality Change (n=93)
Complex Stimuli (Figure/Ground Complex Images and Video with Instructions) (n=105)	**A1** (+/-) **Medium** Deliberate Focus on Personality Change (n=52)	**A2** (+/+) **High** Deliberate Focus on Personality Change (n=53)
Plain Stimuli (Plain Images and Video without Instructions) (n=86)	**B1** (-/-) **No** Deliberate Focus on Personality Change (n=46)	**B2** (-/+) **Medium** Deliberate Focus on Personality Change (n=40)

The experimental design consisted on a 2x2 plan and the four conditions (A1, A2 and B1, B2) were structurally similar. They all started with a visual task that was composed by either a sequence of images that elicited a figure-ground illusion effect (A1 and A2) or a sequence of simple geometric figures (B1 and B2) (APPENDIX B). The inclusion of this visual task in this particular way was based in the assertion made by Gross (1992; in press) that stated that the human consciousness displayed information both in the foreground and background of awareness, similarly to Gestalt's figure-ground illusion. The author defended that the focus of attention in the dyadic communication could also be alternated between foreground and background and by doing so, one could shift between the usual center of attention (the subject of conversation) and the emotional

context that resides in the background of awareness (the emotional needs of the dyad). Taking that into account, this visual task was included in an exploratory fashion in order to scan for any potential gains of having participants (A1, A2) in contact with figure/ground material and having them try to alternate between the two instances, as it was instructed, when compared to the simple geometric figure conditions (B1, B2) from which we expected no benefits.

Afterwards, participants were presented with an excerpt of a client in-session that lasted for 3 minutes and only differed between conditions by having (A1, A2), or not (B1, B2), instructions as subtitles. As previously mentioned, this client excerpt was designed to be something considered difficult and challenging, by having the client exhibit some traits characteristic of PDs (Critchfiled & Benjamin, 2006; DiMaggio et al., 2012) all the while manifesting their desperation and discontentment with the therapy process in a rupture-like fashion (Safran & Muran, 1996; Stevens, Muran & Safran, 2003)

The instructions (APPENDIX C), presented only in condition A1 and A2, had the objective of helping the therapists switch their attentional focus between what the client was saying, how the client was saying it and the impact the client had on the therapist. As previously proposed, participants in conditions A1 and A2 were expected to be influenced by the presence of the instructions by choosing an intervention which focused more on the dyadic strains and potential emotional needs than it focused symptomatic complaints and problem solving.

Right after the excerpt, participants had to answer a couple of questions about the impact the client had on them, namely, we asked them to rate on a Likert scale from 1 to 5, how emotionally aroused they felt by the client and on how hard it was for them to attend to everything the client had said and, also in a 1-5 Likert scale. Afterwards, participants had chosen an intervention out of four possible choices that either focused *Habit Interruption (HI)* or *Habit Validation (HV)* (APPENDIX D).

Further manipulations in order to influence the response trend were attempted by either asking for an intervention that would help the client with their complaint (A1, B1) or an intervention that would best help them with their recurring personality pattern (A2, B2). Finally, participants were asked to rate from 1 to 5 how confident they were about their selected intervention to have a changing effect on the client.

The data collection for sample characterization took place after this section and it was the final part of the study.

Data analysis was performed by resorting to IBM SPSS Statistics 25.

Results

Firstly, a data analysis was conducted in order to scan for potential outliers among our variables. When effectively present, said outliers were kept out of analyses which included the variables from where they belonged. Normality testing for metric variables was also performed to verify which statistical tests would best apply to our sample.

Participants were randomly distributed through four conditions ComplexStimuli_SymptomFocus (A1) (27,2%), ComplexStimuli_PersonalityFocus (A2) (27,7%), PlainStimuli_SymptomFocus (B1) (24,1%) and PlainStimuli_PersonalityFocus (B2) (20,9%). (see Table 2)

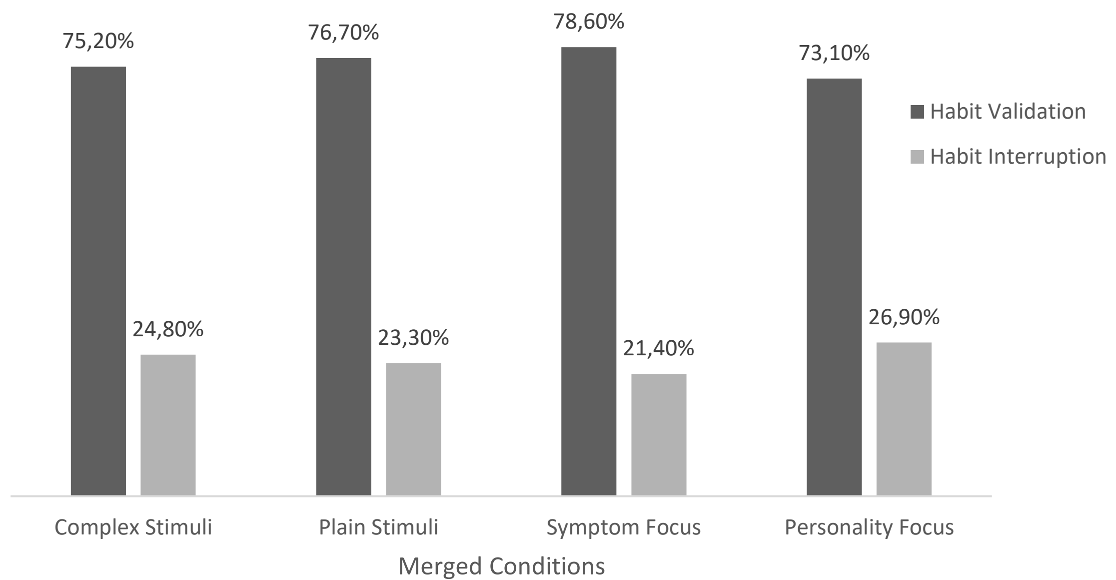
Table 2

Distribution frequency and sample response rate.

	Habit Validation		Habit Interruption	
	n	%	n	%
ComplexStimuli_SymptomFocus (A1)	39	75%	13	25%
ComplexStimuli_PersonalityFocus (A2)	40	75,5%	13	24,5%
PlainStimuli_SymptomFocus (B1)	38	82,6%	8	17,4%
PlainStimuli_PersonalityFocus (B2)	28	70%	12	30%

As mentioned above, the participants were randomly assigned to one of the four conditions (A1, A2, B1, B2) (see Table 2), however, to simplify the data analysis conditions were merged. Therefore, condition A1 and A2 resulted in Complex Stimuli condition and B1 and B2 in Plain Stimuli, and condition A1 and B1 merged into Symptom Focus condition and A2 and B2 into Personality Focus. On Figure 1 the response frequencies of each of the new condition are shown.

Figure 1
Participants response frequency for each merged experimental condition.



To test H1, a comparison of the participants frequencies in the Complex Stimuli (24,8%) and Plain Stimuli (23,3%) conditions, disregarding Personality vs Symptom manipulation, that choose Habit Interruption interventions was conducted. Despite the difference being extremely small, it effectively exists, supporting H1.

Considering H4, and inspecting the Figure 1, the data shows that participants in the Personality condition, independently from the Stimuli manipulation, choose more Habit Interruption (26,9%) interventions than those from the Symptom condition (21,4%). Therefore, H4 is also supported.

Additionally, the relationship between the two manipulations applied (i.e. Symptom Focus vs Personality Focus and Complex Stimuli vs Plain Stimuli) and their responses (Habit Validation vs Habit Interruption) was also investigated. For this purpose, the calculation of the Cramer's V was conducted, resulting in V= ,018 (p= ,809), when inspecting the relation between the Complex Stimuli vs Plain Stimuli and the responses given, HV or HI. This points to the independence between these variables (i.e. the manipulation was not related to the response given). Furthermore, considering the relation between Symptom Focus vs Personality Focus and the responses given, a Cramer's V equal to .064 (p .378) was obtained. Like the relation above, these two variables are not related. Overall, this seems to indicate that the

response ratio difference between Habit Validation and Habit Interruption was not due to the specific manipulations applied.

In order to test for H2 we performed Mann-Whitney test to investigate if there was any significant difference between Complex Stimuli or Plain Stimuli conditions in terms of Emotional Arousal. The test showed that Emotional Arousal on the Complex Stimuli condition was statistically higher than it was on the Plain Stimuli condition (U= 4.986,5, p= .049), which confirms the hypothesis. Regarding H3, another Mann-Whitney test was performed to see if participants in Complex Stimuli condition reported higher difficulty to attend to everything the clients said in comparison with the participants in Plain Stimuli condition. In this case, the data suggests no difference between the reported difficulty to attend in these two conditions (U= 4.122, p=.280), which doesn't support H3.

Considering that this study is an exploratory one, some more analyses were conducted to investigate any potential effects that were not considered in the hypotheses. Namely, in which variables participants that chose HV and HI differed.

Firstly, we checked if the participants that chose Habit Validation interventions reported different levels of emotional arousal, difficulty to attend to everything the client said and confidence in their intervention from those who chose Habit Interruption interventions. To do so, Mann-Whitney's tests were performed. The results suggest that there was no statistically significant difference between the levels of emotional arousal reported by the participants who either choose Habit Interruption or Habit Validation interventions (U=3.667, p=.113). The same is true for the reported levels of difficulty to attend (U= 3.057,5, p=.375) and confidence in the interventions chosen (U=3.242, p=.997), therefore suggesting that participants that chose Habit Validation intervention reported equal levels of difficulty to attend while being equally confident to their counterparts that chose Habit Interruption.

Secondly, it was also investigated if the participants that chose Habit Validation interventions reported different levels of influence of a specific theoretical orientation in their clinical practice from their counterparts that chose Habit Interruption. This was again done by conducting several a Mann-Whitney's tests. Since it was asked how much seven theoretical orientations guided each therapist's approach, there were performed seven analyses, and it was decided to only report the statistically significant results. The analyses indicate that the participants that chose Habit Validation interventions considered their therapeutic approach to be guided by the

Behavioural framework higher than those participants that chose Habit Interruption interventions (*U*= 2.380,5, *p*=.018). Additionally, participants that chose Habit Validation interventions consider their clinical practice to be guided by any of the other theoretical frameworks as much as their counterparts that chose Habit Interruption interventions (*e.g.* participants that chose HV consider themselves to be as influenced by cognitive approach as much as the ones who chose HI).

A comparison of the percentage of male participants (28,6%) as well as female participants (20,4%) that chose HI interventions was also performed, showing that males more frequently than females chose HI interventions. However, the response trend weighs towards HV in both sexes (i.e. more males chose HV interventions over HI ones, and so did females).

Ultimately, we checked if the age, years of experience and weekly caseload of participants that chose Habit Validation interventions differed from their counterparts that chose Habit Interruption. After carrying out normality tests, it was concluded that the only variable with a normal distribution was "weekly caseload", therefore allowing the performance of parametric tests. "Age" and "years of practice" did not demonstrated to have a normal distribution, and consequently Mann-Whitney's tests were performed to investigate the aforementioned comparisons between groups (HI vs. HV).

The test results suggest that participants that chose HV interventions are younger than those who chose HI interventions (*U*= 4.126,5, *p*= .002). However, participants that chose HV interventions do not differ from their HI counterparts in terms of years of experience (*U*=3.496, *p*=.149). Finally, a t-test for independent samples was performed to compare the weekly caseload of those who chose HV interventions and those who chose HI interventions. The results indicate that the weekly caseload did not differ between both groups of participants (*t*= -1,540, *p*=.125).

Guided by curiosity we sought to explore the relationships between the theoretical framework influence and other variables from our study, namely participants age, reported emotional arousal, reported confidence on their intervention, reported difficulty in attending to everything the client had said, years of experience and lastly, weekly caseload. Only statistically significant results will be discussed. Calculating Spearman's correlation coefficient for every theoretical framework influence and participants age it was possible to extract a single significant result which was a correlation between participants age and the extent the participants considered their

clinical practice to be influenced by an integrative perspective (ρ= .153, p= ,037). This result suggests that there is a weak relationship between these two variables in a way that the older the participant is, the more Integrative/Eclectic they consider themselves to be.

Considering the relation between every theoretical framework influence and the participants' years of practice it was observed that there was a weak relation between participants' years of practice and the extent the participants considered their clinical practice to be influenced by an Interpersonal perspective (ρ= -.179, p= ,017). This correlational value indicates that the more years of practice, the less Interpersonally influenced the therapists considered themselves to be in their clinical practice.

Lastly, the Spearman's correlation matrix between every theoretical framework influence and the participants' confidence in their chosen intervention yielded a single significant result, which was the correlation between confidence in their intervention and the extent the participants considered their clinical practice to be influenced by an Analytic/Psychodynamic perspective (ρ= .246, p= ,001) in such a way that the more psychodynamic the participants considered their practice to be, the more confident they were in their chosen intervention.

Discussion

The present's study data is arguably the first examining therapist's clinical decision making when faced with a difficult client while receiving specific instructions to help them focus on specific instances of the client that was presented. Despite the hypotheses H1 and H4 having been confirmed, even if by a small margin, it cannot be assumed that the differences that emerged were due to the specific manipulations applied. The differences are not owed to the characteristics of the conditions, as shown by the data's statistical analysis which indicated their independence towards each other. So, participants being either in conditions in which they were stimulated towards trying to alternate between client's complaints and their emotionality or conditions where there was no such incentive, had a very high probability of being unrelated to their response trend of either choosing Habit Interruption or Habit Validation interventions.

Although this component of deliberate practice had been designed according to Gross' (1992; in press) theorization that the consciousness could function in a Figure/Ground illusion fashion, in the sense that one could alternate between both

instances presented and that by doing so, therapists could, in session, focus on emotional contents presented in the background of conversation, the study set off in an exploratory fashion, with no research supporting the Figure/Ground effect as a stimulus with that potential.

Several reasons can be hypothesized as to why the manipulations seemed to have little to no effect or relation to the participants' response trend. Regarding our *Complex Stimuli vs Plain Stimuli* manipulation from which we expected participants to favour Habit Interruption interventions when attributed to *Complex Stimuli* conditions. It can be argued that participants might've not been able to engage or carry out the task in the intended way of alternating between what was figure and what was ground or perhaps they did but it did not transpose to the clinical decision exercise. This can mean that the participants managed to complete the task, but it did not influence or interfere with their decision making processes. If this was the case, then the expected effect of alternating and being able to focus client emotionality would've not taken effect and that could serve as a possible explanation for participants to have gravitated towards Habit Validation interventions. According to Gross (1992; in press), Habit Validation interventions are usually more frequent as they rest upon contents present in the center of awareness, thus being more easily and automatically accessible. Another possible explanation comes in line with what was indicated by Eubanks et al. (2018), stating that in the face of alliance rupture/strain scenarios – which was the case of our client excerpt - therapists considered exploring the client's experience of the rupture and acknowledging/validating their perspective as the most effective strategies the could employ. Additionally, our *Complex Stimuli* package simply might not have been a good or an effective enough dose of deliberate practice to produce a significant difference when compared to the *Plain Stimuli* condition. Finally, results could be explained by a natural dislike, avoidance, lack of training or lack of courage by clinicians to intervene in such a way as considered effective towards personality change according to Gross' theory.

Regarding our *Symptom Focus* and *Personality Focus* conditions, there was indeed a slight inclination for HI interventions in detriment of HV ones when participants were attributed to the *Personality Focus* condition. This difference was, however, non-significant. Possible explanations for such results might be that the instructions were too vague or unclear. Perhaps participants did comply with the instructions in their own way and they were simply different from what was intended and hypothesized. Or again, results could be explained by a natural dislike, avoidance, lack of training or lack of

courage by clinicians to intervene in such a way as considered effective towards personality change according to Gross' theory.

Considering now all conditions, and the fact that data analysis yielded results pointing towards a trend of about 70% HV answers, it is possible that our HI interventions might have not been very appealing for most therapists as they were based in a quite specific to Gross theory of personality. It is possible that a great number of therapists did not feel inclined to pick those interventions, despite any manipulations applied. Whether it was because of natural dislike, avoidance, lack of training or lack of courage to tap on personality change according to Gross' intervention principles remains a research question. The fact that 30% did in fact pick those HI interventions still shows us that they are recognized as valid and even preferred interventions. In a future study, a qualitative design could help us better understand what is going on therapists' mind when approaching or avoiding these HI clinical decisions.

Now turning our attention to H2 and H3, which were both related to the *Complex Stimuli* and *Plain Stimuli* condition, the results indicated that *Emotional Arousal* was shown to be superiorly reported in the *Complex Stimuli* condition as hypothesized in H2. Moreover, *Difficulty to Attend* was similar in both conditions, which rejected H3's assumption that participants would report higher *Difficulty to Attend* if attributed to the *Complex Stimuli* condition. There can be some explanations for the present results and the results themselves can perhaps function as an attempt to unveil some questions raised regarding H1. First, the fact that participants reported higher levels of *Emotional Arousal* in the *Complex Stimuli* condition might be considered an accomplishment in the sense that this condition was designed to promote a higher contact with the emotional needs of the client and the impact she had on the therapist (the participant). This might help discard the explanation which suggested that participants could not engage in the *Complex Stimuli* condition tasks or that these tasks had no effect on the participants. They did, in fact, have no effect in their clinical decision (response trend) but, as shown, there is an effect regarding *Emotional Arousal*. This relation between *Complex Stimuli* condition and superior *Emotional Arousal* comes in line with what was postulated by Gross (1992; in press), Elliot et al. (2004) and Binder et al. (2008) defending that for the therapist to be truly responsive they would have to assume a feeling role in the dyad in order to connect with the clients' most emotionally-packed contents, which would, in turn, enable them to be therapeutically more effective. Given that the *Complex Stimuli* condition was designed to promote *Emotional Arousal*, results can suggest that the participants contact with the

client's emotionality was facilitated by the manipulations applied. This did not, however, translate in them picking clinical decisions that were designed to, supposedly, be more prone to influence personality change, as previously mentioned in line with Gross' principles.

Taking H3 into account, which was rejected through data analysis, the results were slightly surprising considering the existing literature (e.g. Regenbogen et al., 2012; Shrem & Deouell, 2016) supporting that visual stimuli, which belong in the camp spatial awareness, would overlap auditory stimuli therefore interfering with the attentional processes of attending to them. The results showed no difference between participants of both conditions and their reported difficulty to attend. A possible explanation is that the visual stimuli themselves (subtitle instructions) were not very demanding or overloading and, in fact, when designing the condition researchers tried to keep their size and intensity as minimally intrusive and demanding as possible.

As seen in the results section, various analyses were conducted besides the ones relating to the investigation hypotheses, however, only significant results will be discussed. First, participants who chose HV interventions considered their clinical practice to be more influenced by a Behavioural orientation when compared to those who chose HI interventions, but considered themselves to be influenced by any of the other theoretical frameworks just as much as participants who picked HI interventions did. In other words, the Behavioural orientation was the only theoretical framework in which participants that chose HI interventions differed from their counterparts that chose HV interventions. No particular justification was found for this result, but possibly relates to some specificities of the Behavioural model, probably more inclined towards symptom change and less to personality change.

Another interesting result was that participants who picked HI interventions tended to be older than participants who picked HV options. Additionally, older therapists considered themselves to be more influenced by an Integrative/Eclectic approach than younger participants did. Despite this, as already mentioned, Integrative/Eclectic influence didn't differ from participants that chose HI interventions and those who chose HV interventions.

Several potential result justifications presented can also be considered limitations of the present study, but potentially the biggest limitations were not having a purely control condition which suffered no manipulation. This fact also points to another potential limitation, that this deliberate practice exercise had its impact not measured anywhere

before its use in the current study. The study was, however, not targeting the quality of the deliberate practice exercise, but more so, trying to influence a certain type of clinical decision we expected was more probabilistically avoided. The fact that the HI interventions formulations are based on a very specific theory of personality that might require training to be better embraced as equally valid, or not controversial, can also be considered a limitation. Nonetheless, personality disorders abound, and the clinical territory should be equipped with therapists capable of influencing personality longstanding patterns, irrespective of their specific training. HI interventions did in fact not appeal to the majority of therapists, yet an immense minority still preferred those, and it is not probable that it was due to specific training on Gross' theoretical principles, because it doesn't yet formally exist.

Looking at the study from an overall perspective and considering the literature that prompted its development it was interesting to see that therapists did not differ between each other in their HV and HI response trend when considering their years of experience or weekly caseload, so, therapists who had few years of experience compared to seasoned therapists with over 20 years of clinical practice opted for the same interventions. The same is applied to therapists with different amounts of clinical workload per week, meaning that having 5 or 40 hours of weekly clinical work did not influence our participants' response trend in either choosing HV or HI.

Despite measuring therapist effectiveness being outside the scope of this study, it can be argued that HI interventions could be potentially more effective in helping this client if Gross' (1992; in press) perspective is taken into account. Since this study is based on those assumptions, it can be debated that independently of their experience, most participants missed out on a potentially more effective intervention by preferring to choose a less controversial option. Therapists most picked interventions consisted in acknowledging the client's perspective, but also quickly and nicely presenting some kind of problem-solving strategy or of an explanation for the way they felt. As previously mentioned, Eubanks et al. (2018) investigation yielded results suggesting that therapists preferred strategies for rupture/strain resolution were indeed exploring the client's experience of the rupture and acknowledging/validating their perspective. It is then somewhat surprising to see that HI interventions, which focused deeply on the client's perspective of the rupture/strain were greatly under-picked when compared to HV interventions. There might be something on HI clinical decisions that shy therapists away

from risking looking less nice and gentle to their clients, even if these interventions could be delivered in a very caring and professional way, as suggested by Gross (1992; in press).

According to this author, avoiding that risk caries another risk of not influencing personality patterns in a therapeutic way, favouring much more reflection over experimentally and procedurally induced corrective emotional experience in the context of optimal levels of immediacy and emotional arousal. When a client engages in immediacy, the discussion of the here-and-now in session, it is crucial for the therapist to engage the client in a deeper level of exploration of their affective and interpersonal material in order to promote a corrective relational experience and help clients feel cared for, as shown by Clemence et al. (2012) and Hill et al. (2014). Additionally, Clemence et al. (2012) demonstrated that failing to address the client in such a way or dismissing their immediacy attempts by shifting focus to another topic (such as problem solving), resulted in process deterioration. This kind of intervention that shifted from client experience acknowledgement to other topics, was the core of HV interventions. In this scenario where therapists had to forcefully choose one out of four different interventions (two HV and two HI), it was interesting to see that the pick ratios for every option were extremely similar across conditions, having HV ones been the favoured choice in 70% of the sample. It is worth pointing out the studies of Kline et al. (2018) and Rhodes et al. (1994) regarding the lack of awareness, from the therapists' part, in detecting ruptures and the risks of dismissing alliance strains or not attending to them in a proper way. Taking this data into consideration it can be argued that most of the sample opted for an intervention that had a very high chance of failing to correctly address the client's emotionality and moment of suffering (Gross, 1992; in press).

As stated before, however, this study did not have the objective of measuring therapist potential effectiveness and to do so several limitations would need to be tackled in order to carry out a rigorous research.

The study was built with the core objective of highlighting a potential risky preference by therapists when facing personality driven longstanding patterns or mental habits. For that, we intended to develop a potential Deliberate Practice resource model for therapists to practice and reflect on possible interventions when faced with different scenarios and prompts, in this case the *Complex Stimuli* condition and the instructions for *Symptom* or *Personality Focus*. This can be seen as a work in progress or prototype that can suffer numerous changes not only to strengthen it but also to make it possible to portray several other client scenarios for therapists to practice. As for the present study, there was no

formal measurement or data collection regarding its Deliberate Practice qualities, participants were, however, given the opportunity to offer feedback about the study. Interestingly, a great number of participants mentioned that even though the study had some issues they found it to be stimulating and thought-provoking, making them reflect on their clinical interventions. Further research and experimentation within this framework is seen with great enthusiasm, especially with new and different client scenarios and better adjusted tools for self-reflection and feedback. Also, in terms of future directions, since Zoltan Gross' principles of change seem to be received by therapists with, at least, some reluctance, listening to clients' perspective when undergoing such an approach informed by those principles would be highly welcomed.

Whether or not clinicians are enough prepared to influence personality longstanding patterns or mental habits instead of simply caressing them, remains a research line pursuing further. And clients should also be able to share their preferences regarding getting their longstanding habits transformed or not!

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APPENDIX A – Informed Consent and Instructions for Participants

Welcome!

Our research team at Faculty of Psychology, University of Lisbon, invites you to participate in a research study SOP (Symptoms & Symptoms of Personality) on the interface between psychotherapy and personality. It aims at capturing decision-making processes when faced with a specific choice point regarding a specific client with their symptoms and personality functioning.

The participants of this study are clinicians of any theoretical approach.

We designed an experiment of 15 minutes.

We welcome and appreciate your interest and invite you to read the Informed Consent information below before taking part in the survey, which has been approved by the university Ethics Committee.

You will be randomly assigned to one of the conditions of the experiment, where in each you will be presented with a client that could potentially be your own. It is an actress that captures into a single 3-minute excerpt, several snapshots of a real client in therapy. After listening to this imagined client of yours, you will be asked a few questions about how to reply to her. In the end of the experiment, we will ask you to briefly answer some demographic questions.

Please note that it is very important that you wear ear/headphones or be in a place where you can be fully focused on this client without any interruption.

This research is being conducted by Filipe Lopes, B.A. (Psychology), a master level student, supervised by Nuno Conceição, Ph.D.

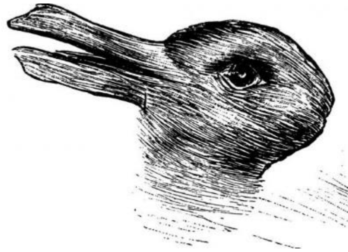
The responses to this questionnaire will constitute some of the data for the 1st researcher's dissertation. The results could potentially be used at conferences and in relevant publications. Your participation is voluntary, and your answers will be anonymous and confidential. We do not know or anticipate risks to your physical or mental health.

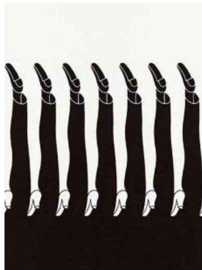
If you have further questions or want to be later informed about the results of the study, please feel free to contact us through the following email: filipe.lopes.1994@gmail.com

Thank you for your willingness to collaborate!

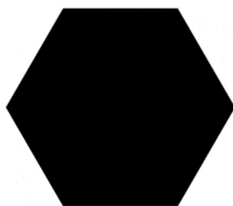
APPENDIX B – Figure/Ground Images for *Complex Stimuli* Condition and Geometric Figures for *Plain Stimuli* Condition

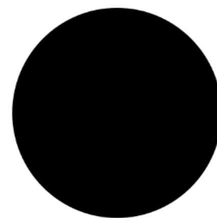
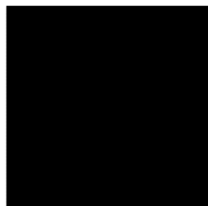
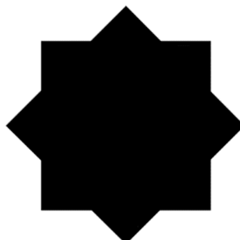
Complex Stimuli





Plain Stimuli



APPENDIX C - Subtitle Instructions for *Complex Stimuli* Condition

Each subtitle lasted for 30 seconds and were shown in this order:

1. Notice what she is verbally telling you
2. Notice what else is she revealing to you
3. Notice impact on you
4. Notice what she tells you explicitly
5. Notice her underlying emotionality
6. Notice your own feelings
7. Notice the content of her complaint
8. Notice if she influences you into some reaction
9. Notice what is your reaction inside

APPENDIX D – Multiple choice interventions available to participants (*Habit Validation and Habit Interruption*)

Now, it's your turn.
From the following, pick your favourite option, the one that you trust you would feel comfortable with and confident in offering just after what she said, in order to help in her complaint.

(for Personality Focus only) PLEASE REMEMBER: YOUR INTERVENTION SHOULD BE AIMED AT HELPING WITH HER LONGSTANDING (PERSONALITY) PATTERN (HABIT).

- [1]*(Habit Interruption)* "And we have worked for all this time and I still haven't helped you. It's like being at square one now! That's terrible! You just want to get rid of that. You don't need to do anything with it. You just let yourself know that you are pissed off with me and disappointed that I am not helping you enough and yet I'm here glad that you came to see me. You are capable of anger and complaint and you find it difficult to let yourself be cared about… So, what are you feeling about me, about the way I'm talking to you?"
- [1]*(Habit Validation)* "I see how upset you are, especially after investing so many resources in therapy. I really appreciate you being able to express your dissatisfaction with our work. I do take you seriously. Have you tried any of the specific strategies we have talked about? Did it not work out? What came in the way of you using them? If you could walk me through this last time, maybe we can both reflect about what actually happened. I suggest that we review them together and see if we co-create something really accessible and useful as a resource for you to apply on these painful moments when they emerge next time."
- [1]*(Habit Interruption)* "You are dreadfully lonely. But there is hope. Right now, it's a step forward that you are pissed off with me, but you don't use it. You complain but you don't directly get mad at me tell me what you want from me. Instead of nourishing yourself emotionally in your relationship with me, you stuff your mouth with food and drink. That hole keeps you lonely. Your urge to miss your appointment with me is another way of keeping yourself lonely, out of emotional contact with others. Tell me how are you reacting to me now? Am I helping you now? Do you find me nourishing now?"
- [1]*(Habit Validation)* "It seems that this part of you really needs to stop and have a break or be on some kind of strike. One part of you wants to get on with life, that is pretty clear! Yet, these moments that do not occur so often, they can still last for a couple of days, and on those days the other part of you just wants to stay there, in your room, for that long indulging herself without worrying about anything, without connecting to anybody, feeling no purpose, no motivation or orientation of any kind. What do you feel towards that part?"

[1]Habit validation and interruption labels were not visible to participants.