"Mr K" –
A successful case of analytic oriented therapy documented empirically
The role of the therapeutic relationship and reflexive self-awareness

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Abstract

A successful case of analytic treatment over the course of 250 sessions is described from different perspectives, including considerations from the two-year follow-up. The therapeutic alliance and the patient's experiencing were evaluated.
Pre-treatment diagnosis was validated via diagnostic interview. Symptoms and interpersonal problems were assessed at intervals. Data were analysed using two different time-series analyses. Aspects of agency with regard to mentalizing capacity were assessed with the Metacognitive Assessment Scale.
We obtained the following main results:
+ Symptoms and interpersonal problems improved continuously until the end of treatment. Symptom severity fell to below the clinical cut-off. This successful outcome remained stable at the two-year follow up.
+ The therapeutic relationship improved during the therapeutic process.
+ The patient's capability for reflexive self-awareness, operationalized as experiencing, decreased.
+ The metacognitive mastery of the patient increased.
The following conclusions were made after combining the empirical data with the clinical observations:
+ Mr K. improved clinically in terms of symptoms, self-regulation and interpersonal problems as a result of his gaining affect control.
+ The patient's experiencing does not capture a positive outcome in all cases.
+ Aspects of agency (i.e., metacognitive mastery) deserve further attention in psychoanalytic treatments.

Keywords: single case study; psychoanalytic treatment; the therapeutic relationship; mentalization; experiencing

Effective factors in psychotherapy are not always those researchers and therapists consider relevant. This holds true for all treatment approaches, including those based on empirical evidence (Kazdin, 2009; Laska, Gurman, & Wampold, 2014). One exception appears to be the therapeutic relationship (Norcross & Lambert, 2011; Wampold, 2010). Questionnaires evaluating the therapeutic relationship capture only some aspects, with an emphasis on the working alliance. However, how the therapeutic relationship contributes to outcome remains unclear. There are sound arguments that the therapeutic relationship is a mediator, not a direct effective factor (Muran & Barber, 2010). Single case studies can shed light on these complex processes by providing a fine-grained analysis of change in psychotherapy (Doran,

2016; Hill, 2006; Stiles & Goldsmith, 2010). Single case studies are explorative and try to integrate clinical case material with standardized measures of process and outcome evaluated at different times during treatment (APA, 2016).

This study describes the therapeutic process mainly via external clinical raters and patient assessment by questionnaires. The therapist was not an assessor due to his involvement in the therapeutic process. Mr. K's case is part of a research project on single case studies.[1]

Aims of the study

While transference and counter-transference are components of the therapeutic alliance, these are difficult to operationalize. We therefore chose to use a modern self-rating questionnaire on the therapeutic alliance. The sessions were audiotaped to examine the patient's reflexive self-awareness during therapy. The experiencing scale (Klein, Mathieu-Coughlan, & Kiesler, 1986) was used to measure the patient's self-awareness. The following research questions were the focus of this study:

(1) How are the patient's experiencing and the therapeutic relationship connected over the course of treatment?
(2) How do the patient's experiencing and the therapeutic relationship contribute to the success of therapy?

The case of "Mr K"

Mr K was 34 years old at the beginning of the treatment and worked as a web designer. He grew up in northern Europe with a mother portrayed as depressed. He did not know his father. His mother divorced his father when the father became violent. His step-father had a warm attitude towards him but frightened him because of his rough nature. As a child, he believed his mother wished him to be the man in the family. He directed rage and aggression towards himself. At the age of 18, he had a child and left both the child and his partner, as he felt overwhelmed, and moved to Germany. Many years later, he married a southern European woman and had a second child. He had a strong longing for security and care and to be looked after and felt that his wife's family satisfied these needs. However, the marriage was coloured by disruptive conflicts and arguments. His wife demanded a considerable amount of care and attention, and his boundaries were poor. His own wishes remained unsatisfied. After an excessive number of verbal disputes, he became guilt-ridden and felt inadequate to fulfil his wife's demands. She accused him of not being sufficiently masculine, and in turn, he became afraid that she might leave him and began to withdraw. He became afraid of his own anger. The marriage was on the verge of collapse, and he thought only he was to blame. In desperation, he sought analytic treatment. In treatment, he rapidly established a level of trust in his therapist. In the first session, the male therapist asked him to participate in a study on the therapeutic process, and he agreed.

Diagnosis

A structured clinical interview for DSM disorders (SCID) (Wittchen, Wunderlich, Gruschwitz, & Zaudig, 1996) was administered by an experienced external clinical

[1] This case forms part of a research project on single case studies registered internationally (Registration: ISRCTN-Nr. 75536830, Current Controlled Trials LTd c/o BioMed Central Ltd).

interviewer with an official SCID certification at the beginning of treatment. He diagnosed Mr K with borderline personality disorder (BPD) of the impulsive type, dysthymia, obsessive-compulsive disorder, and sexual dysfunction, with no history of substance abuse. There was no evidence of self-harm or suicide attempts in the past, but further symptoms included premature ejaculation and anxiety regarding an uncontrollable desire to urinate. An intensive medical workup showed no organic abnormalities. He took no medication at any time.

Self-reports standardized questionnaires completed by the patient confirmed these diagnoses. Symptoms were assessed by the symptom checklist SCL-90-R (Franke, 1995). Mr K showed an overall severity index of GSI=1.4. Symptoms of depression were assessed by the Beck Depression Inventory (BDI-II) (Hautzinger, Keller, & Kühner, 2009), on which he scored 25. Interpersonal problems were assessed by the Inventory of Interpersonal Problems (IIP-D) (Horowitz, Strauß, & Kordy, 2000), on which he scored 2.3. All of these scores are markedly above a clinical cut-off.

Case formulation

Four senior clinicians developed a case-focus formulation based on conceptualizations from psychoanalytic self- and object relation theories: Mr K grew up with a depressed, self-absorbed mother. It was impossible for him to develop sufficient male self-assuredness. He neglected his own needs and believed that he was supposed to be the man in the family. He experienced strong feelings of rage and rejection towards his mother and wife when they did not respond to his intense needs for love and security. He found it difficult to regulate his affect, level of arousal or impulses in his close relationships but reacted instead with a fight-or-flight response. At the start of the therapy, Mr K was convinced that his affective states (in particular, his rage arising from the denial of his needs for intimacy and security) could only be controlled through withdrawal. His frustration and aggression were experienced as disruptive and threatening. His helplessness and anxiety about being abandoned, combined with an ambivalent desire for absolute love and undivided attention, led to his withdrawal from loved ones and were expressed in a feeling of not having a ‘home in the world’. In turn, and as a result of childhood experiences, Mr K held the (somewhat justified) belief that women (his mother, his wife) did not truly know him. He was torn between urgent needs for closeness and impulses to escape. In part, this conflict manifested in symptoms of incontinence and premature ejaculation.

The clinicians were also trained in the plan-formulation method of control-mastery-theory (CMT) The plan-formulation comprises the patient’s goals, his pathogenic beliefs stopping him from achieving those, and how he tests these beliefs in the treatment setting. Reliability of this approach to formulations has been established (Silberschatz, 2005, 2015; Weiss, Sampson, & Mount Zion Psychotherapy Research Group, 1986). The clinicans rated five pathologic beliefs of the patient:

1. He believes his is not a real man. Others are stronger, more potent and better than he is. 2. He believes he is not able to satisfy others’ needs. 3. He believes his feelings and wishes are insatiable, never to be fulfilled and overwhelming. 4. He believes he will be rejected when expressing his feelings and needs. 5. He believes that he is unable to maintain relationships.

Attachment representations and level of mentalizing

Pre-treatment scores from the Bielefeld Attachment Questionnaire (Bielefelder Fragebogen zur Klientenerwartung (BQCE/BFKE) (Höger, 1999; Pollak, Wiegand-Grefe, & Hoger, 2008), a German self-report on attachment, suggested a classification of cluster insecure-avoidant-cooperative attachment.

Reflective function (RF) was coded based on transcripts of the first three therapy sessions and the so-called 'demand' questions identified therein.[2] Two independent coders rated RF at 4.5 and 4.0 and identified it as accompanied by a tendency to hypermentalize.[3]

The treatment

The therapist is licensed as a psychoanalyst in the German healthcare system with approximately ten years of experience. He described himself as influenced most by self-psychology (Kohut, 1971; Lichtenberg & Hadley, 1989). Self-psychology relate to development through an empathic relationship with significant careholders, conceived of as "self-objects". The term self-object refers to the subjective experiences in which the other is in the service of the self. The therapist followed this approach in the therapy of Mr K. For a long time, the analyst was seen as a self-object such that the patient could experience his dependence with little fear and shame. The therapist typically worked within a stable positive transference, which he seldom he interpreted. The patients' early unconscious fantasies centred on being guilty for not satisfying the distress of his primary objects. His unconscious fantasies of man's power and violence against woman led to his unconscious beliefs of guilt and fear that he would lose control over his aggression again. He withdrew and reacted with depression.

The analyst's preferred techniques included interventions focused on accepting, validating, and reflecting the patient's need for psychic regulation of his physiological requirements, his need for attachment and his need for exploration (Lichtenberg & Hadley, 1989). The type of transference did not change significantly throughout the therapy. So one could ask, which part of the core conflicts have never been taken up in transference.

His therapy took place with a frequency of two sessions per week and lasted for 250 sessions. In the process, Mr K was able to make links between his childhood experiences and current problems. In addition to clinical evidence of increasing reflexive self-awareness, he gained more control over his internal world, particularly his affects and wishes.

At the time of approximately the 200th session, the couple separated. Mr K remained able to work. His symptoms and interpersonal problems were exacerbated but only for a short period. Two years after the end of treatment, an external clinician blinded to the patient's history and treatment conducted a follow-up interview.

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[2] Ratings were performed by two trained and reliable coders (trained at the Anna Freud Centre, London). The methodology differed from the classical approach to coding RF in the Adult Attachment Interview (AAI) but focused on demand questions (those for which the participant's answer requires spontaneous and explicit mentalizing), which the therapist asked in the first three therapy sessions.

[3] "Hypermentalizing" is a desperate attempt to understand a situation via intense thinking about it that is characterized by poor constructive problem solving. This is associated with anxiety and tension e.g., heightened worries about the wellbeing of a partner and one's own responsibility/guilt for their wellbeing.

Mr K considered his therapy a success; the external interviewer came to the same conclusion. Mr K then lived by himself, was highly engaged in the care of his son and worked as a freelancer. At the end of the assessment, the interviewer focused on his current tendencies to withdraw, which he was able to acknowledge and, moreover, to critically reflect upon.[4]

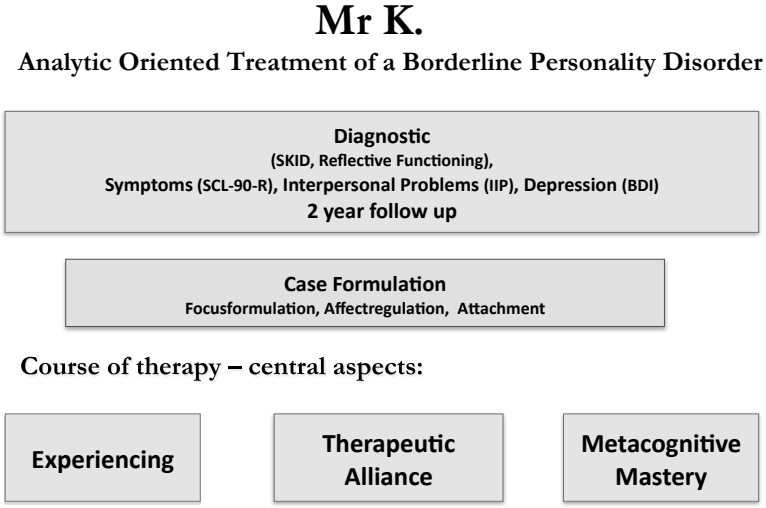

Figure 1. Mr K: a single case study

Methods: assessment and measures

Although we collected data (audio transcripts) from the 2nd to the 240th session, we chose 10 session intervals from the beginning of treatment (2nd to 11th session and 21st to 30th session), the middle (51st to 60th session, 91st to 100th session and 151st to 160th session) and the end of treatment[5].

The therapeutic relationship

The therapeutic relationship is best conceived of as a multidimensional construct (Bordin, 1979). The Scale of Therapeutic Alliance - Revised STA-R (Brockmann et al., 2011) was developed based on work by Hatcher & Shannon (Hatcher & Shannon, unpublished) and the Working Alliance Inventory WAI-SR (Hatcher & Gillaspy, 2006). The WAI-SR yields three subscales: Goals, Tasks and Bonds. The STA-R has been validated regarding its psychometrics and includes the following factors: 'confident collaboration', 'bonds', and two additional subscales, 'patient's fear of opening up' and 'therapist interference'. The factor 'confident collaboration' comprises the WAI-SR subscales 'goals' and 'tasks,' which are highly correlated. The therapeutic relationship was assessed by a self-report.

[4] The therapist was not part of the research team and did not contribute to any analyses. No results were shared with him or with the patient. The therapy (with a total of 250 sessions) was audio-recorded over the whole course of treatment. Data from different perspectives were obtained during therapy and two years after the end of treatment (s. Figure 1).

[5] Audio data of the 241st – 250th session were lost due to human error; only the data of the questionnaires were available.

Assessing the patient's experiencing

To measure aspects of reflexive self-awareness—reflection on one's own desires, feelings and wishes and those of one's significant others—we choose the experiencing scale (Klein et al., 1986). Experiencing is widely investigated in relation to the therapeutic process (Elliott, Greenberg, Watson, Timulak, & Freire, 2013) and is rooted in Rogerian therapy (Rogers, 1961). Experiencing is a 'powerfully felt dimension of experience that is prelogical and that functions importantly in what we think, what we perceive and how we behave' (Gendlin 1970, p. 561). Experiencing focuses on the exploration of emotions in concert with cognitive aspects. The concept overlaps with that of mentalization in terms of assessing a patient's mentalizing in the domains of 'Understanding one's own mind' and 'Understanding others' minds' (Semerari et al., 2003), with a strong emphasis on the former.

The concept of experiencing is closely linked to the central aspects of psychodynamic therapy. One of the key assumptions connected with positive outcome in psychodynamic therapy is the centrality of being able to allow for the in-depth emotional exploration of problematic life experiences. Numerous studies and one meta-analysis have shown that therapists' facilitation of patient affective expression is associated with patient improvement (Diener, Hilsenroth, & Weinberger, 2007). A consistent relationship has been found in that a better outcome is achieved with a higher level of experiencing (Elliot, Greenberg, & Lietaer, 2004; Elliott et al., 2013; Purton, 2004).

However, more general assumptions regarding basic associations were not proven: Rogers' process view (1961) predicted that there would be an increase in the level of experiencing throughout the course of successful therapy. Unfortunately, this finding has not been confirmed in most studies (Elliott et al., 2013, p. 518).

The concept has been operationalized and manualized to define the approach by which raters should code sessions based on the experiencing scale (Klein et al., 1986). A German version has been developed, including instructions to train raters (Bommert & Dahlhof, 1978).

Ratings are performed using a seven-point Likert scale. Experiencing is a continuum ranging from the description of simple, limited actions to a state of interactions between an internally generated awareness of current mental states and experiences and their expression.

For the current study, five independent raters were trained extensively in the manual by Bommert and Dahlhoff (1978), and good intra-class coefficients of reliability between them were established (ICC mean=.7), (Shrout & Fleiss, 1979). Experiencing was coded according to the manual. Therefore, the sessions investigated were divided into five-minute segments, and each session was coded by raters blinded to the session number. The mean score of each session was computed.

Assessment of metacognitive mastery

The Reflective Functioning Scale (RF-S) (Fonagy, Target, Steele, & Steele, 1998) operationalizes the capacity to mentalize. RF-S represents the gold-standard instrument through which to assess mentalizing (Steele & Steele, 2008). There are a number of additional instruments that assess other aspects of mentalizing (for an overview, see Luyten, Fonagy, Lowyck, & Vermote, 2012, p. 55–57).

Complementarily, Semerari et al. (2003), Carcione et al. (2008) and Carcione et al. (2011) developed a multi-dimensional operationalization of the concept in the Metacognitive Assessment Scale (MAS), which delineates three domains of mentalizing: 'Understanding One's Own Mind', 'Understanding Others' Minds' and 'Metacognitive Mastery'. Metacognitive mastery is a new aspect: 'the subject discusses his own behaviour and psychological processes and states not as a simple matter-of-fact dates but tasks to be done and problems to be solved, defining the terms of the problem in a plausible way.' (Carcione et al., 2008, p. 670). Whereas the RF-S is designed to assess mentalizing along a one-dimensional scale, the MAS maps a person's capacity based on the three dimensions outlined above.

The mastery scale of the MAS instrument was used to assess metacognitive mastery during therapy sessions (Carcione et al., 2008, 2011; Semerari et al., 2003). The mastery scale, like the RF scale, is based on expert ratings. Coders identify those aspects of patient narratives of session transcripts that express their efforts to master problems and evaluate the level of reflection/elaboration of these efforts on a scale from 1 to 3. Subsequently, they rate whether each endeavour was successful (+) or not (-). The ratings produce two separate scores for each session: first, the mean level of mastery, and second, a quotient indicating the ratio of successful to non-successful attempts at mastery (M+/M-). A successful attempt at mastery is characterized by: '(...) adopting a rational and critical attitude to the beliefs that are behind a problematic state, using one's knowledge about others' mental states to regulate interpersonal problems and accepting in a mature way one's personal limits when trying to master oneself or influence events.' (Semerari et al., 2003, p. 245). Three raters were trained in the use of the manual.[6] Following the manual, each patient statement framed by two statements by the therapist was coded by three raters. The degree of inter-rater reliability established for the level of mastery was at Kendall's W=.56 and yielded a Cohen's Kappa=.55 for the successfulness of the attempt – both being viewed as fair agreement (Fleiss, 1981). Data for ratings were chosen for the first phase (2^{nd} – 11^{th} session) and middle phase (151^{st} – 160^{th} session) of treatment, but the raters were blind to the session number. Only two phases were chosen by economic reasons. The middle phase was chosen, because at this time the patient had not withdrawn from his wife.

Time series analyses[7]

Psychotherapy is a temporal process involving changes in feelings, thoughts and behaviour. Thus, time-series analyses provide psychotherapy research with a useful tool for analysis of single case studies (Tschacher & Ramseyer, 2009). However, time series are problematic in that they cannot be analysed using classical inferential statistics because repeated measures are not independent of each other (i.e., they are auto-correlated). One rationale for using time series analyses is that autocorrelations are eliminated in the first step, after which one can test whether experiencing affects the therapeutic relationship.

In principle, three different results are conceivable:

[6] Metacognition Assessment Scale 2009-R (unpublished manual by Carcione at al., 2009)

[7] Time series analyses were conducted by Prof Dr B. Schmitz (Heidelberg, Germany), a specialist in this field (Schmitz 1990, 1989).

a) lag +1: the effects of experiencing (at time t) impacts on the therapeutic relationship (at time t+1)
b) lag-1: experiencing (at time t) is influenced by the therapeutic relationship (at time t-1)
c) lag 0: both aspects affect have an impact on each other (bi-directional)

Time series analysis tests models based on time series. The results of time-series analyses depend on the models chosen. Therefore, we used two different methodological approaches to compare their results: autoregressive integrated moving average (ARIMA) (Schmitz, 1989, 1990; Werner, 2005) and multivariate vector autoregression (VAR) (Molenaar & Newell, 2010) ARIMA models were computed using SPSS expert-modeler (IBM SPSS statistics), and VAR models were computed using the JMULTI and R (Cowpertwait & Metcalfe, 2009) software packages. The two different software packages for VAR yield comparable results. A detailed description of the statistical procedures can be requested from the first author.

Time-series analyses were computed for the variables 'experiencing' and 'the therapeutic relationship' as experienced by the patient, each over five phases (2^{nd} – 11^{th} session, 21^{st} – 30^{th} session, 51^{st} – 60^{th} session, 91^{st} – 100^{th} session and 151^{st} – 160^{th} session) (N=50 sessions). The study was designed in advance considering economic reasons. Our major interest was the start of the therapy.

Trends are eliminated by time-series analysis, but these analyses can yield relevant clinical information. The coefficient of determination R^2 is an indicator of fit. An R^2=.4 means that 40% of the variability in the response can be explained by the independent variable. Trends with a coefficient of determination R^2 >.3 are considered significant.

Results

Course of therapy: symptoms, interpersonal problems and the therapeutic relationship

The changes in symptoms as captured by the General Severity Index (GSI) of the SCL-90-R with the IIP-D are presented in Figure 2.

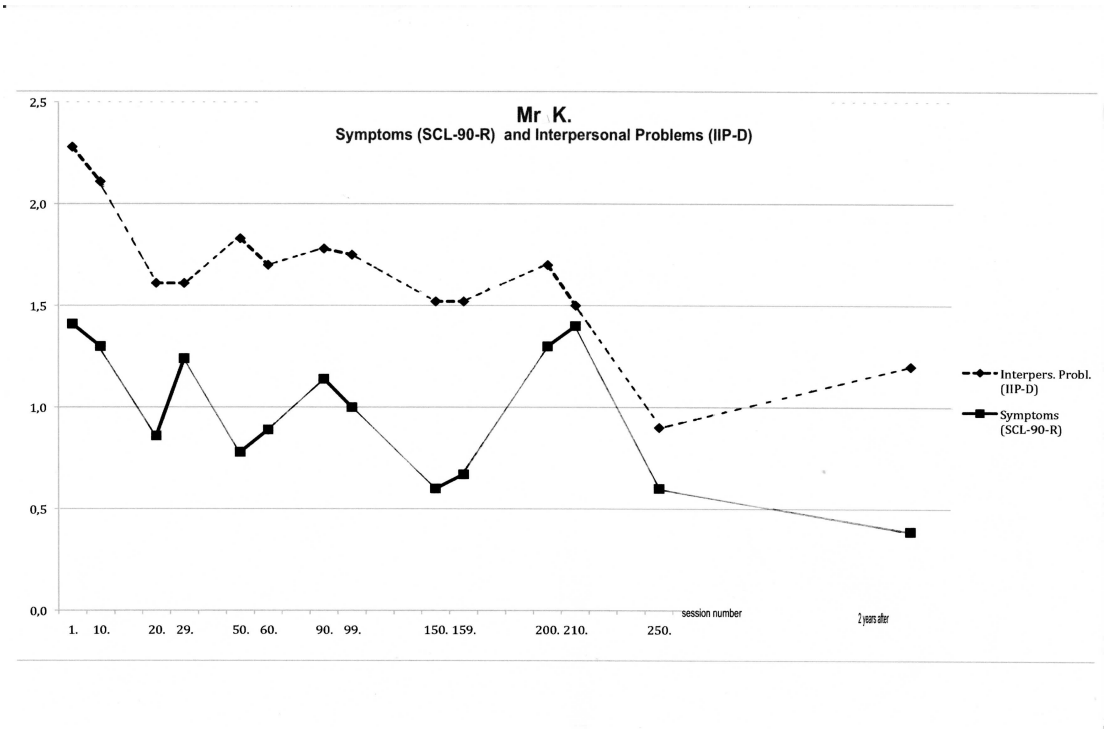

Figure 2. Course of symptom load: GSI (SCL-90-R) and total score of interpersonal problems (IIP-D). GSI: cut-off for severe symptoms=.97; GSI: cut-off for moderate symptoms=.43 (Tingey, Lambert, Burlingame, & Hansen, 1996).

The GSI, which was markedly above the clinical cut-off at the beginning of treatment, decreased to a level found in non-clinical populations by the end of therapy and follow-up. This change is clinically significant. The patient's BDI-II dropped from 25 at the beginning of therapy to 8 (a value seen in healthy controls) at follow-up. The same pattern was observed for changes in interpersonal problems.

Time-series analyses

Two different methodological approaches were used. Both approaches yielded different

results, but the results fit together and can be seen as complementary.

The VAR models did show significant effects for the variables experiencing and therapeutic relationship (Table 1), whereas the ARIMA models showed non-significant effects for the total score (Table 2),

Time lagged correlations (t-1,t)	Experiencing (t)	Therapeutic relationship (t)
Experiencing (t-1)	.37*	-.07
Therapeutic Relationship (t-1)	**-.61***	.39*
Correlations (t)		
	Residuals Experiencing (t)	Residuals Therapeutic Relationship (t)
Residuals Experiencing (t)		**- 0.28***
Residuals Therapeutic relationship (t)		

Table 1. VAR models. Self-report on the therapeutic relationship and experiencing of the patient (3 independent raters); all variables N=50, Correlations (t) were found by VAR through residuals (N=50 sessions for all variables).

Variable1 - Variable 2	lag-1	**lag0**	lag1
Experiencing - Therapeutic relationship (total score)	.23	-.01	-.05
Experiencing - Confident collaboration	,26	**-.30***	-.20
Experiencing - Patient's fear of opening up	-.02	.03	**.31***

Table 2. ARIMA model cross-correlations. The "Therapeutic relationship" total score, "Confident collaboration" and "Patient fear" subscales from STA-R; experiencing of the patient (3 independent raters) (N=50 sessions for all variables).

In general, it is difficult to obtain significant results from time-series analyses. Because the ARIMA models did not yield significant results, we investigated our data more

closely and found significant correlations between experiencing and the scales 'Confident collaboration' and 'Patient's fear of opening up' in the STA-R (Table 2).

No additional time-series analyses were performed due to the high associated costs. Furthermore, no analyses regarding the two STA-R factors, bond and therapist interference, were computed, as no significant results had been expected for them because correlations not adjusted for the effects of autocorrelations have been non-significant.

The results indicate that the therapeutic relationship is negatively correlated with the patient's experiencing (Table 1; correlations (t), r=-.28). The therapeutic relationship at session t-1 influenced negatively experiencing at session t (Table 1; regression coefficient=-.61). Confident collaboration was significantly negatively correlated with the patient's experiencing (Table 2; lag 0, r=-.30). The experiencing at session t was correlated with the patient's fear of opening up in the following session t+1 (Table 2; lag 1, r=.31).

The therapeutic relationship improved from the start of therapy. A marked divergence between experiencing and the therapeutic relationship was identified (Figure 3). Trends were assumed to be robust until the 60th session. For the remainder of treatment, the number of data points was not sufficiently large to show trends with a coefficient of determination R^2>.3.

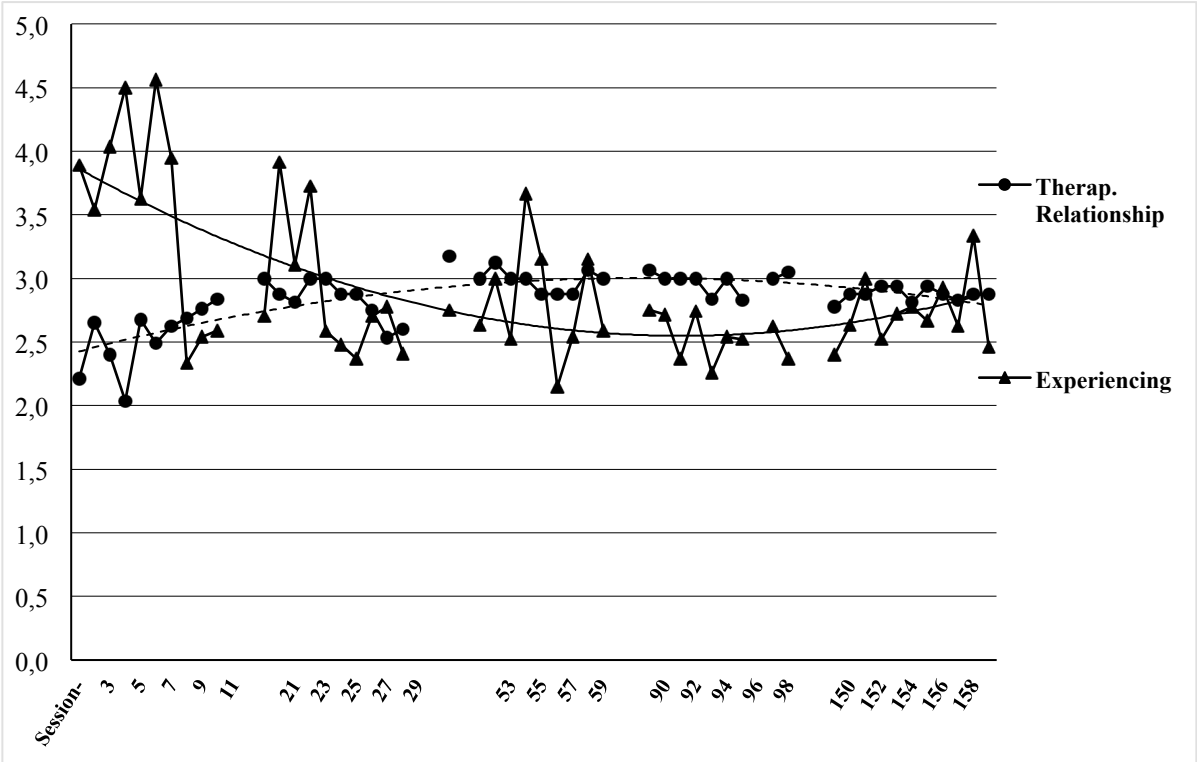

Figure 3. Self-report on the therapeutic relationship and experiencing (3 independent raters), 2nd – 160th session, — experiencing trend (coefficient of determination: R^2=.4), - - - trend in therapeutic alliance (coefficient of determination R^2=.6).

Metacognitive mastery

Ratings were obtained over seven sessions each for the initial phase of treatment (2nd – 11th session) and the middle phase (151st and 160th session). Table 3 displays the values for individual sessions and the mean values across the two phases.

	2. - 11. session							151. - 160. session						
	2.	3.	5.	6.	7.	8.	10.	151.	152.	153.	154.	156.	158.	160.
Mastery level	1.45	12.0	1.95	1.35	1.5	2.1	1..5	1.6	2.3	3.9.	2.8	2.2	2.0	1.5
Mean	1.7							2.3						
Ratio M+ / M-	.2	.4	1.5	.3	.8	.6	1.1	8	17	.6	4.25	7.3	9.5	4.5
Mean	.7							4.0						

Table 3. Metacognitive mastery rating (three coders), M+: successful mastery, M-: failure in mastery.

Metacognitive mastery increased from the beginning (M=1.7) to middle of treatment (M=2.3). Moreover, mastery increased, as indicated by an increasing ratio of M (successful) to M (unsuccessful) (.7 to 4.0).

Two-year follow-up interview

The positive outcome remained at the two-year follow-up according to self-report (cf. Figure 2 for SCL-90-R and IIP-D, BDI-II score: ranging from 25 to 8). According to the external, independent assessor, Mr K was more satisfied with himself and his living situation than he had been at the beginning of therapy. His original symptoms had improved markedly.

At the time of follow-up, he was still living by himself and had a good relationship with his son and little contact with friends. In the interview, he spoke about on-going social anxiety and compulsive behaviour. Mr K still considered it 'hard work' to change these tendencies. He was ambivalent as to the degree to which he wished this change to occur.

> Mr K: '*That'll be hard work, that's for sure. So my aim is not to change that completely. I can see now that I have an understanding of it and an acceptance of it, and I can see that it won't be healthy for it to stay the same over the next ten years. But to change, that is hard work, that's for sure.'*

Evaluation of attachment patterns and capacity to mentalize

Mr K.'s attachment style was assessed at the start of treatment using the BFKE, which classified him as predominantly anxious-avoidant. This finding was confirmed in the follow-up interview. Mr K. continued to avoid intense distressing relationships; he was living on his own and liked to work. He manifested a deactivating (attachment) strategy.[5]

[5] A person using a deactivating strategy appears to be emotionally distant and cool. Mentalizing is seemingly well developed and functional, yet internally, the person is in a state of distress, often without being aware of it. At times, such individuals experience the physiological correlates of stress (e.g., high blood pressure) but not the accompanying psychological aspects/representations.

His attachment pattern and the corresponding mentalizing profile appeared to be fragile; an underlying disorganized attachment can be assumed. This finding was manifested diagnostically in the initial assessment. Both Mr K. and the experienced interviewer experienced high levels of distress afterward. They concurred that they felt overwhelmed not by potentially traumatic material but rather by the confusion that ensued. As seen in the interview, Mr K. felt threatened by his affect and impulses but managed to contain them.

This development was paralleled in his relationship with his wife, which exhibited a deteriorating pattern. His needs for care and proximity and his sexual drive are activated, yet their fulfilment is denied. Desire and subsequent denial lead to disorganized attachment, particularly in relation to his wife, with additional mixed hyper-[6] and deactivating (attachment) strategies (Luyten et al., 2012, p. 44).

Regarding his relationship with his young son, the patient consistently conveyed a picture of a secure attachment. Equally, his capacity to mentalize remained markedly intact when thinking about this relationship. He was able to serve as a good caregiver for his son and to develop a benign and supportive paternal attitude towards the child.

No changes were observed in the level of RF. The assessment of RF again yielded a value of RF=4 in the follow-up interview.

Discussion

The single case study raises questions by confronting empirical research with clinical experience in an explorative way. The long-term treatment of Mr K ended in success. The outcome was confirmed by the patient's self-report and by the independent clinical interviewer at the two-year follow-up.

We expected an increase in experiencing over the course of treatment. Whereas the patient's experiencing decreased, RF remained stable. In the beginning, the patient's RF, as assessed by independent raters, was marked by aspects of hypermentalizing. This RF level remained unchanged at follow-up, but no further hypermentalizing was observed. The lack of change in the general score might be because this measure is too broad. This result is in line with the findings of Staun, Kessler, Buchheim, Kächele, and Taubner (2010), who demonstrated impaired mentalizing regarding specific topics in depressed patients.

Although the perception and differentiation of mental states overall did not increase or even decreased, specific aspects, such as affect regulation, coping, and mastery, improved, which could be interpreted as a result of change in the treatment of Mr K. Some of these changes could be represented in the MAS.

The investigation of the treatment process demonstrated that the patient's experiencing decreased as the therapeutic relationship intensified. These two aspects were

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Therefore, mentalizing is often limited to a focus on external experiences. A dissociation between subjective and biological distress ensues (Bateman & Fonagy, 2013, p. 597).

[6] In hyperactivating strategies, the relational system is intensely activated. They lead to an intense and rapid affective experience of people concerned – negative and positive affects oscillate. Mentalizing is equally rapidly compromised alongside a reduced capacity to form objective judgements (Bateman & Fonagy 2013, p. 597).

negatively correlated even though the treatment was effective in improving both symptomatology and interpersonal problems. Mr K gained interpersonal competencies throughout therapy. This trend was reflected in his self-assessment via the IIP-D, a questionnaire considering interpersonal problems (cf. Figure 2), and could also be established by comparing ratings from the early and later stages of treatment based on the metacognitive mastery scale of the MAS (cf. Table 3).

Mr K. used the therapeutic relationship to improve his symptoms and interpersonal problems. Thus a reduced affect intensity may result from a better containment within the therapeutic relationship. The therapeutic relationship was a mediator through which to develop or re-employ interpersonal competencies (IIP-D), which he then used between sessions in line with improvement of metacognitive mastery. Lasca & Federman conceptualize this trend as 'building a sense of mastery' (Laska & Federman, 2015, p. 205).

Mr K.'s improved symptoms and interpersonal achievements may have resulted from the end of his difficult relationship with his wife and not from therapy. However, the empirical data do not support this alternate hypothesis. Symptoms and interpersonal problems had changed markedly 50 sessions before he separated from his wife at the 200th session (cf. Figure 2). Additionally, successes in metacognitive mastery improved distinctly before separation, as assessed between the 150th and 160th sessions (Table 3).

Mr K progressed in self-regulation, for instance, by becoming more flexible, and thus expanded in affect modulation. He also progressed markedly and continuously in the area of interpersonal problems. These developments occurred in concrete aspects of metacognitive mastery.

The patient protected himself and increasingly controlled his affect in therapy, as seen in decreased experiencing, which includes affective aspects.

The activation of affect is not always experienced as liberation from anxieties and blockages, as implicitly assumed by the concept of experiencing (cf. introduction by Rogers, 1961). Mr K. suffers from BPD of the impulsive type with compulsive aspects. He controls his affect increasingly flexibly in therapy, possibly at the expense of focusing on his experiences of his internal world. The strength of the therapeutic relationship was negatively correlated with the patient's experiencing' (r=-.28, Table 1). The therapeutic relationship had a negative influence on experiencing in the next session (r=-.61, Table 1), and conversely, experiencing influenced the patient's fear of opening up in the next session (r=.31, Table 2). A process of adjustment between therapist and patient took place with respect to the nature of intervention and the patient's responses. Aspects of the therapeutic relationship (i.e., attachment) may explain the positive outcome better than experiencing. The therapeutic relationship was the basis of successful therapy. The patient showed increased epistemic trust, the basic trust in a caregiver as a safe and secure source of information (Sperber et al., 2010; Wilson & Sperber, 2012). This trust enabled him to engage in new experiences between sessions and to attempt to solve problems from a different perspective (Fonagy & Allison, 2014).

Empirical research supports this hypothesis:

+ Affective vulnerability is a cardinal symptom in borderline patients. Although evidence-based treatment of BPD patients modifies behaviour reliably, affective vulnerability often remains unchanged. This point holds true particularly for dialectic behavioural therapy

(DBT), (van den Bosch, Koeter, Stijnen, Verheul, & van den Brink, 2005; Zanarini, Frankenburg, Hennen, & Silk, 2003).
+ Mean experiencing is positively correlated with therapeutic success (see the introduction of Elliott et al., 2004; Purton, 2004), but a moderate level of emotional arousal is optimal for outcome (Carryer & Greenberg, 2010).

The patient had been characterized by a predominantly insecure-avoidant attachment. The accompanying deactivating strategies regarding attachment and mentalizing are associated with avoidance of high emotional/affective involvement. His arousal levels were high, and he was highly physiologically distressed. In his SCID at the beginning of treatment, he talked about how difficult it was to tolerate the affects he fears because they trigger a sense of losing control. In such a case, intense affective involvement may be detrimental to a successful outcome. Rather, the therapeutic relationship is critical: it helps the patient to modulate his affect, reduce his epistemic mistrust in himself and others and have new interpersonal experiences during and between sessions (Fonagy & Allison, 2014).

The results remained stable after two years. Mr K. described himself as having come to terms with his idiosyncrasies, even those that can be viewed as limiting him. However, in the follow-up interview, he reflected on these idiosyncrasies and questioned the extent to which he was willing to change and was capable of changing them in the future.

Critics may view this outcome as poor, but we would respond by citing Freud: 'A man should not strive to eliminate his complexes but to get into accord with them: they are legitimately what directs his conduct in the world' (Freud to Ferenczi, 1911, cited by Jones, 1955, p. 188).

Limitations

Aside from the general limitations of single case studies, there are three main limitations to be considered in the current study. The experiencing scale is well defined and reliable but only covers limited aspects of mentalizing in the therapeutic process. In general, the experiencing scale is not sufficiently complex to provide a deeper understanding of change during analytic psychotherapy. The therapeutic relationship is represented by data from a questionnaire, so it limits the relevance of the concept of therapeutic relationship in which transference and counter transference is included.

Take-home message

+ A successful case of long-term analytic psychotherapy with a patient with BPD was documented empirically.
+ The study focused on affect and how the patient's awareness of mental states is not perceived by all patients as liberating, as is implicitly assumed in the concepts of experiencing and mentalization.
+ Aspects of agency and coping (metacognitive mastery) should receive more consideration when evaluating analytic oriented treatment and the mentalization-based approach.

Disclosure Statement

The authors have no conflicts of interest to declare.

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