8-1-2022

Operationalizing the gift of love (GOL) in Interpersonal Reconstructive Therapy (IRT): An examination of the role of meaning reconstruction in therapeutic change.

Eliza Stucker-Rozovsky

Operationalizing the Gift of Love (GOL) in Interpersonal Reconstructive Therapy (IRT): An examination of the role of meaning reconstruction in therapeutic change.

Eliza Stucker-Rozovsky

A dissertation submitted to the Graduate Faculty of

JAMES MADISON UNIVERSITY

In

Partial Fulfillment of the Requirements

for the degree of

Doctor of Psychology

Department of Graduate Psychology

August 2022

FACULTY COMMITTEE:

Committee Co-Chairs: Drs. Kenneth Critchfield and Elena Savina

Committee Members/Readers: Dr. Lindsey Harvell-Bowman

Dedication

To the G-d of my understanding, who has brought me to this day and made me who I am.

To my father of blessed memory, David Stucker Z''L, for reminding me to "get after it."

Even from the world beyond, you continue to inspire me, motivate me, and love me.

Acknowledgments

IRT Patients-Thank you for being willing to be part of the IRT database and share your story with others who are interested in optimizing ways to release our gifts of love.

Ken Critchfield-Words could not properly describe my gratitude. You have taught me an incredible wealth of knowledge in such a short time, within the context of such a rich, warm, fun mentorship relationship. Thank you for introducing me to IRT and taking me under your wing. I look forward to many years of continued collaboration.

Shreya Namburi, Rebekah Martin, Tanner O'Connell, Christine Mason, Megan Hopkins, Hannah Jarrett, Hayley Becker-Thank you all so much for being part of my coding team. To Shreya and Rebekah who fielded the initial versions of the coding system, to Tanner, Christine, Megan, Hannah, and Hayley who helped me make finishing revisions and applied this complicated system to many sessions. I am indebted to you all, thank you!

Mark Tabbut-Thank you for experiencing profound levels of grief with me. You helped form me into a professional chaplain and, without your supervision in CPE, I would not have been drawn to find connections to religion and spirituality in psychology.

Kunal Sachdev-Thank you for your presence and guidance in two of the most difficult times of my life. You were one of the main reasons I was able to finish my chaplain residency and have such a transformative experience. You continue to help me continue to reach for and attain my goals. Thank you for believing in me.

My parents-Mom and Dad, you are my ride or dies, my number ones. You have always believed in me and pushed me to be my best. Thank you for supporting me even when you didn't understand my choices. They have all brought me to this moment.

My husband, Aaron-You believe in me when I don't believe in myself and love me when it's hard for me to love myself. Your support has been integral to crossing this finish line. Thank you for being my #1, always and forever.

Table of Contents

List of Tables

List of Figures

Abstract

Interpersonal Reconstructive Therapy (IRT) (Benjamin, 2003/2006) is an integrative, principles-based treatment approach and theory of psychopathology that conceptualizes the motivating factor that underlies personality psychopathology as the gift of love (GOL). That is, copy processes are learned and maintained to achieve psychic proximity to the important people and their internalized representations (IPIRs) that were the original teachers. Relinquishing this gift of love allows a person to re-orient their life towards uncovering and living by their own individually held meanings that will then define how they relate to themselves and their world. Spirituality and religion have historically helped individuals make meaning of and endure some of life's most trying events (Canada et al., 2016; Hawthorne et al., 2015; Lichtenthal et al., 2010; Johnson & Zitzmann, 2020). Furthermore, Park and Folkman (1997) and others have studied how spirituality can play a large role in a person's meaning-making processes. The ability to make meaning out of a stressful situation has been shown to promote adaptation and well-being. This study asserts that the process of understanding and learning to let go of the gift of love is inherently a spiritual task. Studies involving IRT have not yet considered explicitly spiritual coping and its connections to the gift of love. This study created a coding system based on existing theory that reliably detects the gift of love as well as spiritual coping in an archived IRT dataset. Results indicated that the presence of spiritual coping, particularly positive spiritual coping, was significantly associated with higher levels of adherence to IRT. In addition, this study revealed that GOL is associated with personal and social spiritual coping and is positively associated with therapeutic change, as measured by GOL stages of change. *Keywords: Interpersonal Reconstructive*

Therapy, interpersonal theory, personality disorders, religious coping, spiritual coping, therapeutic change

Chapter I

Introduction

Interpersonal Reconstructive Therapy (IRT) (Benjamin, 2003/2006) is an integrative, principles-based treatment approach and theory of psychopathology that is believed to have application to all patients given its grounding in principles of normative development but has primarily been used to date to focus on complex and severely personality disordered individuals. It is rooted in several psychological theories yet offers a metatheoretical approach to understanding and organizing treatment that allows individual tailoring for complex diagnostic presentations. IRT conceptualizes patient symptoms and problems as products of failed attempts to adapt to current circumstances using maladaptive patterns of behavior that were internalized from important attachment figures, termed copy processes (Benjamin, 2003/2006). The internalized patterns plus the associated rules and values of loved ones associated with copy processes are believed to be linked to early learning about safety and threat. They are theorized to be driven in part by loyalty to early caregivers and/or a desire to maintain felt proximity to those who represent safety and survival. As such, Benjamin's theory proposes that which underlies personality psychopathology offers a persistent and challenging clinical presentation to disrupt in that it is linked to love, loyalty, and learning in close attachment relationships, and has roles in identity, meaning-making, and safety-seeking.

IRT theory conceptualizes the organizing, motivating factor that underlies this personality psychopathology as the "gift of love" (GOL). This is the idea that copy processes are learned and maintained to achieve psychic proximity to the important people and their internalized representations (IPIRs) that were the original teachers. The

wish underneath gifts of love is that "internalized representations of early figures will forgive, forget, apologize, wake up, make restitution, relent—or otherwise make it possible for there to be rapprochement and unfettered love" (Benjamin, 2003/2006, p. 10). IRT hypothesizes that the sooner a person's gift of love can be recognized, understood, and grieved, the sooner they will be able to differentiate from these IPIRs in ways that enable the reduction of symptomatology and reconstruction of personality (Critchfield et al., 2019). The function of addressing the gift of love in IRT is to enable either more adaptive ways of seeking the fulfillment of wishes relative to loved ones or to let go and grieve them in order to enable finding more adaptive ways of being. Successfully navigating the gift of love means that these wishes are transformed or grieved, and then the patient may more freely engage with and respond to more traditional treatments without these underlying unconscious wishes to maintain maladaptive "Red" patterns that involve self-sabotage out of wishes for love.

The gift of love theory includes the role of grief in change, and specifically notes that the gift of love functions as the underlying meaning that perpetuates Red copy process patterns (Benjamin, 2003/2006). The reconstruction process begins around the patient's capacity and willingness to understand, recognize, and then grieve and relinquish his/her gift(s) of love. The goal of relinquishing this gift of love is to re-orient a patient's life towards uncovering and living by their own individually held meanings that will then define how they relate to themselves and their world, termed in IRT as blocking the Red self and enabling the growth promoting Green self. Said another way, relinquishing the gift of love can be understood as a process that involves transforming core meanings held by the patient, a form of meaning-focused coping.

This dissertation attempts to expand on these themes of meaning, relatedness, and coping in established IRT research through the construction and utilization of a coding system for the gift of love that incorporates religious and spiritual coping. Spirituality and religion have long-standing histories in helping individuals cope with painful life events and find meaning through suffering. Spirituality can provide individuals with tools as they grapple with problems that incite questions about one's purpose, limitations, mortality, and control (Pargament, 2007). An individual's orientation in moral space is comprised of what makes their life valuable and worth living and often involves self-transcendence (Schuhmann & Damen, 2018). When an individual is personality disordered, however, they often have difficulty engaging with a clear sense of their identity, purpose, or meaning in life. As such, they can be conceptualized as being misoriented in moral space and require reorientation in moral space as a clinical intervention in addition to treatment as usual.

Studies involving IRT have not yet utilized a way to study the GOL in tandem with spiritual coping. This dissertation will explore existing literature on coping and its relationship with meaning-making, particularly as a way to resolve the discrepancy between the meaning of a situation and one's global meaning (Park, 2005). It will incorporate attachment styles and neuropsychology of personality disorders to provide grounding to the importance of interventions that allow patients to seek safety without engaging in maladaptive behaviors and patterns. The gift of love will be viewed through the lens of IRT but also existing literature on religious and spiritual coping, hope, grief, and meaning-making processes. Through this investigation, this dissertation seeks to gain

additional insight into the ways that spirituality and religion may enhance treatment outcomes within Interpersonal Reconstructive Therapy.

Chapter II

Literature Review

Introduction

This section explores the literature related to Interpersonal Reconstructive Therapy (IRT) and the gift of love (GOL) as well as themes of meaning, spirituality, meaning, and coping that are part of therapeutic conversations that employ the GOL concept. IRT makes explicit connections to how caregivers are internalized in meaningful ways through copy process, with the underlying love wishes that are the GOL. A spiritual way of conceptualizing IRT would be to understand that early relationships not only cue safety and threat but also infuse our life with meaning. Humans as relational beings are deeply vulnerable to and influenced by those who provide for us our basic needs, with one of the most powerful needs being love/affiliation. These relationships contribute the walls that orient a patient in moral space and point to the sacred, and if maladaptive CPs are internalized, then the patient is fundamentally misoriented, stuck in patterns that beget dysfunction and pathology. Enabling will means enabling conscious understanding and motivation; change from here involves the choice to grieve and live life differently.

Lorna Smith Benjamin, author of IRT, speaks more implicitly about themes of grief and meaning as they relate to the GOL, and this section is meant to offer both the background of her writings on this topic as well as a review of literature that addresses the “depth based” work that is typical in working with the GOL. One implication of IRT’s research to date is that work on the GOL is addressing deeply held values and attachments to figures that contribute to the meaning a person ascribes to their life and reality. Therefore, addressing topics such as grief and meaning reconstruction may be

necessary conditions for therapeutic change to take place. In addition, the work of personality reconstruction demands coping, and coping literature from a psychological as well as religious/spiritual perspective is offered.

Interpersonal Reconstructive Therapy

Introduction

Interpersonal Reconstructive Therapy (IRT) (Benjamin, 2003/2006) is an integrative, principles-based treatment approach and theory of psychopathology that focuses on complex and severely personality disordered individuals. IRT has primarily focused its research on more severe cases of personality disorder, using the acronym CORDS, signifying comorbid, often rehospitalized, dysfunctional, and suicidal to summarize information regarding this patient population (Critchfield et al., 2017). It is rooted in several psychological theories yet offers a metatheoretical approach to understanding and organizing treatment that has been successful for a severely acute population. IRT conceptualizes patient symptoms and problems as products of failed attempts to adapt to current circumstances through the use of maladaptive patterns of behavior that were internalized from important attachment figures (Benjamin, 2003/2006). These internalized patterns and rules are theorized to be linked to safety and threat and driven by loyalty to early caregivers who represent safety and survival. As such, that which underlies personality psychopathology offers a persistent and challenging clinical presentation to disrupt.

Copy Process Theory

Benjamin (2003/2006) articulates through her copy process theory three specific ways that early relational history is copied and demonstrated behaviorally in the present.

The three copy processes are: a) identification (acting like important others), b) recapitulation (acting as if important others are still present and in charge), and c) introjection (treating the self as important others did). Copying can occur both in adaptive and maladaptive ways. Copying is adaptive if it "helps an individual meet the demands of current circumstances in reality-based ways" (Critchfield & Benjamin, 2010, p. 480). However, in the case of personality disorders, the copy processes that link current problems to internalized working models of these important relationships are more powerful than cues from present-day reality and result in dysfunction in numerous domains of patients' lives as well as severe symptomatology (Critchfield, 2010).

Copy process (CP) theory has been validated in several studies from the broader psychology literature and is observable in clinical- and non-clinical datasets (Critchfield, Benjamin, & Levenick, 2015; Critchfield & Benjamin, 2010). There are numerous studies that link early adversity with adult psychopathology, and these coincide with the three CP Benjamin outlines. Studies showing links between early witnessing or experiencing of domestic abuse and later abuse of children and romantic partners (Carr & VanDeusen, 2002; Moe, King, & Bailly, 2004) demonstrate the CP Identification. Links between family-of-origin violence and adult victimization by a romantic partner (Desai, Arias, Thompson, & Basile, 2002) demonstrate the CP recapitulation, and the CP Introjection can be observed in correlational studies showing links between remembered early psychological maltreatment and adult self-depreciation and self-blame (Brewin, Andrews, & Gotlib, 1993).

Gift of love theory

Differentiation from maladaptive copy processes is essential to change in IRT theory. However, this differentiation is complicated by the organizing, motivating factor that underlies personality psychopathology, known in IRT as the gift of love. Gifts of love are theorized to be central to the maintenance of copy processes (CP), including those maladaptive CPs that maintain personality disordered psychopathology. These gifts are theorized to be behavioral manifestations of the wish(es) that "internalized representations of early figures will forgive, forget, apologize, wake up, make restitution, relent—or otherwise make it possible for there to be rapprochement and unfettered love" (Benjamin, 2003/2006, p. 10). IRT treatment targets these GOL wishes to disable the sustaining power of maladaptive copy processes. That is, copy processes are learned and maintained in order to achieve psychic proximity to the important people and their internalized representations (IPIRs) that were the original teachers. The hope underneath this maintenance is for some sort of rapprochement or reconciliation. IRT hypothesizes that the sooner the gift of love can be recognized, understood, and grieved, the sooner the patient will be able to differentiate from these IPIRs in ways that enable the reduction of symptomatology and reconstruction of personality. The function of addressing the gift of love in IRT is to enable either more adaptive ways of seeking the fulfillment of said desires or to let go and grieve these wishes to enable finding more adaptive ways of being. Successfully navigating the gift of love means that these wishes are transformed or grieved, and then the patient is said to no longer remain in the nonresponder category and will respond to more traditional treatments without these underlying unconscious wishes to maintain maladaptive patterns that involve self-sabotage out of wishes for love.

The preliminary analyses of the impact of engaging the GOL on patient outcomes is promising (Critchfield & Benjamin, 2019). Copy processes serve as signals of and partial evidence for the gift of love. CPs have been shown to demonstrate the links between past and present for patients, linking behaviors that were learned from IPIRs and then internalized as the patient developed to presenting symptoms. Critchfield et al. (2015) demonstrated that there is commonality across different psychopathologies when it comes to patterns that can appear as CP: the perception of hostility from early attachment figures that continues in the present. These copy processes are especially useful in the study of GOL, as their enactment in the present suggests the GOL, whether or not the patient is able to explicitly identify the GOL. Copy processes thus act as indicators that allow IRT therapists the opportunity to further develop GOL awareness with the patient and thus increase their capacity to choose more adaptive ways of being.

The GOL is not simply a psychological concept, however. According to IRT theory, just as copy processes are linked biologically to our safety and threat system, so too is the GOL linked to our attachment system. IRT has considered the ways attachment system activation plays a part in the difficulty of personality reconstruction. For CORDS patients, Benjamin speaks to how the links between C1 (maladaptive perceptions of threat and safety), A (affects arising from C1), and B (resultant behaviors) are held in place by the gift of love. Thus, the gift of love (GOL) refers to self-sabotaging C1AB patterns that function to gain psychic proximity and safety system activation for the patient. Complying with internalized caregivers' rules expresses loyalty to said persons, and this loyalty results in reinforcing safety system activation (Benjamin, 2018). However, this safety system activation is not matched to reality-based safety cueing; thus,

personality-disordered patients' attachment systems are miscued. For example, in the case of recapitulation, a person whose father was abusive in childhood may experience safety system activation in the presence of an abusive romantic partner. While this should not cue safety in reality, the attachment system of the person is miscued to recognize such familiar behaviors as safe and their nervous system responds accordingly.

Such miscuing has been shown in primates (Harlow et al., 1965) and is about automatic primitive brain learning, not logic or function as is typically thought. Harlow found that primates would "look to the familiar huggable figure for security, regardless of history or consequences" (as cited in Benjamin, 2018, p. 30). Harlow's finding has direct links to IRT's gift of love. That is, affects and behaviors that arise out of the primitive brain's cueing of safety or threat are copied from attachment figures. In the midst of threat, we copy what our caregivers see, feel, and do, or do what they tell us to do. In addition, complying with our caregivers activates our safety system and we are rewarded biologically with neurochemicals and hormones such as serotonin, dopamine, oxytocin, or opioids (Benjamin, 2018). The pleasing aftereffects on a biological level are reinforcing and can result in a process akin to drug addiction. Thus, the constant temptation for personality disordered individuals to comply with old rules from caregivers that provide safety cueing is analogous to the cravings addicted persons experience in anticipation of the rush of dopamine and other pleasant neurochemicals upon ingestion of an addictive substance. While separating from this addictive pattern is challenging, the lynchpin remains the gift of love motivations that must be addressed before reconstruction can take place.

IRT Case Formulation and Five Steps

A leading feature and standard of IRT therapy is the use of the case formulation that is created collaboratively and shared with the patient. This formulation includes early relational history, with particular attention to copy processes, their links to specific important people (IPIRs), and the wishes that may underlie the continued existence of these maladaptive patterns (GOL motivation) (Benjamin, 2003/2006). While IRT encourages use of interventions and techniques from a wide variety of schools and theories, adherence and interventions that are tailored to the case formulation is a standard procedure. Critchfield et al. (2015) demonstrated that the IRT case formulation (CF) is a reliable, sensitive, and specific measure of links between symptoms and IPIRs.

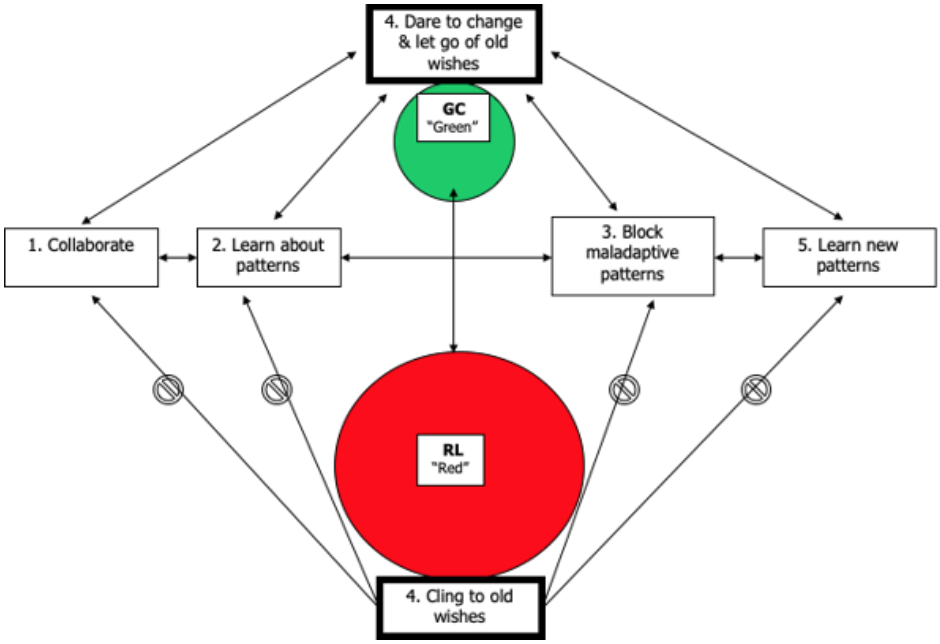


Figure 1. The gift of love within steps of IRT. From Benjamin, L.S. (2003). (Figure 1.1, Early in Therapy). Reproduced under the Doctrine of Fair Use, in accordance with 17 U.S. Code § 107.

Using the case formulation, IRT-adherent therapists engage in the five steps of IRT, which can be sequential in nature (Figure 1). The first step is establishing a warm,

collaborative relationship with the patient. The second step involves learning about patterns, their origins, and their purposes. This step is crucial in creating the case formulation and serves as a shared understanding between therapist and patient about treatment goals that can be referenced throughout the treatment process. This understanding also allows leverage to differentiate the part of the patient that is acting out of loyalty to internalized values and rules (termed the *Regressive Loyalist*, or *Red)* from the part of the patient that wants to actively and consciously choose more flexible, friendly, adaptive, and healthy ways of relating to self and other (termed the *Growth Collaborator* or *Green)* (Benjamin, 2003). The third step, blocking maladaptive patterns, begins the differentiation process from "Red" maladaptive copy processes that maintain problems and symptoms.

The fourth step, enabling the will to change, directly addresses the gift of love in patients. This step involves understanding the underlying longings, desires, and motivations to continue engaging in maladaptive patterns as well as transforming or grieving these wishes in order to enable motivation and energy for creating healthier, more adaptive and conscious ways of living. Step four is the step that sets IRT therapy apart from other more traditional approaches to treatment. This is because it addresses the underlying unconscious motivations that maintain psychopathology rather than focusing purely on symptoms (Benjamin, 2018, Ch. 6). After these have been addressed, patients are no longer considered unresponsive to traditional treatments and are able to learn new patterns and ways of being without being unconsciously drawn to self-sabotaging behaviors that express loyalty to important early caregivers. The fifth and final step, learning new patterns, is the reconstructive process of learning more adaptive, friendly,

differentiated patterns of being, living, and relating with self and other. This step involves reprogramming the miscued affects that were the learned byproduct of early relational figures (Benjamin, 2018, Ch. 6). There is a focus on fostering warm relatedness with self and other, with moderate levels of affiliation. Grief may remain in this process, as patients become aware of what life is like without loyalty to old rules as well as grief about time lost or parental relationships that will never be different.

IRT Adherence

Success in IRT is predicated not only on therapist adherence but also patient adherence to the core algorithm of IRT. Adherence in IRT therapy is measured for each session on a scale of -10 to +10. The scale individually rates the therapist's adherence to the 'core algorithm' of IRT: a) Accurate empathy, b) Supporting 'green' over 'red', c) Using the case formulation, d) Eliciting interpersonal detail, and e) Tracking affect, behavior, and cognition (Benjamin, 2003/2006). It also measures use of the five steps of therapy articulated by Benjamin, which include: (1) Collaboration, (2) Learning about patterns, (3) Blocking maladaptive "Red" patterns, (4) Enabling will to change, and (5) Learning new patterns. The five steps are measured for the therapist as well as the patient. Reliability for each rated sub-scale is strong, with ICC's for an average across two raters ranging from .55 to .92, with the total score having ICC = .91 (Critchfield, Davis, Gunn, & Benjamin, 2008). These strong reliability values are remarkable given the focus on complex clinical features of sessions and benefit from use of manualized training to make key distinctions.

Critchfield & Benjamin (2019) demonstrated that the effect of mean therapist adherence on the GOL stage of change is mediated by the mean patient engagement with

IRT principles, meaning that it takes the collaboration of the patient and therapist for IRT to be successful. Additionally, this study revealed that the effect of mean patient and therapist adherence to IRT on symptom reduction was mediated by the GOL stage of change. This preliminary evidence shows that engaging with the GOL mediates symptom reduction.

GOL Awareness & Choice Scale

It is important to note that basing interventions off the CF and gathering interpersonal detail as well as details about affect, behavior, and cognition are elements of the 'core algorithm' of IRT (Benjamin, 2003/2006). Additionally, engaging with the GOL with increasing levels of detail and awareness are included in the steps of IRT therapy and measured by the GOL awareness & choice scale. This scale (Critchfield, Davis, & Benjamin, 2008), modeled on the transtheoretical model developed in addiction literature, is measured on a scale of 0.0 to 5.0. It measures both the awareness of CP and GOL as well as the patient's motivation and commitment to give up the GOL and choose more adaptive behaviors. The awareness of the GOL advances through stages, including: a) unaware (0.0-0.9)- patient is not aware of any CPs or gift of love, b) precontemplation (1.0-1.9)-patient is beginning to make links about the origins of patterns and can acknowledge some wishes in relation to these patterns to the IPIRs, c) Contemplation (2.0-2.9)-patient begins to be intrinsically motivated to relinquish the gift of love, yet may still be ambivalent, d) Action (3.0-3.9)-patient begins to give up the GOL, through e) Maintenance (4.0-5.0)-patient has made significant changes with the GOL and resists the urge to regress backwards.

Summary

In summary, IRT focuses on the relationships between symptoms and their origins, function, meaning, and motivation. The case formulation provides a narrative as to how an individual's symptoms make sense as well as generate a hypothesis for the gift of love motivation underlying these maladaptive patterns. C1 in this understanding of psychopathology is the miscued perception of safety or threat that has direct links to rules and values learned by important and trusted early attachment figures. C1 is linked to the associated affects (A) and behaviors (B) that are the 'symptoms', and thus understanding and unraveling C1 is essential in therapeutic change. The gift of love drives C1, as loyalty to the rules and values of these early figures gives rise to the maladaptive copy processes. Understanding the desires for connection, love, another chance, or reconciliation are the target of treatment to enable in patients the will to change.

As such, the gift of love theory offers a unique way of conceptualizing personality disorders. By placing the focus on the meaning and motivation behind primitive brain patterns that are linked to love and attachment, GOL theory re-frames psychopathology through the lens of an attachment system that is miscued with regard to safety and threat. Unconscious GOL desires for love, acceptance, protection, and/or reconciliation with loved ones are the fuel of psychopathology and thus the treatment target in IRT. In other words, from an IRT point of view, personality disorders are driven by a love story gone wrong. Patients who are stuck are unconsciously reenacting their childhood through a variety of means (copy processes) in the hope that things will be different this time. Because these patterns are not yet in the patient's conscious awareness, they are not

choosing the level of distress that ensues from the consequences of engaging in maladaptive and self-destructive patterns.

Addressing, re-framing, and grieving this gift of love is thus the essential element in loosening the grips of the maladaptive C1AB links and offering the possibility for change to occur. This is labeled as step four in IRT, enabling the will to change. This process involves an understanding of one's own patterns and case formulation, which allows a person to consciously grasp the links between past and present and understand the impacts on their life. Thus, IRT offers patients autonomy and agency in their own pathology through helping them understand and acknowledge their gift of love. Then, patients can contend with choosing to differentiate from these maladaptive patterns and build healthier ways of being or remain loyal, stuck, and dysfunctional. IRT offers patients a process to understand and work to relinquish the gift of love through increasing self-reflective insight, enabling choice in alignment with one's values, and finding one's own meaning in life. Given that these are common themes within spirituality, IRT is an accessible bridge between psychology and spirituality. The following section will demonstrate connections between engaging with the GOL and engaging spiritual topics.

Spirituality

Defining spirituality

It is important to acknowledge that many definitions of spirituality have been made and edited over the years. The relationship between religion and spirituality has been complex—at times, the terms have been conflated. In more modern times, people have used these terms as if they were mutually exclusive. For the purposes of engaging spirituality in ways that are culturally competent, one must have a definition that allows

space for an idiographic representation. It is not the purpose of therapy to impose meaning or values into the lives of patients. However, part of the task of the practitioner is to "learn about and help clients talk about aspects of life that may be very hard to put into words" (Pargament, 2007, p. 33).

> No decent clinician avoids the most private and sensitive of topics; love, sex, death, jealousy, violence, addictions, and betrayal are grist for the therapist's mill. Questions about spirituality and religion, however, are routinely neglected (Pargament, 2007, p. 7).

Therefore, having a definition of spirituality that is inclusive is paramount, as topics of religion and spirituality remain meaningful to most people. As of a 2017 Gallup poll, 87% of people surveyed answered 'yes' to the question "Do you believe in God?" Kenneth Pargament's (1999) definition of spirituality as "a search for the sacred" offers a broad lens with which we can view spirituality as it appears in the lives of clients (p. 12). Pargament emphasizes the searching aspect of spirituality, as opposed to a definite place of arrival. This ties in quite easily with the existential tradition within psychology. This tradition, pioneered by the likes of Viktor Frankl and Irvin Yalom, emphasize the human capacity to adaptively strive for meaning. Frankl (1946) wrote that "when we are no longer able to change a situation—just think of an incurable disease such as inoperable cancer—we are challenged to change ourselves" (p. 135). Thus, our life is replete with opportunities to develop and adapt. Furthermore, 'searching' for the sacred, as opposed to terms such as knowing or understanding, implies that arriving is not necessary and this search for meaning does not require rigidity or unchanging rules. This aligns with IRT's therapy goals for flexibility and adaptability to reality-based contexts.

The bridge between IRT's gift of love and the sacred will come with a definition that involves and includes everyone. Pargament (2007) defines the sacred as the "soul of spirituality", and notes that it is comprised of the sacred core and sacred rings (pp. 32-33). The sacred core encompasses ideas of God, higher powers, transcendence, and divinity and can be understood as "[standing] at the beginning and end of our struggles, hungers, and feelings" (Oden, 1983, p. 94, as cited in Pargament, 2007, p. 34). Some examples of how the sacred core could manifest for patients are sacred core as God, the Buddha, Jesus Christ, and/or nature. Pargament (2007) goes on to define sacred rings as including other aspects of life that are not inherently divine yet are sanctified by people. Sanctification is the process by which people infuse profane objects with sacred meaning, as these objects now represent the sacred core. Pargament and Mahoney (2005) described sanctification in psychological terms by describing sanctification as seeing life through a sacred lens. This can happen when people a) perceive aspects of their lives as manifesting their understanding of God or b) attribute divine qualities such as transcendence, boundlessness, and ultimacy to objects in life (Pargament, 2007). Pargament (2007) defines transcendence as when one perceives that something in a particular object or experience is out of the ordinary, something beyond their typical understanding. He describes boundlessness as the perception of "endless time and space," and ultimacy as perceiving something as "elemental" or the "ground of truth" (Pargament, 2007, p. 39).

A national survey conducted by Doehring et al. (2009) found that individuals perceive the sacred in themselves, in relationships, and in time/space. Furthermore, they found several variables significantly correlated with perceiving sacredness in life. Of note, the more meaningful one's religion is to their life, the more they perceived the

sacred around them. In addition, religious involvement was significantly correlated with perceiving sacredness. Frequent utilization of prayer and ritual may normalize an openness to that which is beyond an individual. Aside from religious variables, however, these researchers found that having a sense of purpose in life was strongly correlated with perceiving sacredness. Perceiving sacredness was negatively correlated with a strong commitment to empiricism or positivism as well as higher levels of narcissism. However, higher self-esteem and more secure relational attachments were associated with seeing the sacred in life. In essence, spirituality is a journey of meaning making that involves connection with the sacred, whether that be in one's self, in relating with others, and/or in the space and time surrounding an individual in one's life. The more one can see beyond the ordinary, the more they seem to be able to perceive the sacred in life.

As one example, love is often associated with sacred qualities. A woman writes that "[t]he things that make me feel as if I could touch the face of God are times when I am overwhelmed by love and friendship" (Pargament, 2007, p. 44). This spiritual perspective on love also highlights the relational elements that are essential in understanding the gift of love. A spiritual perspective on the power of love to represent ultimacy, boundlessness, and even divinity speaks to its power. And, insofar as the gift of love is thought of as a manifestation of a person's love for their IPIRs, we can appreciate the gravity of engaging in these gift of love conversations.

Furthermore, this conceptualization of the sacred offers a way of understanding the universally human process of meaning-making and integration of life events into identity and purpose. Through a spiritual lens, stressful life events are not simply events but hold greater significance. Pargament (2007) writes that problems "raise profound and

disturbing questions about our place and purpose in the world, they point to the limits of our powers, and they underscore our finitude" (p. 11). In other words, spirituality can highlight and help us come to terms with what may not be controllable or solvable.

Orientation and disorientation in moral space

Furthermore, transcendence is often a part of spirituality and spiritual coping. Philosopher Iris Murdoch (1970) frames transcendence in secular terms as movement "beyond the ego that is simultaneously a movement towards reality…involves looking at the reality of human vulnerability, suffering, and evil" (as cited in Schuhmann & Damen, 2018, p. 407). This transcendent observation of a person in light of human realities is a task that multiple philosophers and anthropologists have defined as key aspects of human existence, that of orienting one's self within some meaning orienting system and towards some goal (Janoff-Bulman, 1992; Park, 2010). Taylor (1989) described how existential questions regarding how we live our lives are located in what he termed 'moral space', and this morality is comprised of how we understand "what underlies our own dignity, or questions about what makes our lives meaningful and fulfilling…what makes life worth living" (Taylor, 1989, p. 4 as cited in Schuhmann & Damen, 2018, p. 407). These processes are inescapable as humans, and the answers to these existential questions locate us in moral space and provide us a vision of the good, which Taylor terms visions of a life worth living. This vision of the good then informs the direction towards which we are striving in life, provides standards for judging our lives against that which is most meaningful to us, and deeply informs our identity.

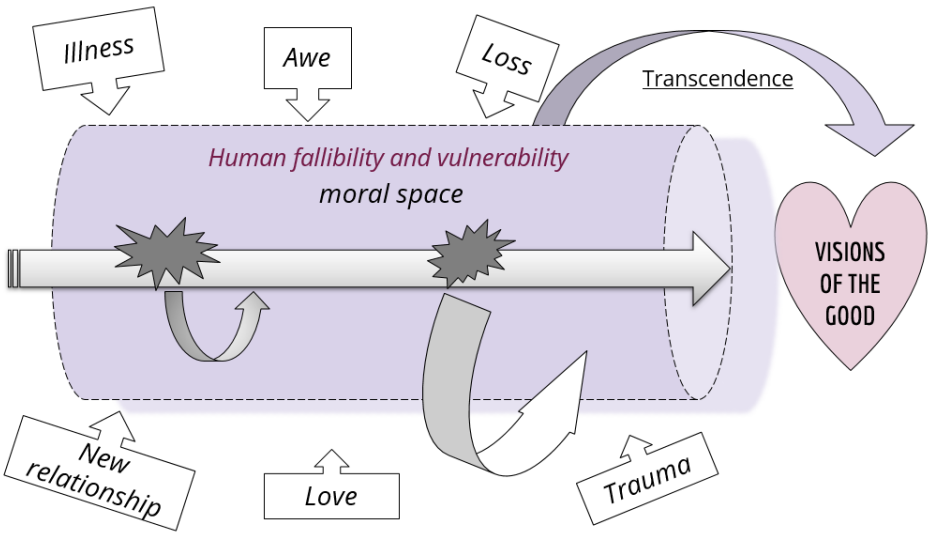


Figure 2. Visual diagram of orientation in moral space. Adapted from Schuhmann and Damen, 2018. Reproduced under the Doctrine of Fair Use, in accordance with 17 U.S. Code § 107.

We are not theorized to maintain connection to our orientation in moral space regardless of the events of our lives. Rather, Figure 2 depicts how trauma, loss, grief, illness, and violence are a few instances of circumstances that disorient us in moral space, for they shatter or challenge our sense of direction or understanding of 'the good' or result in the loss of believability in our previously established visions of the good (Schuhmann & van der Geugten, 2017). Complicating matters, individuals with chronic rather than acute instances of these aforementioned circumstances early on in life may be fundamentally misoriented and lack access to their visions of the good. Afifi et al. (2010) noted the prevalence of childhood adversity in the developmental histories of individuals with personality disorders. Battle et al. (2004) found that 73% of individuals with personality disordered participants reported a history of childhood abuse and 82% had experienced at least one type of childhood neglect. As such, it makes sense that many individuals with PDs are likely misoriented in moral space. Additionally, Baxter et al. (2017) found that individuals with higher adverse childhood experiences (ACE) scores,

which can include individuals with personality disorders, have diminished hope. This involves a decreased capacity not only to make pathways towards their goals but also to dedicate mental energy towards these pursuits. In addition, when faced with challenges, individuals with higher ACE scores may be less likely to problem solve due to "a decreased estimation of their abilities or the resources available to help them manage the situation positively" (Baxter et al., 2017, p. 952). Therefore, individuals with personality disorders are not only misoriented in moral space, lacking full access to what makes their lives meaningful and worth living. They are also typically less able to re-orient on their own without intervention, for their hope has been shattered early on and their internal energy to re-direct towards their visions of the good is impaired.

Thus, one way to conceptualize IRT treatment in the language of moral space is to say that the disrupted attachment system and maladaptive patterns learned in early life produced an individual who is fundamentally misoriented in moral space, causing an individual to often lack a sense of their own identity and lack consistent sense of what makes life meaningful. Amid a lack of directionality towards the good and sense of meaning, intense distress, unprocessed trauma, and maladaptive patterns learned in early life create symptoms that become recognized as personality disordered pathology. IRT treatment works with individuals who are already misoriented in moral space and initiates further intentional disorientation in moral space through engagement with letting go of the gift of love. This work is for the ultimate goal of re-orienting the patient towards their vision of the Good, analogous to what Lorna Smith Benjamin (2003/2006) has termed the healing image. IRT treatment goals include interventions consistent with orienting an individual towards their vision of the good, for example interventions geared toward

building a person's sense of who they are and what is meaningful to them, improving their capacity to be in healthy relationships with self and other, and ultimately seeking to minimize symptoms and maximize their ability to function in the world. Therefore, it is possible that spiritual perspectives can intervene when personality disordered patients have difficulty finding their healing image, their vision of the good. Spirituality has helped individuals make meaning of and endure cancer treatment (Canada et al., 2016), death of a child (Hawthorne et al., 2015; Lichtenthal et al., 2010), survivors of homicide victims (Johnson & Zitzmann, 2020), and many other difficult moments within the human experience. It is plausible that spirituality already exists implicitly within GOL conversations, and this study seeks to better understand the effects of times when spirituality is made more explicit.

Spirituality in IRT

The GOL theory reflects the deeply relational and existential roots of IRT that are essential to therapeutic change and successful IRT treatment. Lorna Smith Benjamin uses an attachment-based, evolutionary frame rooted in learning to track and understand how patterns in thought, behavior, and emotion are invoked by the nervous system to respond to safety and threat.

Although based in evolutionary logic, IRT does not preclude issues of meaning and spirituality as they relate to the GOL, especially using the more relationally grounded definitions of spirituality offered here. For example, another way of understanding step four of IRT, engaging the will to change, is understanding and transforming a patient's meaning making system and how this meaning-making system has influenced a person's perception of their phenomenological world. In this way, GOL interventions within IRT

are existential in that they engage and, at times, question how to live our lives by challenging the way in which maladaptive behaviors are linked to safety and have provided the frame within which our life narrative has unfolded.

For example, Jane remains close to her mother by enacting towards herself and others the control and blame patterns demonstrated by her mom. She is aware that she identifies with her mom in these ways and is even aware of her continued longings for her mom to see how Jane is just like her, in the hopes that Mom will delight in her, call her beautiful, and accept her as she is. However, these patterns of control leave Jane feeling regretful and empty. She feels that she behaves in a way that is not who she sees herself as and feels out of control of these automatic responses. In other words, she has become aware of her misorientation in moral space created by her gift of love to her mom. In realizing the extent of these patterns and their deleterious effects on her and the people she cares about, she now considers if she can come to live her life by her own rules and values rather than these old rules learned from Mom. She considers if she can tolerate letting go of centering her decisions around her mom's approval and learn to approve of and accept herself and surround herself with supportive others. This is but one example of how a patient must transcend their own learning history and assume a self-reflective stance towards their own life in order to understand their CP, their links to IPIRs, and begin to let go of the GOL.

In summary, spirituality and the GOL share a focus on self-reflection, meaning, and questions of a life worth living. Engaging with the GOL and working to let the GOL go requires consideration of living life fundamentally differently, by new rules that are one's own rather than old rules that have been internalized without much prior

consideration. As such, the IRT treatment goal of working to relinquish the GOL introduces a stressor that requires coping in order to work through. The following section will detail both psychological and spiritual/religious conceptualizations of coping, to note how they complement one another and how spirituality may provide additional resources to personality disordered individuals in their quest for alleviation of suffering and therapeutic change. This literature base should provide a holistic understanding of coping, upon which hypotheses can be generated for how coping should be present when turning to actual IRT sessions where the GOL is present.

Coping

Coping within psychology

Within psychology, stress has been conceptualized as an external stimulus (Holmes and Rahe, 1967), a response (Selye, 1956), and a transaction between an individual and the environment (Lazarus and Folkman, 1984). Transactional conceptualizations in particular focus on the meaning a person attributes to their surroundings in light of a stressor. Lazarus and Folkman (1984) created the transactional model of stress and coping and proposed that individuals are constantly appraising stimuli in their environment. When a stimuli is appraised as threatening and exceeding an individual's ability to cope, distress is the result. Lazarus (1991) noted that both environmental factors such as resources or demands as well as an individual's values, goals, and beliefs influence an individual's appraisals. Thus, adaptation to a stressor is influenced by the coping processes individuals use during that stressor. This is a primarily cognitive-based model, focusing on cognitive appraisals to determine one's

initial interpretation of an event (primary appraisal) and deciding what can be done (secondary appraisal) (Park, 2005).

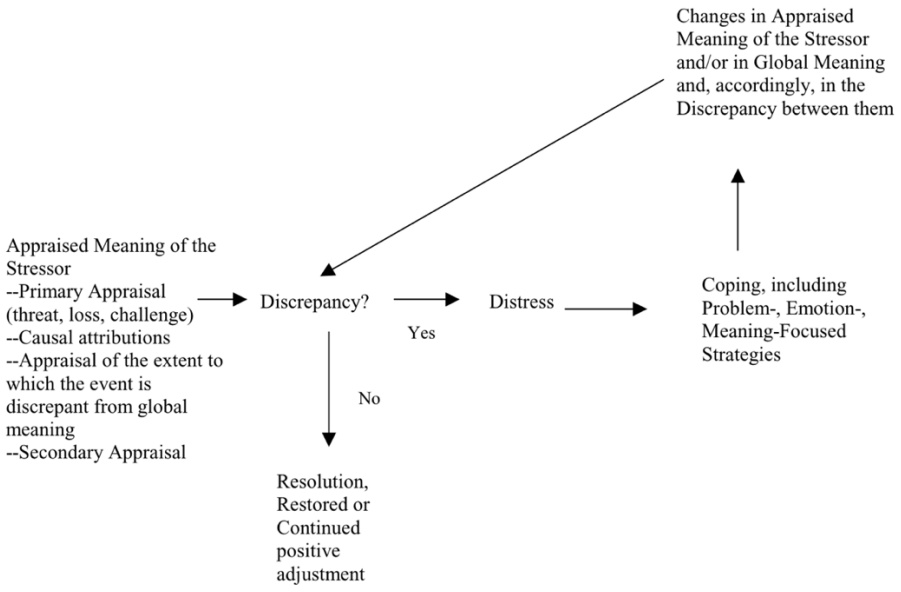


Figure 3. From Park (2005)'s meaning-making coping model. Reproduced under the Doctrine of Fair Use, in accordance with 17 U.S. Code § 107.

Figure 3 provides a visual representation of this process. Coping is the process by which an individual is "constantly changing cognitive and behavioral efforts to manage external and/or internal demands that are appraised as taxing or exceeding the resources of a person" (Lazarus and Folkman, 1984, p. 141). This can occur through strategies geared towards directly solving or managing the stressor (problem-focused) or regulating emotions that are the result of the stressor (emotion-focused). Folkman (1997) updated the original transactional model to account for research findings that coping facilitated positive emotions. This revised theory added that unsuccessful coping and its concomitant distress triggers meaning-focused coping, especially when stressors are perceived to be aversive and uncontrollable. Meaning-focused coping is theorized to utilize one's own underlying beliefs, values, and goals and has been shown to elicit some

positive emotions in a stressful situation where typically negation emotions prevail. Also, these subsequent positive emotions provide individuals with additional resources to enable cognitive appraisal and sustain problem-focused coping over time (Folkman, 2008). In other words, coping that involves one's values, beliefs, goals, and meaning-making may enable continued persistence in coping with difficult situations.

Coping within IRT

As stated previously, step four of IRT, enabling the will to change, invites patients to consciously behave in a way which opposes their maladaptive copy process patterns, or more to the point opposes their perceived safety system. As stated earlier, gift of love behaviors are linked on a biological level to safety. Thus, changing behavior in the process of letting go of the gift of love activates the attachment system and results in emotional dysregulation. This is a particularly difficult stage within IRT treatment, as a person is tasked to resist urges from their nervous system, affective system, and cognitive system to remain loyal to their IPIRs and allow Red to remain in charge. To do this, they must tolerate the dysregulation that results from their brain perceiving threat and acting accordingly.

To complicate matters, attachment system activation supports rapid enactment of learned safety behaviors by reducing frontal lobe activity and mentalizing capacity (Kosminsky & Jordan, 2016, p. 154), an important resource in continuing to observe and react differently than one's action urges. Allen (2011) wrote that a "history of attachment trauma is associated with impaired mentalizing capacity that undermines interpersonal problem solving in subsequent attachment relationships" (p. 88). As can be deduced, it is not uncommon for individuals with personality disorders to have impaired mentalizing

capacity (DiMaggio et al., 2012; D'Abate et al., 2020), and working with the GOL means contending with attachment system activation. Adherent IRT therapists have demonstrated the capacity to continue to bring the GOL into the conversation, helping patients regulate the attachment system activation, and promoting mentalizing capacity through warmth, conveying safety, and asking open-ended and curious questions that help patients continue to work through this dysregulation to have an emotionally corrective experience.

In other words, grappling with the gift of love creates a significant stressor and problem on both spiritual and psychological levels. Therefore, working to relinquish the GOL requires successful coping efforts on the part of the patient to progress through stage four of IRT and begin personality reconstruction.

Coping within religion/spirituality

Park and Folkman (1997) built on previous transactional stress models of coping to incorporate the ways spirituality influences how a person interprets, comprehends, and reacts to life experiences. This model notes not only how spirituality can play a large role in a person's meaning-making processes but also how the ability to make meaning out of a stressful situation promotes adaptation and well-being. While many factors are part of meaning-making, such as hope, spiritual coping style, spiritual appraisal, and religious denomination, the overall model speaks to two different categories of meaning: global and situational. Global meaning is comprised of a person's beliefs about the world as well as their sense of life purpose or goals (Park & Folkman, 1997; Pargament, 1997). In some ways, Park and Folkman's global meaning is similar to the visions of the good described earlier. Situational meaning, on the other hand, relates to a person's appraised

meaning of a specific situation. Park and Folkman (1997) describe that the meaning-making process involves an individual's attempts to reduce distress caused by an incongruence between the situational meaning of a particular stressor and the individual's global meaning. Meaning making is the process by which an individual resolves this discrepancy, and meanings made are the outcomes of a meaning making process (Kumar, 2016).

Kenneth Pargament has been a notable researcher with regard to religious coping and he, in collaboration with Harold Koenig and Lisa Perez, developed a religious coping measure that is incorporated into this project's coding system (Pargament et al., 2000). Pargament (2017) defines religious coping as efforts to understand and deal with life stressors in ways related to the sacred. Religious coping from Pargament's perspective demonstrates various ways a person can be searching for meaning. He and other researchers (Pargament et al., 1998; Van Tongeren et al., 2017) have studied both positive and negative religious coping and their effects. For instance, a two-year longitudinal study found that negative religious coping was significantly correlated with less independence in daily living and lower levels of cognitive functioning (Pargament et al., 2004).

Grief as a form of coping

Given that relinquishing the GOL involves loss, a form of coping invoked by IRT is grief. Relinquishing the gift of love means coming to terms with and perhaps ending the part of a person's relationship with an IPIR that drives maladaptive Red behaviors. This loss takes on different forms depending on the person. For instance, in one person it may mean coming to terms with a dead parents' inability to change or give them what

their Red behavior is asking the IPIR for. For another person, it may mean relinquishing living life based on an IPIRs rules and learning to give to one's self what they didn't get previously, as in the case of Jane. In still another, relinquishing the GOL may mean forgiving an early IPIR and not holding against them past grievances, which allows the person to move forward and regain autonomy over their life.

Figure 4. The Dual Process Model of Coping with Bereavement. From Stroebe & Schut, 1999. Reproduced under the Doctrine of Fair Use, in accordance with 17 U.S. Code § 107.

Whichever process ensues, there is a clear element of grief in working with the gift of love. Multiple theories have been derived over the years to better understand grief, from Kubler-Ross's stage model (1969) to the Dual Process Model (DPM) (Stroebe & Schut, 1999, 2010) and the Two Track Model (Rubin et al., 2012). Bowlby even created a phase model of grief (1980, as cited in Stroebe and Schut, 2010) that details four phases: shock, yearning/protest, despair, and restitution. Worden (1991) derived the Task Model, which provides four tasks that elaborate on Bowlby's original model. DPM builds on Bowlby's phase model and Worden's task model by encouraging shifting between focusing on the loss and focusing on the future. Figure 4 depicts a healthy grieving

process which involves oscillating between feelings and behaviors related to the loss (Loss Orientation) and changing roles and responsibilities (Restoration Orientation).

However, in cases of complicated bereavement, from a DPM perspective the bereaved is stuck in the loss orientation. In many ways, personality pathology can be considered a form of complicated bereavement, as a person is struggling for many years to let go of behaviors that signal to the loss they feel in an important relationship. Within IRT, DPM helps us understand that when a person's Red is in charge, they are stuck in loss orientation. This explains why it is difficult if not impossible for a person's Green self to learn and enact new adaptive behaviors because it would entail learning new skills and moving forward in grief, consistent with restoration orientation. Incorporating this model into the challenge of working with individuals stuck in loss orientation within IRT would entail bringing back into focus the restoration orientation by invoking the healing image of IRT or spiritual interventions such as engaging with the person's life worth living or their image of the good.

In addition, Mario Mikulincer and Philip Shaver (Mikulincer et al, 2013; Mikulincer & Shaver, 2012) have offered empirically supported theories that bridge attachment theory with theories of grief. Their work is particularly useful in better understanding insecurely attached individuals' responses to grief. Mikulincer, Shaver, Kim, Schut, and others have researched how attachment style moderates whether an individual chooses proximity or support seeking as an emotional regulation strategy (Kosminsky & Jordan, 2016). Mikulincer and Shaver's work has elucidated that, once a person's attachment system is activated, they will initiate strategies that are particular to their attachment style to regain a sense of felt security, excluding activities of other

behavioral systems such as exploration. This is important to understand particularly in personality reconstruction, where giving up the gift of love requires an individual to tolerate the loss of an internalized attachment figure (which would be perceived by their nervous system as threatening) without succumbing to Red patterns that would activate their miscued safety system. In addition, practicing new patterns rather than succumbing to Red is akin to exploration from this point of view, which is difficult but necessary for relinquishing the GOL.

Given that personality pathology is largely the result of learning history, it is not uncommon for individuals with personality disorders to have an insecure attachment style. When it comes to bereavement, an anxious attachment style tends to correlate with more complicated bereavement processes. Prior research has shown that individuals with this attachment style tend to exhibit more negative appraisals of stressors, show more intense grief reactions, and primarily use loss oriented coping strategies (Delespaux et al, 2013). Wayment and Vierthaler (2002) found that anxiously attached individuals showed higher levels of grief whereas individuals with an avoidant attachment style showed higher levels of somatic symptoms after one year following the death of a close attachment figure. Studies on bereavement in individuals with avoidant attachment styles have been more mixed. At times, these individuals can appear to manage grief with less distress than those of anxious attachment styles; however, in some studies while individuals reported doing well, their self-reported symptom levels were abnormally high (Fraley et al., 2006).

Connecting Spirituality, Grief, and the GOL in IRT

To connect previous conversations about the gift of love to spirituality and coping, disorientation in moral space, much like letting go of the gift of love, ultimately appears to evoke and involve grief. Painful events that cannot be metabolized with one's current orientation result in a person feeling as though "their sense of being close to or moving towards 'the good'—towards a life worth living or a full life—is challenged or even shattered" (Schuhmann & Damen, 2018, p. 408). Whether it be the language of disorientation in moral space, grief as a spiritual journey, or letting go of the gift of love, what is involved is the loss of what gives a person a clear sense of meaning and direction in life. This is true even if one's sense of meaning is currently defined by their gift of love motivations and IRT intervention initiates disorientation from this position in moral space. This aligns with the experience of bereavement as "a crisis in the meanings by which a person's life is given structure and substance" (Hagman, 2007, p. 25). This loss represents the beginning of a shift in one's identity, as coming to terms with what is now lost or what never was requires us to understand ourselves and our lives differently. Through grief "we must relearn our very selves, including our characters, histories and roles, and identities that we find in them" (Attig, 2007, p. 40). Hagman (2007) adds that the "loss of the function of the relationship with the other in sustaining self-experience" in times of grief and mourning requires self-reorganization (p. 24).

Therefore, grief is not an inherently pathological process. Rather, it is a deeply spiritual one that speaks to how others impact our understanding of ourselves and the world. From this point of view, love is the glue that holds our meaning making systems together, a way of pointing to that which is sacred to each of us. Loss as a threat to the love relationship thus threatens our way of understanding everything. A vignette from a

mother who lost her infant child shows the universality of the struggle of letting go in grief:

> "I was afraid to let go. Afraid that I would forget the details of him, the peculiar color of his eyes, the shape of his nose, the sound of his voice…In a strange way my pain was comforting, a way of loving him, familiar…" (Klass, 1996/2007, p. 87).

This vignette is helpful in demonstrating one aspect of the gift of love. We all seek to bring close those who we love most, even if they are gone in some way. And yet, our ways of seeking this proximity, if only in our minds, can maintain pain and pathology for personality disordered patients. What IRT seeks to accomplish, and what this dissertation proposes is present and can be code-able through spiritual themes, is the fundamental meaning shift or re-orientation in moral space, that is involved in IRT treatment as patients re-orient toward their visions of the good. This way, patients can be like this mother, who reflected: "Finally I had to admit that his life meant more than pain, it also meant joy and happiness and fun—and living…When we release pain we make room for happiness in our lives" (Klass, 1996/2007, p. 87).

Letting go of the gift of love is inherently a grief process that is often temporarily distressing and fundamentally disorganizing. Regardless of specific sacred identifications, step four of IRT asks patients to reconsider the attachment-linked motivations that have guided their behaviors and informed their thoughts and emotions for majority of their lives. Not only is this identity questioning in and of itself a spiritual task, but clinicians and patients who can see this process in spiritual terms may have additional resources. Because spirituality allows people to see their lives through a

transcendent lens, letting go of the gift of love can be re-framed through spiritual coping as gaining a new perspective or offering opportunities for self-growth. In addition, challenging internalized old rules and values learned from IPIRs can be understood as grounding to values that align to each person's most adaptive, Green self. Finally, engagement with what is meaningful and becoming one's truest, healthiest self can be a source of hope that can bolster a patient's endurance through the IRT journey. The depth work employed when engaging with the GOL in IRT can be understood as a type of spiritual intervention, as it engages with deeply held meanings and patterns that have informed one's identity.

Conclusion: Spirituality in GOL conversations

IRT makes explicit connections between how caregivers are internalized in meaningful ways through copy process and the underlying love wishes that manifest behaviorally as the gift of love. Conversations about change in IRT that involve the GOL reflect a patient's fundamental misorientation in moral space, and such misorientation keeps them stuck in GOL patterns that beget dysfunction and pathology. Enabling the will to change means enabling conscious understanding and motivation; change from here involves the choice to grieve, practice new patterns while leaving aside maladaptive ones, and thus live life differently.

This task of engaging the gift of love can be thought of as a process of engaging the most central, survival-based, emotionally laden, meaning-filled places of a person's world. These deeply held values and rules, along with their associated affects and behaviors, are what need to shift in order to enable responsiveness to treatment and improve patient symptoms and overall outcomes. Said another way, engaging with

someone's deeply held meaning making systems is an inherently spiritual process. Engagement with the question of "If I heal, will I lose all hope of you loving me?" must be one that clinicians can invite and deepen, for it is the work in IRT of the gift of love, and it is central to change and personality reconstruction.

Prior research has established the links between CP and pathology and the role of addressing the GOL on outcomes/change in CORDS patients (Critchfield, Benjamin, & Levenick, 2015). Therapists who are rated as more highly adherent to IRT are more likely to address the GOL over those who are rated as low adherence, and the adherence of both therapist and patient to IRT principles is necessary for change to occur (Critchfield, 2019). Spirituality and orientation in moral space are ways of understanding the fundamental meaning making process that everyone is engaged in by virtue of being alive. Furthermore, engaging with the gift of love offers a specific sort of spiritual conversation that must be navigated well and with care. The next, needed step in a programmatic line of research in IRT is a more detailed study of the progression of GOL conversations within both low and high adherence IRT sessions. This study focuses on searching for correlations between religious/spiritual coping and GOL conversations. An investigation of the specifics of GOL conversations across adherence levels of IRT sessions should shed light on how grief, meaning, and relatedness can be engaged to further elicit change.

Chapter III

Methods

The IRT Database

The IRT database is an archived clinical database which contains psychotherapy tapes of patients in Utah collected between 2003 and 2014 by Dr. Lorna Smith Benjamin and Dr. Ken Critchfield. IRT case formulation interviews are comprised of patients referred to the IRT clinic at the University of Utah Neuropsychiatric Institute for further assessment given treatment resistance and/or presence of personality disorders. Following this consult interview, patients were able to self-elect into continuing IRT therapy in the outpatient IRT clinic located in Utah following their discharge from the hospital. IRB permissions from University of Utah Neuropsychiatric Institute were obtained and all participants signed an informed consent for recording the interview and for educational and research use of the therapy tapes before the interview started. An IRB permission from James Madison University has been obtained for further utilizing these data for the current study.

From the patients referred to the University of Utah's IRT clinic while inpatient, some elected to continue IRT therapy in an outpatient context (n=33). Patients were paired with supervised, graduate student IRT therapists when resources were available. In some cases, Dr. Critchfield or another licensed professional associated with the clinic conducted the therapy. Therapies ranged from 2 sessions to 438 sessions, with every sixth therapy session recorded and archived into the database. Most sessions have now undergone adherence and GOL coding that will be used for selection of cases in the present investigation. Many of the sessions have also been transcribed. A wide range of measures

and observational codes were also available for different subsets of the database and were utilized as needed to provide additional context in the current investigation.

Developing the Coding System

Data Selection

This project required selecting from the rather large IRT database for feasibility's sake. Given the literature base suggesting that high adherence IRT therapists elicit more GOL conversations (Critchfield, 2019), patients reviewed for the development of the current GOL and spiritual conversation coding systems included a mixture of high and low adherence coding scores. The GOL stage of change codes assigned in prior work were also considered and patients with a progression of GOL stage of change ratings were prioritized. High adherence coding scores were defined by a value of > +6 for total IRT adherence (on the scale from -10 to +10) and low adherence coding scores were defined by a value of <+6. The high adherence cutoff of +6 falls at the qualitative cut-off for scale anchors indicating strong / optimal adherence (Critchfield et al., 2008).

In total, eighteen (n=18) total sessions were coded across four different patients within the IRT database for this analysis. As noted, the four patients selected for this study represented a range of GOL stages of change and both high and low IRT adherence. Twelve (n=12) sessions were rated prior to this study as high IRT adherence (M=8.15, SD=1.01). and six (n=6) were rated as low IRT adherence (M=2.61, SD=2.71). GOL stage of change data for the high adherence group (M=2.74, SD=0.70) and low adherence group (M=0.92, SD=0.41) was pulled from the IRT adherence database.

One of the four patients selected was used in developing the coding system as well as in its application. This patient was chosen for a number of reasons. She had

previous multiple rounds of non-IRT treatment that were largely unsuccessful. Investigating what promoted change in an individual previously nonresponsive to treatment due to symptom severity and comorbidity aligns well with this study's goals. In addition, she was involved in 438 sessions of IRT, across which she had three IRT therapists. The IRT adherence ratings across these therapists ranged from low to high. Thus, this case offered variability to develop a coding system sensitive to both low and high IRT adherence in context of the same patient and CF. The sessions within each patient's course of treatment were chosen in a similar manner in terms of attempting to capture a range of GOL stage of change. Effort was made to also select from the beginning, middle, and end of treatment for each patient, to try and understand the GOL as it emerges throughout a course of treatment.

As for the application of the coding system, care was taken to select from sessions with available adherence data and transcriptions completed. From there, this researcher selected sessions that attempted to span the course of treatment. Patients selected from the broader IRT database had these ID numbers: 318, 320, 325, and 332. For patient 318, sessions coded and included in this study were sessions 30, 54, 67, and 89. For patient 320, sessions 6, 12, 24, 79, 151, and 212 were included. For patient 325, sessions 24, 48, 86, and 120 were included. Finally, for patient 332, sessions 6, 12, 78, and 110 were included.

Coders

For the development of the coding system, eight independent coders in total were utilized: this researcher, four undergraduate research assistants from James Madison University, and three masters level research assistants from James Madison University

who were studying clinical mental health. The initial coding team was comprised of two undergraduate students and this researcher. The second coding team was comprised of this researcher, three masters' students, and two undergraduates.

The initial coding team was introduced to the coding system's goals through an introduction to the theories of IRT, GOL, and spiritual coping. This team was instrumental in identifying the need for greater specificity. Their feedback in weekly meetings about their thought processes that led to their codes was helpful in identifying discrepancies between raters to correct with more specific codes.

The second coding team was introduced to the coding system after three revisions. A coding manual was created and shared with the coders. In addition, these coders underwent a two and a half hour training on IRT, GOL, and the coding system procedure. The GOL coding manual can be found in Appendix A.

Coding system to identify Gift of Love Conversations in Therapy Transcripts

Iteration 1: Initially, the coding team comprised of two undergraduate students and this researcher. As mentioned earlier, initial development of the coding system was based off tape review of a patient who was involved with the IRT clinic for several years, successfully terminating after strong gains documented across 438 sessions. This patient was chosen to develop the coding system due to having both low and high adherence sessions available as well as multiple therapists who worked with her across her treatment. This allowed for maximum opportunities to identify GOL as well as spiritual and religious coping codes.

The process of coding began with the consult interview that established the beginning context of the patient's formulation and treatment. Before coding outpatient

sessions, each coder used the copy processes and gift of love hypothesis noted in the case formulation to guide identification of GOL codes, as per GOL theory. Coding of outpatient sessions began with the initial outpatient session and advanced through sessions approximately 6-12 sessions apart, depending on recording availability within the database. For the initial case, we independently reviewed and coded 15 sessions with available IRT adherence data to develop a coding system that could be sensitive to GOL conversations. Sessions used were: consult interview, 1, 78, 82, 104, 110, 132, 133, 136, 143, 144, 151, 164, 165, 175, and 176. Each session was divided into five-minute time segments and consensus coding occurred at routine intervals and led to numerous modifications to the coding system.

The initial gift of love codes were comprised of: 1) identifying the copy processes involved and their associated IPIRs, 2) determining whether there was evidence of GOL explicitly, 3) if there was evidence of a "why" in relationship (i.e., loyalty, love, belonging, etc.), and 4) GOL notes for any additional information (optional). These codes were quickly found to be too general to be helpful, as evidenced by poor agreement between raters.

Iterative process of developing the final coding system:

To create more specificity to the gift of love codes and thus improve interrater reliability, the original codes were adapted numerous times in an iterative process of clarification and refinement that would later inform the coding manual.

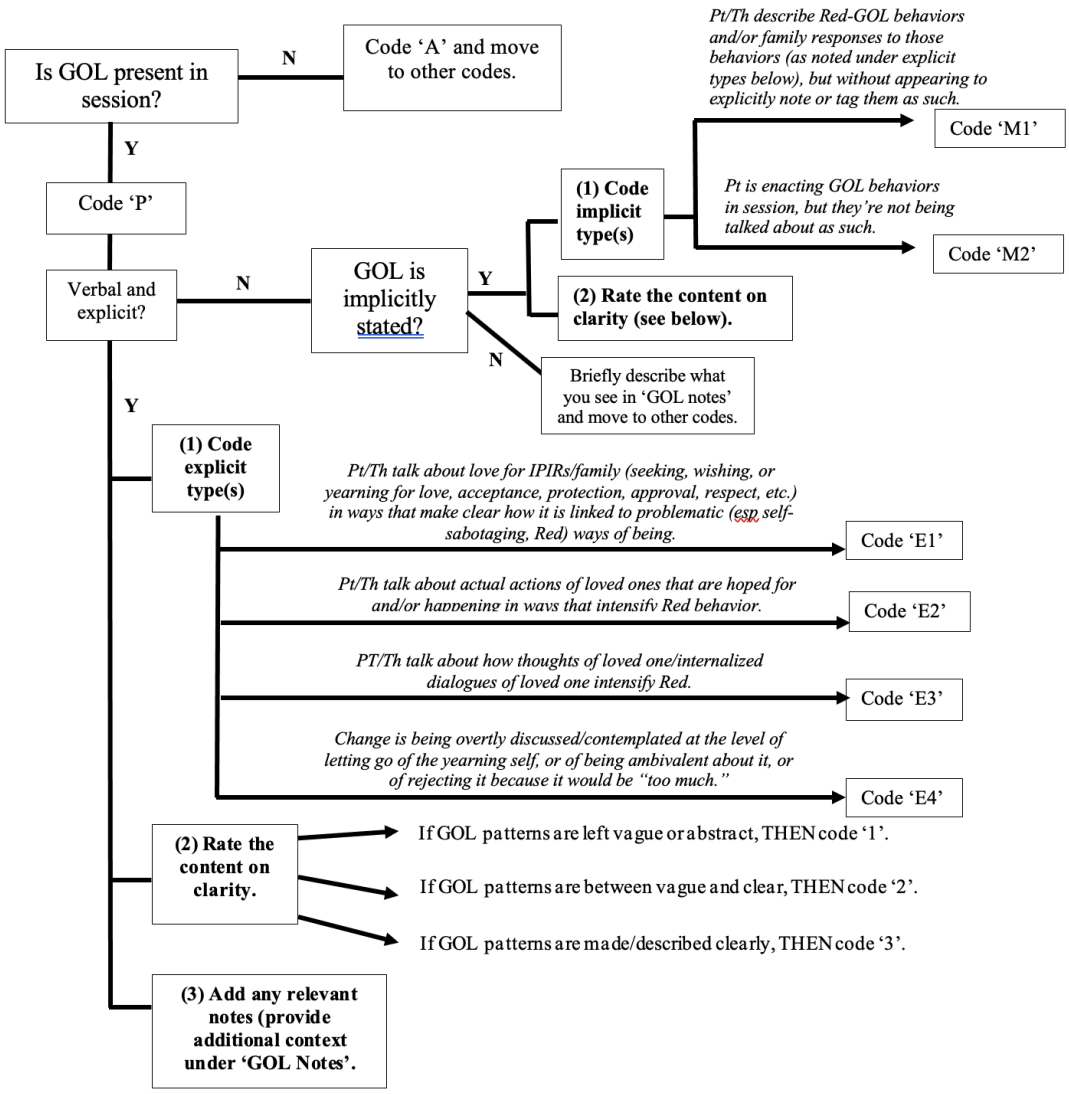


Figure 5. Flowchart for revision 1 GOL.

In the first revision, identifying copy process(es), associated IPIRs, and the open GOL notes section (at the end) were retained (see Figure 5). Following the CP/IPIR code was a binary (yes/no) code for presence of GOL. The coder then needed to decide if the GOL was implicit or explicit. If explicit, the next code was to denote if the GOL conversation focused on the emotional (E1), behavioral (E2), or cognitive (E3) aspects of the gift of love, or conversation about change (E4). The rater then rated the clarity of the

explicit GOL code on a scale from one to three. If the GOL code was deemed to be implicit, the rater then chose between two implicit codes. The first code was when the patient and/or therapist was describing Red/GOL behaviors and/or family responses to those behaviors but not explicitly tagging them as gift of love. The second code described the patient enacting GOL behaviors in session without there being an explicit GOL conversation. The clarity of the implicit GOL code was then rated on a scale of one to three. 'Additional notes for GOL codes' was the final space to mark anything out of place or elaborate on a code. See Figure 5 for a flowchart this researcher developed to describe this process.

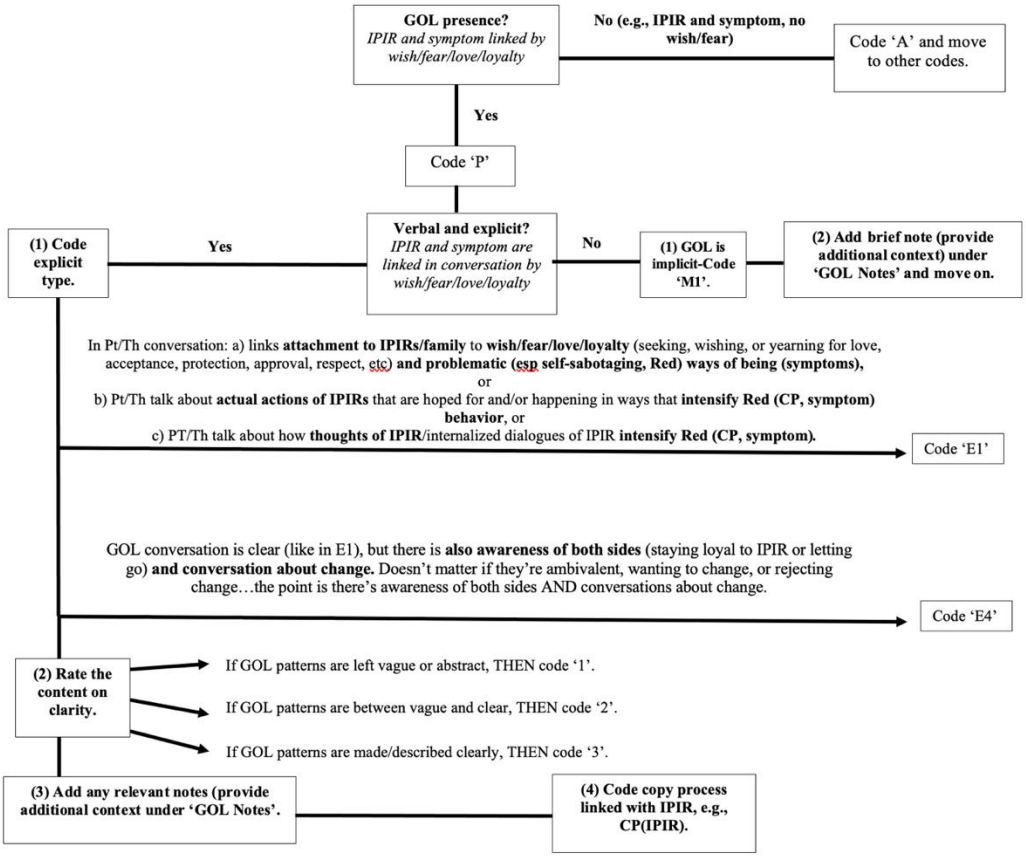


Figure 6. Flowchart for revision 2 GOL.

Consensus coding revealed that identifying CP/IPIR first made deciding on the presence of GOL more difficult for coders and led to poor reliability. In addition, lacking a specific definition for the coders aside from the general GOL theory was ineffective. Therefore, in the second revision (see Figure 6), deciding if GOL was present or absent was the first code. However, GOL presence was defined as "IPIR and symptom linked by wish/fear/love/loyalty." The implicit subcodes were eliminated due to poor interrater agreement, and the explicit GOL codes were simplified, collapsing the affective, behavioral, and cognitive codes into one and retaining the code about change conversations. Rating explicit GOL clarity was retained and implicit GOL clarity was removed.

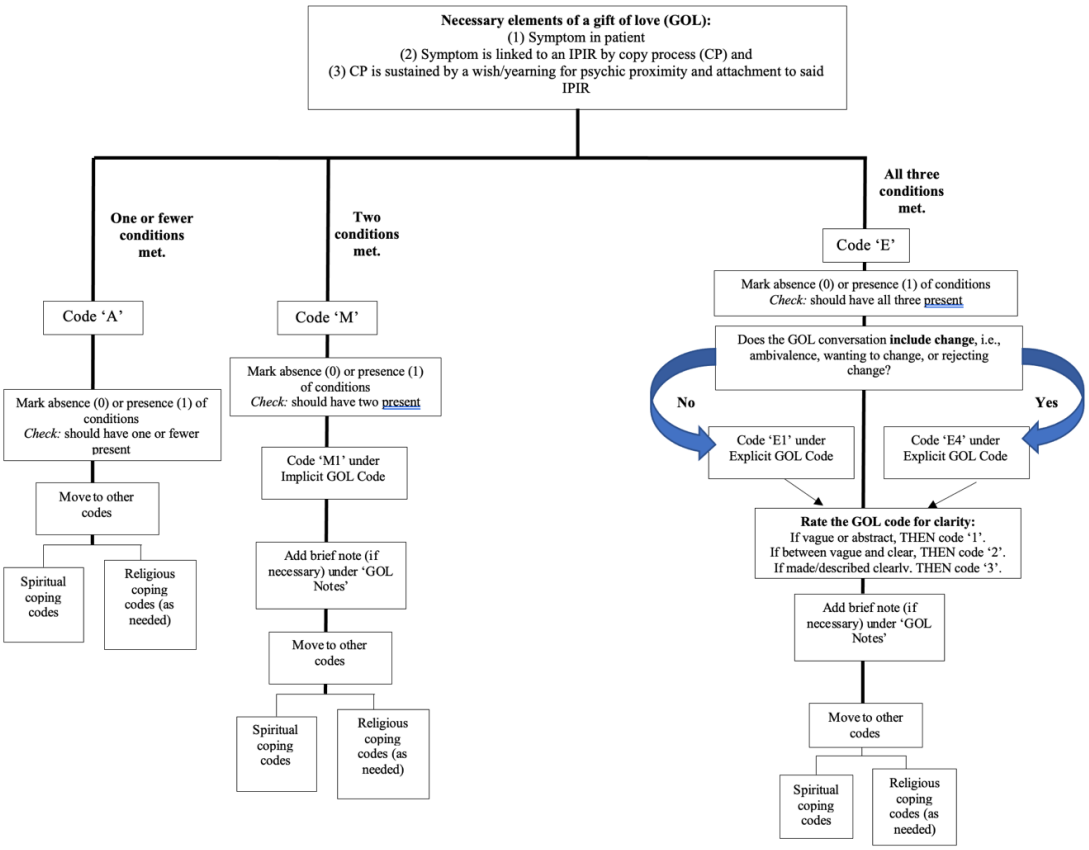


Figure 7. Flowchart for revision 3 GOL

The third revision (see Figure 7) to the coding system was the largest change to the GOL coding system due to the transition to a three-condition coding system. Presence versus absence as the first GOL code was changed to a GOL code type, differentiating between explicit, implicit, and absent GOL codes. A threshold system was devised to further standardize the coding process and thus maximize interrater reliability. GOL theory was referenced to devise three conditions that make up the components of the GOL: 1) a symptom, 2) that is linked to an IPIR via a CP, and 3) a CP is sustained by a wish/yearning for psychic proximity/attachment to that IPIR. The coding procedure was to read through each condition and decide if it was present or absent. If one of these conditions was met within a five-minute time interval, GOL was deemed to be absent. If two conditions were met, this was described as implicit GOL. And, if all three conditions were met, this was an explicit GOL code.

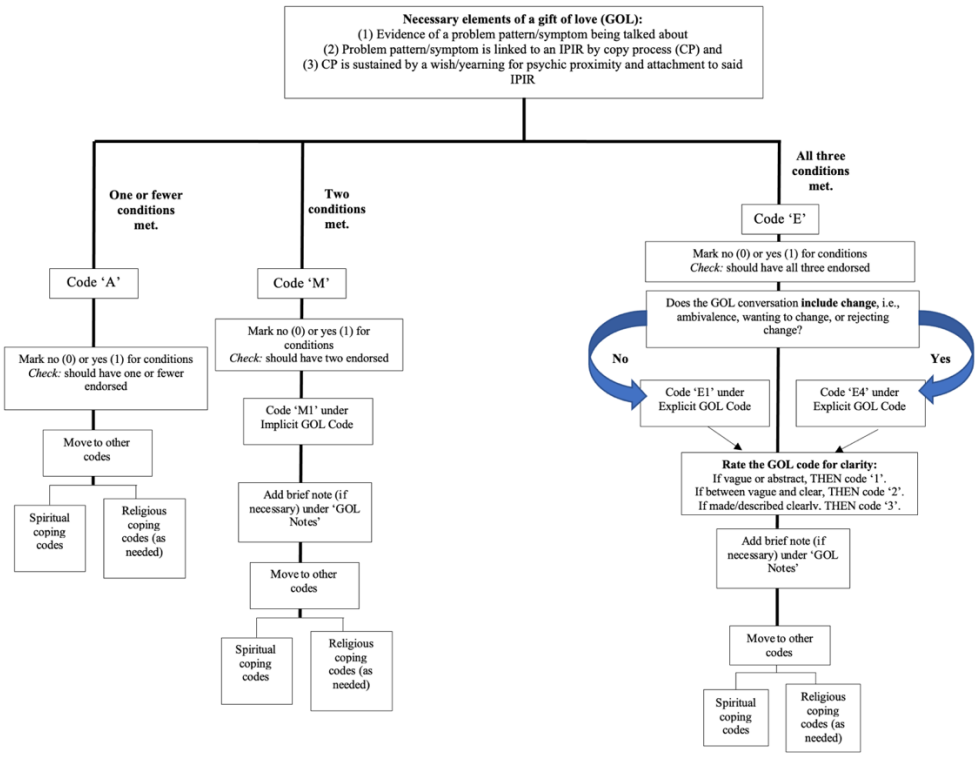


Figure 8. Flowchart for revision 4 (final) GOL.

The fourth and final revision to the GOL coding system (see Figure 8) involved primarily clarifying terms and adding additional details. The factor identified as negatively impacting interrater reliability within the third revision GOL coding system was lack of clarity on terms used. Therefore, definitions for the three GOL conditions were edited in the fourth and final revision (Figure 8). Namely, "symptom in patient" was clarified as "evidence of a problem pattern being talked about." In addition, condition two was expanded as problem pattern/symptom, to reduce the convergence of any symptom being marked instead of only problem patterns related to GOL. No changes were made to condition three. In addition, the language was changed from 'absence/presence' to 'no/yes' to improve clarity.

The process of coding was also revised in this final revision. Another check measure was added to improve reliability around the GOL code type (explicit/implicit/absent). That is, the explicit/implicit/absent GOL decision was followed by assigning the remaining explicit/implicit codes (as needed) and using the conditions afterwards as a 'check' measure. This was due to coders reflecting that they began second guessing their initial code type codes when they coded the conditions right before coding the code type. Using the conditions as a check measure ultimately led to the highest reliability and thus became the final GOL coding system. The coding manual and training were updated to reflect this change.

Developing a Coding Process for Religious and Spiritual (R/S) Coping Conversations in Therapy Transcripts

Spiritual Coding Conversations

Initially, to detect R/S codes the variable prompts were very broad: 1) identifying if meaning was evident within a five-minute segment and 2) identifying if any change talk occurred. To improve reliability and specificity, validated measures for spiritual and religious coping from Charzynska (2015) and Pargament, Koenig, & Perez (2000) were used.

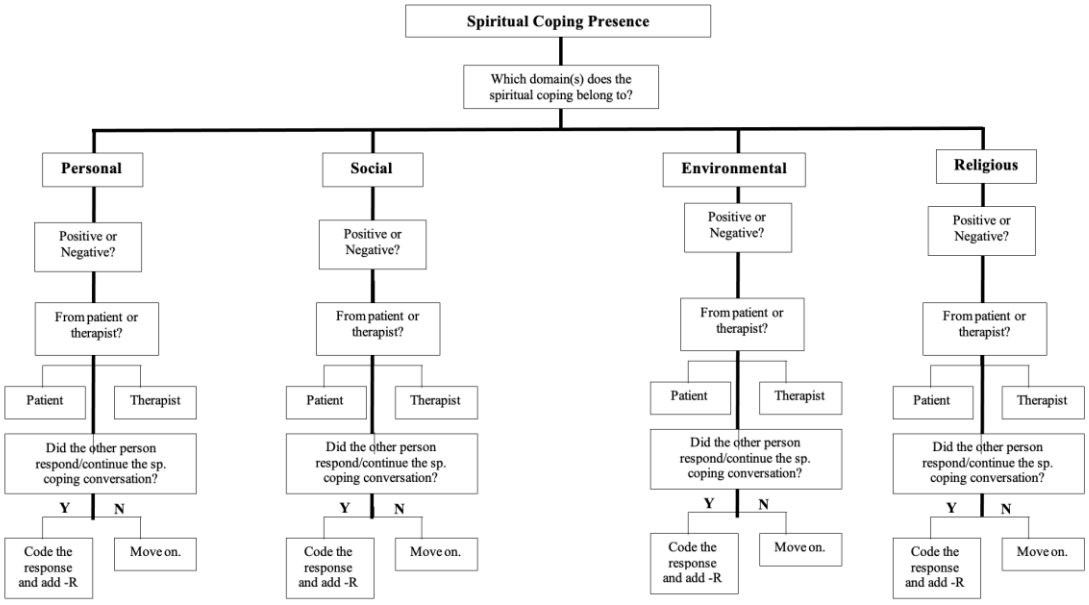


Figure 9. Diagram of spiritual coping subcodes.

Charzynska (2015) designed and validated a spiritual coping measure that was influenced by a comprehensive, multidimensional approach to spirituality, Lazarus and Folkman (1984)'s transactional theory of stress and coping, and Pargament (1997)'s concept of religious coping. Charzynska's Spiritual Coping Questionnaire (SCQ) is comprised of 120 items that refer to positive and negative spiritual coping across four domains: personal, social, environmental, and religious. Charzynska (2015) demonstrated construct and criterion validity of the SCQ measure. Figure 9 depicts the coding process for the spiritual coping system. A summary of Charzynska's spiritual coping domains is illustrated in Table 1.

Table 1. Spiritual coping domains. From Charzynska (2015). Reproduced under the Doctrine of Fair Use, in accordance with 17 U.S. Code § 107.

Domain	Description
Personal domain	**Positive:** pursuit of a goal, sense and meaning, concentration on one's internal life, attempts to overcome one's weaknesses and acquiring more and more self-knowledge, looking for internal peace and harmony
	Negative: negating the goal and meaning of one's life, emphasizing one's weaknesses and limitations, concentration on one's transgressions
Social domain	**Positive:** establishing and maintaining deep and valuable relations with other people, heeding moral values, treating people fair, caring about others, willingness to help, displaying love, empathy and compassion
	Negative: perceiving people as inherently egoistic and caring only about their interests, which results in aversion, hostility or envy toward others, blocking the possibility to establish and maintain deep, valuable interpersonal relations
Environmental domain	**Positive:** concentration on the sense of attachment and belonging to nature, perceiving harmony and order in it, treating nature as friendly to humans, openness to noticing miracles in nature
	Negative: treating nature as hostile to humans and posing threat, emphasizing human helplessness and insignificance in the face of the laws of nature
Religious domain	**Positive:** maintaining solid relation with God/the Supreme Power, based on the sense of presence, love and trust
	Negative: internal religious fight displayed in holding a grudge toward God/the Supreme Power, blaming Him/It for one's own failures, negating His/Its love and care for humans.

Religious Coping Conversations

Pargament, Koenig, & Perez (2000) developed and validated a questionnaire-based, self-report measure of religious coping that was theoretically derived and focused on the five key functions of religion identified by the authors: a) meaning, b) control, c)

comfort/spirituality, d) intimacy/spirituality, and e) life transformation. This measure, the RCOPE, contains 21 subscales which were adapted to complement the GOL coding system described above. These were used to identify and describe both positive and negative forms of religious coping to assess their co-occurrence with GOL conversations. A summary of these subscales is illustrated in Table 2.

Table 2. Religious coping domains. Adapted from RCOPE subscales (Pargament, Koenig, & Perez, 2000). Reproduced under the Doctrine of Fair Use, in accordance with 17 U.S. Code § 107.

Function	Code	Name	Description
Find Meaning	**BENRE (+)**	*Benevolent Religious Reappraisal*	redefining the stressor through religion as benevolent and potentially beneficial
	PUNRE (-)	*Punishing God Reappraisal*	redefining the stressor as a punishment from God for the individual's sins
	DEMRE (-)	*Demonic Reappraisal*	redefining the stressor as an act of the Devil.
	POWRE (-)	*Reappraisal of God's Powers*	redefining God's power to influence the stressful situation
Gain Control	**COLCOPE (+)**	*Collaborative Religious Coping*	seeking control through a partnership with God in problem solving
	ACTSURR (+)	*Active Religious Surrender*	an active giving up of control to God in coping
	PASDEF (-)	*Passive Religious Deferral*	passive waiting for God to control the situation
	DIRINT (-)	*Pleading for Direct Intercession*	seeking control indirectly by pleading to God for a miracle or divine intercession
	SELFDCOPE (-)	*Self-Directing Religious Coping*	seeking control directly through individual initiative rather than help from God
	SPIRSUPP (+)	*Seeking Spiritual Support*	searching for comfort and reassurance through God's love and care

Gain Comfort and Closeness to God	**RELFOC (+)**	*Religious Focus*	engaging in religious activities to shift focus from the stressor
	RELPUR (+)	*Religious Purification*	searching for spiritual cleansing through religious actions
	SPCONN (+)	*Spiritual Connection*	experiencing a sense of connectedness with forces that transcend the individual
	SPDISC (-)	*Spiritual Discontent*	expressing confusion and dissatisfaction with God's relationship to the individual in the stressful situation
	RELBOUND (+)	*Marking Religious Boundaries*	clearly demarcating acceptable from unacceptable religious behavior and remaining within religious boundaries
Gain Intimacy with Others and Closeness to God	**CHURSUP (+)**	*Seeking Support from Clergy or Members*	searching for comfort and reassurance through the love and care of congregation members and clergy
	RELHELP (+)	*Religious Helping*	attempting to provide spiritual support and comfort to others
	INTRDISC (-)	*Interpersonal Religious Discontent*	expressing confusion and dissatisfaction with the relationship of clergy or members to the individual in the stressful situation
Achieve a Life Transformation	**RELDIR (+)**	*Seeking Religious Direction*	looking to religion for assistance in finding a new direction for living when the old one may no longer be viable
	RELCONV (+)	*Religious Conversion*	looking to religion for a radical change in life
	RELFORG (+)	*Religious Forgiving*	looking to religion for help in shifting from anger, hurt, and fear associated with an offense to peace

The R/S coding system went through a parallel set of revisions following an iterative process of applying these codes alongside the GOL coding system. Less revisions were required for the R/S system, however, largely because these codes were derived from existing measures while GOL codes were generated from clinical theory. In short, there was only one revision to the R/S system which was added to provide additional detail to the coding system. In this revision, three codes were added to the religious/spiritual (R/S) coping system. First, patient (Pt) and therapist (Th) subcodes were added to gain additional information about who broached the topic of religion/spirituality. In addition, "-R" was addended to the end of a R/S code if the Pt/Th responded to the other party broaching these topics. Finally, a 'GOL' subcode was added to differentiate spiritual coping present explicitly linked to the GOL from 'Other' spiritual coping, a 'catch-all' of coping unrelated to the GOL. While this additional level of detail is largely beyond the scope of this study, in developing a coding system the goal was not only for this study but also to gain insight into the GOL and religious/spiritual coping in general for future investigations. Therefore, these subtype codes add another dimension of richness to the system.

Testing Feasibility and Validity through Applying the GOL and R/S coding systems

Training and initial consensus coding

Five coders were available to assist this researcher in coding majority of the database on weekdays between May 10-24, 2021. They collectively underwent a two and a half hour training created by this researcher, which provided a background of IRT, GOL, and religion/spirituality as well as oriented coders to the coding system to date. Each weekday, coders independently coded for one and a half to three hours. For the first

eight days, the coders reconvened with this researcher daily to review codes. This researcher answered questions, engaged in conversation around points of coding disagreement between this researcher and the coders, and used this feedback to fine tune the GOL coding system, manual, and coding procedure (see above sections for summary of the revisions). Collectively, this coding team underwent 12 hours of consensus coding.

Reliability was measured at two separate points as part of rater training and testing feasibility of the method. The first round of measuring inter-rater reliability via kappa statistic resulted in almost complete nonagreement, with an average kappa of 0.02. This facilitated aforementioned revisions to the coding system, including the creation of the three-condition system and greater standardization of the coding procedure. Once the coders acclimated to these adjustments, inter-rater reliability was measured again and resulted in an average kappa statistic of 0.47 for point-by-point comparison. It was suspected that reliability was attenuated by the fact of having a limited number of five-minute coding "bins" per session, and that reliability would be higher if measured at the aggregate level across sessions, so coders were allowed to begin coding study cases at this point and the remainder of the coding was split between the five coders. This researcher provided a second set of codes as a separate "expert coder" datapoint.

Establishing Reliability and Validity of Coding System

Two levels of inter-rater reliability were assessed. The first level of reliability looked at rater agreement on a five-minute segment by segment level, hereafter referred to as "bins". This was accomplished using a kappa statistic. Due to each session having a small number of bins, all sessions were combined together to develop an estimate of agreement for the entire study sample. While this violated the assumption of

independence across sessions, it was deemed valuable to provide an initial sense of rater agreement at the code-by-code level of analysis.

To understand rater agreement at the aggregate level of each session, an ICC was also used with the total number of segments receiving a code for each session added up to provide data points. For example, in session 320-79, seven GOL presence codes were assigned out of the 15 five-minute bins available, and so received a session-level value of seven. These values were divided by the number of five-minute intervals in the session to provide a proportion, in this case indicating that 7 / 15 = .47 of the session contained GOL presence codes. For session 320-151, 0 GOL presence codes were assigned out of 15 five-minute bins, indicating that 0 / 15 = .0 of the session contained GOL presence codes. These aggregate proportions were compared across raters. The structure of an ICC is such that differences between raters are compared to differences between sessions. Good reliability indicates that differences between raters are small relative to differences between sessions. Table 3 summarizes these two types of reliability estimates (bin-level kappa vs. aggregate ICC) for each of the study variables. Interestingly, reliability was more stable at the session level than at the five-minute level. In other words, raters agreed as to which sessions had more or less of these concepts and conversations, although they did not necessarily agree as to which segment of the session contained these elements.

Table 3. Summary of reliability statistics for GOL and spiritual coping codes.

Variable	Kappa	ICC average measures
GOL Presence	.53	.73
Spiritual Coping Presence	.20	.67
Positive Spiritual Coping	.31	.81
Negative Spiritual Coping	.12	.34
Spiritual Coping about GOL	.32	.56

Spiritual Coping not about GOL	.06	.10
Personal Spiritual Coping	.25	.58
Social Spiritual Coping	.21	.61
Environmental Spiritual Coping	.28	.22

*Note: Underlined variables were retained for subsequent analysis

Application of Codes to Subsequent Analyses Based on Reliability Properties

All subscales that produced an average ICC of less than .5 were dropped from the final analysis due to lower reliability. These included negative spiritual coping, spiritual coping not explicitly linked to the GOL, and environmental spiritual coping. While environmental spiritual coping was relatively rare in the dataset (M=0.01), negative spiritual coping (M=0.24) and environmental spiritual coping (M=0.30) were present throughout the dataset. It was noted that there were too few codes for Pargament, Koenig, & Perez (2000)'s religious coping codes and Charzynska (2015)'s religious coping codes, which both require explicit content involving deity or specific religious practices (e.g., prayer, consultation with clergy), and so these variables were removed from the final analysis. As such, only findings on spiritual coping will be presented hereafter. More on the observation about a lack of explicit religious content will be taken up in Discussion.

Examining correlations between spiritual coping variables revealed that the spiritual coping presence code is highly correlated with personal spiritual coping ($r(16) = 0.96, p<0.001$), and social spiritual coping ($r(16)=0.85, p<0.001$), meaning these variables are measuring very similar constructs. In addition, positive spiritual coping was highly correlated with spiritual coping presence, personal, and social codes, and spiritual coping related to the GOL. In validating the SCQ measure, Charzynska (2015) found a similar pattern, suggesting validity of the observational coding approach used here.

Planned Analyses

Quantitative

Quantitative data were analyzed to assess several related questions bearing on therapeutic change regarding the gift of love and spiritual coping. Methods involved calculating differences in mean scores between high and low IRT adherence for each of the spiritual coping variables and examining correlations between GOL variables and spiritual coping variables. At the aggregate level, data used were proportions averaging two raters' codes and accounting for the number of five-minute bins in each session. Pearson's correlations were used at the aggregate level and Chi square was used at the session level. This allowed description of associations between gift of love codes and religious/spiritual codes.

An independent samples t-test was used to test the hypothesis that higher IRT adherence sessions would have more GOL conversations identified than in lower adherence sessions. A bivariate Pearson correlation was used to investigate the hypothesis that, consistent with IRT theory and previous research regarding the impact of GOL conversations on change, a later stage of change would be associated with more GOL codes. An independent samples t-test was used to test the hypothesis that higher IRT adherence sessions would have more spiritual coping content than lower adherence sessions. A bivariate Pearson correlation was used to investigate the relationship between GOL presence code and spiritual coping presence codes. Finally, bivariate Pearson correlations were used to examine the relationship between spiritual coping and therapeutic change as defined by GOL stage of change scale. For these exploratory analyses, alpha for all analyses was set to .05.

Qualitative

Qualitative data was used secondary to quantitative findings, to contextualize the findings and offer richness from the therapy conversation itself. Qualitative data was drawn from (1) transcriptions of sessions and (2) GOL and spiritual coping notes from coders within the coding system.

Chapter IV

Results

Results will be presented in order of quantitative data followed by qualitative data. There are two levels of data that are being analyzed: (1) aggregate level, meaning looking at codes at the session level, and (2) bin level: looking at codes generated for each five-minute section of a session. Results are organized by research questions named at the outset of the study.

Relationship between gift of love and spiritual coping

Aggregate-level

Table 4. Average proportions of GOL and spiritual coping codes across sessions.

Variable	*M*	*SD*
Presence of GOL	.15	.15
Presence of spiritual coping	.51	.24
Positive spiritual coping	.40	.23
Spiritual coping explicitly linked to GOL	.22	.23
Spiritual coping-Personal domain	.44	.24
Spiritual coping-Social domain	.26	.26
Positive spiritual coping related to Pt	.13	.12
Positive spiritual coping related to Th	.14	.09

Table 4 shows the average proportions of GOL and spiritual coping codes across sessions. Of note, on average across this dataset, GOL was present for 15% of a session. The average presence of spiritual coping across sessions was 51%. In other words, this dataset shows that GOL is present at lower levels throughout sessions, while forms of spiritual coping were detectable for the majority of time within any given session. Spiritual coping was predominantly positive and occurred both in relationship to self (“Personal” domain) and other (“Social” domain).

In examining the difference between high (*M*=.14, *SD* =.16) and low (*M*=.15, *SD* =.16) IRT adherence sessions and GOL Presence codes, an independent samples t-test revealed no statistically significant difference, *t(16)=0.09, p=.93, d=0.05*. In summary, higher IRT adherence sessions were not associated with significantly more GOL presence codes than low IRT adherence sessions and GOL was observed in both high and low IRT adherence groups.

Table 5. Pearson Correlations between GOL and spiritual coding systems at the aggregate level.

	1	2	3	4	5	6	7	8
1. GOL stage of change	-							
2. IRT adherence	.88*	-						
3. GOL Presence	.01	.21	-					
4. SC Presence	.49*	.54*	.33	-				
5. SC Positive	.55*	.56*	.23	.91*	-			
6. SC explicitly linked to GOL	.27	.35	.60*	.75*	.77*	-		
7. SC Personal	.50*	.55*	.38	.96*	.87*	.76*	-	
8. SC Social	.48*	.40	.48*	.85*	.80*	.79*	.85*	-

*$p < .05$; SC = spiritual coping

Table 5 summarizes the Pearson correlations between the GOL coding system and spiritual coding system variables of interest. In testing the hypothesis that a later GOL stage of change would be associated with more GOL presence codes, a bivariate correlation revealed no statistically significant relationship between GOL presence and GOL stages of change variables, $r(16)=.01$, $p=.99$. This indicates that the proportion of each session occupied by a GOL conversation did not increase as the patient progressed in the GOL stages of change, which involves recognizing and progressively relinquishing their GOL which tends to coincide with progression in IRT treatment. In examining the difference between high (*M*=.48, *SD*=.20) and low (*M*=.25, *SD*=.21) IRT adherence sessions and presence of spiritual coping codes, an independent samples t-test revealed higher IRT adherence sessions were associated with more spiritual coping presence

codes, *t(16)=-2.42, p=.03, d=-1.21*. Of note, higher IRT adherence sessions were associated in particular with positive spiritual coping. In addition, later GOL stages of change were significantly associated with the patient engaging in positive spiritual coping. In examining the relationship between GOL presence and spiritual coping codes, bivariate Pearson correlations revealed GOL presence codes were significantly correlated with social spiritual coping and spiritual coping related to the GOL. In addition, statistically significant correlations were found between GOL stage of change and spiritual coping presence, particularly positive spiritual coping that is within the personal or social domains. In other words, the further along a patient was in terms of reckoning with and letting go of the GOL, the more positive personal and positive social spiritual coping was present. For example, these results indicate that advancement in IRT therapy, as measured by GOL stages of change, coincided with more evidence of the patient: pursuing their goals, sense, and meaning, trying to overcome their weaknesses, looking for internal peace, establishing and maintaining deep relationships with others, heeding moral values, and demonstrating more empathy and compassion.

Bin-level

Additional Chi-square analyses were performed at the level of five-minute segments using the complete set of codes provided by the investigator. Only two findings were significant at this level but are consistent with findings observed at the aggregate level: (1) Spiritual coping was more likely to occur in a given five-minute segment when GOL was present than when it was not, $X^2(1, 251) = 15.81$, $p < .001$ and (2) positive spiritual coping was more likely to be in the conversation when GOL was present than when it was not, $X^2(1, 251) = 17.11$, $p < .001$.

Qualitative Examples of GOL and Spiritual Coping and their Co-Occurrence

This section will provide and explain examples from the dataset of the GOL and spiritual coping coding systems, noting their intersection. For review, please reference Figure 8 and Table 1.

Example of both GOL and spiritual coping present

Session 89 for patient 318 holds an example of where GOL and spiritual coping are both present. Patient 318 articulates rather clearly the wish and love within the GOL construct. Patient 318 and her therapist are talking about critiquing others as a similarity between Patient 318 and her mom. The therapist meets condition one when he identifies this problem pattern (blame/critique). He meets condition two when he links this problem pattern through a copy process (identification) to an IPIR (mom) when he says, "at times you and your mother have been one and the same…when you critique those other people in your life, that ultimately brings you closer to her." He meets condition three when he demonstrates the loyalty inherent in copying this behavior: "in the past you would be loyal to those aspects because, in many ways, you tried to remain loyal to your parents and that was something that they valued." She agrees with this, and all three conditions of an explicit GOL code have been met. This was coded as E4 (see Figure 8), an explicit code about change, because he brings up her Green self, saying "and you're trying to break that cycle. So, what do you think of this aspect that it somehow brings you closer to her?", drawing her into reckoning with this gift of love. Patient 318 engages with this conversation, saying:

> It's almost like as much as I've let go of her in my own self to treat myself better lately it's like I'm like 'but look I'll hold onto you like this'. Just keeping it,

> keeping you at bay right here for myself but I'm going to put it on everyone else…and it's more like a way to stay close to her and when we do finally have this relationship that we have something—together still.

She speaks to her longing for closeness when she says: "I just want to hold onto her in a way." She struggles to understand why she holds onto her mom in this way given she admires many of her mom's positive attributes. The therapist helps her explore the meaning of doing to others what her mom did to her, and she responds in describing what her behavior is trying to communicate to her mom: "you're not alone either we're look we're doing this together." So, in some ways, Patient 318 and her therapist come to a shared understanding that her gift of love serves to try to preserve some semblance of a commonality with her mom for when they have a relationship again (they are estranged currently) and is also a way of comforting her mom in her own isolation. Engaging with this meaning allows her to transition to talking about the difficulty of change, of not knowing how much critique is appropriate and fear about occupying either extreme. This lends itself to the remainder of the session focused on planning for skill building in future sessions to address this skill deficit.

The quantitative findings of this study revealed a significant correlation between GOL presence and social spiritual coping, and this five-minute segment that occurs halfway through the session included positive personal coping, negative social coping, and positive social coping. Patient 318 demonstrates positive personal coping in her attempt to overcome critiquing others and herself in a search for internal peace. She reflects:

> What I'm doing is the same thing [critiquing others] and that I'm getting hurt because other people are doing it but I'm doing the same thing to them…I look back and I don't want to do that again…instead of saying 'how can I enjoy you more? You know? Something of importance.

This particular five-minute segment of coping is also linked to the GOL, as her focus on overcoming her weakness is explicitly a weakness that is a copy process pattern. She demonstrated ambivalence as she considers changing this Red pattern, and the ambivalence is captured in both positive and negative social spiritual coping appearing in this timeframe. She shows positive social spiritual coping in her care for others, saying "mm-hmm and it would hurt me so much when people would talk bad about Chris. That's a lot what I'm afraid of is that I don't, you know, why would I do that too?" On the other hand, her critique consisting of "Why aren't you dressing like this, don't get your haircut at Dollar Cuts" demonstrates critique that hinders deep, valuable relationships with others. Both the positive and negative spiritual coping codes are similarly related to the GOL.

Example of spiritual coping without GOL present

Next, Patient 325, in session 86 provides an example of a time segment that contrasts the previous one by having spiritual coping without any GOL conversation present. The therapist and patient are talking about Patient 325 feeling responsible for the abuse she suffered in the past and her wrestling with what to do with this history. She expresses a desire for change to happen faster than its current pace. A few moments earlier, the problem pattern (condition one) was identified: "everything in your life now is kind of a consequence…so the same old message has found a way, wormed a way into

the present." This old message is never linked through a copy process to a specific IPIR (condition two) or a longing for proximity (condition three), so in the GOL coding system it was coded as an absent GOL, only talking about a problem pattern. From a spiritual coping perspective, however, this woman is grappling with how to resolve the pain of past trauma. Her therapist invites positive personal coping as they encourage Patient 325 to "work with who you are today…if today you want to have a nice walk, feel good about yourself, hang out with friends." In some ways Patient 325 shows negative personal spiritual coping when she speaks to how the pattern temps her to be fatalistic: "who cares that there is something I could do, it still happened?" and "there is part of that pessimist that drowns in the half full bathtub maybe, you know?" As Patient 325 speaks to how this sense of responsibility leaves her helpless to respond in adaptive ways, the therapist encourages positive personal spiritual coping by suggesting self-acceptance and using the conversation to help her identify what she can do to take care of herself as she finds herself in this part of her healing journey. Here we see no GOL conversation but a powerful spiritual coping conversation.

Example of GOL without spiritual coping

Session 79 for Patient 320 illustrates an example of a time segment where the GOL was present but there was no evidence for spiritual coping. In this segment, the therapist and Patient 320 are focusing on the problem pattern identified (condition one) which is Patient 320 calling herself stupid and crazy. The therapist draws a connection between how Patient 320 treats herself and her brother's prior treatment, noting "he called you stupid and indicated in various ways that you were crazy so that's what you learned." At this point, there is a problem pattern identified, then linked to an IPIR

(brother) through a copy process (introjection) which meets condition two. The longing for acceptance comes later, where Patient 320 describes how she used to play along when her family would make fun of her for not knowing things. Patient 320's therapist noted that playing along and believing this served to "honor your family…that was the one way you were able to stay connected to that family, let them make fun of you, pretend they don't bother you, let [brother] win the game…" This conversation about how this Red pattern serves her wish to stay connected to her family in the way that worked meets condition three and, in total, constitutes a GOL presence code. In terms of spiritual coping, however, there is no mention of how she copes with this problem pattern. Rather, she is describing it but they are not working to change or make meaning of it. Therefore, there is no spiritual coping for this time segment.

Example of neither GOL nor spiritual coping present

Finally, session 12 for Patient 332 contains an example of a time segment where neither the GOL nor spiritual coping was coded as present. The patient and therapist earlier in the session established the problem pattern (condition one) of Patient 332's depression and the therapist summarizes: "you're in that depressive just…please! just help me kind of thing. it's everybody, everybody is saying, you're disappointing me over here and you're disappointing over there." The remainder of the five-minute segment entails Patient 332 describing the depression and how she manages the symptoms by using her medication. However, there is no mention in this segment of a copy process linking this problem pattern to an IPIR (condition two) or a wish/longing for psychic proximity (condition three), so it is coded as absent GOL. Furthermore, there is no

evidence that Patient 332 is coping with this problem, for she is simply describing it in this segment. Therefore, no spiritual coping is coded either.

The following section will synthesize the goals of this study, literature base, methods, and results to discuss overall learnings, clinical implications of study findings, strengths and weaknesses of this study, and propose future directions.

Chapter V

Discussion

Overall, the purpose of this study was to (1) create a coding system that operationalized the gift of love (GOL) and religious/spiritual coping within the conceptual frame of Interpersonal Reconstructive Therapy (IRT), and (2) apply the coding system to gain an initial understanding of how therapeutic change as measured by GOL stages of change may be related to IRT adherence as well as religious and spiritual coping. Both of these objectives were accomplished in this dissertation and preliminary findings of the relationship between GOL conversations and spiritual coping offer insight into potential future directions for research as well as clinical implications to the role of spiritual coping in therapeutic change.

Substantive findings from the development of the GOL and religious/spiritual coding systems

Creating the GOL coding system as well as the religious and spiritual coping coding systems was a primary goal of this study. The GOL coding system created in this dissertation was found to be reliable in detecting gift of love conversation elements in IRT sessions. The GOL coding system took several revisions to achieve reliability and there were multiple observations that emerged from the iterative process of improving the interrater reliability of this system. The initial hurdle to overcome was translating a theory into operationalized codes that were understandable to individuals who were not familiar with the underlying theories or with clinical practice (coders).

It became clear to this writer early on that concepts such as the gift of love and copy process were difficult for individuals not well-versed in these theories to understand

without more specific ways of describing these concepts. The detailed training offered coders an introduction to the theories involved in the project and the coding procedures. Consensus coding was a key factor in making the GOL codes more understandable to the coders. Coders were able to ask questions to this investigator that clarified the structure of the coding system, and coders reported boosted clarity and confidence in coding because of these meetings. In addition, consensus coding meetings provided space for coders to give feedback on parts of therapy sessions that were difficult to code. This feedback informed the format and organization of the coding manual. For example, clinical examples of numerous possibilities of code combinations in consensus coding were reported as helpful by the coders, and as such multiple examples exist in the coding manual. Coders also provided feedback that the visual diagrams the coding manual provided to summarize the coding procedure were helpful to them in creating a routine system for progressing through coding a session.

As an example of how coder feedback translated into an improved coding system, one of the findings that emerged early in the analysis was that interrater reliability was higher across sessions versus comparing five-minute intervals at a time. In essence, there was more agreement between raters on what happened within an entire therapy session than what happened in five minutes of that same session. This finding validated early challenges of attempting to operationalize the gift of love motivation, a construct that is difficult to capture in words. While gift of love behaviors can be identified when they manifest, the motivation that drives these behaviors tends to be less pronounced verbally. However, individual coders remarked that they could “feel” when the gift of love was present in a session.

The process of coding evolved to help bridge the gap between the intuitive sense of coders upon understanding the gift of love concept and the nature of a coding system that standardizes an approach to data. One of the most helpful adaptations, as evidenced by coder feedback, was the structure of how information was presented in coding. Initially, the first coding team was using the video archives of sessions. However, due to poor audio quality on some tapes, coders were distracted by the ambient noise and less able to differentiate codes. An early adaptation involved transitioning to reading transcripts rather than listening and watching the tape. Further, when five-minute segments were originally chosen to divide up a session, coders began by coding as they read. However, an observation found during consensus coding was that coding as they read tended to result in coders second-guessing themselves as they encountered new information. To respond to this feedback, the procedure was modified to coding at the end of each five-minute segment. This adjustment led to a more subjectively comfortable coding experience for coders as well as enhanced interrater reliability.

While the GOL coding system took numerous iterations to develop and multiple rounds of consensus coding to appropriately train coders, the religious and spiritual coding systems were easier to construct and train coders on, especially while utilizing Pargament, Koenig, & Perez (2000) and Charzynska (2015)'s existing constructs. These provided operationalized definitions of components of religious and spiritual coping that were simply translated into abbreviations for the sake of coders. Consensus coding for the largely spiritual codes took the form of clarifying what the patient was coping with, as many quotidian activities could be considered coping but would not be coping within this system as it was not directly related to the problem(s) the patient brought into the session.

In summary, minor processes built into the coding system because of coder feedback improved reliability not only by further standardizing the procedure but also by creating a system responsive to human self-doubt and cognitive processes.

Substantive findings from the application of the coding systems

Initial application of the GOL and R/S coding systems yielded interesting preliminary findings. While this study did not find the expected significant association between higher IRT adherence and more GOL presence codes, the GOL was present across both low- and high- IRT adherence sessions. On average, 15% of a session in the dataset contained the GOL, and the difference between mean proportion of GOL in low adherence (15.1%) and high adherence (14.4%) was negligible. Thus, while initial stages of IRT are focused on building a collaborative relationship and increasing insight into one's case formulation, the meaning behind a patient's symptoms are brought into session and discussed. We infer from this observed base rate that meaning, love, and yearning for connection to important others is implicit and subliminal in human behavior.

In addition, higher IRT adherence was associated with more positive spiritual coping. In fact, positive spiritual coping was more likely when GOL conversations were present. This finding can be understood in terms of the therapy goals of IRT, particularly to grow the Green self, which can be accomplished through improving metacognition and exploring meaning through the significance of one's gift of love. This study has drawn connections between enhancing the Green self and positive spiritual coping in particular. As GOL awareness increases, a patient can exercise choice in what to do with this information. They can choose to continue to work to overcome these Red patterns ('limitations' in Charzynska (2015)'s terms), blocking them while growing their Green

self. They can also choose to not relinquish their gift of love but have gained insight into the connection between their deep longing for love and acceptance and their distressing symptoms. Either way, the process of contending with the gift of love provides greater clarity to one's needs and identity. When thought of in the language of moral space, increased insight through progression in IRT and GOL awareness allows someone insight into their values and sense of meaning in life through an examination of important love relationships. IRT interventions can be understood as directed towards the patient's vision of the good and becoming re-oriented in moral space as a person is able to distance in healthy ways from Red patterns that foster misorientation and grow the Green self, re-orienting in moral space.

This study also found that later GOL stages of change were associated with the patient engaging in positive spiritual coping. This finding is consistent with the hypothesis that spiritual coping is involved in therapeutic change as a way of re-constructing meaning. The GOL theory predisposes IRT to be more intentional in its approach to understanding meaning as well as enhancing the Green self and blocking the Red self, which the results of this study substantiate as synonymous with encouraging positive spiritual coping. As patients advance in the GOL stages of change, their Green self becomes more prominent and they are able to learn and practice new, more adaptive ways of being. This study found that parallel to this progression is increased positive spiritual coping. While the enhancement of the Green self involves skills that coincide with positive spiritual coping, spiritual coping is also invoked when questions of transforming meaning held by a person arise. In bringing up conversations about the gift of love and engaging in dialogue about grief of love lost and the possibility of letting go

of these patterns in the service of one's Green self, a therapist introduces a stressor that a patient then needs to cope with. Spiritual coping may increase as a patient adapts to these conversations and re-orients in moral space. In this way, inherent in the process of IRT may be a bi-directional process wherein conversations about meaning promote increased positive spiritual coping skills as well as increase utilization of said skills secondary to the intentional disorientation in moral space caused by IRT interventions.

Related to this finding is the connection between visions of the good, orientation in moral space, and transcendence. As previously discussed, GOL conversations can be understood as increasing insight into one's own misorientation in moral space. When a patient grasps their case formulation and GOL, they realize that the meaning motivating their behavior and subsequent distress is based on a wish that may never become reality. This wish may have been so powerful as to shield them from understanding their own goals and grasping their own sense of purpose in life. However, IRT therapy involves helping patients face the reality of their lives, understanding the learning history of how it all makes sense and making decisions for the future that are based on a person's own identity and values, not those of their old teachers. Engaging with personal values and identity fundamentally re-orients a person in moral space, where they can act towards their goals and feel a sense of purpose. To do this, however, transcendence is required.

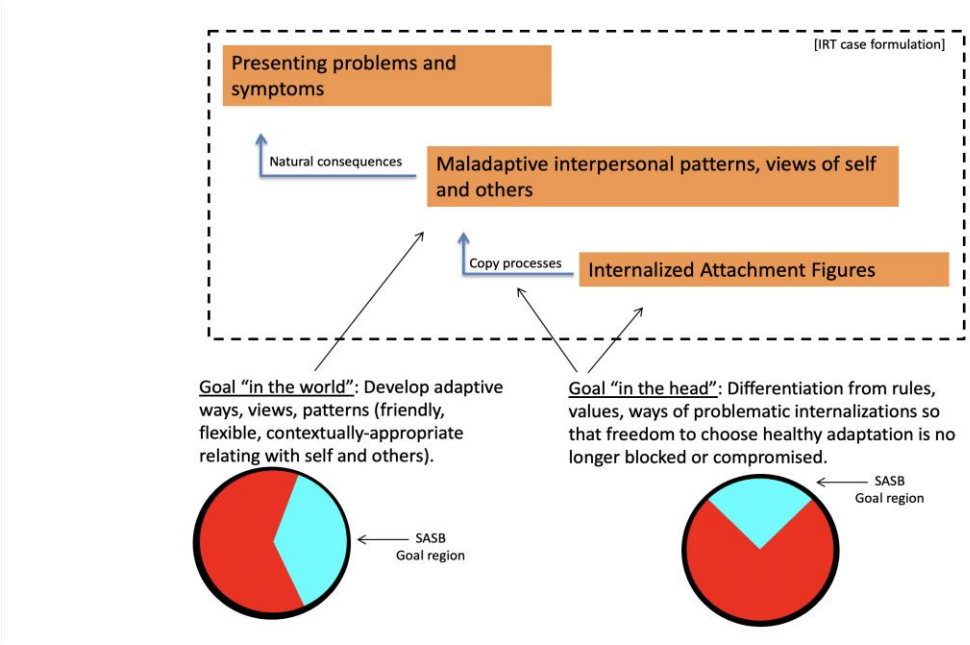


Figure 10. Treatment goals of IRT. From Critchfield et al. (2019). Reproduced under the Doctrine of Fair Use, in accordance with 17 U.S. Code § 107.

Transcendence was defined earlier by Murdoch (1970) as movement "beyond the ego that is simultaneously a movement towards reality…involves looking at the reality of human vulnerability, suffering, and evil." This transcendence can be translated into IRT terms by movement towards the reality of one's suffering, which involves differentiation from the GOL wishes that keep someone attached in hostile ways to old teachers (see Figure 10). In fact, this differentiation is a treatment goal for IRT. Differentiating from these Red patterns through letting go of the GOL allows for transcendence beyond the ego and towards reality, which involves the grief and suffering that is part of many of the lives of individuals with personality disorders. Differentiation from being governed by the rules of IPIRs allows growth of the Green self and movement toward exercising warmth and moderate affiliation in interpersonal relationships that occur intrapsychically as well as in the external world. Therefore, engaging with the GOL is not only a spiritual

intervention itself, but through increased spiritual coping a person also gains practice in transcendence and becomes more in touch with their vision of the good. Doehring et al. (2009) found that individuals who routinely engaged in prayer or ritual were more likely to find the sacred in their lives. Perhaps in an analogous way, the process in IRT of repeatedly reviewing and identifying one's copy processes and their connections to IPIRs through the GOL allows individuals to transcend their Red patterns and re-orient towards that which is beyond them, facilitating finding that which is sacred and promotes healing.

Finally, later GOL stages involve relinquishing the gift of love and understandably evoke grief and loss. Earlier sections have demonstrated the ways spirituality and spiritual coping are utilized in times of grief, loss, suffering, and transition. Later GOL stages of change were also associated with social and personal spiritual coping. In other words, it appears that as patients become aware of and grapple with relinquishing their GOL, they engage in more positive introspection, more investment in overcoming their personal limitations, more investment in meaning, and enhanced care for and relationships with other people. These are optimal treatment goals "in the world" for patients within IRT (see Figure 10), where the learning of one's case formulation requires deep introspection for the purpose of creating differentiation from internalized IPIRs and an enhanced capacity for moderate, friendly relationships with others. Therefore, the findings of this study are consistent with the intersection of IRT interventions and spiritual coping.

Limitations of the study

A limitation of this study is that time constraints of coders placed a limit on sample size. The small sample size of this study restricted statistical analyses and places

caution to more full interpretations due to lower statistical power. However, for the purposes of an initial study, this limitation seems acceptable.

In addition, while Pargament, Koenig, & Perez (2000)'s types of religious coping delineated many different forms of religious coping, God needed to be specifically invoked for one of the religious coping codes derived from this measure to apply. As a result, these religious coping codes were rarely utilized and were subsequently removed from the analysis. This limited the exploration of religious coping and GOL. Given the context of the IRT clinic in Salt Lake City, Utah, a central location for the Church of Jesus Christ of Latter-Day Saints (LDS), next to no religious coping codes is unexpected. Religion was touched on briefly in a few sessions, but little depth of exploration about religious coping was observed in the sessions utilized in this dataset. When religion was mentioned, particularly regarding the dominant LDS culture, there was a negative connotation. Future studies that could expand the religious coping elements from this study into broader language would allow for religious coping to be more accessible for study.

While Charzynska (2015)'s spiritual coping definitions were useful in this investigation, at times these definitions seemed limited in clarity and scope. For example, positive spiritual coping is defined by Charzynska (2015) as "pursuit of a goal, sense and meaning, concentration on one's internal life, attempting to overcome one's weaknesses and acquire self-knowledge, and looking for internal peace and harmony." While pursuing a goal can be easily identified, there is a level of interpretation of what constitutes attempting to overcome one's weaknesses, including how 'weakness' is defined. In essence, the level of interpretation required to apply some of these definitions

introduced a level of error into this analysis. In addition, some of the domains delineated by Charzynska seem limited in their scope. For example, negative social spiritual coping is defined as:

> "perceiving others as inherently egoistic and caring only about their interests, which results in aversion, hostility, or envy toward others, blocking the possibility to establish and maintain deep, valuable interpersonal relations."

However, one could argue that treating others with hostility in general, not only hostility resulting from a negative perception of others, can be considered negative social coping. The definition provided by Charzynska (2015) assumes that negative perceptions of others and self-interest are the sole factors that negatively impact social relationships. However, other factors such as negative behavior or emotions towards others can also impair relationships. It would be helpful for future studies to address these limitations of Charzynska (2015)'s spiritual coping domains in a revision to the spiritual coping coding system. More specific definitions that include additional ways spiritual coping can manifest would likely capture more spiritual coping as well as improve clarity of codes for coders utilizing the system.

Final thoughts

A major implication of this study is that it allows for future researchers to build off the now existing GOL, religious coping, and spiritual coping coding systems to continue to study the GOL as well as meaning-making through spirituality as it occurs in IRT. Future studies will hopefully follow up to expand on the current findings of this study.

In addition, this study demonstrated that positive spiritual coping coincides with later GOL stages of change, our study's measure of therapeutic change. Previous sections have discussed the role of positive spiritual coping in enhancing the Green self in line with IRT treatment goals. Given that prior research has demonstrated that trauma increases emotional arousal and inhibits meaning making, the association between spiritual coping and GOL stages of change seem particularly important for additional study (Kosminsky & Jordan, 2016). This dissertation revealed that the patient's spiritual coping most notably increases with more highly adherent IRT and as GOL stages of change progress. In addition, positive spiritual coping was associated with greater levels of IRT adherence. Put together, these findings suggest that the process of IRT coincides with an enhanced ability in patients to identify and block their GOL motivated Red patterns and treat themselves and others through a more positive, transcendent lens. Rather than unconsciously playing out old rules and values that beget suffering, IRT invites patients to step outside of this learning history, reflecting inward and working towards improving self-treatment as well as relationships with others through differentiating from problematic rules and values of IPIRs. IRT uses the ways that problematic relationships engender psychopathology to help patients learn how to re-orient in moral space through reckoning with the lynchpin of change, desire for love from caregivers. In essence, this study provides evidence that spirituality is associated with therapeutic change in IRT. A potential implication of this finding is that additional research on ways to enhance spiritually-integrated psychological training for clinicians may help clinicians continue to steer into important conversations such as the GOL that promote change.

In IRT, patients are invited to consider how the love they have for their early caregivers and teachers could look different, and in many ways they are tasked to love their caregivers in love's truest form. That is, letting go of the GOL means forgiving, giving space, grieving what wasn't and perhaps cannot be, and learning to appreciate caregiver(s) for their gifts and wounds without defining one's own life by this history. Iris Murdoch (1970) speaks of the power of love and spirit in her work *The Sovereignty of Good*:

> Love is the general name of the quality of attachment and it is capable of infinite degradation and is the source of our greatest errors; but when it is even partially refined it is the energy and passion of the soul in its search for Good, the force that joins us to Good and joins us to the world through Good. Its existence is the unmistakable sign that we are spiritual creatures, attracted by excellence and made for the Good. It is a reflection of the warmth and light of the sun. (p. 100)

In Murdoch's terms, the gift of love motivation is a form of attachment that can be "the source of our greatest errors." However, in working with the gift of love patients can refine this energy towards the Good, reigniting one's energy towards the Good, towards reorientation in moral space. Our spiritual search for connecting to the Good gives us meaning in life, through experiencing and processing suffering. Frankl (1946) expounds on this idea when he writes:

> If there is a meaning in life at all, then there must be a meaning in suffering…the way in which a man accepts his fate and all the suffering it entails…gives him ample opportunity—even under the most difficult circumstances—to add a deeper meaning to his life (p. 88).

When this meaning is found, Frankl asserts that suffering ends. Logotherapy, Frankl's contribution to existential psychology, describes that when we create a work or do a deed, experience something or someone, and/or when we accept unavoidable suffering, we can take action and find meaning in life. Work with the GOL invites patients into this meaning-making realm, and interventions consistent with IRT adherence coincide with spiritual coping. In other words, IRT has been shown to involve spiritual interventions through meaning-making, intersecting with the spiritual matter of psychopathology, a 'love story gone wrong' in the words of Lorna Smith Benjamin.

This study sought out to find bridges between clinical psychology, religion, and spirituality for the sake of increasing insight into the internal, psychological processes of meaning-making and transformation. This project has demonstrated that engaging with the GOL involves spiritual coping. First, this depth-based work poses a stressor to the patient in the invitation to face one's own suffering and grieve the deep longings for love and attachment that may not be possible. Findings of the study revealed that the response to this stressor, the response to GOL conversations, involved positive spiritual coping. Second, spiritual coping is involved with the GOL in IRT in the ways that interventions geared toward helping someone focus on their internal world and invest with warmth towards self and other are consistent with definitions of spiritual coping previously established. As the Green self grows and IRT therapy progresses, more positive spiritual coping was found in sessions.

It is the hope of this project that these findings will continue to develop and help all people, regardless of their circumstances, understand their gift(s) of love so that they have more choice to live out their lives in accordance with their true self, oriented in

moral space, moving towards their vision of the good with a clear sense of meaning and purpose in their lives. This access to meaning is so important, as Frankl (1946) writes, “for every human life, under any circumstances, never ceases to have a meaning” (p. 104).

This project has provided evidence that IRT involves spiritual interventions through engaging with the GOL, re-orienting a patient’s focus from the yearned for meaning of closeness, love, and acceptance from IPIRs to the meaning of one’s life based on one’s own visions of the good. This is a powerful spiritual and clinical intervention that alleviates suffering in individuals who have faced trauma, loss, and chronic emotional distress. In this way, healing personality psychopathology through IRT is about re-writing a love story gone wrong by teaching humans how to love the realities of self and other once and for all.

Appendix A

Manual for assessing gift of love (GOL) in IRT

Eliza I. Stucker-Rozovsky and Kenneth L. Critchfield

James Madison University

draft: 1/28/2021

updated: 5/15/21

Table of Contents

Overview of Codes

Identifying information

- Rater initials
- Client #
- Session #
- Timestamp-5 min intervals
- Transcript lines-align to timestamps

General Coding information:

- Separate codes by a semicolon ';' and link codes that need to be paired with parentheses (e.g., copy process (CP) with its associated important people and their internalized representation (IPIR) if there are multiple CP codes within a 5 min span)
- Transcripts will be provided for use in coding as available. Coding generally uses transcripts, with audio available if needed to clarify what's in the transcription.

Brief orienting to IRT

- Copy processes: "mechanisms by which early relationships are connected to presenting symptoms," whereas gifts of love are the "motivation that sustains the copy processes" (Benjamin, 2003/2006, p. 33).
- Clinical symptoms and presenting problems are viewed as failed attempts to adapt to current circumstances using problematic rules/values learned with important caregivers.
- Maladaptive patterns resist change because they are ways of seeking proximity and attachment to internalized loved ones (i.e., the gift of love).
- Presenting problems[1]: Problems noted by patient or clinician that are related to the request for treatment. These get translated to symptoms characteristic of DSM disorders (p. 59)
- Symptoms: in this coding system, symptoms are not the same thing as emotions or complaints that people are bringing into session. They can be, but a symptom in GOL coding is only a symptom *if a clear link to a problem pattern is being talked about*. This link to a problem pattern gives the symptom meaning, and that's part of the GOL condition.
    - That is, it is not enough for someone to enact in session or identify "I am feeling mad", even if you know from the Case Formulation that mad is theorized as a symptom and can be connected to Red patterns.

---

[1] Benjamin, L. S. (2003/2006). *Interpersonal reconstructive therapy: Promoting change in nonresponders*. New York: Guilford Press.

- If someone says, "I feel mad at him because he puts me down like Dad used to," this is evidence of Condition 2 (CP (recapitulation) linked to an IPIR). It identifies an emotion but doesn't talk about the link.
- However, if later on the person links how their anger is connected to Dad ("I used to feel so mad because no matter what I did, I could never get it right with Dad"), then you can endorse Condition 1 (a symptom is being linked to a problem pattern).
- If somehow the conversation continued to steer into the wish/yearning behind 'trying to get it right' and the person noted "I wanted him to love me like he loved my siblings", then you've got Condition 3 (wish/yearning being expressed).

Gift of Love (GOL) Introduction

- Gifts of love are characterized as (problematic) behavior that can be seen as a "gift" to *Important Persons or their Internalized Representations* (IPIRs) in hopes of receiving love, acceptance, approval or protection in return, from the IPIRs, by doing so.
  - Maintained "by wishes for psychic proximity to IPIR's. By acting according to an IPIR's perceived rules and values, the patient attempts to receive the IPIR's approval…The purpose of the gift is to be loved at last." (Benjamin, 2003/2006, p. 49)

Necessary elements of a gift of love:

(1) Evidence of a problem pattern/symptom being talked about

a. Problem patterns can be thought of as ways the Patient has used to adapt to the rules/lessons of IPIRs and/or ways of expressing loyalty to IPIRs. These patterns are problematic because they are now failing to help them adapt to present life situations. These problem patterns can have an affective component—a common example is that self-critique often coincides with depression, and avoidance and anxiety tend to go hand in hand.

b. Problem patterns/symptoms can be affective, behavioral, or cognitive
   i. Affective—depression
   ii. Behavioral—inability to tolerate others being different
   iii. Cognitive—cognitive avoidance (not thinking about something)

c. However, the above examples may not be sufficient if they are stated at this face value. The essential element of a symptom/problem pattern is that it *functions and ties into the IPIR/GOL*!
   i. For example, someone's depression is just that…unless being depressed is an attempt to get love from an IPIR. If that isn't clear, it's not coded as a symptom. See below section with examples for more clarification.

(2) Problem pattern/symptom is expressly linked to an IPIR by copy process (CP)

a. To code this condition, you must have evidence that the Patient and/or Therapist sees and is making the connection between the problem pattern/symptom and the IPIR through a copy process. They don't have to name the copy process (e.g., introjection, identification, or recapitulation), but it needs to be clear that's what they're talking about (e.g., 'You treat yourself like Mom once treated you' is an example of introjection).

(3) CP is sustained by a wish/yearning for psychic proximity and attachment to said IPIR

a. This wish or yearning for love, acceptance, approval, etc. *must* be stated. It cannot be inferred through copy process (they married someone like Mom so they must want to be close to Mom) or enactments (they're acting like the CF says Dad did, so they must be seeking Dad's love).

b. Remember that the wish/yearning of the GOL begins as an unconscious process that is brought to conscious awareness over the course of the therapy.

c. There is not always relational 'distance' that the Patient is trying to close through the GOL. It can also be that the GOL cannot be threatened through therapy because it would mean disloyalty or losing the connection the Patient already perceives they have with their IPIR. This is usually brought up in conversations around change as someone is ambivalent and imagining what it would look like to give up the GOL.

GOL Coding Instructions:

1. Please read 5-minute intervals of time before beginning to code that section. Do not read the whole session then return to code at the beginning and do not code line by line.

2. After reading/listening to a 5 min interval, step back and ask yourself "What's happening here (general content)? Is there a GOL conversation occurring? (reference the 3 necessary elements above in making this decision)"
3. Code starting from the GOL code type, then fill in conditions and the remainder of the codes.
    - The conditions of the GOL coding are meant to 'check' your work and are not meant to be mechanisms for overthinking. Catching the GOL tends to be easier and more reliably accurate when you step back and think about the larger picture rather than specific details. This is likely because GOL is about connections and motivation, which is nearly impossible to find in one sentence. It emerges in a conversation.
    - Note: As conversations progress, similar codes may continue into subsequent time intervals if it is clear they still apply. So, re-evaluate at each new time interval to make sure that you are continuing forward codes that are still operating as a conversation progresses. For example, if a problem pattern is explained early on and then the conversation continues this way, they don't have to re-state it every 5 minutes for you to code this as present.

GOL absent (A): One or fewer of the necessary elements of GOL are present.

In other words, the motivation that sustains the CP is not evident.

GOL present, explicit (E): in the conversation, you see all necessary elements noted above. If there is also conversation about change, code 'E4'. Otherwise, code 'E1'.

GOL present, implicit (M): Two of the three necessary elements of GOL are present, but there is one missing.

Examples:

"I'm depressed because I never got my needs met and really just want to be loved."

Meets no conditions. While there is an emotion that could be a symptom mentioned (depression), it has no clear function in this narrative. If depression was a way to gain an IPIR's love or approval, that would be counted as a symptom. This, however,

is simply a Patient's expression of a feeling and gives no information about their GOL. 'I never got my needs met' hints at a potential history of neglect, but there's not enough information to determine the IPIRs being invoked or specifically how that statement is a copy process. Finally, 'just want to be loved' hints at no IPIR in particular and also doesn't shed insight into how the Patient's pattern and CP get them close to any particular IPIR.

"I'm depressed this week because I let my thyroid meds run out and that's always a side effect for me."

Meets no conditions. This is similar to the above scenario. If the CF provided context that this Patient's parents never took them to the doctor because they were too expensive and a symptom that's a target of therapy is the resultant self-neglect in the Patient, then you'd have more context to view this statement as an enactment of an old narrative. Then, the symptom/problem pattern is clearly self-neglect and you can code presence for Condition 1 (symptom).

"When I think of memories with mom, I wish she could have loved me after all."

Meets no conditions. While a wish for Mom to love this Patient is mentioned, it is simply a wish for love. There is no "I'm doing X, Y, Z in order to gain Mom's love." It's a simple longing for a parent's love that may be connected to a GOL, but it's not clear from this narrative. There is also no mention of a copy process that is connected to Mom or how the Patient seeks this love through problematic patterns.

"I don't let myself look at it because if I do then I'll get anxious and start criticizing myself like my dad used to."

Meets Conditions 1 & 2. The problem pattern here is cognitive avoidance—refusing to analyze one's self or the situation. There's a connection there to an emotional symptom (anxiety), too. Then, there's evidence of the copy process of introjection, learned from Dad. There is no wish or yearning being talked about, so Condition 3 is not met.

"(in talking about being exasperated with a spouse—ambivalent about leaving versus trying to fix the relationship) When I realized I married my father, I felt panic. My husband treats me just like my dad used to!"

Meets Conditions 1& 2. In this vignette, there is a clear copy process of recapitulation that she is recognizing in her husband recapitulating her prior history with her father. The dialogue speaks about how her husband teases and talks down to her, making her feel small. Yet, she notes her reaction is to try to fix the situation. She makes the connection to her past, making it clear that this propensity to try and fix a clearly abusive situation is her problem pattern/symptom. The only thing missing here is a wish for closeness/love from Dad.

If she had said something about how her attempts to fix these types of situations, even at the expense of herself, was in pursuit of her dad's attention, love, or approval, this would be sufficient to meet Condition 3.

"I remind myself of how my dad was with me when I critique myself."

> *Meets Condition 2. There is no apparent GOL here. What is clear is the Patient's awareness of a problematic pattern—that the Patient was taught critique by Dad. There's no symptom here, though, because a symptom would make clear how this "lesson" around critique functions. That is, how does this person try to pull that lesson into the future in problematic ways? Do they stop eating or self-harm in the hopes that it will get Dad's attention? So, how does this copy process of introjecting blame end up presenting in this person's life?*

(for a Patient with a history of lack of ability to tolerate mistakes in self and others, as we are talking about a flaw she sees in herself) "I have to get rid of it (the flaw)! Hide it, it's ugly! That's the only way I got Mom's attention—I could never mess up and so I got rid of any evidence of flaws so Mom would see me as perfect and love me."

Meets all conditions. From this CF, there is a history of control and blame from Mom. This narrative reveals the problem pattern that is a target of treatment—attempts to hide or destroy imperfections. Because her Mom would only pay her attention if there were no evident mistakes, this Patient learned how to control herself and blame herself in the midst of any flaws, thus showing the copy process and its associated IPIR as connected to the problem pattern. Finally, there is a clear link to how this problem pattern functions to earn Mom's love, and there is the yearning/wish for love that completes this as an explicit GOL code.

Patient's CF indicates a learning history of an exacting military father with high standards that the Patient could not consistently meet. Presenting concerns are crippling anxiety around tasks that cannot be completed to his standards, culminating in depression when he realizes he is 'failing'. His father is now dying, and the Patient is coming in deeply depressed and unable to function, talking about how their to-do list is so long and they can never keep up. They are now finding themselves sleeping more and more, positing that they may be avoiding life because it's so overwhelming. The Patient draws connections between his perfectionism and his dad taught it to him, and even goes so far as to make the connection between perfectionism and his current level of distress and self-blame in not meeting his own expectations (internalized from Dad). But, the thought of changing is impossible to him—he wouldn't be his father's son anymore.

Meets all conditions! There is a clear problem pattern of unrealistically high standards that create self-blame, with a link to learning history with Dad (introjection). Additionally, there is a clear demonstration from the narrative that change, even if it would help him psychologically, is unfathomable because it threatens the link he has to his father. There is a clear yearning for continued closeness to Dad here, and this is an explicit GOL example.

Copy process (CP) and Important People and their Internalized Representations (IPIRs)

1) Identification (ID)- "Be like them" - <u>Identification</u>

e.g., Pt had abusive parent and then becomes an abuser him/herself.

2) Recapitulation (RE)- "Act as if they are still there"

e.g., Pt had abusive parent and then finds oneself attracted to/chronically in abusive relationships/being victimized.

3) Introjection (IJ)- "Treat yourself like they treated you"

e.g., Pt had abusive parent and then treats self abusively, e.g., substance abuse, self-harm, suicidal behavior, etc.

Given the purpose of this coding system is on detecting explicit GOL statements, to provide additional detail ***we will only be coding CP(IPIR) for explicit GOL codes***.

So, if you code GOL as absent or as present but implicit, you do NOT code CP/IPIR.

Coding for CP(IPIR) Instructions:

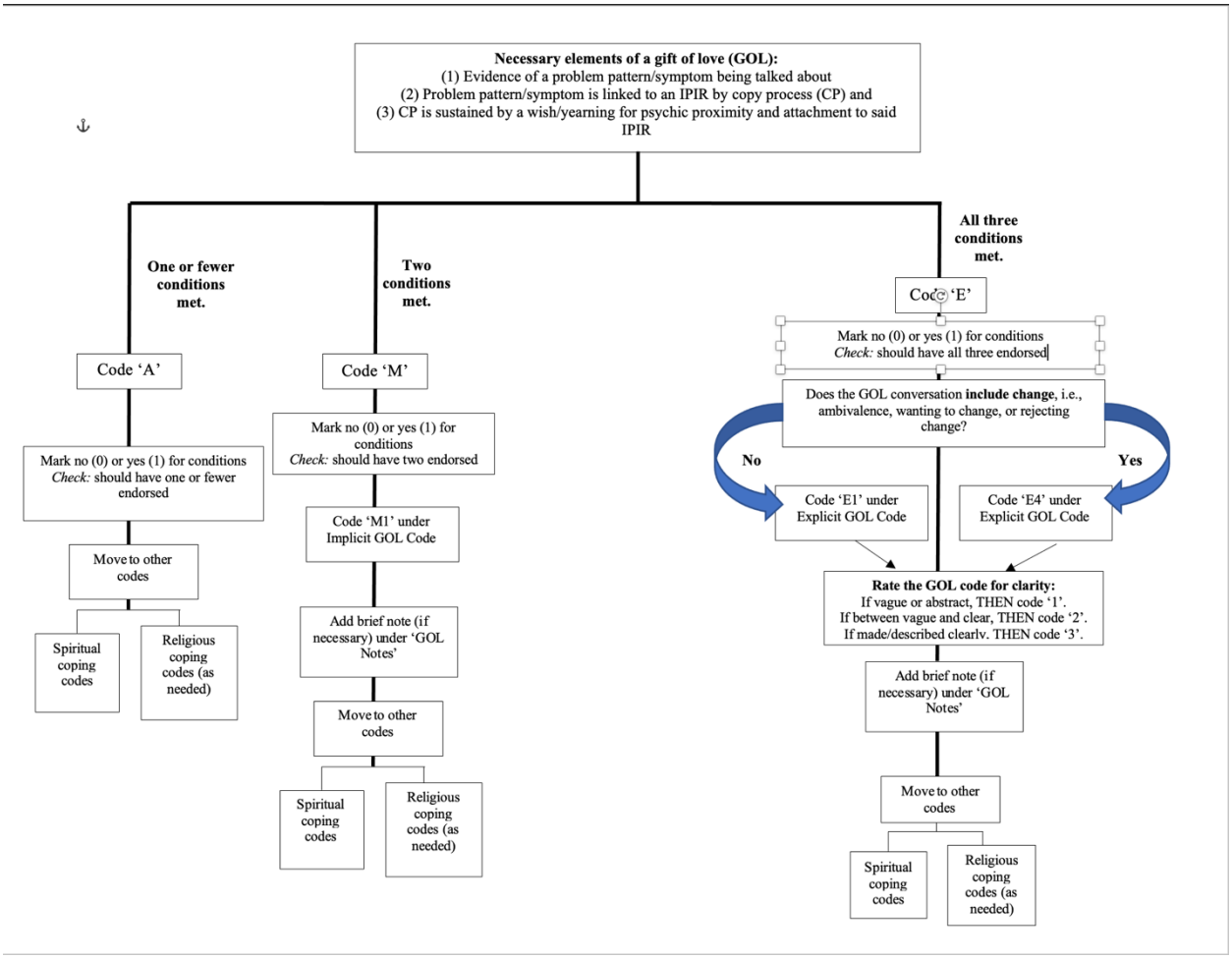
(1) Identify copy process(es) within each time interval where an explicit GOL code is present (i.e., the CP(IPIR) that links to that GOL being coded).
    a. Note: multiple CP(IPIR)'s can operate in a 5 min time interval. We are interested in the CP(IPIR)'s that are invoked related to the explicit GOL code only.
(2) Associate important person in relationship (IPIR) that is connected to each copy process.
    a. IPIRs change with each person depending on the case formulation—orientation to each case before GOL is provided.
(3) Syntax rule: Link CP to IPIR using parentheses and separate codes using a semicolon (not a plus, slash, or comma).
    e.g. ID(M); RE(D)

COPY PROCESSES & ASSOCIATED GIFTS OF LOVE

Copy process	**Gift of Love (GOL) message**
Identification (Same):	"I am like you. This means I love and forgive you. We are birds of a feather. See how I provide testimony to you. Please love me for it."

Identification (Opp):	"I am the exact opposite of you. I devote my life to being everything you are not, and I want you to know it. Admit you were wrong, and make it up to me. Love me after all.
Recapitulation (Same):	"Your rules and views are my rules and views. I will hold faithfully to them now and forever. When you se how powerfully you have affected me, you will love me more.
Recapitulation (Opp):	"I will do the opposite of what you want from me until you admit I am right and you are wrong. I want you to accept me on my own terms. Please love me 'as is.'"
Introjection (Same):	"I treat myself as you treated me. I agree with you about me. Love me for agreeing with you."
Introjection (Opp):	Not observed except in triangles -- for example, "Dad hated me; Mom adored me; I hate me = opposite of Mom." But the pattern also represents agreement with Dad."

GOL Codes:



(1) GOL Presence/Absence: 'A' for GOL is absent, 'E' for explicit GOL, 'M' for implicit GOL

(2) Explicit GOL codes

- All three necessary conditions must be met to code as explicit GOL (in conversation)
  - Evidence of a problem pattern/symptom being talked about
  - Problem pattern/symptom is linked to an Important People and their Internalized Representations (IPIR) through a copy process
  - Copy process is sustained by a spoken about wish/yearning/loyalty for psychic proximity and attachment to IPIR
- **(E1): explicit manifestations of gift of love, without conversation about change (awareness only)**
  - Emotional: Characterized by Patient or Therapist talking about *love/loyalty* for IPIRs/family in ways that link to *problematic ways of being*

        - Verbs you may hear to describe this *love/loyalty*: seeking, wishing, or yearning for: love, acceptance, protection, approval, respect, rapproachment, etc.
        - E.g., I drink (**symptom**) like Dad used to (**linked to deceased IPIR through CP**) so I can bond with him and feel close to him again (**wish for closeness/attachment)**
    - Behavioral: Characterized by the Patient or Therapist talking about actual actions of loved ones that are hoped for and/or happening in ways that intensify Red behavior.
        - E.g., Mom's (**IPIR)** harsh critique of Pt in present illicits wishes to/plans to commit suicide (**symptom/problematic pattern is self-harm in the face of critique**) and 'comply' (**wish/loyalty)**
    - Cognitive: Characterized by Patient or Therapist talking about how thoughts of IPIR or internalized dialogues of loved one intensify Red.
        - E.g., memories of deceased parents increase desire to hasten end of Pt's life to be reunited with them
        - E.g., IPIR is talking to Pt in their mind, and these thoughts intensify symptom.
- **(E4): Gift of love conversation is explicit (as in E1), but there is ALSO conversation about change (awareness plus choice).**
    - In the conversation, it is clear that there is awareness of the GOL from both sides (i.e., staying loyal to IPIR and letting go of this GOL). Change conversation can entail conversation about ambivalence, actively letting go of GOL, or seeing the change that is possible but rejecting it and wanting to remain loyal.
        - E.g. of letting go: contemplating what life would be like if Red was consistently blocked; this could manifest in ultimate goals, ways of growing past this time of life, letting go of the part of self that is hanging onto old ways, etc.
        - E.g. of ambivalence: wanting to change and feel better but also not wanting to separate from comfort of being close to IPIR
        - E.g. of rejecting: wants to maintain Red patterns because can't tolerate the distress of distancing from Red; wants out of pain/discomfort and succumbs to old patterns that provide temporary relief; can't tolerate the anticipated reaction of IPIRs were Pt to let go (they'd be disappointed or angry, wouldn't recognize me, etc.)
- **If there is explicit GOL, code CP (IPIR) under corresponding column. Otherwise, leave blank.**

(3) Implicit GOL code ('Other' pile): Some elements of GOL are present but not part of the conversation

- Code 'M1'

- Could be characterized by Patient or Therapist describing Red-GOL behaviors and/or family responses to those behaviors (as noted in E1-E4 above), but without explicitly naming these patterns as gifts of love.
- Could be characterized by enactment of GOL behaviors in session, without explicit conversation
- E.g., Pt describes feeling overwhelmed by anxiety and wanting to commit suicide, which is a CP linked to an IPIR but there's no explicit connection to the wish/fear.

(4) For explicit GOL codes, dimensional ratings for clarity of GOL are needed.

- Code '1' if: GOL patterns are left vague or abstract
  - E.g., talking about patterns but not identifying them as motivating continued/intensified Red behaviors
- Code '2' if: GOL patterns are between vague and clear
  - E.g., not clear association to IPIR, but copy process and motivations of love/loyalty present
  - Limited insight into the details of GOL as it occurs in the conversation
- Code '3' if: GOL patterns are made or described clearly
  - i.e., links to IPIRs, clear understanding of meaning behind engaging in patterns, perhaps even conversation about what to do about this linkage that is causing problems (conversations about letting go and grieving)

(5) For explicit and implicit GOL codes, add any additional relevant notes not covered by the codes that provides additional context under the 'GOL Notes' section of the coding worksheet.

NOTE: Avoid multiple GOL codes. Choose the most parsimonious option.

Spiritual Coping Introduction

We are using Charzynska (2015)'s existing definitions for domains of spiritual coping. This can be especially useful in places where explicit religious language isn't being used. These spiritual codes are meant to capture any examples of spiritual coping that are spoken about in session, but we will code in such a way to distinguish coping that is related to the GOL or not. Codes are possible for coping provided by Patient and/or Therapist. Designations for different contexts and speakers need to be provided for clarity.

Charzynska (2015) defines positive spiritual coping as taking cognitive and behavioral efforts aimed at solving a difficult situation. It can also be defined as "attempts to overcome the stressor on the basis of what is transcendent." (Ibid., 1631). In contrast, "negative spiritual coping makes it impossible for an individual to draw strength from spiritual resources, blocks the pursuit of sense and meaning in life, hinders its growth, ''upward movement'' and going beyond what is material" (Charzynska, 2015, p. 1632).

Important Note: **Please keep in mind that these codes should capture intentional ways to cope, as in try to solve a problem or adapt to a stressor. Do not code any personal, social, environmental, or religious action as coping—only code if it's germane to the problem being discussed in session.**

Spiritual coping coding instructions:

Note: Please see table below for more details on specifics of each domain.

NOTE: Charzynska and Pargament agree that positive and negative spiritual coping can occur simultaneously and independently of one another. So, if there are multiple dimensions that you see, you can code each separately within the same time interval.

General coding semantics:

a. Presence/Absence
    i. Code ‘0’ for negative
    ii. Code ‘1’ for positive
    iii. Code ‘n/a’ for none present
b. GOL/Other-These further filters spiritual coping into a) ones that are spoken about in reference to the Patient’s IPIRs/Gift of Love (see gift of love section for further details) and b) other generic spiritual coping that is invoked over the course of a therapy session.
    i. Code ‘GOL’ for spiritual coping code that is related to the IPIR/GOL
    ii. Code ‘Other’ for spiritual coping code that is not related to the IPIR/GOL

For each time chunk:

(1) Decide if Patient and Therapist brought up spiritual coping within each domain (personal, social, environmental, and religious) and endorse presence/absence codes.
(2) For spiritual coping that is present, please also code in parentheses whether the coping is related to the GOL or not and if what is being coded is the individual’s thought or if they are responding to the other person.
    i. For example, a Pt is talking about the GOL and gives an example of positive religious coping, under the ‘religious domain, patient tab’, code ‘1 (Pt)’.
    ii. If Patient is talking about their own coping with regard to the problem being discussed, simply code presence/absence and type.
    iii. If Therapist is responding to Patient who is speaking about their own coping, place an ‘R’ next to the Therapist’s code to indicate that they are responding to the Patient’s content (e.g., Patient is demonstrating negative coping and Therapist paraphrases, Th’s code would be ‘0-R and type (GOL or Other)’.
    iv. If, however, the Therapist is making their own suggestion (i.e., not simply paraphrasing what Pt is saying), simply code the presence/absence (0 or 1) and type (GOL or Other).
    v. If the Therapist is making their own suggestion for a coping strategy for Patient (e.g., Patient isn’t mentioning coping or is coping negatively and

Therapist is offering a suggestion), code the presence/absence (0 or 1) and type (GOL or Other).

vi. However, if Patient then responds in affirmation to Therapist about the suggestion the Therapist just made about coping (e.g., they agree, are wanting to talk more about Therapist's suggestion to understand, etc.), place an 'R' next to the Patient's code to indicate that they are responding to the Therapist's content (e.g., 1-R plus type (GOL or Other)).

vii. However, if Patient responds to Therapist's suggestion with anything other than the Therapist just made about coping (e.g., they disagree with suggestion, re-state their own code, etc.), simply code the presence/absence (0 or 1) and type (GOL or Other).

(3) Add notes in 'Spiritual Coping Notes' section to add context or provide additional clarity as needed.

i. If you code 'Other', please include a note about coping not included in Charzynska definitions about the nature of the coping plus the transcript line

ii. E.g., coping with way her husband is treating her by being assertive (line 29)

A few examples:

- E.g., Mom's (**IPIR)** harsh critique of Pt in present elicits wishes to/plans to commit suicide (**symptom/problematic pattern is self-harm in the face of critique**) and 'comply' (**wish/loyalty)**
  - In this example, the symptom is clearly related to the GOL, so it would be coded under the 'personal spiritual coping' as '0 (GOL)' under the 'Pt' tab
  - If the therapist's reply to this conversation was around making a suggestion or inviting conversation about perhaps trying to block Mom's critique and try to provide care and protection to herself. This would also be coded under the 'personal spiritual coping', it would be '1' under the 'Th' tab
  - So, the total code for this example would be: Pt tab: 0 (GOL) and under Th tab: 1-R (GOL)

Charzynska (2015) spiritual coping domains:

Domain	Description
Personal domain	**Positive:** pursuit of a goal, sense and meaning, concentration on one's internal life, attempts to overcome one's weaknesses and acquiring more and more self-knowledge, looking for internal peace and harmony
	Negative: negating the goal and meaning of one's life, emphasizing one's weaknesses and limitations, concentration on one's transgressions
Social domain	**Positive:** establishing and maintaining deep and valuable relations with other people, heeding moral values, treating people fair, caring about others, willingness to help, displaying love, empathy and compassion
	Negative: perceiving people as inherently egoistic and caring only about their interests, which results in aversion, hostility or envy toward others, blocking the possibility to establish and maintain deep, valuable interpersonal relations
Environmental domain	**Positive:** concentration on the sense of attachment and belonging to nature, perceiving harmony and order in it, treating nature as friendly to humans, openness to noticing miracles in nature
	Negative: treating nature as hostile to humans and posing threat, emphasizing human helplessness and insignificance in the face of the laws of nature
Religious domain	**Positive:** maintaining solid relation with God/the Supreme Power, based on the sense of presence, love and trust
	Negative: internal religious fight displayed in holding a grudge toward God/the Supreme Power, blaming Him/It for one's own failures, negating His/Its love and care for humans.

Religious Coping Codes

Brief introduction

Pargament, Koenig, & Perez (2000)'s RCOPE measure drew out below codes after a factor analysis. This measure has good reliability and validity!

Pargament, Koenig, & Perez (2000) religious coding instructions:

Note: Please see table below for more details on specifics of each domain. Please familiarize yourself with these codes and their generic designations into positive or negative religious coping before beginning to code.

Use these codes only *when God or religion is brought up*. Always code Charzynskya codes, but only code Pargament et al. when God/religion is brought up. Re-evaluate within each 5 min time interval.

(1) For each religious coping subscale, look at the definitions below and then assign the proper numeric code:
   a) Code '0' for absent
   b) Code '1' for present

NOTE: Charzynska and Pargament et al. agree that positive and negative spiritual coping can occur simultaneously and independently of one another. So, if there are multiple dimensions that you see, you can code each separately within the same time interval.

(2) Code for each person stating the religious coping, in parentheses next to your code under the domain
   a) Code under the 'Pt' tab for patient is talking about how they are coping
   b) Code under the 'Th' tab for therapist is introducing a religious coping mechanism or responding to Pt

   Note: As stated in the spiritual codes, please place '-R' next to any code (from Pt or Th) that is responding to the other without offering a different point of view.

(3) Code whether the coping is related to the GOL or not (GOL) or (Other)
   a) Code '(GOL)' for religious coping code that is related to the IPIR/GOL
   b) Code '(Other)' for religious coping code that is not related to the IPIR/GOL
      i. E.g., 1 (Other)

(4) Add notes in 'Religious Coping Notes' section to add context or provide additional clarity as needed (feel free to say the line of transcript)

Pargament, Koenig, & Perez (2005)'s religious codes:

Function	Code	Name	Pos/Neg
Find Meaning	**BENRE**	*Benevolent Religious Reappraisal*	+
	PUNRE	*Punishing God Reappraisal*	-
	DEMRE	*Demonic Reappraisal*	-
	POWRE	*Reappraisal of God's Powers*	-
Gain Control	**COLCOPE**	*Collaborative Religious Coping*	+
	ACTSURR	*Active Religious Surrender*	+
	PASDEF	*Passive Religious Deferral*	-
	DIRINT	*Pleading for Direct Intercession*	-
	SELFDCOPE	*Self-Directing Religious Coping*	-
Gain Comfort and Closeness to God	**SPIRSUPP**	*Seeking Spiritual Support*	+
	RELFOC	*Religious Focus*	+
	RELPUR	*Religious Purification*	+
	SPCONN	*Spiritual Connection*	+
	SPDISC	*Spiritual Discontent*	-
	RELBOUND	*Marking Religious Boundaries*	+
Gain Intimacy with Others and Closeness to God	**CHURSUP**	*Seeking Support from Clergy or Members*	+
	RELHELP	*Religious Helping*	+
	INTRDISC	*Interpersonal Religious Discontent*	-
Achieve a Life Transformation	**RELDIR**	*Seeking Religious Direction*	+
	RELCONV	*Religious Conversion*	+
	RELFORG	*Religious Forgiving*	+

Descriptions of Pargament, Koenig, & Perez (2000)'s Religious/Spiritual Coding Terms:

- **Benevolent Religious Reappraisal (BENRE, +):** redefining the stressor through religion as benevolent and potentially beneficial
    - Saw my situation as part of God's plan
    - Tried to find a lesson from God in the event.
    - Tried to see how God might be trying to strengthen me in this situation.
    - Thought that the event might bring me closer to God.
    - Tried to see how the situation could be beneficial spiritually.
- **Punishing God Reappraisal (PUNRE, -):** redefining the stressor as a punishment from God for the individual's sins
    - Wondered what I did for God to punish me.
    - Decided that God was punishing me for my sins.
    - Felt punished by God for my lack of devotion.
    - Wondered if God allowed this event to happen to me because of my sins.
    - Wondered whether God was punishing me because of my lack of faith.
- **Demonic Reappraisal (DEMRE, -):** redefining the stressor as an act of the Devil.
    - Believed the devil was responsible for my situation.
    - Felt the situation was the work of the devil.
    - Felt the devil was trying to turn me away from God.
    - Decided the devil made this happen.
    - Wondered if the devil had anything to do with this situation.
- **Reappraisal of God's Powers (POWRE, -)**: redefining God's power to influence the stressful situation
    - Questioned the power of God.
    - Thought that some things are beyond God's control.
    - Realized that God cannot answer all of my prayers.
    - Realized that there were some things that even God could not change.
    - Felt that even God has limits.
- **Collaborative Religious Coping (COLCOPE, +)**: seeking control through a partnership with God in problem solving
    - Tried to put my plans into action together with God.
    - Worked together with God as partners.
    - Tried to make sense of the situation with God.
    - Felt that God was working right along with me.
    - Worked together with God to relieve my worries.
- **Active Religious Surrender (ACTSURR, +):** an active giving up of control to God in coping
    - Did my best and then turned the situation over to God.
    - Did what I could and put the rest in God's hands.
    - Took control over what I could and gave the rest up to God.
    - Tried to do the best I could and let God do the rest.
    - Turned the situation over to God after doing all that I could.
- **Passive Religious Deferral (PASDEF, -):** passive waiting for God to control the situation

    - Didn't do much, just expected God to solve my problems for me.
    - Didn't try much of anything; simply expected God to take control.
    - Didn't' try to cope: only expected God to take my worries away.
    - Knew that I couldn't handle the situation, so I just expected God to take control.
    - Didn't try to do much; just assumed God would handle it.
- **Pleading for Direct Intercession (DIRINT, -)**: seeking control indirectly by pleading to God for a miracle or divine intercession
    - Pleaded with God to make things turn out okay.
    - Prayed for a miracle.
    - Bargained with God to make things better.
    - Made a deal with God so that he would make things better.
    - Pleaded with God to make everything work out.
- **Self-Directing Religious Coping (SELFDCOPE, -):** seeking control directly through individual initiative rather than help from God
    - Tried to deal with my feelings without God's help.
    - Tried to make sense of the situation without relying on God.
    - Made decisions about what to do without God's help.
    - Depended on my own strength without support from God.
    - Tried to deal with the situation on my own without God's help.
- **Seeking Spiritual Support (SPIRSUPP, +):** searching for comfort and reassurance through God's love and care
    - Sought God's love and care.
    - Trusted that God would be by my side.
    - Looked to God for strength, support, and guidance.
    - Trusted that God was with me.
    - Sought comfort from God.
- **Religious Focus (RELFOC, +):** engaging in religious activities to shift focus from the stressor
    - Prayed to get my mind off of my problems.
    - Thought about spiritual matters to stop thinking about my problems.
    - Focused on religion to stop worrying about my problems.
    - Went to church to stop thinking about this situation.
    - Tried to get my mind off my problems by focusing on God.
- **Religious Purification (RELPUR, +):** searching for spiritual cleansing through religious actions
    - Confessed my sins.
    - Asked forgiveness for my sins.
    - Tried to be less sinful.
    - Searched for forgiveness from God.
    - Asked for God to help me be less sinful.
- **Spiritual Connection (SPCONN, +):** experiencing a sense of connectedness with forces that transcend the individual
    - Looked for a stronger connection with God.

  - Sought a stronger spiritual connection with other people.
  - Thought about how my life is part of a larger spiritual force.
  - Tried to build a strong relationship with a higher power.
  - Tried to experience a stronger feeling of spirituality.
- **Spiritual Discontent (SPDISC, -):** expressing confusion and dissatisfaction with God's relationship to the individual in the stressful situation
  - Wondered whether God had abandoned me.
  - Voiced anger that God didn't answer my prayers.
  - Questioned God's love for me.
  - Wondered if God really cares.
  - Felt angry that God was not there for me.
- **Marking Religious Boundaries (RELBOUND, +):** clearly demarcating acceptable from unacceptable religious behavior and remaining within religious boundaries
  - Avoided people who weren't of my faith.
  - Stuck to the teachings and practices of my religion.
  - Ignored advice that was inconsistent with my faith.
  - Tried to stick with others of my own faith.
  - Stayed away from false religious teachings.
- **Seeking Support from Clergy or Members (CHURSUP, +):** searching for comfort and reassurance through the love and care of congregation members and clergy
  - Looked for spiritual support from clergy.
  - Asked others to pray for me.
  - Looked for love and concern from the members of my church.
  - Sought support from members of my congregation.
    Asked clergy to remember me in their prayers.
- **Religious Helping (RELHELP, +):** attempting to provide spiritual support and comfort to others
  - Prayed for the well-being of others.
  - Offered spiritual support to family or friends.
  - Tried to give spiritual strength to others.
  - Tried to comfort others through prayer.
  - Tried to provide others with spiritual comfort.
- **Interpersonal Religious Discontent (INTRDISC, -):** expressing confusion and dissatisfaction with the relationship of clergy or members to the individual in the stressful situation
  - Disagreed with what the church wanted me to do or believe.
    Felt dissatisfaction with the clergy.
  - Wondered whether my church had abandoned me.
  - Felt my church seemed to be rejecting or ignoring me.
  - Wondered whether my clergy was really there for me.
- **Seeking Religious Direction (RELDIR, +):** looking to religion for assistance in finding a new direction for living when the old one may no longer be viable

    - Asked God to help me find a new purpose in life.
    - Prayed to find a new reason to live.
    - Prayed to discover my purpose in living.
    - Sought new purpose in life from God.
    - Looked to God for a new direction in life.
- **Religious Conversion (RELCONV, +):** looking to religion for a radical change in life
    - Tried to find a completely new life through religion.
    - Looked for a total spiritual reawakening.
    - Prayed for a complete transformation of my life.
    - Tried to change my whole way of life and follow a new path—God's path.
    - Hoped for a spiritual rebirth.
- **Religious Forgiving (RELFORG, +):** looking to religion for help in shifting from anger, hurt, and fear associated with an offense to peace
    - Sought help from God in letting go of my anger.
    - Asked God to help me overcome my bitterness.
    - Sought God's help in trying to forgive others.
    - Asked God to help me be more forgiving.
    - Sought spiritual help to give up my resentments.

Appendix 1

Anchors for the GOL: Awareness & Choice scale (Critchfield, Davis, & Benjamin, 2008):

For our GOL, we are coding two high adherence and one low adherence with the coding system developed from a mixed adherence case.

High Adherence: >6

Low Adherence: <3

0.0 0.5 **1.0** 1.5 **2.0** 2.5 **3.0** 3.5 **4.0** 4.5 **5.0**

|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

< Unaware>< Pre-Con >< Con >< Action >< Maint >

0.0: Unaware of possibility of change via the gift of love, or denies validity of previous learning and will not engage on any topic related to copy processes or changes that might imply some connection to the gift of love.

0.5: Limited awareness of copy processes and possibility of gift of love but not fully engaged in process of further exploration of this or related themes.

1.0: Precontemplation: Focus is primarily on making links to learn about patterns and where they come from. Patient has begun to be aware of gift of love issues in minor ways including initial recognition and acknowledgment of the need to give up the wishes in relation to the IPIRs.

1.5: Advanced precontemplation: Shows more experience with seeing and understanding gift of love issues, is relatively more experienced in exploring links to the past, seeing copy process links, identifying the gift of love, but still only minimally engaged in exploration of what giving up wishes may entail.

2.0. Contemplation: Begins to mobilize some intrinsic motivation to give up wishes related to gift of love through, for example, realizing how much the fantasy has cost, changing the view of the IPIR, engaging anger in the service of differentiation, reconsidering perceived family wishes/values, allowing compassion for and tolerance of self. Awareness is increasingly in evidence about the choice to give up wishes, but is also accompanied by ambivalence about the choice.

2.5: Advanced contemplation: As above, but with increasing awareness and less ambivalence about the choice. Patient is moving towards giving up the wishes but does not yet meet description of the Action phase.

3.0: Action: Patient begins to actually give up the wishes as evidenced by, for example, grieving for the losses, letting go, forgiveness, internalizing new figures (if Green), compassion for IPIRs, constructing new goals and ways that feel right, accepting or rejecting responsibility appropriately, dealing with fear of feelings, enduring the pain of giving up the fantasy, changing Klute syndrome (i.e., sexual fantasy that parallels Red case formulation pattern), being willing to be starkly honest with oneself regarding gift of love and copy process patterns. Some ambivalence may still be in evidence in the early part of the action phase, for example, through reversal of commitments, or discrepancies between verbal decisions to change and follow-through on behavioral implementation.

3.5: Advanced action: Patient shows more than initial commitment in choice to give up gift of love and implement Green behaviors, sustained efforts or successful letting go.

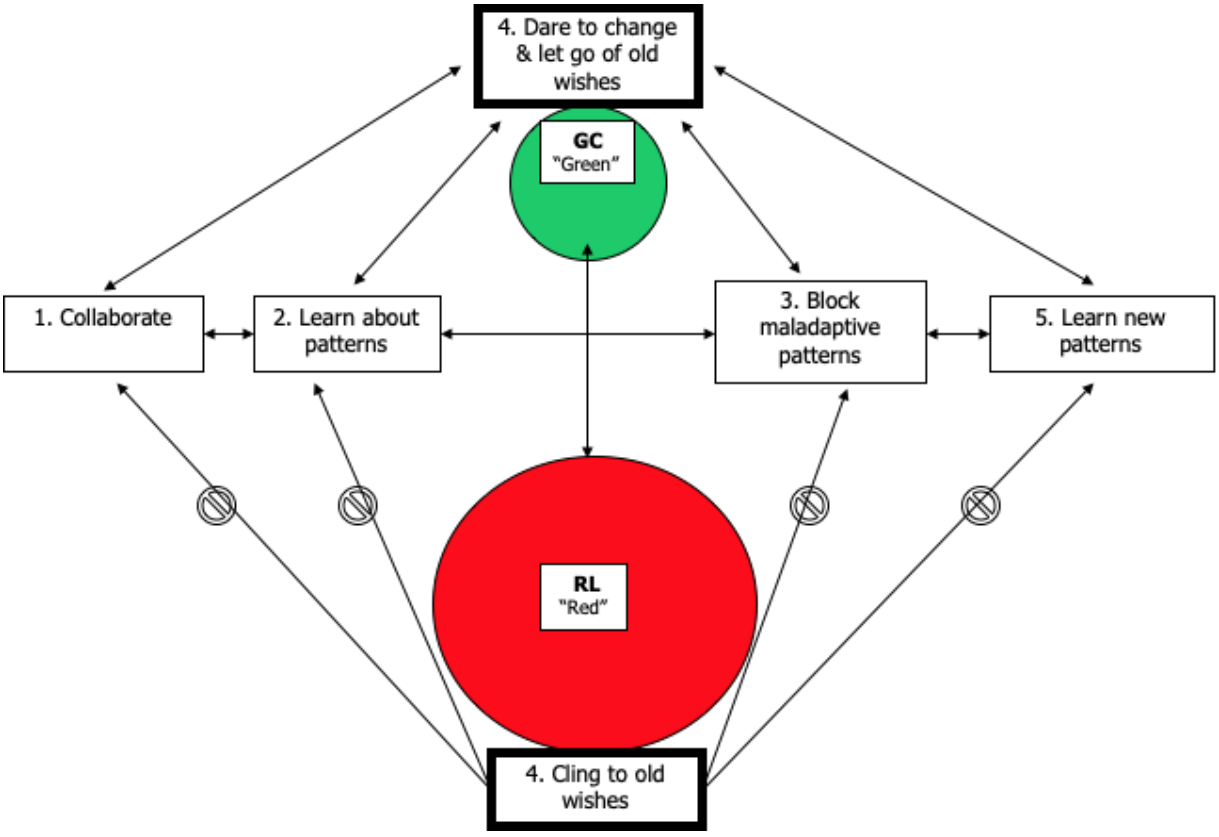
4.0: Maintenance: Patient has made significant changes and clear progress with gift of love issues, and now works to resist the wish to go back. May include, for example, dealing with panic over 'what now'?, confronting the wish to return to being stuck, working at forms of Green self-discipline (i.e., saying 'no' on a continuing basis to the wishes and the case formulation patterns that reflect them) and making the right choices (i.e., Green; consistent with IRT treatment goal and interpersonal baseline of flexible, friendly differentiation), considering rewards and losses in recovery, tolerating variability in progress. Reversals may occur under stress or provocation from IPIRs, but without a shift in basic commitment to work toward Green patterns.

4.5: Advanced maintenance: Patient is more advanced in recognizing and resisting wishes to go back, can recognize and implement plans to resist wish to go back to old ways, but now with relative ease and fluency, even under considerable stress and/or provocation by IPIRs.

5.0: Successful sustained maintenance without significant impact of former wishes, patient recognizes, understands, and chooses relative to feelings about former wishes, may construe them in adaptive enriching ways characteristic of Green patterns.

Appendix 2

Steps of IRT (Figure 1.1 in Benjamin, 2003/2006)



References

Afifi, T. O., Mather, A., Boman, J., Fleisher, W., Enns, M. W., MacMillan, H., & Sareen, J. (2010). Childhood adversity and personality disorders: Results from a nationally representative population-based study. *Journal of Psychiatric Research 45(*6), 814-822. Doi: 10.1016/j.jpsychires.2010.11.008

Allen, J. G. (2011). Mentalizing suicidal states. In K. Michel & D. A. Jobes (Eds.), *Building a therapeutic alliance with the suicidal patient.* (pp. 81–91). American Psychological Association. https://doi.org/10.1037/12303-005

Attig, T. (2007). Relearning the world: Making and finding meanings. In Neimeyer, R. A. (Ed.). (2007). *Meaning reconstruction & the experience of loss*. Washington, DC: American Psychological Association.

Battle, C. L., Shea, M. T., Johnson, D.M., Yen, S., Zlotnick, C., Zanarini, M. C., Sanislow, C. A., Skodol, A. E., Gunderson, J. G., Grilo, C. M., McGlashan, T. H., & Morey, L. C. (2004). Childhood maltreatment associated with adult personality disorders: Findings from the collaborative longitudinal personality disorders study. *Journal of Personality Disorders, 18*(2), 193-211. Doi: 10.1521/pedi.18.2.193.32777.

Baxter, M. A., Hemming, E. J., McIntosh, H. C., & Hellman, C. M. (2017). Exploring the Relationship Between Adverse Childhood Experiences and Hope. *Journal of Child Sexual Abuse*, *26*(8), 948–956. https://doi.org/10.1080/10538712.2017.1365319

Benjamin, L. S. (2018). *Interpersonal reconstructive therapy for anxiety and depression: It's about broken hearts, not broken brains.* Washington, D.C.: American Psychological Association. doi: 10.1037/0000090-000

Benjamin, L. S. (2006). *Interpersonal reconstructive therapy: Promoting change in nonresponders*. New York, NY: Guilford. (Original work published 2003)

Biggs, A., Brough, P., & Drummond, S. (2017). Lazarus and Folkman's Psychological Stress and Coping Theory. In C. L. Cooper & J. C. Quick (Eds.), *The Handbook of Stress and Health* (pp. 349–364). John Wiley & Sons, Ltd. https://doi.org/10.1002/9781118993811.ch21

Bowlby, J. (1980). *Attachment and loss*; Vol. 3, Loss: Sadness and depression. London: Hogarth.

Brewin, C. R., Andrews, B., & Gotlib, I. H. (1993). Psychopathology and early experience: A reappraisal of retrospective reports. *Psychological Bulletin 113*(1), 82-98. doi: 10.1037/0033-2909.113.1.82

Canada, A. L., Murphy, P. E., Fitchett, G., & Stein, K. (2016). Re-examining the Contributions of Faith, Meaning, and Peace to Quality of Life: a Report from the American Cancer Society's Studies of Cancer Survivors-II (SCS-II). *Annals of behavioral medicine: a publication of the Society of Behavioral Medicine, 50*(1), 79–86. https://doi.org/10.1007/s12160-015-9735-y

Carr, J. L., & VanDeusen, K. M. (2002). The relationship between family of origin violence and dating violence in college men. *Journal of Interpersonal Violence, 17*(6), 630-646. doi: 10.1177/088626050201700603

Critchfield, K. L. (2010). Lorna Smith Benjamin: Love, loyalty, and learning in close attachment relationships. In L. G. Castonguay, J. C. Muran, L. Angus, J. A. Hayes, N. Ladany, & T. Anderson (Eds.), *Bringing psychotherapy research to life: Understanding change through the work of leading clinical researchers.* (pp. 221–231). American Psychological Association. https://doi.org/10.1037/12137-019

Critchfield, K. L., & Benjamin, L. S. (2010). Assessment of Repeated Relational Patterns for Individual Cases Using the SASB-Based Intrex Questionnaire. *Journal of Personality Assessment*, *92*(6), 480–489. https://doi.org/10.1080/00223891.2010.513286

Critchfield, K. L., Benjamin, L. S., & Levenick, K. (2015). Reliability, sensitivity, and specificity of case formulations for comorbid profiles in interpersonal reconstructive therapy: Addressing mechanisms of psychopathology. *Journal of Personality Disorders*, *29*(4), 547–573. https://doi.org/10.1521/pedi.2015.29.4.547

Critchfield, K. L., Davis, M. D., & Benjamin, L. S. (2008). Manual for assessing adherence in IRT. Unpublished manuscript. University of Utah.

Critchfield, K. L., Dobner-Pereira, J., Panizo, M., & Benjamin, L. S. (2019, August). The Gift of Love as a key mechanism of change in Interpersonal Reconstructive Therapy. Paper presented as part of a panel titled “Effective Psychotherapy Using Principles from Attachment Theory and Developmental Psychopathology” (Lorna Smith Benjamin, chair) to the American Psychological Association, Chicago, IL.

Critchfield, K. L., Mackaronis, J. E., & Benjamin, L. S. (2017). Characterizing the integration of CBT and psychodynamic techniques in interpersonal reconstructive therapy for patients with severe and comorbid personality pathology. *Journal of Psychotherapy Integration*, *27*(4), 460–475. https://doi.org/10.1037/int0000092

Critchfield, K. L., Panizo, M. T., & Benjamin, L. S. (2019). Formulating Key Psychosocial Mechanisms of Psychopathology and Change in Interpersonal Reconstructive Therapy. In *Case Formulation for Personality Disorders* (pp. 181–201). Elsevier. https://doi.org/10.1016/B978-0-12-813521-1.00010-2

Critchfield, K.L., Stucker, E., Benjamin, L.S. (2019, June). Case formulation in Interpersonal Reconstructive Therapy for CORDS patients: Theory and evidence to date. Paper presented as part of a panel titled "Case formulation in the Age of Evidence-Based Practice" (Ulrich Kramer, moderator) to the Society for Exploration of Psychotherapy Integration, Lisbon, Portugal.

D'Abate, L., Delvecchio, G., Ciappolino, V., Ferro, A., & Brambilla, P. (2020). Borderline personality disorder, metacognition and psychotherapy. *Journal of Affective Disorders*, *276*, 1095–1101. https://doi.org/10.1016/j.jad.2020.07.117

Delespaux, E., Ryckebosch-Dayez, A.-S., Heeren, A., & Zech, E. (2013). Attachment and severity of grief: The mediating role of negative appraisal and inflexible coping. Omega: Journal of Death and Dying, 67(3), 269–289.

Desai, S., Arias, I., Thompson, M. P., & Basile, K. C. (2002). Childhood victimization and subsequent adult revictimization assessed in a nationally representative sample of women and men. *Violence and Victims*, *17*(6), 639-653. https://doi.org/10.1891/vivi.17.6.639.33725

Dimaggio, G., Salvatore, G., Popolo, R., & Lysaker, P. H. (2012). Autobiographical memory and mentalizing impairment in personality disorders and schizophrenia: Clinical and research implications. *Frontiers in Psychology*, *3*. https://doi.org/10.3389/fpsyg.2012.00529

Doehring, C. (2019). Using spiritual care to alleviate religious, spiritual, and moral struggles arising from acute health crises. *Ethics, Medicine, and Public Health, 9,* 68-74. https://doi.org/10.1016/j.jemp.2019.05.003.

Doehring, C., Clarke, A., Pargament, K. I., Hayes, A., Hammer, D., Nickolas, M., & Hughes, P. (2009). Perceiving sacredness in life: Correlates and predictors. *Archive for the Psychology of Religion*, *31*, 55-73. https://doi.org/10.1163/157361209X371492

Folkman, S. (1997). Positive psychological states and coping with severe stress. Social Science & Medicine, 45(8), 1207–1221.

Folkman, S. (2008). The case for positive emotions in the stress process. *Anxiety, Stress, & Coping*, *21*(1), 3–14. https://doi.org/10.1080/10615800701740457

Folkman, S., & Lazarus, R. L. (1984). *Stress and coping.* New York: Springer.

Frankl, V. (1946). *Man's search for meaning*. Boston, MA: Beacon Press.

Gall, T. L., Charbonneau, C., Clarke, N. H., Grant, K., Joseph, A., & Shouldice, L. (2005). Understanding the Nature and Role of Spirituality in Relation to Coping and Health: A Conceptual Framework. *Canadian Psychology/Psychologie Canadienne*, *46*(2), 88–104. https://doi.org/10.1037/h0087008

Hagman, G. (2007). Beyond decathexis: Toward a new psychoanalytic understanding and treatment of mourning. In Neimeyer, R. A. (Ed.). (2007). *Meaning reconstruction & the experience of loss*. Washington, DC: American Psychological Association.

Harlow, H. F., Dodsworth, R. O., & Harlow, M. K. (1965). Total social isolation in monkeys. *Proceedings of the National Academy of Sciences of the United States of America.*

Hathaway, W. L, Scott, S. Y., & Garver, S. A. (2004). Assessing religious/spiritual functioning: A neglected domain in clinical practice? *Professional Psychology: Research and Practice, 35(*1), 97-104. https://doi.org/10.1037/0735-7028.35.1.97

Hawthorne, D. M., Youngblut, J. M., & Brooten, D. (2016). Parent Spirituality, Grief, and Mental Health at 1 and 3 Months After Their Infant's/Child's Death in an Intensive Care Unit. *Journal of pediatric nursing*, *31*(1), 73–80. https://doi.org/10.1016/j.pedn.2015.07.008

Holmes, T. H., & Rahe, R. H. (1967). The social readjustment rating scale. *Journal of Psychosomatic Research, 11(*2), 213-218. https://doi.org/10.1016/0022-3999(67)90010-4

Hrynowski, Z. (2019). *How many Americans believe in god?* Gallup.com. Retrieved from https://news.gallup.com/poll/268205/americans-believe-god.aspx

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma.* New York: Free Press.

Johnson, S. K., & Zitzmann, B. (2020). A Grounded Theory of the Process of Spiritual Change Among Homicide Survivors. *Omega: Journal of Death & Dying*, *81*(1), 37–65. https://doi.org/10.1177/0030222818755285

Klass, D. (2007). The inner representation of the dead child in the psychic and social narratives of bereaved parents. In Neimeyer, R. A., (2007). *Meaning reconstruction & the experience of loss (*pp.77-94). Washington, DC: American Psychological Association. (Original work published 1996)

Kosminsky, P. S., & Jordan, J. R. (2016). *Attachment-Informed Grief Therapy: The Clinician's Guide to Foundations and Applications*. New York, NY: Routledge.

Kübler-Ross, E. (1969). *On death and dying.* New York, NY: Collier Books/Macmillan Publishing Co.

Kumar, U. (2016). *The Routledge International Handbook of Psychosocial Resilience* (1st ed.). Routledge. https://doi.org/10.4324/9781315666716

Lazarus, R., & Folkman, S. (1984). Stress, appraisal, and coping. New York: Springer.

Lichtenthal, W. G., Currier, J. M., Neimeyer, R. A., & Keesee, N. J. (2010). Sense and significance: A mixed methods examination of meaning making after the loss of one's child. *Journal of Clinical Psychology*, *66*(7), 791–812. https://doi.org/10.1002/jclp.20700

Mikulincer, M., & Shaver, P. R. (2013). Attachment insecurities and disordered patterns of grief. In M. Stroebe, H. Schut, & J. van den Bout (Eds.), *Complicated grief: Scientific foundations for health care professionals* (pp. 190–203). Routledge/Taylor & Francis Group.

Mikulincer, M., Shaver, P.R., & Berant, B. (2013). An attachment perspective on therapeutic processes and outcomes. *Journal of Personality*, *81*(6), 606-616. Doi: 10.1111/j.1467-6494.2012.00806.x

Moe, B. K., King, A. R., & Bailly, M. D. (2004). Retrospective accounts of recurrent parental physical abuse as a predictor of adult laboratory-induced aggression. *Aggressive Behavior, 30*(3), 217-228. doi: 10.1002/ab.20019

Munoz, R. T., Pearson, L. C., Hellman, C. M., McIntosh, H. C., Khojasteh, J., & Fox, M. D. (2018). Adverse childhood experiences and posttraumatic stress as an antecedent of anxiety and lower hope. *Traumatology*, *24*(3), 209–218. https://doi.org/10.1037/trm0000149

Murdoch, I. (1970). *The sovereignty of good*. New York, NY: Routledge.

Neimeyer, R. A. (Ed.). (2007). *Meaning reconstruction & the experience of loss*. Washington, DC: American Psychological Association.

Oden, T. C. (1983). *Pastoral theology: Essentials of ministry.* San Francisco: Harper & Row.

Pargament, K. I. (2011). *Spiritually integrated psychotherapy: Understanding and addressing the sacred*. New York, NY: Guilford.

Pargament, K. I., & Mahoney, A. (2005). Sacred matters: Sanctification as a vital topic for the psychology of religion. *International Journal for the Psychology of Religion, 15,* 179-198.

Pargament, K. I., Koenig, H. G., & Perez, L. M. (2000). The many methods of religious coping: Development and initial validation of the RCOPE. *Journal of Clinical Psychology*, *56*(4), 519–543. https://doi.org/10.1002/(SICI)1097-4679(200004)56:4<519::AID-JCLP6>3.0.CO;2-1

Pargament, K. I., Koenig, H. G., Tarakeshwar, N., & Hahn, J. (2004). Religious coping methods as predictors of psychological, physical and spiritual outcomes among

medically ill elderly patients: A two-year longitudinal study. *Journal of Health Psychology*, *9*(6), 713–730. https://doi.org/10.1177/1359105304045366

Park, C. L. (2005). Religion as a Meaning-Making Framework in Coping with Life Stress. *Journal of Social Issues*, *61*(4), 707–729. https://doi.org/10.1111/j.1540-4560.2005.00428.x

Park, C. L. (2010). Making sense of the meaning literature: An integrative review of meaning making and its effects on adjustment to stressful life events. *Psychological Bulletin*, *136*(2), 257–301. https://doi.org/10.1037/a0018301

Park, C. L., & Folkman, S. (1997). Meaning in the context of stress and coping. *Review of General Psychology, 1*(2), 115-144.

Ralph, N., Birks, M., & Chapman, Y. (2015). The methodological dynamism of grounded theory. *International Journal of Qualitative Methods, 14* (4): 1-6. https://doi.org/10.1177/1609406915611576

Rubin, S. S., Malkinson, R., & Witztum, E. (2012). *Working with the bereaved: Multiple lenses on loss and mourning.* New York, NY: Routledge/Taylor & Francis Group.

Schuhmann, C., & Damen, A. (2018). Representing the Good: Pastoral Care in a Secular Age. *Pastoral Psychology*, *67*(4), 405–417. https://doi.org/10.1007/s11089-018-0826-0

Schuhmann, C. M., & van der Geugten, W. (2017). Believable Visions of the Good: An Exploration of the Role of Pastoral Counselors in Promoting Resilience. *Pastoral Psychology*, *66*(4), 523–536. https://doi.org/10.1007/s11089-017-0759-z

Selye, H. (1956). *The stress of life*. New York: McGraw-Hill.

Strauss, A., & Corbin, J. (1994). Grounded Theory Methodology: An Overview. In N. Denzin & Y. Lincoln *Handbook of Qualitative Research. 1st ed.* (pp. 273–284)

Stroebe, M. S., & Schut, H. (1999). The dual process model of coping with bereavement: Rationale and description. *Death Studies, 23*(3), 197–224.

Stroebe, M. S., & Schut, H. (2010). The dual process model of coping with bereavement: A decade on. *Omega: Journal of Death and Dying, 61*(4), 273–289.

Taylor, C. (1989). *Sources of the self: The making of the modern identity.* Cambridge, MA: Harvard University Press.

Van Tongeren, D. R., Hill, P. C., Krause, N., Ironson, G. H., & Pargament, K. I. (2017). The Mediating Role of Meaning in the Association between Stress and Health. *Annals of Behavioral Medicine, 51*(5), 775–781. https://doi.org/10.1007/s12160-017-9899-8

Wayment, H. A., & Vierthaler, J. (2002). Attachment style and bereavement reactions. *Journal of Loss and Trauma, 7*(2), 129–149. https://doi.org/10.1080/153250202753472291

Worden, J. (1982/1991/2002/2009). *Grief counselling and grief therapy: A handbook for the mental health practitioner (4th ed.).* New York: Springer.