

Response to Commentaries on: Affect Phobia Therapy for Mild to Moderate Alcohol Use Disorder: The Cases of "Carey," "Michelle," and "Mary"

**Wanting Too Much and Too Soon –
The Therapist's Clinical Perspective**

MY FRANKL^{a,b,c}

^a Department of Behavioral Science and Learning, Linköping University, Linköping, Sweden

^b Stockholm Center for Dependency Disorders, Stockholm County Council, Stockholm, Sweden

^c Correspondence regarding this article should be sent to My Frankl, Magnus Huss-mottagningen, Beroendecentrum Stockholm, Gävlegatan 22C, SE-113 30 Stockholm, Sweden

Email: my.frankl@sll.se

ABSTRACT

This article is a response to commentaries by Kristin Osborn (2020) and Bjorn Philips (2020) on three case studies I conducted (Frankl, Wennberg, Berggraf & Philips, 2020), which involved the use of a 10-session Affect Phobia Therapy (APT) with individuals diagnosed with mild to moderate Alcohol Use Disorder (AUD). The response focuses on four main areas: (a) the tension between the need for systematic assessment and core conflict formulation in each case versus the need for efficiency and accessibility in the design of a "first-line," 10-session version of APT, which is typically much longer in length; (b) specific considerations in applying APT to AUD; (c) research design considerations associated with the three case studies; and (d) my personal experience as the therapist in conducting the 10-session APT with these three AUD cases. I conclude with a proposal for incorporating the critical points from the commentaries into future studies.

Key Words: Affect Phobia Therapy (APT); Experiential Dynamic Therapy; Short Term Psychodynamic Therapy; Alcohol Use Disorder (AUD); clinical case studies; case studies.

TREATMENT OBJECTIVES IN AFFECT PHOBIA THERAPY

Assessment and Core Conflict Formulation

Making a thorough psychodynamic assessment to begin to understand a patient's pain, and planning for the forthcoming treatment is an important step in resolving the problems that may arise in treatment. This step helps to rapidly find a focus in therapy and to avoid obstacles due to factors in the patient's environment. In her commentary on my case studies of "Carey," "Michelle," and "Mary," Osborn (2020) stresses this importance of assessment and case formulation in APT. In short-term experiential psychotherapy the rationale for treatment is important to describe to and discuss with the patient at the start of therapy, including the treatment method involving exposure to affects and simultaneous anxiety regulation. The experiential focus is likely to be anxiety-provoking, making it that more crucial to stress the

collaboration between patient and therapist in the patient's process of change. Considering the above, in retrospect, I believe my three cases would have benefitted on more extensive patient preparation prior to inclusion.

The aim of my three case studies was to investigate whether 10 sessions of APT could help Carey, Michelle, and Mary reduce their alcohol use and gain symptom relief, as a first-line treatment. Since the goal was to study the feasibility of such a first-line treatment, the therapy was designed to be easily given and open for many. Thus thorough assessments were not conducted since they would delay the start of treatment and would reduce accessibility for the patient. In an effort to stay close to the circumstances of psychotherapy routinely conducted at the Stockholm Center for Dependency Care, the regular standards for assessment in first-line psychological treatment were applied in our study.

In psychodynamic psychotherapy the central theme or core conflict should always guide the therapeutic process. In short-term therapy, this becomes essential, but it is not an easy task, especially when there are multifaceted problem areas within the patient's inner structure related to history as well as to the patient's current life. Osborn (2020) suggests that the core conflict formulation created for Michelle and Mary were too complex for the ten-session APT format, and that the two therapies should have been more focused on the goal of *restructuring sense of self and others* as opposed to the additional goal of *adaptive defense and affect restructuring*. (See the discussion of these goals in terms of Malan's two triangles in the original case study article [Osborn, 2020] and the description below).

Osborn may well be right. The aim of our study was to begin to explore if APT was a possible treatment for patients who struggle with mild to moderate Alcohol Use Disorder (AUD) and dysfunctional adaptive affective functioning. In that respect we were eager to see if the main objectives in APT—that is, defense and affect restructuring, and self- and other-restructuring—were achieved for our three patients. Following the APT manual (McCullough et al., 2003), I was inclined to formulate the core conflict formulations together with Carey, Michelle, and Mary in the spirit of the manual by focusing on their basic affects. Even though McCullough et al. clearly point out that the therapy needs to be focused on self- and other-restructuring when the patient's sense of self is too weak for affect exposure, it is easy to set the goal of defense and affect-restructuring first, since that is the core objective in APT.

Sense of Self/Self-Compassion, Sense of Others/Closeness

The construct of *sense of self* in APT includes empathetic and realistic qualities in a patient's experience of an adaptive self-image (McCullough & Andrews, 2001; Schanche, Stiles, McCullough, Svartberg, & Nielsen, 2011), including self-understanding and self-care. Self-compassion is a closely related concept that is intended to capture a compassionate self-to-self relating when confronted with personal suffering (Neff, 2003), which can then be linked to abundant feelings of guilt and shame. *Sense of others* involves one's views of others, that is, whether the experience and understanding of others can be open, compassionate, and realistic but with healthy boundaries and interdependence (McCullough et al., 2003). Adaptive sense of self and sense of others are needed for the ability to develop and sustain close relationships with others and to maintain a balance between autonomy and closeness. *Self-restructuring* and *self-other restructuring* are the processes in APT in which exposure and response inhibition to

phobias connected to sense of self and others are worked through. Osborn links difficulties that arise in the therapies with Michelle and Mary to the insufficiency of the care-giving they received in early childhood. McCullough views sense of self and others as affectively-based attachment complexes (McCullough Vaillant, 1997). When problems in these areas are abundant, adaptive defense and affect restructuring is not possible. High levels of self-critique and self-misconceptions in relation to the possibility of receiving support will impede the APT treatment objectives.

In the case of Mary, since she grew up in a seemingly safe environment with her mother, father, and two siblings, the lack of care and problems arising accordingly were not detected in the assessment phase face of treatment. In the case of Michelle, more evidence was at hand pointing to early care-givers failing to provide safety due to Michelle having been brought up with an absent mother and a father with an alcohol problem. Nevertheless, Michelle's façade of calm and content made problems in self-related affects difficult to uncover. Thus, the information collected at the start of therapy led me to have high hopes that affect restructuring would be possible for all three patients.

I believe that Osborn (2020) makes a very good point in stating that all three therapies had benefitted with a primary focus on self-restructuring, especially in the short format of ten sessions. If Carey's, Michelle's, Mary's and my own core conflict formulation had all been framed on enhancing positive feelings for self, our limited time frame could have been used more effectively. In our study on Affect Phobia Group Therapy for patients with Substance Use Disorder and comorbid Attention Deficit Hyperactivity Disorder (Frankl, Wennberg, Konstenius & Philips, 2017) there was a significant increase in self-compassion, measured with the Self-Compassion Scale (Neff, 2003) pre-to-post therapy. The use of self-ratings of self-compassion would have contributed importantly also in our case study.

Transference and Countertransference of Positive Feelings for Self and Others, Anger and Loss

A weak sense of self and others involves either devaluation or idealizing views of self and others or a combination of both. Hence the individual possesses a poor ability to see their own and others' strengths and weaknesses in a balanced and realistic manner. My hypothesis is that Michelle's and Mary's weak sense of self in different ways created a transference idealization of me as therapist and of what therapy could accomplish that neither my clinical supervisor nor I detected. The reason for my blindness was most likely due to my own high hopes of positive outcome, which trapped me in undetected countertransference.

In APT attachment-related treatment objectives include facilitating positive feelings for the self; interest and pride in the self; and positive feelings for, interest in, and closeness to others. Exposure to these affective complexes often occurs in the therapeutic relationship, which makes it very potent since it becomes truly experiential in the here and now. Osborn notes that my presence activated strong transference feelings in all three therapies, and she raises the need to work more actively within the transference system, especially with Michelle and Mary.

With Carey, who was able to easily sense and gratefully receive my caring, I myself had problems with accepting her thankfulness, showing how difficult positive feelings for self also

may be for the therapist. Osborn skillfully acknowledges that I missed how shameful Michelle's longings for support and comfort were. If Michelle and I had worked both with positive feelings for self and others, the latter more in relation to me, we could have targeted (a) her inhibitory feelings of shame for not being able to receive the support I was giving her; and (b) her maladaptive defensive anger in relation to me, concealed by her façade of calm and content. In the therapy with Mary, Osborn suggests that we should have explored whether exposure to my positive feelings for Mary and closeness between her and me elicited anxiety and hence defenses to ward the anxiety off.

In reading Osborn's (2020) commentary, I realize that although it is hard to receive positive feelings from a patient, it may be even harder to detect and verbalize potential defensive anger in a patient that is well hidden or unconscious. There was very little anger activated in my therapy relationships with Carey, Michelle, and Mary, possibly because I did not make room for those feelings. In his foreword to McCullough and Valliant's (1997) book, *Changing Character*, David Malan compares APT to Habib Davanloo's Intensive Short Term Dynamic Therapy (ISTDP), the original method of experiential dynamic therapies, where the therapist uses confrontation in full force to block the patient's defenses. Malan argues that McCullough's method of carefully and sensitively pointing out defenses and what use they have had in the past, alas now damaging more than helping, might suit the majority of therapists, and still be as helpful for the patient. Nevertheless, when transference feelings of anger are either at play or the therapist can imagine that they are lurking in the shadows of the unconscious, we as therapists need to have the courage to set them free.

AFFECT PHOBIA THERAPY FOR ALCOHOL USE DISORDER (AUD)

APT as a First Line Treatment for AUD

Testing APT as a first-line treatment for AUD means that treatment can begin at once when the patient seeks help for their alcohol problems, and without a prolonged period of abstinence from alcohol. Hence APT could function as an alternative to such established first-line treatments for AUD as Relapse Prevention (RP) or Motivational Interviewing/Motivational Enhancement treatment (MI/ MET). In the study we included three women with mild to moderate AUD and problems in adaptive affective functioning. One inclusion criterion was seven sober days preceding the baseline measurement. Our results show that this procedure was sufficient for a patient like Carey with a positive outcome. On the other hand, the lack of a positive outcome with Michelle and Mary suggests that Osborn's point about typical APT practice is well taken: that the recommendation for Substance Use Disorder in usual experiential-dynamic therapy (EDT) is one-year of sobriety and absence from drugs before treatment commences.

Shame, Guilt and Alcohol

In her commentary, Osborn (2020) points out that "all three patients hide their drinking from others due to their shame and guilt" (p. 260), and she suggests that "treatment change and outcome [might] improve if we were to explicitly focus on regulating shame related to drinking

instead of decreasing alcohol consumption” (p. 261). Osborn’s point resonates with the literature. Luoma, Guinther, Potter, and Cheslock (2017) point out that feelings of shame relate to an individual's own perception that she or he is flawed or that others have that same belief, while guilt signals to the individual’s self that she or he has done something wrong or hurtful (Luoma, Guinther, Potter, & Cheslock, 2017). Shame has been generally found to be a risk factor for the development of substance abuse, as it leads to avoidant coping behavior with substances and social withdrawal (Dearing, Stuewig, & Tangney, 2005; VanDerhei, Rojahn, Stuewig, & McKnight, 2014). In Nathanson’s (2008) understanding, drug and alcohol abuse is an attempt to deal with shame. In this view, shame serves as an *antecedent* to AUD.

Equally, shame and guilt feelings are *consequences* of substance use, since the addictive behavior is hurtful for the individual and to their close kin, which leads to secondary feelings of shame and guilt. Thus, the problematic feelings become twofold and the need to subdue painful feelings intensifies. In addition to working with shame, I have clinically found that adaptive guilt is essential to work through with individuals with AUD. Psychoeducation is used in APT when describing the rationale for treatment and when working with defense restructuring and anxiety regulation. As such, psychoeducation is one of the main interventions to block defensive behavior. Within a supportive therapeutic relationship it is possible to expose for adaptive guilt; regulate inhibiting feelings of fear, pain and anxiety; and block defensive avoidant behavior, with the purpose of helping the individual to sustain the guilt without fear. In light of the above, an enhanced emphasis upon psychoeducation on the meaning and function of shame and guilt would be valuable in future cases like those of Carey, Michelle, and Mary.

THE STUDY DESIGN

The Design of the Study Versus the Person Being Studied

In his commentary, Philips (2020) describes the criteria for naturalistic outcome designs. One of them is the use of strict rules in selecting patients. I am struck by the fact that even though the selection of the three patients in our study were strict, the three patients turned out to be very heterogeneous in terms of how much trust they dared to put in me as their therapist, their sense of self, and their fear of feelings. We chose socially well-functioning women in stable relationships with not more than moderate alcohol problems. On the other hand, their life circumstances varied, e.g., in the amount of support they received from their partner. Hence, in a small group of three patients with mild to moderate AUD and with no or little comorbidity, the patients revealed very different needs and resources. This level of detail disappears in the quantitative data collection of group design. A patient like Carey and a patient like Michelle could potentially enter an RCT and be given different treatments, with the results showing that one treatment is superior to the other. However, the primary reasons for their different treatment results—that is, the individual differences between the clients on treatment-relevant personality characteristics—would go undetected.

Evaluation of APT with Micro-Process Measures

Both Osborn (2020) and Philips (2020) propose the use of established psychotherapy process measures for systematic and in-depth analysis of the therapy process. The Achievement

of Therapeutic Objectives Scale (ATOS; McCullough et al., 2004) was designed to assess a patient's degree of learning and incorporation of specific treatment objectives in APT. The concept is that when a therapist provides psychotherapy for a patient, the effect of that psychotherapy cannot be determined unless one observes in systematic detail a range of particular and extensive patient responses in the therapy process to indicate that treatment has actually made an impact (McCullough, Kuhn, Andrews, Hatch, et al., 2003).

A great benefit with ATOS is that the treatment objectives importantly coincide, both theoretically and clinically, with the important change mechanisms in Short-Term Dynamic Psychotherapy. (In addition, these objectives clearly represent common factors across different therapeutic methods.) For example, *insight* refers to how well patients can recognize their maladaptive cognitive schemas or defensive behavior. *Motivation* refers to how much the patient wants to give up the maladaptive or defensive behavior. *Exposure* refers to how much bodily arousal of feeling is experienced in the session. *Inhibition* refers to how much anxiety, guilt, shame, or emotional pain is elicited in this exposure process. *New learning* refers to how effectively the patient is able to express these feelings interpersonally outside the session. *Sense of Self* (called "self-image" in typical psychodynamic psychotherapy) refers to a patient's portrayal of positive feelings for the self globally during the session. *Sense of Others* (called "alliance and relationship" in typical psychodynamic psychotherapy) refers to patient's portrayal of positive feelings for others globally during the session. ATOS is a scale designed to assess patients' attainment of these treatment objectives, reflecting the results of a search for the active ingredients in treatment (McCullough, Bhatia, Ulvenes, Berggraf, & Osborn, 2011).

I fully agree that ATOS would have been a very valuable instrument for my case studies of Carey, Michelle, and Mary, as it would have augmented the narrative analysis in the evaluation of the three therapies. The reason for not using ATOS was primarily related to a lack of resources. There was no research budget for the time-consuming ATOS-ratings, which is unfortunate since it would have contributed to essential information to our knowledge of AUD and affect regulation, for example; and, as mentioned in Osborn's commentary, to our knowledge of the role of shame. The use of ATOS ratings would also have been informative about the roles that Sense of Self and Sense of Other played in the therapeutic process when I as the therapist explicitly and implicitly exposed the patients for positive feelings for self and others. A rich sample of what we may have seen in the micro-analysis of ATOS is provided by Osborn in her commentary. When the study was planned and conducted, our focus was on the multiple baseline design. Hence, we organized the evaluation methods accordingly. Later, the significance of the specific content of the therapy process grew as we realized how informative and rich the therapeutic material was along with our realization that the three individual therapies were too small a sample for the multiple-baseline approach to be fully applied.

Note that the Ten-Session Summary Form Osborn refers to in Appendix 1 of her commentary was not in use when conducting APT in Sweden. Consequently, my colleagues and I lacked knowledge of this instrument.

THE THERAPIST'S NEEDS AND WISHES

The primary goal of APT is to help relearn the natural response of expressing emotions, with the wants and needs associated with them, and to do this in a regulated manner and in consideration of what others want and need. Reflecting on and evaluating my own emotions, needs, and wants as an APT therapist, as stimulated by Osborn's commentary, I find that I need more confidence in myself, more courage, and more practice in facilitating experiential work with patients (a) in restructuring their sense of self and sense of others, and (b) in challenging and blocking their defenses.

As a larger context for my experience as a therapist, in his foreword to McCullough-Vaillant's (1997) book, *Changing Character*, David Malan (1976), a pioneer in brief dynamic psychotherapy, argued for a method that intensifies the therapy process. The goal is to resolve the patient's central problem, an endeavor that needs anxiety-provoking methods and a clear and consistent focus. Along with Habib Davanloo, Malan called his model "intensive short-term psychotherapy," although he had wanted to call it "radical," to emphasize the model's potential to reach fundamental changes in working with relatively severe and chronic illnesses using a very active technique of interpretation containing all the elements of full-scale analysis. This was in contrast with the more conservative stance of what brief psychodynamic psychotherapy could accomplish (Malan, 1976). (Colleagues warned Malan not to use the word "radical" because its political connotations might alarm the American public.)

Malan's concept is that when the therapist blocks a patient's defenses by pointing them out, and thereby challenges the patient's guarded, helpless stance, the patient is confronted with the need to take command of her or his own change process. In helping professions like psychotherapy, actively challenging patients is particularly difficult since we are typically taught that our goal is to be supportive of our patients and to take care of them. In contrast, in Affect Phobia Therapy, which incorporates Malan's model, a therapist—myself included!—has to overcome the desire to be supportive at all times. Rather the therapist has to put the change process in the hands of the patient by being free to challenge and confront the patient so that she or he can uncover unconscious core conflicts and make them explicit.

The APT method gives the therapist freedom to adapt the therapeutic work to her or his own personal style, for example by using a variety of imaginative methods, and to be the object of exposure for affects, in the service of the patient. This endeavor is challenging but opens up great developmental possibilities for me personally as well as professionally. After all, these were the very reasons I became a psychotherapy researcher.

DOING MORE CASE STUDIES

Osborn raises questions about two aspects in the design we employed in applying APT to the mild to moderate AUD cases like Carey, Michelle, and Mary. Namely, Osborn suggests that we should not have limited APT to 10 sessions and that we should not have allowed patients to participate unless they were sober for one year before beginning therapy. My experience in the case of Carey shows that for some patients, these two aspects of the design are viable. Moreover, in other mild to moderate AUD cases like Michelle and Mary, who were not successful in my

therapy with them, we might find success by including these two aspects and in addition adopting Osborn's other suggestions: providing a more thorough assessment and case formulation, perhaps selecting out certain cases from treatment based on this information; paying more attention to the issues of shame and guilt; and using microprocessing measures like the ATOS ratings and the Ten-Session Summary Form to provide improved monitoring of the therapeutic process, with associated guidance for corrective action where needed.

REFERENCES

- Dearing, R. L., Stuewig, J., & Tangney, J. P. (2005). On the importance of distinguishing shame from guilt: Relations to problematic alcohol and drug use. *Addictive Behaviors, 30*, 1392–1404. <http://doi.org/10.1016/j.addbeh.2005.02.002>
- Frankl, M., Wennberg, P., Berggraf, L., & Philips, B. (2020). Affect Phobia Therapy for mild to moderate Alcohol Use Disorder: The cases of “Carey,” “Michelle,” and “Mary.” *Pragmatic Case Studies in Psychotherapy 15*(3), Article 1, 214-257. Available: <http://pcsp.libraries.rutgers.edu/>
- Frankl, M., Wennberg, P., Konstenius, M., & Philips, B. (2017). *Affect Phobia Group Therapy for Substance Use Disorder and comorbid ADHD*. Submitted and under revision for resubmission.
- Kazdin, A. E. (2008). Evidence-based treatment and practice: new opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. *The American Psychologist, 63*, 146–59. <http://doi.org/10.1037/0003-066X.63.3.146>
- Khantzian, E. J. (1997). The self-medication hypothesis of substance use disorders: a reconsideration and recent applications. *Harvard Review of Psychiatry, 4*, 231–44. <http://doi.org/10.3109/10673229709030550>
- Malan, D. (1976). *The frontiers of brief psychotherapy. An example of the convergence of research and clinical practice*. New York: Plenum Publishing Corporation.
- McCullough, L., & Andrews, S. (2001). Assimilative integration: Short-term dynamic psychotherapy for treating affect phobias. *Clinical Psychology: Science and Practice, 8*, 82–97. <http://doi.org/10.1093/clipsy.8.1.23>
- McCullough, L., Kuhn, N., Andrews, S., Kaplan, A., Wolf, J., & Hurley, C. (2003). *Treating affect phobia: A manual for short-term dynamic psychotherapy*. New York: The Guilford Press.
- McCullough, L., Kuhn, N., Andrews, S., Valen, J., Hatch, D., & Osimo, F. (2004). The reliability of the Achievement of Therapeutic Objectives Scale: A research and teaching tool for psychotherapy. *Journal of Brief Therapy, 2*, 72–90.
- McCullough-Vaillant, L. (1997). *Changing character: Short-term anxiety-regulating psychotherapy for restructuring defenses, affects, and attachment*. New York: Basic Books.
- Nathanson, D. L. (2008). Prologue: Affect imagery consciousness. In S. S. Tomkins (Ed.), *Affect imagery consciousness: The complete edition*. New York: Springer Publishing. Retrieved from <http://www.tomkins.org/wp-content/uploads/2014/07/PROLOGUE-nathanson.pdf>
- Neff, K. (2003). The Development and Validation of a Scale to Measure Self-Compassion. *Self and Identity, 2*, 223–250.

- Nordfjaern, T., Rundmo, T., & Hole, R. (2010). Treatment and recovery as perceived by patients with substance addiction. *Journal of Psychiatric and Mental Health Nursing*, *17*, 46–64. <http://doi.org/10.1111/j.1365-2850.2009.01477.x>
- Osborn, A.R. (2020). The impact of Affect Phobia Therapy (APT) on Alcohol Use Disorders (AUD)—Evaluating three case studies. *Pragmatic Case Studies in Psychotherapy* *15*(3), Article 2, 258-271. Available: <http://pcsp.libraries.rutgers.edu/>
- Phillips, B. (2020). The quest for causality in psychotherapy research. *Pragmatic Case Studies in Psychotherapy* *15*(3), Article 3, 272-280. Available: <http://pcsp.libraries.rutgers.edu/>
- Schanche, E., Stiles, T., McCullough, L., Svartberg, M., & Nielsen, G. (2011). The relationship between activating affects, inhibitory affects, and self-compassion in patients with Cluster C personality disorders. *Psychotherapy*, *48*, 293–303. <http://doi.org/10.1037/a0022012>