Existential Issues and Representations of God in Psychotherapy: A Naturalistic Study of 40 patients in the VITA Treatment Model

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Summary

This article describes a naturalistic effectiveness study of a day-treatment program in an hospital setting designed for treatment of resistant depression and comorbid Axis II Cluster C disorders. The treatment was designed to meet a missing need in the patient population by focusing on the relational aspects of religious and existential issues. The treatment is based on existential and an object-relational approach to human nature with the objective of facilitating transformation of rigid object representations and addressing existential issues such as the meaning of life, shame, and guilt. This broader perspective of life issues is hypothesized to improve depression and personality functioning and minimize the risk of relapse. Forty patients mostly suffering from depressive disorders with additional anxiety and/or Cluster C personality disorders entered a 12-week day-treatment program. These patients experienced significant reduction in symptoms and increase in occupational functioning. Their relational patterns moved towards increased self-representation (e.g., self confidence, self worth, being active in the world) reflected by reduced submissiveness and reduced over-conscientiousness. The gains were maintained and in some cases had further improved at follow-up. This naturalistic prospective study represents a first step in an evaluation of this new integrative treatment.

Key words: Existential issues, Psychotherapy, Representation of God, VITA treatment model

Introduction

Although existential questions such as meaning, loneliness, guilt and suffering frequently arise in people's lives, they are rarely addressed systematically in psychotherapeutic treatment programs (Ghaemi, 2001). Appropriate methods such as existential psychotherapy, as developed by Binswanger and Boss five decades ago and later elaborated by May and Yalom, are largely ignored in contemporary mainstream psychiatry (Ghaemi, 2001). It is nevertheless assumed by various schools of psychology and psychotherapy that the way a person

deals with religious and existential issues influences his or her sense of identity and perception of everyday relational psychosocial demands (Frankl, 1963; Yalom, 1980, Kernberg, 2000).

Psychotherapists seldom address the psychological function of religion, although it is documented that a large proportion of clients report that religious belief is an important part of their life (Bergin, 1991; Baker, 2000). In a culture where God is an important concept, people will have an emotional and dynamic perception of God as an 'issue', irrespective of whether they confess to be believers or not (Lukoff, Lu & Turner, 1992; Rizzuto, 1979). Addressing existential and religious issues in psychotherapy, as a part of a more culturally sensitive and advanced differential diagnostic evaluation, is increasingly and strongly advocated (e.g., Miller, 1999, Milstein, Midlarsky, Link, Raue & Bruce 2000; Richards & Bergin 2000, 2005; Dowd & Neilson, 2006). The significance of existential crises and religious content in affect-laden cognition and the impact of these matters on the development of psychopathology have been overlooked in research on psychiatric disorders. Recent studies indicate the need for psychotherapists to become better equipped in this field (Pieper & Van Uden, 2000). This is particularly relevant regarding the increasing incidence of depression. In a study from the Harvard School of Public Health, depressive disorders, characterized by feelings of hopelessness and a loss of meaning in life, are expected to be the most frequently reported reasons for a reduced ability to work in the 18–45 year age group by 2020 (Murray & Lopez, 1996).

Schore (1994) argued that existing clinical paradigms should be revised to fit better the goal of facilitating structural changes in patients' relational patterns. Relational issues might well be central in both the aetiology and the perpetuation of chronic psychological distress such as depression (Zuckerman, 1999) and general anxiety disorder (Borkovec, Newman, Pinks & Lytle, 2002). Relational problems and subsequent symptom distress are held to have the same basic origin as personality disorders in an individual's learning history (Pretzer, 1994). In ongoing research and theoretical discussions on personality disorders (Parker, Hadzi-Pavlovic & Wilhelm, 2000),

Widiger (1998) argued that relational problems and subsequent symptom distress can be viewed as simply maladaptive extreme variants of common personality traits. A multi-axial system such as DSM is neutral with respect to the implications of causative relationships for specific conditions listed in Axis I and Axis II (Klerman, 1990). When planning treatment, therefore, the issues of comorbidity, substantial overlap, and the possibility that many disorders might share a common pathogenesis should be considered (Shea, Widiger, & Klein 1992; Kessler, Nelson, McGonagle, Liu, Swartz & Blazer, 1996).

In psychodynamic based approaches, it may be perceived that personality pathology underlies and drives symptoms, and is closely related to maladaptive dealing with affects and existential issues such as shame and guilt (Nathanson, 1992; Schore, 1994). Recent research into shame and depression (Gottschalk, 2001; Andrews, Qian, & Valentine, 2002; Epstein, 2001), guilt-related submissive behaviour (O'Connor, Berry, Weiss, Schweitzer & Sevier, 2000), and the influence of guilt on the severity of depression (Ghatavi, Nicolson, MacDonald, Osher & Levitt, 2002), calls for a greater emphasis on these issues in psychotherapy.

Efforts to develop better treatment programs for patients with depression, anxiety and social impairment should include strategies for intervention that minimize the chance of relapse. It is therefore logical to focus on existential and relational issues through methods which enhance wisdom by meta-reflection and thereby contribute to the patients' ability to cope with psychological distress (Hanna & Ottens, 1995). Furthermore, new models should provide a context for addressing maladaptive intrapsychic and interpersonal problems that are integrated into a active and focused treatment design, and contain planned use of specific concepts and principles in a focused, purposeful way for the population targeted (Cooper, 1995). Contemporary approaches emphasize that we have to match the optimal approach to appropriate candidate (Anchin, 2003), a statement which reflects Kiesler's (1966) programmatic 'specificity' statement for future psychotherapy research. This study's evaluation of a treatment to specifically address patients' exis-

tential problems is a direct attempt to address the call for treatment specificity.

Clinical experience
Having worked for several years in Modum Bad, a national psychiatric hospital, we observed that certain patients who were struggling with existential and religious issues did not seem to benefit from the standard group treatment for inpatients. They tended to score moderately on symptom distress measures, but to report significant psychological pain in confronting existential themes (often termed 'existential pain'), and they were burdened by interpersonal problems associated with social impairment, submissive relational style and persistent occupational disability. Their life histories revealed a self-sacrificing tendency in everyday life, and a submissive, unassertive interpersonal style. Many were suffering from guilt, shame and a repressing and condemning superego containing representations of parents and God.

Theoretical background
The existential approach focuses on underlying issues rather than on the symptoms themselves (Halling & Nill, 1989). Husserl (1936, 1970) used the term 'intersubjectivity' to indicate how, at a fundamental level, humans are at once separate and interconnected. In Binswanger's existential therapy, 'self' and 'world' are correlative concepts, and the impact of experiences in relationships may contribute to the development of psychopathology. From this perspective, we argue that healing (change) of maladaptive rigid structures of inner object world must proceed within relationships, and that groups should be acknowledged as an important agent in such healing.

This argument is in accordance with what is called Lewin's law: "it is easier to change individuals formed into a group than individuals who are alone" (Lewin, 1951). Leary (1957) saw the main motivation for the development of relational styles as the avoidance of the existential fear of abandonment and death. From this perspective, symptoms are external signs of unsuccessful adaptation to the emotional pain of rejection, fear of social disapproval, and low self-esteem. The existential psychologist May (1961) stated that ontological guilt

has solitary effects on the personality, including increased interpersonal sensitivity. On the other hand, the experience of relationships with significant others can structure the psyche and develop relational patterns (Benjamin, 1993; Piper & Duncan, 1999). These dynamic processes are at the core of a common understanding in which the formative relational experiences are the main elements for the development reflected in different theoretical traditions such as: object-representations (Winnicott, 1971; Rizzuto, 1979), affect organizations (scripts) (Tomkins, 1987; Nathanson, 1992; Kernberg, 1990; Monsen, Eilertsen, Melgård & Ødegård, 1996), cognitive schemas (Young, 1990), and narrative key stories (Bruner, 1986, 1987; White & Epson, 1990; Spence, 1982).

The social construct of God (Lindeman, Pyysiäinen & Saariluoma, 2002) and the varieties of psychological representation of God in the individual may be regarded by some commentators as a forgotten subject in mainstream psychology. Recent developments in psychodynamic understanding, however, have to a certain extent changed this situation (Kernberg, 2000). Through clinical research and theoretical reflection inspired by Erikson (1959) and Winnicott (1971), Rizzuto (1979, 1993) has elaborated a theory of the formation of representations of God through the course of identity development. This understanding acknowledged the interplay between development of representations of self, parents and God, supported by several authors in the clinical psychology of religion (Meissner, 1984; Jones, 1991; Shafranske, 1992; Murken, 1998). Clinical research acknowledges the link between bad experiences with parents and the development of psychological illnesses (Parker, 1979). These relational experiences also influence the development of the psychological representation of God (Rizzuto, 1979). The psychological function of the representation of God may be either as a compensatory contrast or strengthening of a punishing inner voice of parents. The representation of parents and also of God are in empirical studies shown to play a role in the individual's object world, and should therefore be focused in therapeutic interventions (Tisdale et al., 1997). The individual might have

concepts of God that differ from his or her inner representation of God. Early affective experiences, in the mirroring from primary caregivers and relational experiences in the different developmental phases (Erikson, 1963) influence the development of the inner representation of God.

For our purpose the understanding of the psychological function of the God representation, as a guiding concept in this treatment, includes fantasies, affects, projections, wishes, fears and defence (Rizzuto, 1979; Meissner, 1984; Jones, 1991). In the field of clinical psychology of religion a central therapeutic focus is to identify pathological aspects of a given belief system and the way it might have a deleterious effect on health, psychological well being, character structure or life adjustment (Meissner, 1996). Specific interventions were designed to work to foster the restructuring of the maladaptive organization of beliefs, meaning-making and affects.

We map each client's religious history and also how each affect is organized in relation to their God representation. This provides enriched information of the client's inner dynamics. The goal is to uncover the psychological issues hidden when a religious presentation of a problem is given.

Theoretical developments suggest that individuals construct narratives or life stories to make sense of who they are and how they relate to others (Bruner, 1986). Negative memories can be targeted in narrative group therapy (White & Epston, 1990) by reframing and reinterpreting the past (Neimeyer, 1995), and by reconsidering conclusions about parents and self in highly sensitive people (Aron, 1996). This approach has provided new tools in psychotherapeutic practice and has expanded our understanding of human beings as creators of meaning, particularly in dealing with painful life events (Bruner, 1986, 1987) and the reasons that these meanings profoundly influence people's lives (Riskind, 1995).

The religious influence on moral standards involving high expectations of self and others, typically associated with a high degree of conscientiousness and submissive and unassertive behaviour, is also reflected in narrative approaches in pastoral care (Augsburger, 1979; Gerkin, 1984). Non-assertive relational strategies are often con-

sistent with a cultural interpretation of 'being for others' as a true expression of Christian love (Augsburger, 1979), which may also be adopted culturally by non-believers. Submissive behaviour is clinically associated with the repression of anger, which often contributes to the development of depression. Submissive behaviour is also more strongly associated with introversion and neuroticism than is assertive behaviour (Gilbert, 1994). Submissive behaviour may also be associated with persistent sick leave, relational problems and symptoms, factors that may also bring an individual to the edge of meaninglessness with shame, guilt and thoughts of death. These factors, especially shame, are viewed as strongly inhibiting natural spontaneity and self-representative behaviour (Nathanson, 1992). We therefore decided to develop a treatment program specifically addressing these inner representations and existential issues related to psychopathology. The model is developed by a psychologist (Gry Stålsett), a psychiatrist (Arne Austad) and a theologian (Leif Gunnar Engedal) and initially supervised and inspired by the work of Ana-Maria Rizzuto and Irvin Yalom (Stålsett, Engedal & Austad, 2010).

Research questions

The purpose of the present study was to:
Investigate whether the levels of symptom-distress, interpersonal problems, occupational functioning, and use of medication would change during treatment, and whether this change would be consolidated during the follow-up period, as reflected in increased work performance.

Test our hypothesis that self-representativeness (i.e, self assertiveness) would develop during the treatment and follow-up period, as reflected by reductions in submissiveness and over-conscientiousness.

MATERIAL AND METHODS
The model

The VITA model integrates different theories and therapeutic interventions into a highly structured treatment plan, focusing on the combination of existential issues and representations of God from various angles. The purpose of the various elements during the program, (based on systematic

weekly and monthly cycles of intervention) was to facilitate patients' capacity to lessen the rigidity of inner objects and to develop the capacity for meta-reflection of their own illness and relationship to significant others by fostering a psychotherapeutic culture of inquiry. Meta-reflection refers to the ability to take a birds-eye view of oneself from many different perspectives including one's affects, inner dynamics, past history, relationship roles – all in the context of one's shared humanity and ultimate concerns. This broad view of the self helps to reduce pathological shame and guilt, normalizes one's dilemmas and increases self compassion and thereby self assertion and self-representativeness.

Therefore, in addition to its object-relational perspective, the model integrates existential, affective and narrative approaches. The narratives are understood as processes by which images of self, parents, and God are interactively created. The VITA model aims at facilitating a process of change in maladaptive object relations and relationship patterns through multiple, repetitive highly focused exercises.

THEORETICAL FOUNDATION

The VITA day-treatment program integrates theoretical assumptions about the significance of emotional and existential issues related to the psychological representations of God. These are considered important maintaining factors in the patients' suffering. The treatment program was the same every week for all groups. The purpose of different elements during the weekly program was to facilitate patients' development of meta-reflection of their own illness and relations to significant others including God by fostering a psychotherapeutic culture of inquiry. The emotional activation of maladaptive object relations; self, mother, father and God in focused art therapy are the core elements of the program. Humans are viewed as creators of meaning, especially in dealing with painful life events. The aim was to help patients to discover how these meanings profoundly influenced their lives today.

The goals of the treatment were to facilitate a process of modifying rigid and destructive internal representations of parents and God. We aimed at strengthening the patients' self representations, helping them to develop wisdom of metareflection, and facilitate changes in maladaptive relational patterns.

TREATMENT PROGRAM

The treatment was composed of highly structured psychotherapeutic programs of a carefully chosen variety of groups conducted between 9 and 3 pm (e.g., psycho-educational groups, art therapy group, evaluation group, existential group, narrative group, affect group and psychodynamic relational group). Every morning started with meditation group for mindfulness training. For example, a short existential text from Dag Hammarskjold's book was read: "The longest journey is the journey inwards." This was followed by silent meditation, ending with the ringing of a bell. The working day ended with training to be aware of emotions as a kind of 'emotional weather-report' around the table (15 minutes), followed by a 15 minutes relaxation exercise.

PSYCHO-EDUCATION GROUPS

Psycho-educative lectures introduce key elements in the treatment model. The patients gets lectures about therapy culture, 'a culture of inquiry', the intention behind the different parts of the program, and about affects. They learn about the two main ways of loosing contact with their feelings. One is 'deadening' the affect due to repetitive painful experiences (Monsen, 1996). The other is 'criminalization' of affects in the family and cultural/religious context (Follesø, 2003, 2005), where some feelings are experienced as 'forbidden' or not acceptable to express. The affects shame and guilt and other existential issues as basic trust, to belong, meaning, isolation, death, freedom are dealt with more in depth and different ways to write a life-story, a narrative, are introduced.

After these lectures the clients are asked to write narratives where they may use concepts introduced in the lessons.

ART THERAPY

The art therapy functioned as a projective method for expressing unconscious inner representations of self, parents, and God. The purpose was to facili-

tate structural changes of rigid images and develop awareness of and ability to express and contain strong emotions.

The weekly art therapy program offered during the three month treatment period, was organized in a monthly cycle in which patients painted their images of self, father, mother and God sequentially, once a week. Every painting session had the same short instruction: First week paint the self, next week father, then mother and at last God. This cycle was repeated three times. Each session lasted 90 minutes. The painting lasted 30 minutes, and then they had 7 minutes each to share what they had painted. The other group members were invited to comment on the picture if they wished to do so. The therapist noted what was said, and this was later written in the record together with a scanning of the picture. The art therapy evoked important emotional material to dynamic group therapy, writing of narratives, and existential reflection.

EVALUATION GROUP

Once a month during the treatment programme, each patient had half an hour evaluation with group members and staff. It is not formatted as a discussion but as a speaker/listener situation, similar to coaching, where the objective is not for the patients to engage in a (defensive) discussion, but to get feedback in order to reflect upon feedback provided. One quarter of the session was used by the patient to evaluate his or her process, and then the group members and staff gave feedback on progress and constructive critic.

EXISTENTIAL GROUPS

To learn to contain and master feelings, the existential group session, which lasted for forty-five minutes at the end of the week played a key role. The session was structured in the sense that each patient had to identify the themes they had worked on during the last week. They were encouraged to develop a meta-perspective on the past week's central existential issues such as basic trust, shame, guilt, meaning of life, freedom and death. The intention was to gain a meta perspective or the bird's-eye view on the past week and the main existential issue they had dealt with. They were encouraged to try to differentiate between emotions and

existential issues, even though these often overlap.

NARRATIVE GROUPS

The narrative groups, arranged once a week, provided a more structured possibility to self-disclose, where they were provided with the opportunity to share their current concerns related to conclusions drawn about themselves and others from earlier life events and experiences. The same instructions were repeated every week: You have 10 minutes each to share a key story from your life. This narrative approach contributes in the transformational process of changing rigid images about parents, God and self. The patients write a narrative about their life three times during the treatment period, enclosing every cycle of painting of self, father, mother and God. The purpose is to capture and consolidate new aspects and nuances which develops in perceptions of their own life and conclusions about self during the treatment process.

AFFECT-AWARENESS GROUP

This group session is conducted in the end of every day. It's called 'the affect-weather report'. The goal is to increase the awareness of the affect in the actual moment and work on the ability to recognize and identify the affect. The aim here is to develop a more elaborated language for affects and be able to learn to contain and differentiate between one's own emotional states and others (e.g. if you feel anxious that other persons are critical to you, it does not necessarily mean that they are critical).

RELATIONAL PSYCHODYNAMIC GROUP PROCESSES

The psychodynamic-relational groups were conducted twice a week, and focused on affects and transference reactions towards the therapists and other group members. Patients were encouraged to explore the qualities and content of their emotions to understand and address other origins for the strong feelings which occurred (e.g., towards parents). The weekly individual session was mainly to foster work with individual processes in the group therapy. Patients were encouraged to write down their feelings and thoughts in a diary at the end of the day and share it during group sessions at daytime.

An objective of the psychodynamic group session was to explore here-and-now experiences and affects in relation to past history, and to contact with more unconscious material connected to the inner object relations, in order to facilitate the integration of affects and insights that have evolved during treatment. Specifically, the aim is to facilitate transformation processes of rigid representations of self, parents and God into more flexible and mature representations.

Sample

Modum Bad is a psychiatric hospital that receives voluntarily-admitted patients from throughout Norway. Patients were selected from typical referrals to the hospital, who reported existential and relational problems as a core part of their chronic mental distress. The final selection came after a two-day pre-examination. Patients were excluded when symptoms were so severe that in depth psychotherapy was not indicated. The patients had to be able to contain their emotions from day to day and not be at significant risk of acting in a destructive manner. Each individual's affect organization was assessed by the semi-structured Affect Consciousness Interview (ACI) (Monsen et al., 1996) which has demonstrated adequate to excellent psychometric properties (Monsen et al., 1995). The ACI was used to map the degree of consciousness of, tolerance for both non-verbal and verbal expressions of nine affects (interest, joy, fear, anger, shame, sadness, jealousy, guilt, and tenderness). For the purpose of this study, the ACI was extended by the first author to include these affects also in relation to mother, father and God. Only patients with an affect organization related to God were evaluated as suitable for the VITA program, irrespective of their personal belief. The ACI has demonstrated good psychometric properties.

The contract between participating patients and the researchers included an affirmation of patients' motivation for group therapy and an agreement to collaborate on their existential and religious problems from a psychological perspective. The clinical evaluation included a diagnostic assessment as well as a belief history. Participants agreed to take part in follow-up investigations one year after discharge.

Table 1. Sociodemography and treatment/illness durations (N = 40)

Gender and marital status	N	%
Females	20	50.0
Single (vs. married or cohabitant)	23	57.5
Highest level of education		
School	8	20.0
College (high school)	17	42.5
University	15	37.5
Previous psychiatric treatment		
Inpatient	7	17.5
Outpatient	35	87.5
Pastoral care	26	65.0
Alternative treatment	23	57.5
Durations (years)	Mean	SD
Age	43.3	9.7
Mental disorder	11.9	8.6
Psychotherapy	4.5	4.3

In the period from April 1999 to January 2001, five groups completed the 12-week program. All patients completed assessments at pre-treatment (T1), at post-treatment (T2), and at a one-year follow-up (T3), all conducted at the hospital. The sample consisted of 20 men and 20 women aged from 28 to 61, with a mean age of 43.3 years (Table 1).

Eighty percent of patients were educated beyond primary school (Table 1). Seventy-five percent were out of work due to long-term sick leave, and 50% were on medication (Table 3). Most patients had suffered from long-lasting distress, and the mean duration of their present disorder was 11.5 years. The majority had previously received treatment without success, with a mean duration of 4.5 years of previous therapy. More than a half had sought additional alternative treatment, and 65% had received pastoral care at some stage.

According to selection criteria, all patients had affect organizations involving the psychological representation of God; 17% did not report themselves as personal believers. One patient attended the program because she mourned her loss of belief in God. Another patient reported surprisingly

strong affects of anger towards a God he did not believe in, but he was not conscious of anger in relation to any significant other. This was an important reason for him to attend this treatment program. Among the participants the affects of guilt and fear dominated, although joy and tenderness seemed to play a role in their attitude towards God. Some patients reported a lack of positive feelings towards their parents as a part of their emotional pain. The issue of shame was central, although many had according to ACI initial problems differentiating this state of affect from the other states of affect.

Assessment

Both qualitative as well as quantitative measures were used. The qualitative measures included the content analysis of patients' narratives and paintings of self, mother, father and God in a weekly sequence. This analysis will be described in a later paper.

A diagnostic distribution is set out in Table 2. DSM-IV diagnoses on Axis I were made by consensus between the first author, who had been involved in the treatment of all the patients, and the last author, an experienced psychiatrist, who reviewed the records and had the patients' scores on the rating scales available. Diagnoses on Axis II were obtained by using the Personality Disorders Questionnaire (PDQ-R) at the pre-examination (Table 2). This is a self-report instrument that screens personality disorders with high sensitivity but a moderate specificity based on the same

Table 2. Distribution of AXIS I and AXIS II Disorders

	T1 Pre-treatment		T3 Follow-up*	
Axis I disorders	N	%	N	%
Major depression, recurrent	33	82.5		
Bipolar disorder	1	2.5		
Dysthymic disorder	14	35.0		
Panic disorder	7	17.5		
Social phobia	6	15.0		
Agoraphobia	4	10.0		
Generalized anxiety disorder	9	22.5		
Post-traumatic stress disorder	1	2.5		
Dissociation disorder	1	2.5		
Pain disorder	1	2.5		
PDQ personality disorders				
Avoidant	22	55.0	16	
Dependent	6	15.0	3	7.5
Obsessive compulsive	18	45.0	8	20.0**
Passive aggressive	4	10;0	0	
Borderline	3	7.5	2	
Schizoid	3	7.5	0	
Schizotypical	3	7.5	1	5.0
Paranoid	3	7.5	2	0.0
Histrionic	0	1.0	0	0.0
Narcissistic	0	0.0	0	47.5
Depressive	29	72.5	19	20.0

* Axis I testing was not conducted at 1 year followup.
** = Pearson chi-square, P<.05

categories and containing the same items as the SCID-II interview (Hyler, Rieder, Williams & Spitzer, 1987).

The following instruments were administered at T1, at T2, and T3. The Symptom Checklist 90 (SCL-90) is a psychometrically-sound symptom scale (Derogatis, Lipman & Covi, 1973) that contains 90 items scored on a Likert scale from 0 ('not at all') to 4 ('extremely'). The mean score is labelled Global Symptom Index (GSI).

The Beck Depression Inventory (BDI) (Beck, Steer & Garbin, 1988) is a widely-used and validated self-reporting instrument for assessing the severity of depression.

The Inventory of Interpersonal Problems (IIP-48) (Gude, Moum, Kaldestad & Friis, 2000) is a self-report instrument with a three-dimensional structure and both theoretically appealing and statistically robust dimensions. It was developed from the original 127 items (Horowitz, Rosenberg, Baer, Ureno & Villasenor, 1988) and validated on a Cluster C sample (Gude et al., 2000). The dimensions are assertiveness, submissive/dominant), sociability (avoiding/intrusive), and interpersonal sensitivity (neglecting/over-conscientious). Owing to the particular characteristics of the sample, the bipolar dimensions of the IIP were calculated as separate scales.

Statistics
Data were analysed using SPSS version 10.0. Chi-square and paired t-tests were used in the statistical analyses. The effect sizes were calculated (M pre-treatment, −M post-treatment/SD pre-treatment and M pre-treatment, −M follow-up/SD pre-test).

Table 3. Change in symptoms and interpersonal problems

	T1 (pre-treatment)		T2 (post-treatment)		T3 (one-year follow-up)		Change T1–T2		Change T1–T3	
	Mean	SD	Mean	SD	Mean	SD	t-value	ES	t-value	ES
SCL-90-R, GSI	1.21	0.50	0.75	0.47	0.59	0.41	6.50***	0.92	7.46***	1.24
BDI	19.70	8.67	11.50	7.96	9.05	7.56	6.35***	0.95	7.18***	1.23
IIP-48 §										
Global score	1.58	0.59	1.26	0.69	1.07	0.66	4.09***	0.54	5.99***	1.27
Domineering	0.93	0.71	0.76	0.62	0.59	0.57	2.21*	0.24	3.63***	0.45
Submissive	2.44	0.75	1.99	1.01	1.85	0.98	2.90**	0.60	3.99***	0.79
Intrusive	1.11	0.76	0.96	0.80	0.75	.66	1.41*	0.20	3.46***	0.47
Avoidant	1.57	0.85	1.18	0.68	1.06	1.01	4.27***	0.46	4.34***	0.60
Over-conscientious	2.42	1.01	1.99	1.04	1.64	0.97	3.73***	0.43	6.52***	0.77
Neglecting	0.98	0.82	0.67	0.70	0.55	C.56	3.52***	0.38	4.41***	0.53

*p < .05 **p < .01 ***p < .001
ES = pre/post effect size, SCL-90-R, GSI = Global symptom index of the Symptom Checklist 90, as revised; BDI = Beck Depression Inventory; IIP-48 = 48-item version of the Inventory of Interpersonal Problems
§ In this paper we used Gude et al's (2000) terminology for the IIP subscales. However each scale corresponds to the original IIP scale (Horowitz et al, 1988) named as follows: Domineering (Hard to Submit), Submissiveness (Hard to Assert), Intrusive (Too Controlling), Avoidant (Hard to be Social), Over-conscientious (Too Responsible), Neglecting (Hard to be Intimate).

Results

Symptom distress

There was a significant reduction in GSI and BDI during treatment (p < .001). During the follow-up period, there were further non-significant reductions in mean scores on both scales (Table 4). The effect sizes were 1.24 for GSI and 1.23 for BDI for the whole course from T1–T3.

Interpersonal problems, capacity to work, and medication

Mean global IIP-scores were also statistically reduced during the treatment and the follow-up periods. The effect size from pre-treatment to one-year follow-up (T1–T3) was 1.27, and for the treatment period (T1-T2) was 0.54 (Table 3). The change in submissive behaviour was significant for both T1–T2 and T1–T3, with effect sizes of 0.60 and 0.79, respectively. The level of over-conscientiousness was also significantly reduced in both periods (T1–T2 and T1–T3), with effect sizes 0.43 and 0.77, respectively. Only 25% of patients were in paid work at admission, and 90% at one-year follow-up (T3). At pre-treatment (T1), 77% used medication (mostly antidepressants), compared with only 22% at one-year follow-up (T3) (Table 4).

Personality

While 45.0% of patients met the PDQ criteria for obsessive-compulsive personality disorder at pre-treatment, only 20.0% fulfilled the criteria at follow-up. A similar pattern was observed for depressive personality disorder (in concordance with the former DSM diagnostic system), which was reduced from 72.5% at T1 to 20.0% at T3. Avoidant personality disorder was reduced from 55.0% to 37.0% at follow-up. For other results, see Table 2.

Discussion

Our main finding, confirming our hypothesis, was that the patients became increasingly more 'self-representative', as defined here by decrease in submissiveness and over-conscientiousness, during the whole course with a parallel reduction in symptom-distress (to sub-clinical levels). The change in relational patterns (IIP-subscales), particularly the reduction in over-conscientiousness, correlated significantly with the reduction in depression (BDI) (Table 4). The improvements continued during the follow-up period.

The patients reported a significant clinical change in their initial existential problems, as well as in their levels of symptom-distress and relational

Table 4. Change in occupation and medication

| | Pre-treatment | | Follow-up | | [2] |
	N	%	N	%	
Occupation					
Employed	10.0	25.0	36.0	90.0	34.58*
On sick leave	27.0	67.5	3.0	7.5	
On disability pension	3.0	7.5	1.0	2.5	
Medication[1]					
Antidepressants	16.0	42.1	3.0	7.9	11.67*
Benzodiazepines	10.0	25.0	2.0	5.0	
Analgesics	6.0	15.0	4.0	10.0	
No medication	20.0	50.0	37.0	92.5	

[1]Some patients used all categories of medication, so the percentage of those using no medication does not directly reflect the percentage.

* = Pearson chi-square p < .001

problems. The combination of reduced submissiveness and over-conscientiousness was consistent with patients' personal reports one year after (at T3) and the clinical impression obtained by the staff, with an overall clinical improvement towards higher degrees of self-representation. The patients were not impaired in their everyday functioning to the same degree as before, as demonstrated by their increased participation in paid work. Despite the limited duration of the treatment program and the complicated intrapsychic and interpersonal problems involved, one year later there was either stability or further improvement on all assessments.

The reduction of symptoms (GSI, BDI) and the increased psychosocial functioning, as measured by employment status, are noteworthy, since symptoms and work as such were not explicit focuses of the treatment. These findings support the underlying assumption of the treatment program, namely that to regain psychic health it is of the utmost importance to come to terms both with existential and religious questions and with relationships with others. Our data suggest that if patients succeeded in resolving these issues, they would be better equipped to face the demands of life. The shift in the weekly program between attaining awareness of affects towards representation of parents and God, and developing meta-reflection in identifying existential issues, may have contributed to this stability of improvement. Meta-reflection as a term is also used in studies that demonstrates the importance of reducing relapse rates after treatment for depression (e.g. Teasdale, More, Hayhurst, Pope, Williams & Segal, 2002).

Several researchers have argued that the idea of focusing on single symptoms in treatment when comorbidity is present (i.e., comprising other Axis I disorders and personality disorder) is insufficient (Pretzer, 1994). In the present study, most patients had a diagnosis of depression at admission with comorbidity on both Axis I and Axis II. The symptom scores were moderate to low, considering their level of functioning and reported psychological pain. The fact that patients received psycho-education and daily training in reporting their emotions and achieving a meta-perspective, might have helped them both in identification of affects and in reducing the global impact on the individual's ability to tolerate and regulate affects in a more healthier way.

Our results may indicate that working on affects such as shame and guilt connected to inner object-relations including God contributed to the reduction of submissiveness and over-conscientiousness. These results may also lend support to a hypothesis that working with these topics contributes to a reduction in the avoidant and obsessive-compulsive (Cluster C) personality traits. Other studies (Schaap-Jonker, Eureling-Bontekoe, Verhagen & Zock, 2002) show strong correlations with punitive God images, religious belief and the personality disorders mentioned above.

Patients diagnosed as having obsessive-compulsive personality disorders are characterized as relating to the world through their own strict standards. There is a logical connection between being over-conscientious and being submissive. It may be the case that a treatment addressing rigidity in images of parents and God, and developing skills in meta-reflection, may have reduced patients' emotional and cognitive rigidity as well as a pathological degree of over-conscientiousness. One explanation of why personality measures were brought within normal range after treatment may be that Cluster-C personality traits are concomitants or sequelae of treatment-resistant depression as is also suggested in relation to major depression (Peselow, Sanfilipo & Fieve 1994). The change in scores on Cluster C personality traits at one-year follow-up (T3) may reflect the likelihood that the treatment has targeted both the depression, the core issues of the personality disorder, as well as the problematic relational patterns.

The presence of any Cluster C disorder is invariably associated with a poorer outcome in the treatment of symptom disorders (Shea, et al., 1990; Hardy, Barkham, Shapiro, Stiles, Rees & Reynolds, 1995; Gude & Vaglum, 2001). Against this background, it is interesting to note that the subjects in this sample who received VITA treatment that did not focus specifically on their symptoms experienced a reduction in symptoms along with a reduction in personality pathology and an improvement in relational problems. This highlights the question of whether the etiology of symptoms really differs from the sources which contribute to

the personality disorder as well as the unhealthy relational patterns. The fact that so many patients were able to return to work and reported a significant change in their everyday life after participating in this existential and affect-focused program should be considered as an important clinical effect that is not restricted to changes in symptoms alone. Even with only a one-year follow-up period, it is reasonable to consider that the treatment may have had significant social benefits including a reduced burden on the social security system (Foster & Mash, 1999).

The reduction in symptom-distress consolidated from pre-treatment to follow-up (T1–T3) may indicate that the treatment did not merely provide a short-term relief, or that the improvement was a result of natural recovery from depression over time, but rather a possible treatment effect. Both at discharge and follow-up, patients reported a high degree of matching between their presenting problems and their treatment focus. In addition, they reported satisfaction on working with inner object representations in art therapy. Patients particularly commented on the importance of the weekly and monthly repetitive cycle: i.e., the repetition of working on representations of self, mother, father and God three times (including writing their stories three times, each time from a different perspective). In this way patients had the opportunity to integrate new glimpses of memory, insights and affects into the representational inner world. They also reported having acquired useful knowledge and skills, particularly with respect to relational issues and tasks, which they continued to use after the completion of treatment. The improvement cannot be explained by the use of medication, because psychotropic medication was decreased during treatment, and most patients (78%) were off medication at follow-up. An important curative factor might be the development of a therapeutic group culture fostering patients' responsibility for taking care of their own healing process, as has been suggested by Lewin (1951), Yalom (1995) and Forsyth & Elliott (1999).

Limitations
The study has several limitations. A naturalistic design without a control group is better suited for generating rather than testing hypotheses. Thus, the study does not demonstrate Level I proof, that of treatment effectiveness. However, the positive results merit further investigation of the VITA treatment model as an alternative to traditional forms of treatment for a group of patients with long-standing suffering. Another limitation is that improvement could be attributed to a 'vacation effect', i.e. the positive impact of being away from home in pleasant surroundings for 12 weeks. We obtained clear indications opposing such a view by patients' statements of perceived match between the treatment focus and recovery from their psychic distress. But in order to reject a 'vacation-hypothesis', comparative research is necessary and is underway at our institution.

A further limitation is that the design does not allow us to conclude which elements have contributed the most to improvement. Also, the patients were highly selected, which may have contributed to the good outcome and which may reduce the generalizability of our results. Our selection procedures may also reduce the generalizability of our findings. However, there is a strong call in the field to design treatments to target the needs of specific patient populations, and this study is a beginning attempt to evaluate a treatment model that targets existential and religious issues in psychotherapy.

Implications for clinical practice and further research
There is a need for comparison studies, and for testing the results in larger samples incorporating a control-group design, and for studying individual processes either in growth-curve studies or in single-case in-depth studies.

It would be interesting to obtain further empirical knowledge about how representations of God are related to the organization of affects, particularly guilt and shame, and the relevance of this for diagnostic and psychotherapeutic understanding. Both affective awareness and existential concerns merit further study as possible contributors to patients' improved health and functioning. The development of a language for affects and existential issues may have given the patients a feeling of self worth, seeing themselves as individuals among others who face the same basic issues of life.

Further exploration of the interplay between object-relations and images of God and self in

different personality disorders is needed through single-case in-depth studies. It is of great importance to examine further how addressing underlying existential and religious issues, such as the psychological representation of God, might benefit health.

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