The Persecuting God and the Crucified Self: The Case of Olav and the Transformation of His Pathological Self-Image

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ABSTRACT

This case study describes the treatment of “Olav,” a divorced lawyer in his mid-30’s, who, at the time of treatment, had been continuously hospitalized in closed, short-term psychiatric wards for more than seven years with severe treatment-resistant depression, transient psychotic episodes, self-destructive behavior, suicide attempts, and Axis II diagnoses of Borderline and Paranoid Personality Disorders, with narcissistic traits. He was about to be admitted to a long-term ward for chronic schizophrenics. A great deal of his psychopathology revolved around his feeling tortured from condemning inner voices of what he called “The Committee,” which he believed were the sacred voices of God. Olav’s treatment took place in our institution’s “VITA” unit, a 12-week, group-based, residential day-treatment program that explicitly concentrates on existential and religious issues, and is based on principles drawn from existential, narrative, object relations, and affect theories. The VITA program includes diary-writing, affect consciousness exploration, individual therapy, and regular group sessions with such activities as mindfulness training; art therapy focusing on drawing or painting internal representations of self, father, mother, and God; reflection on existential issues; "here-and-now-oriented" psychodynamic group therapy; and physical exercise. An assessment battery of standardized, quantitative, clinical questionnaires documents Olav's dramatic improvement over the course of treatment and at one-year follow-up.

Key words: God representation; affect organization; existential-affective-dynamic-treatment model (VITA); treatment-resistant depression; shame; guilt; self representation; self-image; psychodynamic group therapy

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1. CASE CONTEXT AND METHOD

Historically, religious belief as a part of a patient's mental health treatment has not been given the attention it deserves, and the patient's relationship to God is often a neglected issue in psychotherapy (e.g., Rizzuto, 1979; Shafranske, 1992). Rizzuto's (1979) research 30 years ago demonstrated the psychological significance of the individual's representations of God for psychic health and sickness. Many patients state that religious belief is an important part of their life (Bergin, 1991). Recently a journal, *Psychology of Religion and Spirituality*, has been established by the American Psychological Association, and other developments in the field have shown a gradually increasing focus on religious issues in psychotherapy (e.g., Rizzuto, 1979; Meissner, 1984; Shafranske, 1992; Sperry & Shafranske, 2005; Silverstein, 2008). Nevertheless, there is a long way to go in learning how to address systematically religious belief and related affects in psychiatric treatment. The present case is intended as a contribution to this ongoing development.

A. The Rationale for Selecting This Particular Patient for Study

A patient we will call "Olav" had a severe, long-standing, treatment-resistant depression linked to religious pathology, with psychotic episodes and suicidal behavior. This case was chosen to demonstrate how our institution's "VITA" model (Austad & Folleso, 2003; see below) could impact on severe pathology as well as personality structure, affect organization, and inner representations of self, parents, and God.

B. Method for This Clinical Study

This case study used a modified, consensual, qualitative research approach (Hill, Thompson, & Williams, 1997). The team worked to achieve consensus in understanding the patient's major issues and dynamics. Data were drawn from multiple sources such as transcripts of group sessions, therapist notes, interviews, the patients own written narratives and diary notes, and standardized scales as recommended by Elliot's comprehensive process analysis (CPA; Elliot, 1993). The team included experts' reflections on Olav's case from major theoreticians in the fields of clinical psychology and religion, namely, Ana Maria Rizzuto, Irvin Yalom, William Meissner, James Masterson, John McDargh, James Jones, and Donald Capps. Olav's treatment was audio-taped and reviewed in depth by the authors to (1) identify what may have contributed to the pathological construction of Olav's inner object-world, beliefs, and affects, and (2) identify and describe the guiding conceptions for this treatment and the main therapeutic factors that might have contributed to his improvement.

C. The Clinical Setting in Which the Case Took Place

Modum Bad Clinic is a private Norwegian psychiatric hospital that offers treatment programs for a wide range of DSM Axis I and II diagnoses such as depression- disordered patients of long-standing who are non-responsive to an average of three prior treatments, and who are referred from clinics throughout Norway. Over the years, many of these patients had reported that religious and existential issues had not been addressed in previous psychotherapies.

With funding from the Norwegian government, the authors were able to develop a treatment program to address religious and existential issues from a psychological perspective. The treatment is called "VITA," from the Latin word for "life," to focus on a patient's vital core issues hidden beneath the inhibitions of psychopathology, and to emphasize the connection of affects and ultimate concerns of human life.

D. Sources of Data Available

This case study included data from reports of Olav's former hospitalizations and of the VITA treatment, including written narratives, art work, diaries, video tapes, comments on treatment process, diagnostic testing, and a standardized assessment battery (see below).

E. The Therapists' Prior Training and Experience With Similar Cases

The first author (GS) is a psychologist and psychotherapy researcher with a specialization in the clinical psychology of religion and with special interest in affect theory. The second author (LGE) is a Professor in Practical Theology with the Psychology of Religion and Pastoral Counseling as a specialization. The third author (AA) is a senior psychiatrist and an approved supervisor in psychodynamic psychotherapy, with a specialization in Existential Character Analysis and advanced training from the Dûrckheim Centre (Initiatory Therapy) in Todtmoos-Rütte, Germany. GS and LGE were founders of the Norwegian Forum for the Psychology of Religion. All three authors had had experience with similar cases.

F. Confidentiality

All required precautions were taken to prevent identification or disclosure of the patient's identity. Following Norwegian ethical guidelines, the patient gave full informed consent for research and publication and has read and approved his case presentation.

2. THE PATIENT

Olav was a 35-year old divorced lawyer who had been hospitalized in closed psychiatric wards for more than 7 years. He manifested severe, treatment-resistant depression, transient psychotic episodes, self-destructive behavior, and suicide attempts. He had a strictly religious upbringing with high moral standards. During his adolescence, his parents were divorced, and he felt obliged to side with his father as well as achieve perfection to obtain his father's love. His own growing marital problems in his late twenties and a relatively minor professional mistake (presenting incorrect data at a trial, without consequences) that he perceived as catastrophic led to severe panic attacks. Repeated hospitalizations provided only temporary symptom relief from his restricted life. He felt tortured by condemning inner voices of a "Committee" he felt as the sacred voice of God.

3. GUIDING CONCEPTION WITH SUPPORT OF RESEARCH AND CLINICAL EXPERIENCE

Main Goal

The main goal of the VITA model is to facilitate transformation of rigid, emotionally charged beliefs to more flexible and adaptive modes. VITA's primary hypothesis is that patients' inner representations of God originate in the relationships with their parents. The parental representations are important dynamic elements in the formation of the self. The psychoanalytic concept of "representation" is defined as a complex perceptual, conceptual, and affectively charged inner "organization" which expresses how an individual experiences himself and others (Gullestad & Killingmo, 2005 p.46). This phenomenon is also called a relational scenario, the relation between self representation and an object representation that have a relatively stable pattern, which is possible to identify in different situations and through patterns of transference (2005, p.118). Ana-Maria Rizzuto describes the God representation as a special type of object representation created by the child in that psychic space where transitional objects—whether toys, blankets, or mental representations—are provided with their powerfully real illusory lives (Rizzuto, 1979, p. 177). Inner representations are connected to aspects of ourselves (our self-representations) and include wishes, conflicts, or fantasies (1979, p.56). This also means that representations of self and object are connected to affects. Affect differentiation and integration of affect states are seen as central to the development of self-regulation capacity, experience of the self, and the transformation of inner representations.

Thus, in order to change an impaired sense of self, the affects and beliefs associated with inner representations of mother, father, and God must be transformed from rigidly held, harsh, and punitive images to more differentiated images. In the following we will sometimes interchangeably employ the words "representation" and "image" for the sake of simplicity. To accomplish such transformation the patient needs to build an awareness of affects, differentiate and synthesize affectively discrepant experiences, increase affect tolerance, and be able to understand and use affects as signals (see Stolorow & Atwood; 1992; Monsen & Monsen, 1999). This has to be a part of developing a capacity for meta-reflection to prevent relapse (Teasdale, More, Hayhurst, Pope, Williams, & Segal, 2002) by viewing and experiencing oneself from increasingly broader, more accepting, and more compassionate perspectives. The strategies and activities designed to achieve these goals are described in the section below on "Operation of the VITA Program" and are outlined Tables 1, 2, and 3.

Clinical and Theoretical Basis of the VITA Program

The VITA Model was developed in response to growing awareness of the need for treatment models that address religious and existential concerns in a psychological framework. The VITA model grew out of four main theoretical orientations:

- Existential theory (e.g., Yalom, 1980; Binswanger, 1963; Boss 1963; Heidegger,1927)

- Narrative theory (Pennebaker & Segal,1999**;** Hermans,1999; White & Epston, 1990; Bruner, 1986; Spence, 1982.)

- Object relations theory (Winnicott, 1953; Rizzuto, 1979; Meissner, 1984;Masterson, 1988; Kernberg, 2000)

- Affect theory (Tomkins, 1987; Nathanson, 1987; Schore, 1994; Monsen, 1996; McCullough-Vaillant, 1994).

In developing the VITA model, these theoretical traditions and strategies were modified and integrated into a unified approach that focuses on a multifaceted therapeutic elaboration of religious experiences and existential concerns. In scholarly discourse such complex concepts as "religious experience" and "existential concerns" are defined in many different ways in accordance with different theoretical traditions and contexts of research. Within the psychology of religion most researchers prefer one or another version of a functional or substantive definition of the field. The point of the first is to define "religion" and "religious experience" from the perspective of its functions in the believer's life. One acknowledged definition of this kind is well suited for our VITA context because it links together "religion" and "existential concerns" within the same perspective. It states that religion is "*whatever we as individuals do in order to come to grips personally with the questions that confront us because we are aware that we and others like us are alive and that we shall die"* (Batson, Schoenrade, & Ventis, 1993, p 8). When commenting on their definition, Batson et al. emphasize that the questions implied in their functional definition are properly named "existential questions." This, then, is in line with the way the VITA model understands the relation between religious and existential issues. Individual religious experiences are in many complex ways involved with and related to existential issues such as basic trust, loneliness, shame and guilt, identity, freedom, responsibility, meaning, and death. Every client is encouraged to investigate and be aware of his or her own particular way of handling such existential issues, related affects, and the function of religious belief and experiences in this context.

How to apply an existential model in a group context is described in contemporary literature (Johnson, 1997; Jacques, 1998; Yalom, 1980). Irvin Yalom was a close consultant in VITA's design stage, particularly concerning how to work with narrative material and existential issues in psychodynamic group therapy focused on "here and now." We also drew from knowledge and insights about what fosters changes in maladaptive belief systems (Meissner, 1996) and affect organization (Tomkins, 1987, Nathanson, 1996, McCullough-Vaillant, 1994; Schore 1994, Monsen, 1996).

Empirical Support for the VITA Program

Two naturalistic studies have shown that VITA is effective for treatment-resistant depression with co-morbid Axis II Cluster C pathology (Austad & Folleso, 2003; Austad & Stålsett, 2007), and significantly more effective than treatment as usual (Stålsett, Rønnestad, & Monsen, submitted).

Operation of the VITA Program

The VITA treatment model is a highly structured, focused, and intensive, 12-week residential day-treatment program. Patients are referred from all of Norway, live in residences on the hospital grounds, and receive treatment during the day. No staff is available at night, except for emergencies. Many patients have a long history of former treatments (many with recurrent depression and Cluster C Personality Disorder) and thus can be diagnosed as having treatment-resistant depressions. Sixteen patients are admitted at a time for two parallel groups of 8 patients each.

To enter the VITA program, an existential and/or religious issue must be formulated as a part of the patient's presenting problem during the pretreatment assessment at Modum Bad. Other inclusion criteria include: (a) those who have specific emotions (e.g. shame, fear, anger) related to God, regardless of whether they believe in God or not, (b) those who report existential issues in relation to their psychological distress, and (c) those with motivation to collaborate on their existential and religious problems from a psychological perspective. Exclusion criteria include: (a) destructive impulsivity, (b) recent suicide attempts, and (c) recent psychotic episodes.

Treatment Strategies, Goals, and Activities (see Tables 1, 2, and 3)

Strategy A: Identify and share existential issues. Goals here are to apply a broad perspective or "bird's eye" view of the self and the therapy process by identifying the central existential issues and sharing them with the group at the end of the week. This kind of weekly practice develops the art of "meta-reflection," creating a distance from a patient's emotional turmoil and enhancing his or her coping and insight. The sharing of personal issues with the group provides the individual a feeling of belonging to a fellowship with ultimate concerns of being human. The daily meditation exercise enhances mindfulness and increases the awareness of existential concerns.

Strategy B: Examine rigid beliefs about self and others**.** By writing three different narratives, patients have the opportunity to view their lives from different perspectives. This strategy also contributes to the development of meta-reflection.

Strategy C: Discover dynamic origins of relational conflicts. Goals here include linking feelings and conflicts to early life relationships (mother and father), including the God representation; and noting how these patterns are repeated in therapy groups so that transference-elicited relational and emotional patterns can be made conscious and traced to the appropriate person ("the right address"). This helps develop capacity for "mentalization" (Bateman & Fonagy, 2006), i.e., the ability to understand the mental state of oneself and others based on overt behavior, and thus to see oneself from the outside, and others from the inside.

Strategy D: Develop affective capacity. The Affect Consciousness Interview (ACI) is used to assess and help build the patient's consciousness, tolerance, and expression of nine basic affects (see Appendix 1 for more details on this procedure). Daily practice occurs in affect reports in an end-of-the-day group and in diary writing. This practice is an important part of the

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process of identifying and differentiating between one's own affects and others'. It thereby strengthens the ability to mentalize, and, with enhanced mindfulness, to develop healthier affect regulation.

Sample Program Content

VITA consists of activities structured in a fixed, group-based, weekly program (see Table 3). Daily activities include morning meditation, affective reports, relaxation group, and diary writing. Dynamic group therapy and physical exercise groups take place twice a week. Weekly activities include narrative group, art therapy group, existential reflection group, and an individual psychotherapy session with a psychodynamic focus.

Three psycho-educational lectures introduce key elements in the treatment model. The first lecture is on the therapy style, "a culture of inquiry," to encourage patients to question and examine their thoughts, feelings, and experiences (Why am I feeling this now? What just happened that elicited that response?). Psycho-education also teaches the reasons for different parts of the program, and the basic instruction about affects (e.g., how affects become feared, avoided, criminalized, and deadened). Before discharge, a third lecture focuses on separation issues to help close the therapeutic process.

Three lectures introduce key existential issues and the various ways existential and religious concerns contribute to the development of each person's unique life story. The lectures are related to and interact with the subsequent writing of personal narratives. They address such personal themes as the lost or not yet realized opportunities in life ("the unlived life"), painful losses and grief ("the lost life"), violated and destroyed life ("the broken life"), the experiences of coping and dignity in spite of difficulties in life, and identification of one's own resources to develop self-compassion and empowerment ("the upright life"). This involves the life-bearing relational web and related affects like shame and guilt, grief and sorrow, anger and jealousy, rage and revenge, interest, pride and joy. Reflections on this inevitably raise questions concerning reconciliation, forgiveness, and hope for days to come.

Religious issues are explored in various ways, e.g., (a) using narrative methods (patients write an overview of their belief history), and (b) using projective methods such as painting to depict the patient's images of self, parents, and God; and to heighten the awareness of affects linked to the paintings. Religious belief as part of defense and affect regulation is dealt with and often challenged in the twice-a-week psychodynamic group therapy.

Attitude Towards Religious Language and Religious Concepts

In contrast to many spiritually oriented therapies, VITA's existential perspective emphasizes the importance of affect in the psychodynamic inquiry into beliefs and relationships and how affects are connected to ultimate concerns of life. Another difference from other spiritually oriented therapies is that the VITA model is clear about "the rule of abstinence" or "not influencing the patient's beliefs" by preaching, praying, and so forth. Religious concepts are explored in terms of their psychological function, and the difference between psychotherapy and pastoral counseling is made clear. However, pastoral counseling is available if desired, and

religion is acknowledged to be potentially adaptive and health promoting, and a possible source of hope and meaning.

Another of VITA's guiding conceptions is that the representation of God is viewed as related to important people in the patient's life. Early relational experiences in different developmental phases influence the development of various forms of inner representations of God as a transitional object (Rizzuto, 1979, Meissner, 1984), as a self-object (Kohut, 1971), as a transforming object (Bollas, 1987), and/or as an attachment figure (Kirckpatrick, 1995, Granqvist, 2006). As Rizzuto notes: "Being a regular or a deviant member of a community of believers always has a deep psychological significance" (1993, p.17). Thus, the VITA treatment offers patients a self-investigation of their personal meanings and beliefs, and help with transforming the maladaptive organization of these beliefs.

The Therapist's Role and the Therapist-Patient Relationship

Therapist role. The VITA therapist's role is first to convey that all human beings share the same universal existential concerns. In treatment the patients share and explore what they believe and do not believe. Therapists do not disclose personal beliefs. External supervision is provided when therapists need help to maintain their boundaries in regard to religious belief.

Prevention of Regression and Encouragement of Autonomy**.** The traditional inpatient model of treatment often provides medication, soothing support, and bedside care, which can unintentionally invite regression when the patient is in pain and seeking immediate relief. In contrast, the VITA therapists encourage the development of autonomy, and they help patients face anxiety, terror, and "the dark night of the soul" when alone and in turmoil. Patients are encouraged to use their personal and spiritual resources when alone and in anguish, and to document their experiences in their diaries. The goal is to build the capacity to tolerate painful feelings and to strengthen self-confidence and resilience.

4. ASSESSMENT OF THE PATIENT`S PRESENTING PROBLEMS, GOALS, STRENGTHS AND HISTORY

Quantitative Assessment

Prior to admission, at post-treatment, and at one-year follow-up, Olav completed the Symptom Check List-90 Revised (SCL-90-R; Derogatis, Lipman & Covi, 1973); the Beck Depression Inventory (BDI; Beck, 1971); and the Inventory of Interpersonal Problems (IIP; Horowitz, 1988). The results of these scores are presented in Table 4. As can be seen from the table, Olav's pre-treatment assessment scores were all in the severe range, with an SCL-90 Global Severity Index (GSI) score of 2.50; a BDI score of 38; anda IIP-global score of 2.56, with the highest scores on difficulty being assertive and being too responsible

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Affect Consciousness Interview

The semi-structured Affect Consciousness Interview (ACI; Monsen, Eilertsen, Melgård & Ødegard, 1996) assesses nine basic affects to determine the patient's capacity for affect consciousness, tolerance, and expression (see Appendix 1). The complete ACI interview was given four times to Olav, one year before treatment, at admission, post-treatment, and at one-year follow-up. During the year of "preparation" for the VITA treatment (see the text on "Preparation Phase" in the "Treatment Plan section below), the ACI was also used as an in-depth intervention, giving one hour to explore each affect and helping Olav become closely acquainted with how he handled his specific affects, such as anger, fear, shame, and guilt. At pre-treatment Olav's affect-consciousness (awareness of emotions) was moderate to high. He had greater difficulty with affect tolerance. He felt condemned by God for having feelings, and if he showed feelings he felt ashamed and negatively evaluated himself ("the 'others'' negative evaluative eye inside me") and therefore had to punish himself. At admission to treatment Olav reported the following affective associations:

Mother: Interest, joy, tenderness, fear, shame, sadness, and guilt
Father: Fear, anger, sadness, shame, and guilt
God: Sadness, shame, and guilt

Narrative History

Olav was born a twin. His twin brother died at 18 months of age, and Olav was later told that his brother was so good and lovable that God took him home to heaven as an angel. At each of Olav's birthdays, the dead brother was memorialized as "living in the light," which made Olav feel unlovable. He was extremely bothered that God preferred his brother to come to heaven instead of him, and that his father preferred his brother. Thus he felt destined to carry on the brother's mission to "live in the Light of God." His father was described as emotionally distant and demanding submission, admiration, and reverence, while his mother was perceived as submissive and self-effacing. Olav felt very close to his mother. He wrote in a narrative that he experienced her as depressed after the death of the brother and that she seemed to overprotect and cling to Olav in a way that might have been in order to soothe her own sorrow. As a boy he was not allowed to play football or other "worldly games," and he was warned of the many potential dangers outside the "safe" family. In his late adolescence a conflict arose between the parents and they divorced. This event had disastrous consequences for Olav's relationship to his mother. He wrote in his life story:

> Mother was lost in darkness. She became depressive, left home and never came back. Dad said she was mad, and she was a whore. My love for her was crushed and annihilated.

After the divorce, Olav stayed with his father. To obtain his father's love Olav felt he had to support him and that he had to live up to what he called "a gold standard" of moral perfection and achievement. Yet, even when he achieved high academic and professional accomplishment, he was left with a feeling of not being good enough. He married and had children, and was able to function professionally for about five years.

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As Olav faced growing marital problems and the earlier-mentioned relatively minor professional "error," he had a nervous breakdown with severe panic attacks requiring hospitalization. Attempts at family therapy did not succeed. After his wife divorced him, Olav grew worse and was hospitalized in a closed ward for long-term treatment. During the years that followed, he became seriously ill with violent behavior requiring frequent physical restraints. He had transient psychotic episodes, and long, severe depressions with self-destructive behavior and suicide attempts. In between his long-term treatment in the local closed ward he had three short-term stays at Modum Bad Clinic where he received "treatment as usual" programs. When the religious issues occurred in therapy, Olav regularly became anxious and regressive, with dissociative attacks that alarmed the staff. Although he made some progress in the hospital, he regularly relapsed after discharge. After seven years Olav was about to be admitted to a long-term, closed ward for chronic schizophrenics. His prognosis was considered poor.

Presenting Complaints and Problems

Olav came to treatment because he felt tortured by haunting, condemning inner voices coming from what he called "The Committee," including God, his father, and people he felt he had offended. He felt that he deserved to suffer because he had failed to become the worthwhile, religious professional his father desired. The voices began the moment he decided to leave God (a decision made shortly after his first hospitalization), forbidding him to have his own feelings and thoughts. He had been encouraged to "leave out God" by his treatment team (who may have believed his religion harmed him); but his God image and its psychological function were not dealt with in treatment, and so his suffering increased. He applied to the VITA treatment program because of the focus on existential and religious issues.

At admission, Olav was paranoid, delusional, and on high doses of anti-epileptic, anti-depressive, and anti-psychotic medication with side effects of weight-gain, drowsiness, and urinary incontinence. He was heavily burdened by guilt and shame and had great difficulty in tolerating and regulating his feelings, which frequently resulted in regressive dissociations and panic attacks. He could not stand being alone and he repeatedly became involved in short, clinging relationships, often ending in sudden break-ups with subsequent suicidal despair. He was not able to picture the future realistically and thus had little hope for improvement.

Goals

Olav's goal was to attain freedom "to be Olav;" i.e., to be an autonomous self, to own his feelings, needs and thoughts, and to make his own choices. He expressed a deep spiritual longing to feel received and loved by a merciful God, without the heavy burden of his father's perfectionist aspirations and ideals.

Diagnosis

Olav's five-axis, DSM-IV diagnosis was assessed at three time points: admission, discharge, and one-year follow-up. (See Table 5.) These assessments were completed employing the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I; First, Spitzer, et al., 1997), and for Axis II Disorders (Structured Clinical interview for DSM-IV axis II; First,

Gibbon, et al., 1997). Olav's diagnosis at admission revealed a variety of severe psychopathology:

Axis I: Major Depression with psychotic features
Axis II: Borderline Personality Disorder
Paranoid Personality Disorder
Narcissistic traits
Axis III: Urinary Incontinence
Axis IV: Occupational Problems and Social Isolation.

Strengths

Olav was highly intelligent, with a broad access to language and conceptual thought. His motivation for treatment was very strong. The newly developed VITA Model stirred his hope of coming to terms with his religious conflicts. The existential language suited him very well. According to Olav, his trust in his therapist (AA) strengthened the hope that this treatment really could help, in spite of his prior treatment failures. His spiritual longing to find a benevolent God was a strong motivating force.

5. FORMULATION AND TREATMENT PLAN

Case Formulation

Olav's main issues at admission were related to (a) how a harsh God and his haunting "Committee" tortured him and prevented him from freedom to feel and live, and (b) how he experienced what he conceptualized (in his narratives and paintings) as his "Crucified Self."

Religious Upbringing and Development

Olav's rigid and pathological belief system was strongly influenced by his developmental history. His mother's depression after the loss of a child may have led to an inadequate response to Olav's emerging self. The parents' idealizing of his dead twin brother, and his jealousy, anger, and existential guilt for surviving, may all have contributed to his pathology. His strictly religious upbringing probably reinforced his considerations of certain affects as unacceptable and probably contributed to reinforce a self-image of be-ing "bad."

Loss of Mother

Olav's unresolved grief when his mother left the family, combined with his desperate need to please his father by living up to the father's expectations, seemed to compromise Olav's fragile self structure. He was totally unable to face and bear rage over abandonment, rejection, and his own feelings of failure related to his parents.

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First Breakdown and Emergence of "The Committee"

We hypothesized that adult life conflicts had led to Olav's breakdown because of his underlying, impaired and highly vulnerable self-image and self-structure (Masterson, 1988). His defenses regressed to a paranoid and borderline level—including, splitting, projective identification, denial, primitive idealization, and devaluation—exaggerating negative aspects of self and others. Olav's defensive operations led to his inner creation of "The Committee," "the harsh God," and the "Crucified Self;" and these were experienced with panic attacks, severe shame and guilt, and severe depression. These creations seemed to help him avoid aggression toward his parents by projecting the aggressive feelings onto a persecuting God and thereby turning his anger on himself.

The Committee and the Harsh God Image

Olav's God image was split into a harsh, punishing God, and a benevolent God—a God image with whom he alternatively wanted to get rid of or longed for closeness with as "the light in the gloom of his inner darkness." His harsh God image and his father image seemed to be fused in "The Committee." To openly revolt against his father was experientially associated with his father's suicidal despair when his wife left him. Both Ana Maria Rizzuto and William Meissner, in their roles as consultants to Olav's case, proposed that Olav needed The Committee as a defense, until he had developed a milder superego and developed a more compassionate sense of self.

The Crucified Self

Olav's attempts to live up to his father's perfectionist standards led to chronic self-attack, not only by forbidding positive feelings, but also by constant guilt from The Committee for moving away from God. He felt metaphorically "crucified," nailed and bleeding, as a little child on a big cross, doomed to suffer for the break-up of his family.

Treatment Plan

The treatment plan was intended to gradually help Olav to stop splitting the harsh Committee from the loving God for whom he was searching, and to then facilitate an integration of these. The treatment plan, as outlined in Table 1, involved:

a. Deconstructing his pathological belief system (Identifying Existential Issues and Suffering—Strategy A).

b. Transforming rigid inner representations and the sense of being crucified. (Transforming Life Story—Strategy B).

c. Developing an autonomous and healthier sense of self and others (Understanding relationship dynamics and inner representations—Strategy C).

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d. Acquiring the capacity to bear and regulate his affects (Building affective capacity—Strategy D).

A main treatment goal was to help Olav dare to explore and transform his harsh God representation, and the condemning voices of The Committee. To achieve this goal he would need help to reduce the blocking function of his anxiety, shame, and guilt so that he could tolerate and express feelings like anger and tenderness. The treatment plan also encouraged his autonomy by promoting mastery of aloneness, and confronting his defensive clinging behavior. Treatment provided a safe but firm environment to express his anger and despair, and to learn to trust and be close to others, without regression.

Preparation Phase

Prior to being allowed to enter the VITA treatment, Olav was strongly advised by the psychologist to have a year's course of monthly sessions to help him to recognize better and regulate his affects, and to learn to mentalize and reflect upon the damaging effects of The Committee. It was crucial to help him to understand how his affects of shame ,guilt, and fear related to his God. After one year, Olav had obtained sufficient affect consciousness, impulse control, and mentalization capacity to enter the VITA program and to examine his inner Committee from a psychological perspective.

6. COURSE OF THERAPY

The VITA strategies are incorporated into a 12-week program of fourteen interrelated activities designed, in interaction with each other, to achieve the treatment goals. Table 2 lists and describes the activities, and Table 3 indicates the frequency and group composition of each activity. The VITA program is divided into three phases: weeks 1-4, weeks 5-8, and weeks 9-12. The most relevant of Olav's activities and responses during each phase are presented below. Each activity is numbered from "1" to "14" in Tables 2 and 3, as well as in the text, to aid the reader in keeping track of them.

Overview of Phase 1 (Weeks 1-4): Daring to Join With Others

During the first week, Olav's treatment consisted of becoming adjusted to the other group members and identifying his main issues and affects. Although Olav responded well to the Morning Meditation Group (activity # 3 in Table 2), he had difficulty with most of the other programs. Affect work had identified his shame and guilt about anger, but he could not yet share this with the group. He had trouble writing his life story and struggled to share it with the others. During the Physical Exercise Group (# 9) in week 1, Olav's body "felt like lead." However, after the first Self-Evaluation and Feedback Group (# 12), he felt more upright and clear in his self-presentation to the group.

Phase 1 Treatment Activities

1. Affect Consciousness Interview (ACI)

ACI sessions with GS taught Olav how his main affects functioned and what persons they were attached to, e.g., shame was mainly linked to punishment of The Committee, and guilt was mainly linked to being a "crucified" child.

2. Daily Diary

In the first week, Olav was anxious and ashamed that his urinary incontinence (a side-effect of his medication) would interfere with his participation. He wrote in his diary that he was terrified that The Committee would not let him join the program. He stated that the Committee had condemned him for being a heartless egotist for not giving his room to a fellow patient who wanted it (even though his therapist supported Olav's decision). Olav wrote of anger towards other group members. He noted and tried to understand why he felt attracted to Nina, a female patient in the group.

3. Morning Meditation Group

Olav wrote that he liked meditation. The texts stimulated his intellectual curiosity about feelings and existential dilemmas. After the first meditation he wrote in his Daily Diary (#2) an excerpt from that day's existential text: "The demands of life bear comparison only with your own strength. Your eventual victory consists of not deserting."

4. Psycho-Educational Group.

After the first lecture about affects and therapy as a "Culture of Inquiry," Olav acknowledged the importance of gaining insight into his feelings and becoming more authentic and liberated from his harsh Committee. With the psychologist, he continued exploring how his affects were organized, and how guilt and shame suppressed anger and joy. He then reported feeling sad, uneasy, and restless. He had difficulty sharing his life experiences with the group and trouble writing his first life story. He described how threatening it was to write about the meaning of his life. His fear felt like "slamming his inner fire doors," to avoid his feelings.

5. Daily Affect Reports

Olav felt he had nothing to tell.

6. Psychodynamic Group Therapy

In the first group meeting Olav said he had problems finding his place, didn't want attention, and felt ashamed. He later wrote that he hated himself for his depressiveness and vulnerability. A group member asked him to lift up his face, a request he said he liked, but also disliked because he preferred to stay hidden. In week 2, Olav shared with the group his inner struggle with the harsh Committee and his longing for a merciful God. He told about his fear of

anger at his father and God. He felt his right to live had been stolen for most of his life, and believed he was denied God's blessing.

In the middle of phase 1, Olav's issues involved difficulties in trust, envy, lack of confidence, and feeling condemned. Even though Olav felt more included in the group, he could not share his struggle about another patient, "John," whom Olav felt controlled him, invaded him and reminded him of his father. Olav felt he needed to use his anger more constructively to build a border around himself, and felt relieved that he could feel angry without condemning himself.

7. Art Therapy Group

During the first week Olav struggled with The Committee, with its harsh, condemning voices depriving him of freedom and giving him his sense of "being crucified." He felt forced by the Committee to use dark colors in his art therapy. In his first drawing, "Two circles" (Figure 1), Olav drew a huge black eye and commented:

> A big, black, engulfing eye holding me caught like a backwash. The black is not rage, but unavoidable sadness. I have an inner tribunal of judges who keep me and condemn me. I feel suppressed and squeezed, but also secure.

In his diary he wrote about the first art therapy session:

> I drew a gloomy picture. No colors. A therapist commented: How long are you going to let the Committee decide what you are allowed to paint? I said that I had to show the power and mercilessness of the Committee. Many asked what would happen if I defied The Committee. I answered that I became ill when I tried to defy The Committee.

The second art therapy task was to draw one's family of origin (see Figure 2). Olav drew his family standing side by side on the deck of the Titanic approaching an iceberg. The father was drawn as an eye inside a triangle, placed above the rest of the family. Olav commented:

> Everything seemed to be safe inside the ship. There was no danger. But outside danger was lurking. My mother, placed at the same level as the children, was drawn as a heart. She represented the love in the family. My father was drawn as an eye; as a condemning God. I want to disclose the lie that makes me furious. As a family we sunk to the bottom. We did not learn anything about normal life, so we were not prepared to live as adults.

When Olav was asked to paint himself a week later, he turned in a blank sheet of paper. He felt ashamed not to be able to draw himself, and commented:

> I couldn't draw anything. There are no resources to draw. The Committee did not allow me to show myself. I feel empty.

Olav's comments on the first painting of mother show how his good and loving mother image from childhood was crushed after his parents divorced (see Figure 3):

> From my childhood I remember her as light and warm. She saw me and gave me her approval for what I made and did, she read books to us, she was sweet. Then conflicts

> between my parents started; mother was lost in darkness, she became depressive, left home and never came back. Dad said she was mad, and a whore. My love for her was crushed and annihilated. --- I have felt that my mental illness has been an attempt at being united with my mother. I have once said that I would rather be with mother in hell than staying with father in heaven.

The first drawing of his father showed the father as hiding behind a stonewall, locked in a triangle symbolizing God (see Figure 4):

> A stone wall; father is behind the wall where he hides because of his own helplessness and weakness, making him unable to show care and compassion. His face is divided; the red is warm feelings and humor, the black is heaviness and helplessness. The triangle is his God; it fills the space not giving room for other Gods than him alone.

Olav's first drawing of God was painted mainly in black with five dark eyes and a big blue cross with a crucified child in the darkness. Beside the cross he painted a yellow area where five people were standing in the light (see Figure 5). Olav commented:

> I have not painted God the right way. I did paint what he has done to me. In the light area are people, my family, living in the blessing of God. The crucified little child, nailed to the big blue cross, is me. I cannot get loose. I am watched by God, not the good God, but the Committee, who remind me of the last judgment. The eyes of The Committee are God's angels sent from heaven to watch that I don't get his blessing. I shall not be given a good life because I have turned away from God. The darkness is despair, sorrow and rage. I have to hang on the cross to carry the pain and cleavage in my family. I feel guilty to have moved away from God, because I will not kneel to ask for forgiveness. To do so would imply being engulfed for the sake of the others.

8. Narrative Therapy Group

In the first narrative group session Olav told about his dead twin brother. Afterwards he reported feeling gloomy.

> At first I was searching for him everywhere. Later I was competing with my dead brother for my father's attention. I tried to be an angel like my brother, who was kind and loving; I was reckless and rude. One day everything exploded. I grew nasty, became hospitalized, angry at my father. My efforts were useless. I never had a language to contain the loss of my brother.

In session three, Olav reported resistance to writing or telling his life story, feeling that he would tell "legends." His lack of courage to present the stories as *his* life was due to mistrust that life is not a safe place. He told about the tragic losses he suffered in the death of his brother and loss of his mother, but afterward felt ashamed to have used the stories to make others feel sorry for him. He reported great resistance to open to hope and meaning.

10. Existential Reflection Group

Olav especially needed to increase his capacity for meta-reflection, so that he could see the condemnation of The Committee from a bird's-eye view. In week two during the Existential

Reflection Group, Olav reported feeling uneasy and sad when the issue of responsibility for his own life was brought up. He was upset by the challenge to be able to be alone, and by being responsible for his own feelings. In week three he dealt with the issue of shame:

> I can see now that The Committee actually is a self-attack. It's the shame. I have also taken on guilt that is not mine. I have to find out more about that.

11. Individual Therapy

In the first session, Olav thought that the psychiatrist would be bored by his gloomy feelings. He practiced a strict censorship, fearing loss of control if he expressed his feelings. He said he often went to bed to avoid feelings. He tried not to give in to magical thinking, because he had learned from the psychologist that giving in to psychotic, delusional thinking was a way of withdrawing from reality. He told the therapist that when he tried to enjoy the group's company, The Committee forbade him, saying: "You shall not have a good time."

A central issue in Olav's psychotherapy was his conflicted relations with women. Olav could recognize a repetitive pattern which also happened in the group: giving in to women's feelings as if mutual, because of fear of hurting them by his rejection. He had married his wife without being in love, and then constantly fell in love with her friends, thereby creating marital problems. While telling these stories he wept openly for having given up himself and his life. His treatment goal was to stand up for his own feelings and work with them in the group.

As his medication was reduced, he told his therapist that he felt more alive and in contact with his feelings and sexuality. He went to a dance with the group at a nearby hotel.

Summary of Phase 1

At the end of Phase 1, Olav had begun to see how the Committee represented shame, and he began to be more accepting of himself and his anger (Strategy A: awareness of affects). He dealt with his conflicts about longing for connection versus feelings of separateness when he tried to be himself. Olav found a safe place in the VITA program and was more able to be calm and check out his perception of others. He became more comfortable with sharing parts of himself with the group. (Strategy C: Gaining skills of mindfulness and mentalization.)

Overview of Phase 2 (Weeks 5-8): The "Inner Wolf" Emerges to Battle The Committee

The Phase 2 goals were to improve Olav's *affective capacity* and mindfulness by being able to tolerate anger, criticism, and negative feedback, and by learning how to assert himself and set limits. With help from mentalization, Olav also needed to learn to bear loneliness and rejection, to decrease dependency, and to strengthen autonomy. He also needed to use *meta-reflection* to deal with ambiguity and black-and-white thinking. He began to develop greater trust of others through VITA's safe environment and the relationship with his therapist. He also began to consider important choices that could make him feel more alive and secure, e.g., rejecting a harsh God, containing unpleasant feelings, and soothing his inner pain.

New Relationships

Olav continued to develop the ability to *mentalize* and develop new capacities for relationships (Strategy C) through new relational experiences and narrative review of earlier relationships. He was encouraged to gather more information from others and to re-evaluate his assumptions and conclusions about others.

Experience of Feelings

In the mid-phase sessions Olav was encouraged to express his feelings, either negative or positive, to fight the force of The Committee that forbade him to feel, and to examine whether The Committee was a part of him. Olav's paranoid disposition was a sub-type, being more paranoid towards an internal force (The Committee) than delusional towards external relationships. We felt that gradually challenging Olav in the groups would not lead to decompensation, although he was very sensitive interpersonally. When it came to The Committee, however, we had to be more careful and take it step by step.

Struggling with The Committee

To help reduce The Committee's harshness, Olav was encouraged to explore the distinctions between his representations of God and those of his mother and father. Olav disclosed how powerless and helpless he felt due to The Committee "rattling their bunch of keys," making him afraid of losing his membership in the group and in humanity. During this phase the psychologist was working systematically with Olav's affects through individual Affect Consciousness Interview sessions, focusing on one affect at a time, and also to differentiate between emotional and existential issues (see Table 1, Strategies A and D). Olav took upon himself the task to explore the different sources for his repressing guilt feelings. He had to search for and differentiate between existential guilt, real guilt (for a wrong-doing), and guilt as wrong narrative construction, e.g., related to his parents' divorce and survival guilt for his brother's death. A part of struggling with the Committee was also understanding guilt as a defense against inner pain, and guilt for forbidden or "criminalized" feelings. The psychologist wanted to help Olav understand how his longing for Nina might be a way of seeking relief either from guilt over the loss of his brother or pain over the loss of his mother. As Olav became more secure, there seemed to be less rumination about The Committee. However, he had to fight against shame and work to reduce the guilt that made him feel he did not deserve to have justifiable anger or positive feelings.

Phase 2 Treatment Activities

6. Psychodynamic Group Therapy

During a group session, Olav said that he wanted to be angry, but "the inner wolf" was locked in. The group helped him understand what the wolf represented and that *he* actually locked in the wolf (i.e., his angry feelings). A recurring issue in group therapy sessions was his fear of setting limits and disagreeing because he was afraid of hurting others or being rejected. He commented in week seven:

> I showed anger and aggression. AA [his individual therapist] said that he felt that I was angry at him. I said yes. But I was scared that he could become angry at me. That he would feel disappointed and turn away from me, abandon me. I am scared of losing AA as an ally. I was tempted to knock at his door afterwards and talk to him, pleading for peace and consolation. *Is it a victory for me if I can manage to stand these difficult feelings until the affect report in the afternoon?*

We felt this was a major step for Olav in line with VITA's goal of containing existential pain.

A group member, John, had tried to escape inner pain by establishing an extra-marital relationship with a woman outside the hospital, a pattern Olav knew well. Together Olav and John tried to challenge this pattern, which helped Olav reflect on his own dependency issues.

7. Art Therapy Group

In Phase 2, the strategy was to raise Olav's awareness of his affects in relation to his past relationships and The Committee, to enhance his process of meta-reflection, and to transform his rigidly held beliefs and images. This initiated a second sequence of drawings. Olav drew himself as a child in a cage locked by blue bars (Figure 6):

> The blue is sorrow. Beneath is a concrete wall hiding flames and passion. I want to dare to be happy, to let go. But the feelings are locked up beneath the reinforced concrete. Above I have drawn bombing raids from enemy lines. I am occupied land.

Olav described the second painting of his father (see Figure 7) as follows:

> My father is strong and powerful with black armour and divided face. One part is a smile with an empty eye, the other is furious and scared. Deep inside is suppressed desire and passion. He has God in his pocket. He is standing on a pedestal. He looks big, but is a little scared child, prone to fall down. Me, I am little compared to dad, standing on the floor in front of a staircase, trying to reach my father by brushing his shoes, be clever, studying to be a lawyer, everything to gain acceptance, attention, smile, closeness.

Olav had the following comments to the second painting of his mother (see Figure 8):

> The first time I painted a nice picture of mother. This time I need to paint a bad picture of her. The red color is my anger at her for leaving us. There are whirls of pain, anger and chaos. She is reaching out her hand for me. There is something frightening and attractive in her eyes, a kind of flirt. I feel ambivalence; wanting to be close to her and at the same time being afraid. I don`t feel safe. I feel ashamed of making this bad picture of her.

The second picture of God (see Figure 9) showed two tables of Holy Communion representing Olav's struggle with old condemning feelings versus positive ones. At one table, at Modum Bad's hospital church, he can sit on the altar rail and feel embraced by love and warmth. At his home table, he is left out of the Communion in sorrow and loneliness. In his words:

> A big, black judicial eye took most of my power today. It was drawing me closer.

8. Narrative Group Therapy

In session five, Olav told childhood stories about losses and his fear about being lost himself. His basic trust at home was lost when conflicts surfaced. In week six he told about his fight for God's blessing, and said he was tired and empty afterwards. In week seven he talked about his longing for peace, but he had death wishes and wanted to scare away anyone who had good wishes for him. He said he yearned to be accepted and loved, yet felt he was "the opposite of an angel." He told how he had attacked others and physically hurt himself—unable to find peace anywhere—and longing for psychosis. He said he longed for love, but all relationships became demanding, forcing him to end them.

10. Existential Reflection Group

The strategy for phase 2 was to continue to work with Olav's survivor guilt (from his brother's death), guilt from his parents' divorce, and to differentiate between dependency, enmeshment, and the existential need to belong. Early in phase 2, he said that he had felt more passive and tired the first weeks, but more alert and present after having stopped the medication. He reported that he felt accepted by the group and did not miss the nursing care during evenings which is absent in VITA, but was present in prior hospitalizations. After daring to feel anger and rebellion against God (The Committee) and his therapist, alternating with longing for his father's lap, he reported resistance toward going further. He struggled with resistance to reduce the power of the Committee and open himself for new ways of understanding.

Later in phase 2, he wrote that he began to see the image of "the upright Olav," not the extension of his father's ambitions, but a man who had carried heavy burdens of pain, despair, and insanity but survived without remaining in psychosis. He reported feeling a glimmer of hope. "In all this I am closest to my real self. I don't want to retouch anything."

After reducing medication, Olav had to work to contain strong emotions. He identified his existential issues as dependency, autonomy, and freedom. He reported resistance towards the psychologist (GS) for her mentioning "a developmental therapeutic project with him," and reported fearing loss of soothing if he developed more maturity.

In week seven Olav reported that he felt more self-confident, more able to express himself clearly, and to say yes and no. He dared to express his anger and opinions towards AA. He was aware of more differentiated feelings towards others, and he allowed himself to long for his father and acknowledge anger towards his mother. In the last existential group before "Home Week" (week 8), Olav said that he felt exhausted by his fight to hide and escape from God, as he struggled with trust and mistrust. He said that he could feel a glimmer of acceptance by the God he experienced at the hospital, but he feared that the God he would meet at home was not benevolent. He felt fear about meeting his father.

11. Individual Therapy

Olav began to see that anger and entrapment by The Committee was not the whole picture, and he could dare to have positive feelings. He reported being angry but also unsure of

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himself and threatened when AA seemed to have different opinions than his. The therapist reminded him of his father, who always had the truth on his side. Olav had to crawl towards him, which made him both angry and anxious. He could not take the risk of losing the therapist's good will. However, he was coming to understand that AA was not his father, and he was no longer a child who had to crawl. The crucial strategy for the individual sessions was to help a positive image of Olav to emerge. Olav was encouraged to stand up for himself in the group. With the reduction of medication, Olav felt more present, involved, and alive. He reported a strong reaction when he was challenged to spend more time alone to recognize his inner pain and work with it in the therapy. Olav opposed this by writing:

> Isn't enjoying falling in love and feeling happiness and playfulness a part of becoming Olav? Is my dependence on others only a problem? Maybe it is both this and that, and AA means that just now my greatest challenge is to exercise loneliness to be able to live on my own.

Although he was angry, a quotation from his diary tells that he had understood the message given by his therapist, when he was able to say no to a request from a female group member.

In the middle of phase 2 Olav discussed his fear of life connected to his belief that God was not on his side. He saw his years of mental illness as a rebellion against his "old God—his father's God"—without succeeding in loosening his chains. He said he had chosen to turn away from God and believed there was only one way back: to crawl. The possibility that God might be different was explored and related to new "here and now" relational experiences.

12. Self-Evaluation and Feedback Group

During week seven, the group experienced Olav as being more alive and coping, and gave him positive feedback for the serious work he had been doing. Olav reported that the "howl" from his "inner wolf" was awake, and he dared to feel happiness and vitality. After this session Olav wrote that he felt sad and angry, feeling that the group and the therapists only wanted to see progress and strength, leaving him alone with his weakness. In his diary he wondered why he resisted admitting that he was feeling more vital, and thought that The Committee tried to lock the wolf in. Even so, he seemed to accept the feedback about his growing capacity to listen, to share feelings, to set limits, and to show concern for others.

13. Pastoral Counseling

Since he was in a long-term process with the struggle and longing to find a benevolent God, Olav applied for pastoral counseling in the last two phases of the VITA program. (Olav had a total of 8 pastoral counseling sessions during the program.) Olav was unable to pray for himself, so he asked the chaplain to intercede for him with God. He expressed his deep longing for God by repeatedly singing a hymn of John Henry Newman:

> Lead, Kindly Light, amid the encircling gloom. Lead Thou me on!
> The night is dark, and I am far from home. Lead Thou me on!
> Keep Thou my feet; I do not ask to see
> the distant scene—one step enough for me.

In week seven Olav said he wanted to express his anger at God. He said that he felt God had turned away from him, abandoned him, and shown contempt for him. The chaplain encouraged him to give words to his feelings. He screamed loudly: "Fuck you, God!" He also felt guilt and shame for holding on to his pain instead of receiving God's love, and wrote in his diary:

> I don't know what I felt most strongly: God's betrayal or my own. I wept and sobbed loudly. I let go some of my despair and anger. I felt calm afterwards.

He told the chaplain that The Committee did not allow him to drink from a cup in his home, because his name, Olav, was written on it. The chaplain commented, "You are not nameless. You are Olav. You have the right to be Olav." He was reminded of a phrase from the Bible: "I have called you by name, you are mine." Olav's wrote in his diary:

> I will try to accept that God wants me to be Olav. God shall not require that I have to give up being myself to serve him. I am created as a capable, upright human being.

At the end of phase 2, before the "Home Week," Olav was engaged in clearing up misunderstandings about his angry feelings, both in the group and in his own life. He had issues with trust and mistrust, involved with his urge to withdraw versus taking a place in the group and being able to manage criticism.

14. Home Week (Week 8).

Olav returned to his apartment and felt lonely, restless, and depressed upon arrival. He reported a good meeting with his children, who said that they saw him as more present and more balanced. He also met with friends and his local therapist, who gave him credit for being better. He arranged for group therapy and individual treatment upon his return home. The visit with his father at the end of the week provoked strong feelings, especially anger. He confronted his father for not visiting him during his many prior years of hospitalization. He said his father grew angry and defended himself. His father told him that he had been warned by the hospital staff not to visit his son, because his presence could make him grow worse. Olav tried to understand his father's reasons for not visiting him, though he deeply felt his longing to be seen and embraced by his father. He tried in vain to explain to his father his thoughts about God, the Committee, and himself hanging on a cross.

Olav felt that his father did not understand his suffering, because his answer to Olav was: "This belongs to the therapy room." When alone in his room at his father's home Olav cursed to himself, wondering how he could better express his thoughts and feelings to his father. The next morning Olav told his father that he had tried too hard to spare him from hearing about his problems and suffering. His father answered (a quotation from Olav's diary): "This is how it shall be—shouldn't we spare each other our difficulties?"

Summary of Progress in Phase 2: The Battle with The Committee Versus Authentic Life

Olav was facing a fear of an authentic life, reporting difficulties in being honest because he was afraid of rejection or punishment, of letting go of the survivor guilt he carried about his brother, and the guilt he felt for his parents' problems. He reported more awareness of the wrong conclusions he had drawn early in his life, and their consequences. This understanding developed through feedback from group members, his own reflections, digesting interpretations given in individual therapy, drawing in art therapy, narrative groups and especially in relationship to his "survivor guilt" in the existential group. Also his intensive work with affects had improved his capacity to *mentalize* and *meta-reflect*. He could better distinguish himself from his inner fantasies of the Committee.

He still felt threatened by the Committee, and he worried about threatening others, just as he felt threatened by them. He realized that he also held back the best in himself. However glimpses of his authentic self were emerging amidst the struggle with The Committee. He was tiring of all his defenses and said how good it felt to receive credit from John for his active participation in art therapy. He saw his need for positive responses, and he feared rejection if he did not respond to others. His therapist asked a question that made him uneasy, "What is your most important therapeutic project?" In his diary he compared his dependence on others with a heart-lung-machine, thinking how he might survive if he turned off the machine and starting to listen to his own heartbeats. He was not willing to "give up" his feeling of closeness to Nina, whose smiling response made him feel alive.

Overview of Phase 3: Weeks 9-12 (Termination Phase) -- Strengthening Autonomy and Preparing for Discharge

During this phase Olav was challenged to go deeper into feelings, life stories, and to assert himself in dealing with destructive inner representations. The affect work aimed at differentiating his affects related to his inner images of father, mother, God, and self.

Capacity for Anger

Olav worked with his ability to be angry at others instead of himself, although this frightened him. However, he was able to express anger without falling apart in shame and guilt, which was a strong positive indicator for the future. In his diary he wrote about anger at the therapists for not being understanding enough. He was aware of his anger towards his father for not coming to visit him during his earlier hospitalization, and in Morning Meditation Group (#3) during week nine, he considered the issue of forgiveness.

Mourning his Lost Life

It was important to help Olav to grieve unfulfilled dreams, wounds, and losses in his life, as well as the sadness when facing departure from the soothing and safe VITA group environment.

Strengthening Autonomy

Another goal was to validate Olav's gains in autonomy and encourage him to fight regression, while at the same time preparing him for some degree of regression that often occurs towards termination. Psycho-education emphasized that earlier farewell experiences can activate defenses and painful abandonment feelings as a normal part of the ending of treatment. He also was able to acknowledge his deep longing for unconditional love from his father, from God, and from a woman. A final aspect of this goal was to facilitate meta-reflection throughout the different sessions to prevent relapse and to prepare Olav for returning home, while being realistic about chances for relapse.

At the end of each VITA 12-week program, the group of patients is terminated with a phase review with the patients in the group, where their process is reviewed and commented upon by all, and feedback given.

Treatment Activities in Phase 3

4. Psycho-Education Group

Olav wrote that the last existential lecture about freedom, choice, and personal responsibility was excellent because of the reminder to be responsible. Later, in the Existential Reflection Group (#10), different sources of guilt were addressed:

> I have to choose what I want to stand for, what I find valuable and worth fighting for. By betraying these values I must admit sin and guilt, not hide them. For many years I have escaped from God, closing ears and eyes to realization of my guilt and sins. The Committee has continually hammered my guilt and sins into me, almost crushing me to death. At the same time I am told that I am not guilty, nor sinful. It is difficult, in the midst of this drama, to say: "Yes, this was a sin, this I did wrong, against myself and against others. To approach the word confession is extremely difficult.

5. Affect Reports and Relaxation Group

In week 10, during a relaxation exercise, Olav started to cry, knocking his fists on the floor, swearing loudly and cursing The Committee for having damaged his life. AA sat down beside him, put his hand on Olav's shoulder, and encouraged him to let the feelings come, assuring both Olav and the group that his anger was legitimate, not dangerous. The other patients stayed with him in silence until his outbursts of anger faded away. Olav commented in his diary:

> Again feelings came to the surface: Tears, deep sobs, anger, and anxiety. I let the feelings come, expressed the anger and anxiety. AA touched me with his hand. I dared to express my despair loudly. He gave me permission to use my own strength! Nobody left the room. They endured my feelings. After the relaxation I stood up, with my feet planted on the ground and my hands lifted over my head, singing: "Now I want to go home. If I could write on the sky, I would write your name. Please, take me on your wings, fly my beautiful bird, fly ---." I can stand in this fight, a battle of life and death. It is my life!

6. Psychodynamic Group Therapy

The main issues in phase 3 were trust, flight from pain, and avoidance of termination. Olav wondered what healthy self-assertiveness really meant and what" the guiding rules" for relationships normally were? He still had feelings towards Nina, and opposed what he felt were "unfair rules." He wrote in his diary, "I don't think that talking to her privately is a flight from pain. I am fed up with the rules."

He was challenged to find out what Nina represented: attraction, twinship, or repetition. He felt resistant to looking into these issues, and instead, worked on believing in himself, not being a victim and not giving so much power to his parents. He wrote in his diary: "I must stand up for me."

In a group where AA was absent, Olav felt disappointed and unsafe:

> On the other side I have to learn to manage by myself. He is not my father although a kind of father figure. The challenge given to me by GS to dare to be responsible for my own feelings is ringing in my ears. I must build up confidence in myself on that.

Olav still feared his own anger, and how destructive he could be. However, he worked on his anger differently, with greater awareness of his treatment goal, saying, "I want to be me, Olav."

Olav brought up the question of weeping in the presence of others. He asked the group what they thought about him when he showed his tears. He realized that tears could be good and healing, but also self-pitying. Olav dared to express anger at GS for not knowing him:

> GS behind the mirror, she knows me although I have mixed feelings for her. She demands something from me, but more healthily than The Committee. But it's provoking: Am I flying from being healthier because it is safer and I feel freer in illness? Do I fly from being healthier?

In the last week before discharge Olav wrote that he felt unsafe and insecure when saying goodbye to the group. He was angry at AA for being away one of the last days, and angry for not feeling seen by him lately, but also afraid of losing AA. The demands of the future scared him. He was anxious about getting well again, taking responsibility for his life, stepping forward and returning to his former surroundings outside the hospital.

In the last group Olav commented on his loneliness and his relation to The Committee:

> Now I have the responsibility. The voices of The Committee are my own lack of mercy toward me. During the three months here I have had a leave of absence from my jail. I am longing for mercy, to see mercy; I need to look at my image of God again before I leave. I have shouted, I have been angry, I have prayed. In my fantasy I crushed the crucifix. I expected furious faces, but I experienced understanding and felt accepted for who I am. I cannot understand why this God doesn't dwell at my home. I do not want to be a little cry-baby anymore. I want to say what I need in a different way. For the present, I am not in a

> good mood; I don't feel my fighting spirit now. But that does not take away the fact that I have shown strength, spirit and will while I have been here.

The group dynamics were very intense in phase 3. In week 10, after the Home Week (activity # 14), Olav mentioned his relationship with Nina. The group seemed to support their relationship, but both therapists called it a soothing of pain and a flight from the heavy task of therapy.

In his diary, Olav reported a late evening event when some of the group sat together. John suddenly rushed into the room accusing the group of being self-pitying and whiny.

> He pointed at me, saying that he was furious at me for sitting upright with dignity, and in the next moment lying on the floor weeping like a cry-baby. "Stop your self-pitying and get back to work!"

Olav felt deeply hurt by John and angry at him, but also worried about him, and was scared of his fury and contempt. Olav described his reaction in his diary:

> I must try to say, "You are you. I am myself. I will try to put me and what is mine first." John's words are just what I have expected to hear every time I have expressed affects and acting out behavior. It is as if my inner father moves into John. The Committee gets a body and face. My old God is scolding me. At the same time my inner wolf is awakening. I get angry, furious. I try to let "the culture of inquiry" ask me a question: "What might be right in what John says to me?" I can feel my inner conflict. I thought what I dared to express here was sound, true and important. I think that I am on the right path. I must stick to my therapeutic work of being honest, express the feelings that are coming up, and listen to the stories the feelings are telling me.

7. Art Therapy Group

After the home week Olav painted his father for the third time, and his anger came to the surface. He painted his father's tears when Olav was sick and when his brother died, and his father's bitter tears when his mother left (Figure 10). Olav painted himself, imprisoned in a tear of glass, feeling he had to carry his father's sorrow (Figure 11). He commented: "I am bloody and scared. I have guardians, The Committee, who hold me down and will not allow me to express my sorrow and rage."

In his diary Olav wrote that the father's helpless tears did not move him. His felt he had to carry the father's anguish and sorrow without being allowed to express his own suffering. The rejection of his feelings made him furious. He wrote in big capital letters covering three sheets of paper: "DAMN YOU! BLOODY HELL!"

In his third and last picture of his mother (see Figure 12) he expressed his anger at her for leaving the family. The painting is of whirling red colors of anger but also passionate love. He said:

> I wanted to be in fury today, the rage because she left me. I cannot escape father's image of mother; therefore I am afraid of coming too close to her. She is great. I am longing for

> melting together with her. However, to be close to her makes me afraid and sick. I am afraid of losing her as somebody I can lean against.

Later he wrote in his diary that he felt anger and grief over his mother's leaving. He felt ambivalence when his mother wanted to be close, and his own limitless longing for closeness to her, creating anger, anxiety and shame.

Regarding the last picture of God he had the following comments (see Figure 13).

> I painted the rage that I gradually dare to say is mine. I have felt that Jesus on the cross is but empty words. The cape of lead is my life when I come home. The eyes in the painting wish me no good. I experience mother and me like two birds when we are on good terms. I long for her love. Here I have material for a dream of how life could be.

8. Narrative Group Therapy

In Narrative Group Therapy during phase 3, Olav told the story of his marriage, and felt sorrow and shame in telling about his marital failure. He told the story of his professional life, and how resuming his career frightened him. He was afraid of losing the good things he had experienced in the treatment group.

11. Individual Psychotherapy

The Home Week (activity # 14), especially the meeting with his father, was an important issue in the final individual sessions. Olav had reflected on his father's viewpoint that the reason for not visiting him at the hospital was due to the staff warning that he represented a threat to Olav's treatment process. It struck Olav that his father might have been afraid to be pushy and intrusive, and afraid of provoking Olav to suicide. Olav still longed to tell his story of suffering to his father and to receive his understanding and compassion. Olav reflected:

> Did my father show a love that could bear the pain of being apart—to show that my life was more important than his wish to see his son? Is this true? It's threatening to replace my own experience with this "new" truth. Can I still keep my own feelings as true for me?

12. Self-Evaluation and Feedback Group

At the last evaluation group in week 10, Olav received recognition, warmth, and support from the group and therapists. A quotation afterwards from his diary states:

> I am gaining applause for being "the ideal patient." Can I give applause to myself? I think I am the world's best actor. When I come home there will be no applause. Only anxiety and mistrust of my own will. AA was moved to tears when he recognized that my long and painful journey towards my goals exceeded all expectations. I feel a gap between what he said and my own feelings of anxiety facing discharge and my life at home. After having expressed my negative thoughts I must say that what has happened here is not without significance. A necessary condition for being myself as

> Olav when I come home is to stand upright there. That is what I do here and now. Nobody can take this experience from me!

In Phase 3: The Last Week of the Program

Thinking about living an independent life and possibly resuming his professional career frightened Olav. A recurrent issue was his strong resistance to identify with his strength and spirit, and to face his recovery. He was anxious and depressed before leaving the hospital, feeling utterly dependent on the therapists and the group.

> I feel anxious to leave; it hurts me to lose being a part of this treatment group. I fear that I will be sitting alone in my apartment, totally left to myself.

Olav's last evaluation of the treatment process in his diary read:

> To be together with gifted and strong people has been an exciting, new experience for me. I have been standing on my own feet. I have felt accepted by the group in my fear and despair. I have felt embraced. I have dared to revolt against the inner God and The Committee, supported by warm care and insight. The long fight has had a big impact on me. There will be no more injections, pills, straps, and strong male guardians. I have seen glimpses of a good God here. I will not let go of this experience.

Summary of Phase 3: Mission Accomplished.

Though Olav had a relapse with anxiety and depression at the time of discharge from the hospital, he did not relapse when he returned home, and his abandonment feelings were worked through in six follow-up individual therapy sessions in the course of the following year, given to help Olav maintain his gains. After one year he had surprisingly few symptoms and was functioning more stably, even without medication. He did not have further hospitalizations during the following five years. The overview of progress in the whole treatment is summarized in section 8 below.

7. THERAPY MONITORING AND USE OF FEEDBACK INFORMATION

During the therapy process we used the feedback from the patient and groups as guiding information for planning further steps in the subsequent therapy. The therapists read Olav's narratives and diary notes (see activities #8 and #13, respectively, in Table 2). The group evaluation gave important feedback from the group members, as well as Olav's daily affect reports and existential report at the end of every week (see activities #5 and 10, respectively, in Table 2). Further information was received from Olav's comments about his paintings and follow-up sessions. The therapy was also monitored by repeated assessment measures described above, including diagnostic interviews (SCID I and II), the Affect Consciousness Interview, and self-report instruments (SCL-90, BDI, IIP).

8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME

Therapy Outcome

A. Changes on Standardized, Self-Report Questionnaires (Table 4)

BDI**:** Olav's severe depression score at pre-treatment (38) had fallen to a moderate level of depression at post treatment (24), and at follow-up was at a sub-clinical level (1).

SCL-90: Olav's pre-treatment global scores for symptom distress were at a severely high level (2.50). At post-treatment discharge his symptom level was significantly lower (1.50), and at one-year follow-up there was complete absence of report of symptoms.

IIP**:** Olav's IIP-Global score was very high at pre-treatment (2.56), and slightly increased at post–treatment discharge (2.63). However, at one-year follow-up, the interpersonal problem global score was strongly reduced (1.69), and all subscales were strongly reduced, except for over-conscientiousness and submission, where there were only moderate reductions.

According to Jacobson and Truax's (1991) criteria, at one-year follow-up on the BDI and SCL-90, Olav achieved achieved *reliable change* on his depressive and other symptoms from admission. This means that (a) he achieved statistically significant improvement from admission on his scores, and (b) he achieved a move from the clinical to the normal range on his scores.

Also according to Jacobson and Truax's (1991) criteria, at one-year follow-up on the IIP, Olav achieved *reliable improvement* in interpersonal functioning. This means that he showed statistically significant change, although his scores were still in the clinical range at follow-up.

B. Changes in Diagnosis from Pre-treatment to Discharge, to One-year Follow-Up

At former hospitalizations Olav was diagnosed as having major depressive disorder with psychotic episodes and bipolar affective disorder. At our SCID I assessment (see Table 5) we did not find any evidence of bipolarity. His major depressive disorder was long-lasting with only short periods of symptom relief when he felt safe in hospital environments. His condition was assessed as chronic with recurrent episodes of serious symptoms with psychotic hallucinations.

His Axis II diagnoses included borderline and paranoid personality disorders with narcissistic traits. (According to ICD 10 he was diagnosed as "F 61 Mixed personality disorder.") Clinically he filled the following borderline personality disorder criteria: Frantic efforts to avoid real or imagined abandonment, unstable and intense interpersonal relationships, identity disturbance, affective instability, recurrent suicidal depressive episodes, paranoid ideation, and severe dissociative symptoms. His chronic depression was at the diagnostic registration level seen as related to his borderline personality disorder.

At one-year follow up there was no Axis 1 diagnosis, no psychotic features, no scores on depressive episodes or dysthymia, no suicidal ideation, no panic disorder, agoraphobia, social

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phobia, OCD, specific phobias, or PTSD. On Axis II, Olav no longer met diagnostic criteria for paranoid and borderline personality disorders, but had some narcissistic traits. He shifted from paranoid to more intellectual defenses, indicating maturation (Perry & Ianni, 1998). There was also no diagnosis for Axis III or IV. He had not resumed his profession, but was active socially in positions of trust in mental health patient organizations. His Axis V, Global Assessment of Functioning Scale, was 80. This was a remarkable change on all diagnostic axes, considering his long-standing severe pathology and social impairment.

Finally, a six-year follow-up revealed that Olav had maintained all the gains at one-year follow-up.

Relating the Guiding Conception to the Course of Therapy and the Outcome

According to our Guiding Conception, Olav's deep depression and existential pain was closely related to his harsh God representation, called The Committee, and the associated image of himself as a small, crucified child hanging on a big cross. An overview of the VITA strategies in relation to the Guiding Conception of Olav's treatment follows.

Changes Related to Olav's Existential and Religious Issues (Strategy A, see Table 1).

We believe the work with existential concerns is the greatest strength of the Guiding Conception, and one of the most important contributors to Olav's improvement. The transformation of the God image and the harsh Committee from abusive to affirming was the crucial therapeutic work to heal Olav's "Crucified Self." Olav continually expressed the need for a God representation that could be available as an object of faith. The emergence of an affirming God representation seemed to contribute to his growing ability to live alone and renounce his regressive, clinging relational patterns.

His deep religious anguish was expressed through his reference to Genesis 32: 22-28. In this text from the Bible, Jacob is fighting with God through the night, not giving up before he receives God's blessing. Olav identified with Jacob, angry and wrestling against submission to God, but with a deep longing for God's mercy and confirmation. In terms of psychodynamic theory, this conflict with God could be understood as transference of his ambivalent relation to his father. His father and God images were similar, as expressed in his first painting of father (Figure 3). The gradual process of distinguishing between his father and the God image, and the expression of anger towards both, freed Olav to be able to be himself.

At the one-year follow-up, Olav reported that The Committee was dismissed to the distant mountains. The fear, guilt, and rage towards God were replaced by closeness and tenderness to a benevolent God whom Olav felt received by and who loved the real Olav. Olav no longer felt "crucified." Through the reconstruction of his childhood beliefs, he no longer felt obligated to live up to his father's ideals, and he felt free to be himself. This had been Olav's goal from the beginning of therapy, and he began to sense what he described as inner peace, faith, and confidence through a personal ritual he designed for himself. One could say that he learned to use God as a soothing object rather than a persecutory one.

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Narrative Reconstruction (Strategy B, see Table 1)

The variety of VITA writing and drawing activities related to life stories appeared to have helped Olav discover from multiple perspectives (i.e, via meta-reflection) how his illness was based on harsh conclusions drawn from his childhood. Olav wrote that these tasks (especially drawing mother, father, and God) "hit the nail on the head," making clear how the father and God representations seemed to be fused and helping to shift his rigid beliefs. Olav said that the Existential Reflection Group (see #10 in Table 2) also helped him to examine his life from a broader viewpoint, and to change his reactions to it.

Dynamic Relational Patterns (Strategy C, see Table 1)

The strong affirming relationships of Olav's therapists and group members provided Olav the safe environment and "alliance" to work through his destructive emotions and transference reactions, and to help teach him to *mentalize*. The Committee had been his only security. He said he could only give it up when he began to develop trust in what he called "The Outer Committee" (two of his therapists, AA and GS, and the pastoral counselor), and felt secure enough to question God's harsh authority and feel angry at The Committee's voices. Olav also was able to express anger at his therapists and to be affirmed. These new relational experiences seemed to help Olav develop a new sense of a God that affirmed and embraced Olav as himself, without requiring subjugation and self-sacrifice.

Changes in Affect Organization (Strategy D, see Table 1).

The most striking difference from pre- to post-treatment assessment on Olav's Affect Consciousness Interview (ACI) was greater affect-tolerance and affect-expression, due to the fact that The Committee was less harsh and more integrated as part of Olav's self. During the therapy Olav moved from shame, guilt, and not daring to be angry at God, to be able to tolerate and express anger.. After one year, Olav no longer associated only negative feelings with God, but felt closeness and tenderness to God. There were also changes in affects towards his mother and father. When he entered treatment, he could only experience positive feelings or fear, shame, sadness and guilt to his mother, but after treatment he was able also to tolerate and integrate anger and jealousy towards his mother for leaving the family. Olav said the affect work helped him realize that he has similar feelings to his father and God (mainly anxiety, shame, guilt, and sadness), and dared not to be angry with either. After Olav accessed anger toward his father, he started to feel interest and happiness toward his father, though not tenderness,.

Overall, the intensive, repeated work to identify, tolerate, and manage his affects laid the groundwork for Olav to face and bear the feelings connected to these haunting inner images and relationships. An important part of the affective work was becoming aware of how he maintained shame and unbearable self-criticism by using God and The Committee's "voices" to punish, condemn and "crucify" himself for not living up to his father's high expectations. He also became aware that his identification with the crucified Christ was his way of paying the penalty for the pain and break-up of his family and for his "survivor" guilt due to the death of the twin brother. As the shame and guilt receded, he said he increasingly experienced intense feelings of

anger and grief, which then led to change in his overall defensive functioning (e.g., a reduction in paranoia and self-attack).

Meta-Reflection

Finally, the development of meta-reflection allowed Olav to step back and take a broad, more compassionate and universal perspective on himself, his feelings, his relationships, and his life. Olav reported that he gradually became able to contain ambivalence without externalizing it into "all bad" or "all good," and to understand the difference between the *feelings* of being haunted and *actually* being haunted.

These recorded changes were evaluated and confirmed in repeated discussions among the three authors and external consultants, and thus suggested reliable changes in Olav's interpersonal and social functioning, tolerance for affects, insight, and problem-solving adaptive capacity. These data lend support to the VITA treatment contributing important changes during Olav's treatment stay.

Six-Year Follow-Up

Olav's last letter was received five years after his one-year follow-up and confirmed that he had maintained his gains. He had re-married, and was working in another field. Thus, Olav's continued changes, including the almost complete absence of reported symptoms and strong reduction of interpersonal problems. Although the self-other restructuring was far greater than expected in this case, he still had maladaptive interpersonal patterns and he was actively struggling to find new ways of relating to others. Thus, Olav was able to regulate affects in a non-regressive and not destructive way without medication, which suggests that the VITA treatment provided Olav tools to continue the psychotherapeutic process on his own.

Strengths and Weaknesses of the Guiding Conception in the Case of Olav

This case illustrates the value of applying concepts from psychoanalytic object relations theory and intensive work with affects to religious belief and the image of God. It also illustrates the importance of looking at narrative material, for enhancing meta-reflective processes to deal with and change pathological constructions of meaning and religious ideation developed through childhood and adolescence.

This was crucial for instilling and sustaining hope in Olav and for providing him the experience of a safe place. In this safe place he could dare to explore his religious issues psychologically and to develop a language and ability to increase mentalization processes and a capacity for meta-reflection. Without the preparation process he would probably have had a high risk of regression to self-attack and dissociations. His low degree of affect-tolerance would probably had lowered his chance of being capable enough to engage in the psychotherapeutic work to transform them. This case study is in line with other studies that links facilitation of patients emotional experience, tolerance and expression with patients improvement over the course of psychodynamic psychotherapy (Diener, Hilsenroth, & Weinberger, 2007)

A limitation of this study might be that the case analysis has been carried out by the founders of the VITA Treatment Model, who also served as therapists and supervisors in the program. Therefore we as authors naturally would be selective due to our guiding conceptions and as such biased in the formulation of therapeutic change factors. Nevertheless, the extensive research on the VITA treatment (Austad & Follesø, 2003; Austad & Stålsett, 2007; Stålsett, Austad, Gude, & Martinsen, in press; Stålsett, Rønnestad, & Monsen, submitted) lends support to our assumption that the VITA Treatment Model was crucial for positive change in this case study for long-standing existential suffering and psychiatric illness. The therapy had changed Olav in a way that made a difference, which is the way former patients may define "good outcome" in psychotherapy (Binder, Holgersen & Nielsen, 2010). Research is currently underway aimed at empirically documenting in even more depth the specific processes and pathways involved in change elicited by the VITA- treatment model.

Conclusion

This case study of Olav illustrates the importance of acknowledging and validating a patient's deep religious longings as genuine. At the core of Olav's pathology was the belief that he was being persecuted by God and "God's Committee," but seven years of prior treatment had not dealt with his affects and thoughts related to religious material. Because VITA directly addressed his affects and meaning constructions about God, Olav could begin to see the defensive aspect of his God image. He could explore and gradually alter the associated affects (e.g., from shame to self-compassion), and could then transform his rigid and destructive belief system of a "Crucified Self" to the freedom to be "Olav." This transformation may suggest that the VITA model integrating an existential model anchored in psychodynamic theory was of importance for the specific therapeutic work with his defenses and resistance to change. The patient developed his own resources and became able to address anxiety-related existential topics. Olav also developed skills through working with self-narratives as meaning construction (see Hermans, 1999), as affect-regulation, and as meta-reflection exercises that seemed to have given him strength to resist relapse.

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Table 1. VITA's Main Strategies, Goals, and Activities

Strategies	Description	Main Goals	Main Activities *
A. Identify existential and religious issues and related painful feelings	Patients are helped: (1) to identify, experience, and reflect on (a) hidden existential issues, (b) associated painful affects, and (c) the psychological function of maladaptive beliefs (what the belief does for the patient); and (2) to share these experiences with others.	Meta-Reflection (the capacity to have a "bird's eye" view of the self as seen from a universal perspective): To help patients achieve meta-reflection To focus treatment interventions by tailoring treatment to the individual patient To help patients feel accepted as part of all humanity with universal concerns To transform rigid affect-belief systems	3. Morning Meditation Group 4. Psycho-Education Group (on existential issues) 10. Existential Reflection Group
B. Explore life stories and rigid conclusions	Patients write their life stories three times during treatment to identify rigid beliefs (narrative constructions) & feelings about self & others. Patients also paint or draw images of themselves, their parents, and God three times during the program.	Meta-Reflection & Mentalization (the ability to understand the mental state of oneself and others based on overt behavior): To view one's own life from different perspectives To strengthen tolerance of ambiguity, uncertainty, and contradictions in life To alter rigid conclusions about the self and others To contain ambivalent feelings in one's life stories	2. Daily Diary 8. Narrative Therapy Group (writing life story three times)
C. Identify origins in dynamic-relational patterns	Patient's emotional conflicts are traced back to origins in early life relations of mother, father, and God ("self-object representations"'). Psychodynamic group sessions with a "here and now" focus activate scenes from the past to be processed with other group members.	Mentalization: To make the patient aware of relational patterns and transference reactions, and the subjectivity of their perceptions To trace emotional conflicts to the "right address" so feelings are not acted out inappropriately towards the wrong person To alter destructive interpersonal responses, e.g., projections, submissiveness, and over-conscientiousness due to shame and guilt.	6. Psychodynamic Group Therapy 7. Art Therapy Group 11. Individual Psychotherapy 12. Self-Evaluation and Feedback Group

Table 1. VITA's Main Strategies, Goals, and Activities (continued)

Strategies	Description	Main Goals	Main Activities *
D. Intensive focus on specific <u>affects</u>	Patients explore nine specific affects with the Affect Consciousness Interview (ACI; details in Appendix 1) that evaluates affect awareness, tolerance, integration, and expression. Patients practice daily to learn about affects by writing, painting, sharing, and diary-writing.	<u>Mindfulness: "Calm Eye in the Midst of a Storm":</u> To heighten awareness of affective signals and their meaning. (What does affect tell about past experiences, present relationships, and expectations about future?) To validate, express, and regulate emotion. To integrate opposing emotions and tolerate ambivalence.	1. Affect Consciousness Interview 2. Daily Diary (reports on affects) 3. Morning Meditation Group 4. Psycho-Education Group (on affects) 5. Affect Reports & Relaxation Group

* The Activities listed in this table, numbered 1-12, are described in Table 2. Note that each of the 14 Activities described in Table 2 contributes, in varying degrees, to the achievement of each of the Main Goals. However, only the most relevant Activities for each main goal are listed above.

Table 2. Treatment Activities and Descriptions in the VITA Program

Treatment Activity	Description of Activity and Specific Goals
1.Affect Consciousness Interview (see Appendix 1)	An assessment of nine specific affects and their functioning. This knowledge is incorporated whenever needed during treatment, especially in individual therapy. Goals: To help patients identify affect signals, as well as tolerate, experience, and express feelings
2.Daily Diary	During alone-time each day, patients write in diaries about significant happenings during treatment. Goals: To identify and express emotions. (Helps develop affect regulation and meta-reflection.)
3.Morning Meditation Group	To begin each day, silent meditation follows reading of a short existential text. Led by AA. Goals: To develop mindfulness by increasing awareness of body and feelings; to strengthen the capacity to tolerate and regulate feelings; and a step toward developing meta-reflection.)
4. Psycho-Education Group	Lectures on emotional topics (by GS), e.g., the "culture of inquiry" and "becoming a detective" about one's reactions (why responses occur, with whom, and with what purpose). Lectures on existential topics by LGE, e.g., the "Path of Life" task: to write one's life story from birth to the present at three times during treatment. Goal: To educate the patients about affect & narrative work and the process of therapy.
5. Affect Reports & Relaxation Group	At the end of the day, first, an "emotional weather report" of feeling in "here & now"; and then relaxation to reflect on feelings. Goal: To practice affect consciousness and "mentalization" (see Table 1), that is, to understand both behavior and feelings and their links with specific mental states, in oneself and in others.
6. Psychodynamic Group Therapy	Sessions, led by AA, have a "here and now focus" to examine conscious and unconscious feelings and experiences. Supervised (by GS) behind one-way mirror and followed by discussion with whole team. Goals: To detect past relationship patterns transferred to the staff & patients, and to find "the right address" (the appropriate target) of one's feelings. All this aids in mentalization.
7. Art Therapy Group	Patients draw or paint in silence, then comment. Drawing is done each week in the following sequence—(a) self, (b) father, (c) mother, and (d) God—once each in each 4-week phase of the 12-week treatment. Goals: To evoke affects and new memories related to inner representations of self, father, mother, and God. Drawing helps gradually transform rigid representations of self and others, and it contributes to new memories and views about self.

Table 2. Treatment Activities and Descriptions in the VITA Program (continued)

Treatment Activity	Description of Activity and Specific Goals
8. Narrative Therapy Group	In weekly narrative group, each client tells a key life story and receives comment. Goals: To identify key life stories; to see humans as "meaning makers"; to identify rigid conclusions about self and others; and to understand how these contribute to dysfunctional living.
9. Physical Exercise Group	Physical, playful group activity (mostly outdoors) to help recognize bodily responses and positive affects, but also to note negative feelings, such as jealousy and shame arising from competition and comparison of performance. Goals: To release tension, to reduce depression, and to build coping.
10.Existential Reflection Group	Patients reflect on the week from a "bird's-eye" view to identify existential issues beneath their affects and struggles, and to share this with the group. Led by GS. Goals: To develop meta-reflection (see Table 1); to build capacity to tolerate ambiguity; to see self in a broad perspective & experience being vulnerable, imperfect, & human, like all humanity. To reduce mistrust of others & shame about the self.
11. Individual Psychother-apy	Dynamic exploration of all facets of the program, including alliance with therapist, a focus on affects & inner conflicts, & encouragement to share concerns in group sessions. Goals: To provide support during the program and to make connections among the different parts of the treatment, the past, and the future.
12. Self-Evaluation and Feedback Group:	Patients evaluate themselves in relation to the reasons and goals for treatment, what goals are reached, and what still needs to be worked on. Feedback is given from the group. Goal: To help see existential dilemmas as universal concerns, and part of all humanity.
13. Pastoral Counseling	Optional: Patients may choose to speak with a pastor. Goal: To address religious belief and doubt, and sometimes prayer, blessings, and rituals.
14. "Home Week"	One week's break in the 8th week to go home and practice new learning related to everyday demands. Goal: To help maintain treatment gains by providing practice time & support before the end of the program.

Table 3. Frequency of the Treatment Activities

Treatment Activity *	Frequency	Times during 12 weeks	Duration of Activity
1. Affect Consciousness Interview (ACI)	Weeks 1 and 12 **	2	1-3 hrs
2. Daily Diary	Monday-Friday	60	Open
3. Morning Meditation Group	Monday-Friday	60	15 min
4. Psycho-Education Group Session	Every other week	6	60 min
5. Affect Reports and Relaxation Group (end of day)	Monday-Friday	60	30 min
6. Psychodynamic Group Therapy	Twice a week	24	90 min
7. Art Therapy Group:	Once or twice a week	12 to 24	60 min
8. Narrative Therapy Group	Once a week	12	75 min
9. Physical Exercise Group	Twice a week	24	60 min
10. Existential Reflection Group	Once a week	12	45 min
11. Individual Psychotherapy	Once a week	12	45 min
12. Self-Evaluation and Feedback Group	Once every 4 weeks	3	30 min
13. Pastoral Counseling	Weekly for 8 weeks	1	45 min
14. “Home Week”	Eighth Week	1	1 week

* All Group sessions are observed through a one-way mirror, and the supervisor holds discussions with the staff for 60 minutes afterwards.
In Olav’s treatment, the authors were involved as follows: AA was the individual therapist and a group therapy leader; GS, a group therapy supervisor and leader in the existential group, a Psycho-Education Group co-leader, and offered extensive individual affect work sessions; and LGE, a Psycho-Education Group co-leader and a supervisor on existential group issues.

**Olav received a year of monthly ACI interviews prior to treatment and additional work within treatment.

Table 4. Reliable Change and Reliable Improvement from Admission to Discharge and from Admission to 1-Year Follow-Up in Olav's Scores on the SCL-90, BDI, and IIP

Measures	Admission	Discharge	1-Year Follow-Up	Cut off scores for normal samples
BDI	38	24*	1**	10
SCL90 GSI	2.50	1.50*	0.00**	1.0
Somatization	2.80	1.20*	0.00**	
Obsession	3.60	1.40*	0.10**	
Sensitivity	2.80	1.30*	0.10**	
Depression	3.70	2.60*	0.00**	
Anxiety	2.80	1.80*	0.10**	
Hostility	1.80	0.80**	0.00**	
Phobic	2.60	1.40*	0.00**	
Paranoid	2.30	1.70*	0.00**	
Psychotisism	2.10	0.90**	0.00**	
IIP – Global	2.56	2.63	1.69*	.88
Hard to Submit	0.75	0.75	0.25**	
Hard to Assert	3.88	3.75	3.00	
Too Controlling	1.25	1.88	1.88	
Hard to be Social	2.38	2.50	0.00**	
Too Responsible	3.63	3.75	3.13	
Hard to be Intimate	3.50	3.13	1.88*	

* *Reliable improvement* on Jacobsen & Truax's (1991) Reliable Change Index, that is, (a) statistically significant change occurred between admission and the subsequent assessment, but (b) the score did *not* move from the clinical range to the normal range.

** *Reliable change* on Jacobsen & Truax's (1991) Reliable Change Index, that is, (a) statistically significant change occurred between admission and the subsequent assessment, and (b) the score moved from the clinical range to the normal range.

Table 5

Olav's Clinical Diagnosis at Pre-treatment, Discharge, and One-Year Follow-Up

	Admission DSM III-R Diagnoses		Discharge DSM III-R Diagnoses		One-Year Follow-Up* DSM III-R Diagnoses	
Axis I	296.34	Major Depressive Disorder, Recurrent, Severe With Psychotic Features	296.34	Major Depressive Disorder, Recurrent, Severe Without Psychotic Features	------	None
Axis II	301.83 301.0	Borderline Personality Disorder Paranoid Personality Disorder Narcissistic traits	301.83 ------	Borderline Personality Disorder --------- Narcissistic traits	------ ------	---------- ---------- Narcissistic traits
Axis III	4	Urinary Incontinence	------	None	------	None
Axis IV	5	Occupational Problems Social Isolation	------	None	------	None—not working, but active in non-profit organizations in positions of trust
Axis V	50		65		80	

* Six-year follow-up indicated maintenance of one-year follow-up gains, with Olav working again and married.

Figure 1. Two Circles: An inner tribunal of judges

Figure 2. The Family of Origin: On the Titanic heading for an iceberg

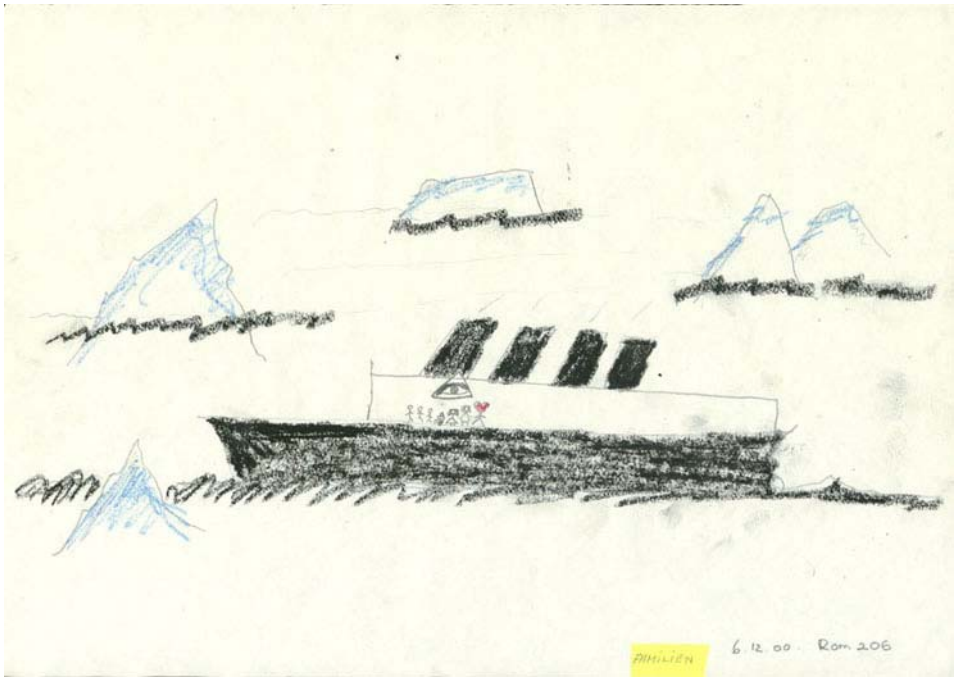

Figure 3. First drawing of mother: A crushed image

Figure 4. First drawing of father: father with divided face hiding behind a stone wall

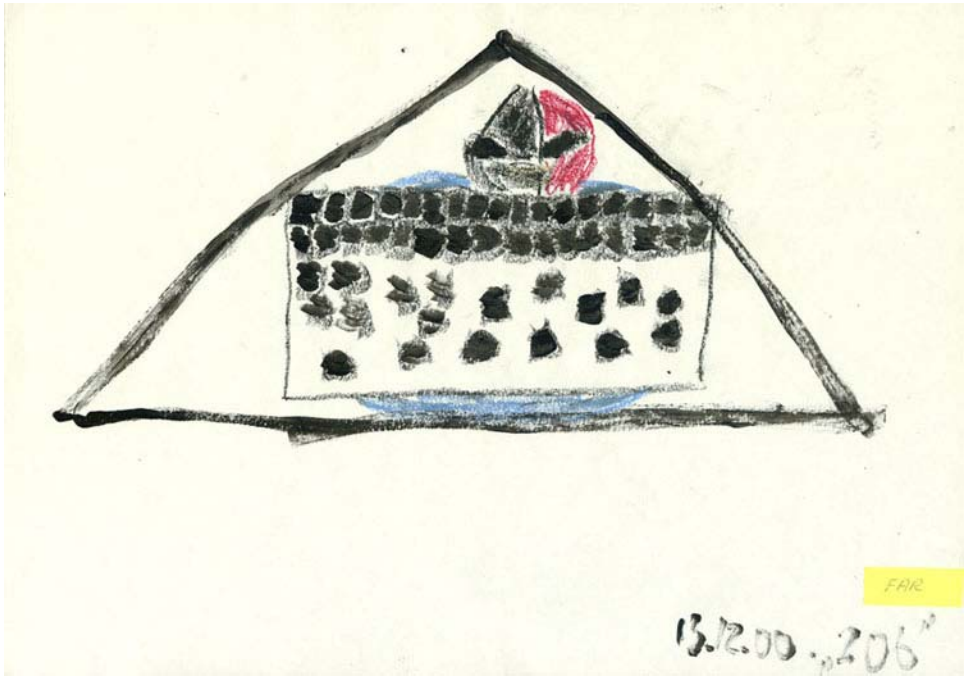

Figure 5. First drawing of God: crucified child on a cross watched by God and The Committee

Figure 6. First drawing of Self: Olav as a child locked behind blue bars

Figure 7. Second drawing of Father: With a divided face and Olav in his pocket

Figure 8. Second drawing of Mother

Figure 9. Second drawing of God: two tables of Holy Communion -- Sorrow vs. Love

Figure 10. Third and last drawing of Father:
his tears over Olav's sickness, his brother's death, and his mother leaving

Figure 11. Third and last drawing of Self: imprisoned in a tear of glass & his father's sorrow

Figure 12. Third and last drawing of Mother: whirling red colors of anger and love

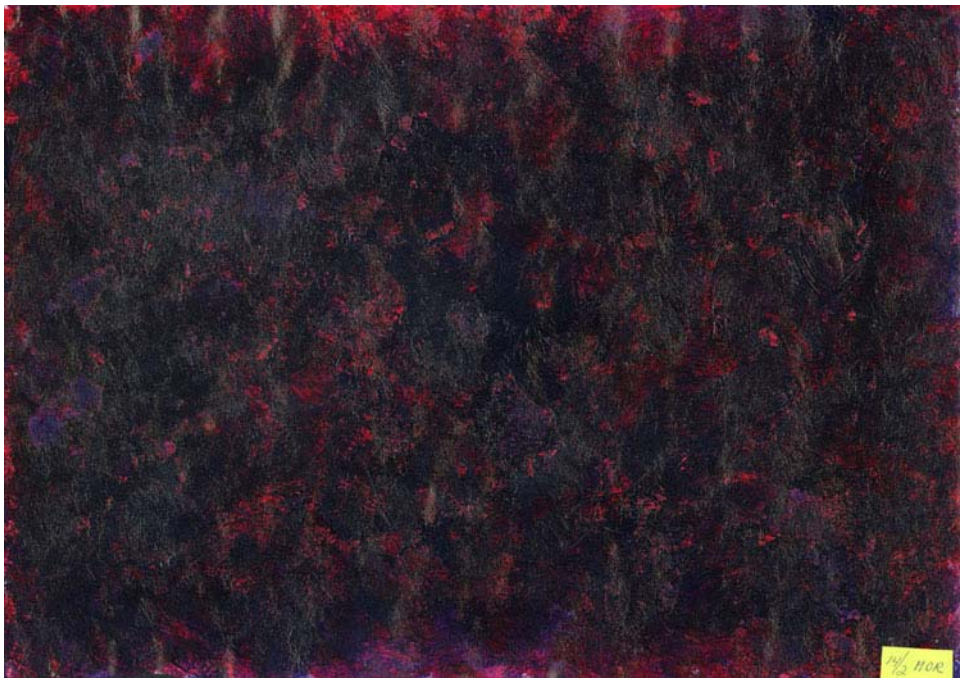

Figure 13. The last picture of God

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Appendix 1: Affect Consciousness Interview

A semi structured Affect Consciousness Interview (Monsen, Eilertsen, Melgård, & Ødegard, 1996) was administered four times: at pre-treatment, in the first phase of treatment, at post-treatment, and at one-year follow up. Patients were evaluated and asked questions related to awareness, tolerance, non-verbal expression, and verbal expression across the nine basic feelings: interest, joy, fear, anger, shame, sadness, jealousy, guilt, and tenderness. By an extended version of this interview (Stålsett, 1998) patients were asked how they associate each of the affects to their father, mother, and God.

The affect consciousness concept describes the mutual relationship between activation of basic affects and the individual's capacity to consciously perceive, reflect on, and express these affect experiences. Affect consciousness is defined as degrees of awareness, tolerance, nonverbal expression, and conceptual expression of the nine specific affects (Monsen & Monsen, 2001). The underlying assumption is that a generally low level of affect consciousness implies a disturbance of the adaptive functions of the affects in the organization of self-experience, and this also includes the capacity to represent oneself interpersonally (2001, p 289).

The main questions in the interview inquire about in which situations patients feel an affect, how it feels, how the specific affect leads them to act, what they are doing with the specific affect when it occurs (repress, allow themselves to feel it, and so forth), what meaning they attribute to the affect, and if they show the affect to others (and why or why not). Typical questions in exploring awareness signals, such as in fear, include: " How do you know you feel fear?" Here's an example from Olav's case:

> Interviewer: " How do you know you feel fear?"
>
> Olav: "When I hear The Committee, when I think about loosing my therapist or leaving this treatment, to be abandoned and trapped forever by The Committee."
>
> Interviewer: "How do you sense and recognize the feeling as fear?"
>
> Olav: "I am breathing faster, my heart is beating, I feel the need to fly away. But I am trapped, so I close my eyes and try to hide. I feel very alone."
>
> Interviewer (exploring tolerance, asks such questions as): "When you are afraid, how does this feeling affect you?" "What can this feeling do to you?" "When you notice that you are afraid, what do you do about this feeling? " Do you believe that this feeling can tell you something?"
>
> Olav (responding to the latter question): "Yes, it tells me how afraid I am to be abandoned."

The following types of questions explore emotional expression on each single affect (A1-A9): "How do you feel about showing others that you are (A1-A9)?", and "How do you feel about telling others that you are (A1-A9)?" (Monsen & Monsen, 1999).

In addition, the first author (GS), in the context of VITA's theoretical basis and treatment goals, expanded the interview to include questions how the affects (A1- A9) were related to object-relations, including inner representations of mother, father, and God. Each affect was mapped. For example, Olav said: "I associate fear with my mother because I am afraid to lose her. In some situations I am afraid the image of her as a liar might be true, that she is dangerous and heartless, and other times I am afraid that I am longing too much for her, that this longing might be too intimate." In relationship to his father, Olav was afraid of not living up to his standards. Olav also said he felt that his father was afraid of his own feelings and also afraid that Olav would commit suicide. In relationship to God, Olav answered that he was afraid of God as a harsh judge who persecuted him, and that God would condemn him.

Olav was administered the ACI interview as a whole four times, just as everyone else in the VITA treatment. Each interview was tailored for him by adding some extra sessions in which one affect was addressed at a time. The purpose was to map his particular affect organization with regard to how his affects were linked to his inner drama with the Committee, and by this to elicit awareness and facilitate his ability to mentalize and participate in inquiry into his automatic associations and his interpretations of these. These interpretations included at the beginning how his affects initially impaired his psychological well-being, contributing to his lack of experiencing "freedom" and to his pathology; and later, how the awareness, acceptance, and tolerance of affects could assist his growth towards increasing health.