Consciousness about own and others’ affects

Börje Lech
At the Faculty of Arts and Science at Linköping University, research and doctoral studies are carried out within broad problem areas. Research is organized in interdisciplinary research environments and doctoral studies mainly in graduate schools. Jointly, they publish the series Linköping Studies in Arts and Science. This thesis comes from the Division of Psychology at the Department of Behavioural Sciences and Learning.

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Acknowledgments

The creations of a thesis give rise to a lot of affects. Without doubt feelings of boredom, fatigue, despair and resignation has been there from time to time. The shame and fear of never coming to an end with the thesis are other less pleasant affects that I have experience during the process. Mostly, though, it has been a time of positive affects. Without curiosity, interest and joy in exploring the world of affects there would not have been any thesis. The happiness of meeting all pleasant and interesting persons during the process has however been the strongest driving forces and the most pleasant aspect of the work. Some of you have become new and close friends and some of the old friendships have become dearer and closer thanks to the sharing of all those affects. An important feeling that I often felt but too rarely expressed is gratitude. I therefore want to thank all of you who aided me and spent your precious time on me and my thesis. The limited space makes it impossible to name all of you who in so many way aided me during the work of this thesis. I would anyway like to express particular gratitude to some.

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I feel the greatest gratitude, toward Ellen and Ingrid, who taught me everything about the importance of affects and how important it is to recognize, tolerate, express and respond to one’s own and others' affects.
To
Ellen & Ingrid

The whole joy of making rock’n’ roll
is the interaction between guys playing

Keith Richards
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Abstract

It is essential for individuals’ well-being and relationships that they have the ability to consciously experience, express and respond to their own and others’ affects. The validity of a new conception of affect consciousness (AC), incorporating consciousness of both own and others’ affects, was investigated in this thesis. The clinical usefulness of the new conception was explored and an interview (affect consciousness interview – self/other; ACI-S/O) intended to capture this new definition was validated. In study I the interrater reliability and the concurrent validity of the ACI-S/O were assessed and found to be acceptable. There were significant differences in all variables of ACI-S/O between the four groups that participated in the study. Joy and interest had the highest ratings in all groups and guilt and shame had the lowest. By means of a factor analysis, two factors, labeled “general affect consciousness” and “consciousness about shame and guilt,” were obtained. General affect consciousness was related to different aspects of relational and emotional problems and possibly protection against them. In study II the clinical implications of AC were further explored in relation to eating disorders (ED). The level of AC in the ED group was compared with a comparable non-clinical group. The relation between AC and aspects of ED pathology were explored, as well as whether AC should be seen as a state or trait in patients diagnosed with ED. ACI-S/O was not significantly related to ED pathology or general psychological distress. There were no significant differences in AC between the different sub-diagnoses of ED but there were between the ED group and the non-clinical group. Significant pre-post correlations for both factors of ACI-S/O were found, indicating that AC could be seen as a stable dimension that might be important for ED pathology but is unrelated to ED symptoms. In study III the relationship between AC and self-reported attachment style (ASQ) was explored in a non-clinical group and three patient groups. There were significant correlations between all scores on ACI-S/O and the ASQ, with the exception of consciousness about guilt. Multiple regression analyses showed that AC, and especially others’ affects, contributed significantly to the ASQ subscales. AC and in particular own joy and others’ guilt and anger seem to be of importance for attachment style. In study IV the importance of AC for the treatment process was explored. Patients’ AC before therapy was significantly correlated with patients’ positive feelings towards their therapists but not with their alliance ratings. Patients’ warm and positive feelings were related to pre-therapy AC, whereas negative feelings were related to low alliance ratings in the previous sessions.
Svensk sammanfattning

List of papers

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<td>AC</td>
<td>Affect Consciousness</td>
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<td>ACI</td>
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<td>ACI-R</td>
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<tr>
<td>ACI-S/O</td>
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<td>AN</td>
<td>Anorexia Nervosa</td>
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<td>ANOVA</td>
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<td>ASQ</td>
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<td>BN</td>
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<td>EDNOS</td>
<td>Eating Disorder Not Otherwise Specified</td>
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<td>EI</td>
<td>Emotional Intelligence</td>
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<td>Feeling Checklist</td>
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<td>IPC</td>
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<tr>
<td>LSD</td>
<td>Least Significant Difference</td>
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<td>MANOVA</td>
<td>Multivariate Analysis of Variance</td>
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<td>SASB</td>
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<td>SASB-I</td>
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<td>ToM</td>
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INTRODUCTION

The concept of affect consciousness
Affect consciousness was conceptualized by Monsen and Monsen as “the mutual relationship between activation of basic affects and the individual’s capacity to consciously perceive, reflect on and express these affect experiences” (Monsen & Monsen, 1999, p. 288). Affect consciousness consists of the capacity to experience affects and the capacity to express affects. The first dimension encompasses the individual’s awareness and tolerance of affects and the latter the individual’s understanding of his or her non-verbal and verbal capacity to express the affect. Monsen, Eilertsen, Melgård and Ödegård (1996) also developed an interview, the affect consciousness interview (ACI), intended to measure an individual’s ability to be conscious of his or her affective reactions and thus capture the concept of affect consciousness.

The concepts of affect, emotion, and feeling
There are many different ways to conceptualize affect, emotion, and feeling, and the relationship between them. Izard (1991) describes affect as a general non-specific term that includes discrete emotions but also drives other motivational states and processes. Discrete emotion is a biologically rooted innate, universal process, according to Izard (1991), whereas feeling is a conscious experience. Gross and Thompson (2007) similarly to Izard (1991) consider affect to be a superordinate category for a number of states that have quick good-bad discrimination in common. These states include drives, stress responses, moods, emotions and other motivational impulses. According to Gross and Thompson (2007) the different states or processes differ from each other in terms of duration, the number of bodily responses involved, the kind of affective response involved, the specificity of response tendencies, how flexible they are and how they bias cognition and behavior. According to Nathanson, the term “affect” describes nine specific inborn physiological reactions whereas “feeling” refers to the awareness of the triggering of affects. According to Nathanson (cited in Tomkins, 2008) emotion is the combination of the triggered affect and our memory of previous experiences of that affect. Mood is seen as a state where a triggered affect reminds us of a personal historical experience. Stein describes in a similar way as Gross and Thompson (2007), Izard (1991), and Nathanson (2008), “feeling as awareness of affect, affect as a more comprehensive term, including all thinkable components belonging to this domain, and emotion as the complex mixture of affect and our previous experience with a particular affect, as a rather strongly felt
feeling” (Stein, 1991, p. xiii). Monsen, et al. (1996) use this description, and since the conceptualization of affect consciousness used in this dissertation is a development of their perspective, the same characterization of feeling, affect and emotion that Stein (1991) uses will be applied here.

**Differences between affect and emotion**

Theories about emotion and affect are seldom mutually exclusive and many researchers use multiple perspectives in their work. The differences that exist are usually owed to the question that is asked or the perspective that is studied or even the conceptualization of the studied object. Most of the theories fall into one of two broad categories, however, here referred to as “cognitive and social construction theories” and “theories of discrete inborn basic affects.”

One central difference between these categories concerns how emotions are related to cognition and motivation. Some theories consider emotion and cognition to be fairly separate but interacting systems (Damasio, 1999; Darwin, 1998/1872; Tomkins, 2008) whereas others regard emotion, cognition and motivation as parts of the same system or tightly connected (Averill, 1996, 2007; Lazarus, 1991). Another difference is how cognition or language and affect or emotion are related to each other. Frijda (1986), Averill, (1996, 2007), and Lazarus (1991) emphasize emotion as a product of cognitive elaborations whereas Tomkins (2008) views affect as a primary motivational force integrating and guiding cognition. Similarly, Harré (1986) considers emotions as social constructions limited by our language whereas Krystal (1988) views our verbal language as a product of our phylogenetic urge to express inborn emotions in a more fine-tuned way.

This distinction could also be viewed as one between biological theories (e.g. Damasio, 1999; Darwin, 1872; Panksepp, 2005, 2009) that emphasize how emotions are expressed through other means than the subjective feeling (e.g. facial expression; neural state), and cognitive or social constructive theories that emphasize emotion as a subjective, conscious experience (e.g. Averill, 1996, 2007; Lazarus, 1991).

**Cognitive and social construction theories**

**Affect as cognition**

Cognitive theories of affect imply that the bodily experienced emotion must be interpreted and labeled to become significant to the individual. According to this view it is the interpretation of the physiological response within a social context that gives rise to the emotion (Burleson & Goldsmith, 1998; Nussbaum, 2001; Solomon, 1980). An example is the
appraisal theory, which implies that emotion results from a combination of the perception and appraisal of a situation. This theory argues that physiological reaction is a consequence of the individual’s cognitive interpretation of events (Frijda, 1986; Lazarus, 1991).

Affect or emotion as a social construction

In social constructive theories human emotions are seen as constructed differently in different cultures from social practices and language. Harré (1986), who adopts a social constructionist perspective on emotions, argues that emotion is an ontological illusion. He argues that the experience of emotion is based on selection, ordering and interpretation, limited by our linguistic resources.

Common to the cognitive approach and the social construction theory is the argument that the bodily experienced emotion must be interpreted and labeled to become significant to the individual. This view that emotion is learned or is based on subjective interpretation implies that the social constructive theories of emotion are closely linked to the cognitive theories.

Theories of discrete inborn basic affects

The theory of inborn affects maintains that distinct patterns of physiological responses are associated with different emotions and that an emotion occurs not as a consequence of cognitive appraisal and evaluation but as a consequence of physiological reaction. Darwin (1998/1872), Ekman (1992, 2003), Izard (1991) and Tomkins (2008) have argued for such theories. In these theories, affects or emotions are seen as basic, discrete and inborn.


Tomkins

Tomkins (2008) also regards affect as inborn and discrete. According to him, affect is one of five basic systems of human functioning, together with homeostasis, drives, cognition and senso-motoric systems. One of the most important features of affects is that they amplify whatever triggers them, making bad things worse and good things better. Because affect makes everything that they connect to more urgent they constitute the primary motivating
force for humans (Tomkins, 2008). One important implication of this is that affect is regarded as an integrating and organizing force.

Levels of affect and consciousness

According to Ekman (1998/1872), emotion (or affect) is both a product of evolution (their physiology and expression) and learned (the ability to manage them, represent them verbally and reflect on them). Damasio (1994, 1999), LeDoex (1996), and Panksepp (2005) argue in a similar way that on one level there exist basic, inborn affects that influence consciousness and cognitive reflection. On another level, environmental influence, past experiences, and reflection create from the basic affects the subjectively experienced emotions that also incorporate reflection and cognition. Damasio’s (1994, 1999), LeDoex’s (1996), and Panksepp’s (2005) notions about different levels of affects and integration of affects might explain and solve some of the conceptual differences described previously. Theories in the group labeled “basic inborn affects” describe affects on the primary level whereas cognitive and social-constructive theories are described on the second level.

Monsen et al. (1996), Monsen and Monsen (1999), and Tomkins (2008) regard affect as the integrative and organizing force creating and directing cognition and action. The concept of affect consciousness (AC) in the way it is used in this thesis and by Monsen et al. (1996) could be seen as describing the process of how the integrative and organizing force of affect operates. Thus, affect, behavior, and cognition are viewed in this thesis as separate but interdependent aspects of the mind and body. AC is thought to describe how basic inborn affects become subjectively experienced emotions.

The general score on ACI has been found to co-vary with ego strength, global mental health, extravert personality style and lack of interpersonal problems (Monsen et al., 1996; Monsen & Monsen, 1999; Gude, Monsen, & Hoffart, 2001), and negatively with alexithymia, somatoform disorders (Waller & Scheidt, 2004, 2006), and psychopathic traits (Holmqvist, 2008).

The main focus of the studies by Monsen et al. (1996) was the individual’s perception and organization of his or her own affects. In line with self-psychological formulations (Stolorow, Brandchaft, & Atwood, 1987; Stolorow & Atwood, 1992) they described affects as organizers of self-experience. They paid less attention to the interpersonal and interactional aspect of affects. They were also inspired by Tomkins (1995, 2008) and Izard (1991) who stressed the
value of affect as an intra-psychical signal and motivator and as an intra-psychical integrative force more than the interpersonal side of affect.

**Affect as communication**

The most obvious reason for displaying affects in the face, by body posture and in the voice is to send messages to other members of our family, group or society. Although affects and emotions may be experienced and displayed in loneliness, emotions are usually experienced in social interaction (Andersen & Guerrero, 1998). Emotions and affects have significant impact on interpersonal relationships and communication (Andersen & Guerrero, 1998). Several researchers from different theoretical traditions have emphasized the interpersonal characteristics of affects and emotions (e.g. Campos, Campos, & Barrett, 1989; Darwin, 1998/1872; Ekman, 1992, 2003; Frijda & Mesquita, 1994; Lazarus, 1991; Salovey & Mayer, 1990).

**The ability to communicate emotion**

Individuals differ in how emotionally expressive they are, intentionally or unintentionally, but traces of our emotions are almost always still interpretable for others (Ekman, 2003). Not only do other people's emotional signals often determine our interpretation of their words and behavior but they also trigger our own emotions and emotional response (Ekman, 2003). Thus, we do not just express our emotions but communicate them (Planalp, 1998). This communication derives, however, from the ability both to send and to read emotional signals. The individual’s capacity to communicate emotions is shaped by the individual's personal history but also by the cultural rules (Ekman, 2003; Planalp, 1998). Planalp (1998) argues that since emotions or affects are transmitted through several different channels, facial expression, body posture, tone of voice, verbally and so forth they could fine-tune or cover up the message and sharpen or diminish our chance to read the emotional message accurately. The cover-up or fine-tuning of the emotional message is partly dependent on the communicative motive and goal (Planalp, 1998) but also on the ability of the transmitter. Ekman et al. (1969), and Ekman (1972), use the term “display rules” to refer to norms that determine the adjustment of different facially expressed emotions to social situations.

In addition to the ability to send emotional signals it is also essential to be able to decode the information, tolerate the experience of the transmitted emotion and respond adequately to the sender of the emotion in order to establish an emotional communication.
According to the social-functional approach, emotions coordinate social interactions in a way that helps humans shape and maintain helpful relationships (Keltner & Kring, 1998). Keltner and Kring (1998) argue that emotions coordinate social interactions by providing information about the interacting individuals’ intentions, emotions, and relational orientations. They also state that emotions evoke complementary and similar emotions in others which in turn motivate behavior that promotes relationships and that the emotions guide the interactions regarding preferred conditions.

Analysis of micro-sequences of face-to-face interaction has revealed that at the same time as the affect display on the face reflects the individual’s intra-psychic regulation of affects, it communicates meaning to the interacting partner about how the individual wants the other to behave and what can be expected in return (Banninger-Huber, 1992). This is a rapid and mostly unconscious process. Depending on which emotion is felt, the social context and the quality of the relationship, the presence of another person can either amplify or de-amplify the expression of emotion (Ekman & Rosenberg, 1997).

Thus, the context and the purpose of the interaction provide clues that help the receiver of the affect to inform himself or herself about the function of the affect.

**Consciousness about own and others’ affects**

Besides being able to identify and express his or her own affects, it is also essential for the individual to have the ability to identify the affects of other persons. In the interaction with other individuals, it is important to know what quality the emotional display of the other entails, to be able to interpret emotionally colored behavior, and to respond to that behavior in adequate and modulated ways. An important aspect of a person’s relationships pertains to the ability to be aware of and be attentive to the other’s affective reactions. The person must also be able to recognize and tolerate the other person’s affects, and to express a proper response to that affective expression. In fact, the reception of emotional information is perhaps the basis of social skill, communicative competence, and empathy (Andersen & Guerrero, 1998).

**Reconceptualization**

In order to capture this interactional aspect of affect consciousness, the affect consciousness concept was reconceptualized as “the mutual relationship between activation of basic affects and the individual’s capacity to consciously perceive, reflect on and express or respond to these affect experiences in himself or others” (Lech, Andersson, & Holmqvist, 2008, p. 515).
This new conceptualization focuses on affect consciousness as the organizer of the subject’s own affect and the organizer of the impact from others’ affect on the subject.

**Affect as a primary organizing force**

The AC construct refers to affect as the primary organizing force in both conscious and unconscious aspects of human functioning. The AC construct attempts to conceptualize the overall organization of how basic affect occurs in the individual and between individuals and how they impact on the individual (Tomkins, 2008; Monsen & Monsen, 1999). The organization of the affect episode involves elements available for reflection, i.e. semantic symbolization, as well as unsymbolized or presymbolized mental states (i.e. bodily felt states) and affect signals outside awareness (Damasio, 2003; LeDoux, 1998). Affect-loaded assumptions about the self and others and possible interactions and reactions to them are inherent in affect organization and will shape the individual’s perceptions, interpretations and reactions to self and others.

**Affect as amplifier and motivational force**

Tomkins (2008) claims that affect is of extraordinary importance for humans as a motivating force. The affect consciousness concept presupposes in line with Tomkins (2008) that affects organize self-experience and interpersonal interactions partly by working as amplifiers, making whatever triggers the affect urgent and extending its duration. The affect consciousness concept is built on a presumption that affect, along with other life-supporting forces like drives, pain and homeostatic processes, constitutes the primary motivating force for humans (Tomkins, 2008) and that other forces, like the sexual drive and hunger, are dependent on affects (Ekman, 2003; Tomkins, 2008).

**Disintegration of affect**

If for some reason the signal function of the affect breaks down, and affect is without meaning to the individual, it results in a disorganization of experience about ourselves and the external world and of the communication between ourselves and the external world (Damasio, 1999; Greenberg, 2002; Panksepp, 2009). This could happen for a number of reasons (e.g. brain damage, psychological or physiological trauma, or maltreatment).
The process of affect consciousness

The AC construct implies that the consciousness of affects develops through a step-wise process in the individual. The construct attempts to conceptualize the general organization of the processes of the individual’s own affects and reaction to others’ display of affects as they occur to the individual. This process develops from the activation of the perception of basic affect, through the impact of the affect on the individual to the expression or response of the same affect (Tomkins, 2008, 1995; Monsen & Monsen, 1999).

The experience of affect

The ability to use affect as a signal about oneself and others is dependent on two integrative functions conceptualized as awareness and tolerance. To be aware of and tolerate affects is the ability to convert affective signals to concepts, knowledge, insight and understanding. Through active reflection, a person is able to understand the context to which the emotional responses belong.

Awareness

Awareness is the manner in which the individual pays attention to, recognizes and observes their own or others’ emotional experiences when a specific affect is activated. The awareness function is understood as focusing and selective. The kind and number of awareness signals as well as the habitual manner a subject adopts in this process constitute the main elements of individual variation. The awareness signals which the subject uses to identify specific affects may be on a concrete physical level of experience as well as on an imaginative, symbolic level.

Tolerance

Tolerance describes how an individual allows himself or herself to experience affect and the impact that affect has on the individual’s psychological and physical functioning. This is viewed as a prerequisite for being able to decode the information aspects of distinct affects. The capacity to use affects as signals and as conveyers of meaningful information is an essential aspect of specific affect experiences.

The expression of and response to affect

The expression of own affects or responses to others’ affect display can be non-verbal or verbal.
Non-verbal expressiveness and responsiveness

Non-verbal expressiveness of own affects and responsiveness to others’ affect display comprises all the non-verbal cues (mimic, gestures, bodily posture and other behavior) that an individual can display in order to convey and communicate his or her emotional experience or his/her indication to others that she or he has noticed their emotions.

Verbal expressiveness and responsiveness

Verbal expressiveness and responsiveness concern the ability, by linguistic means, to communicate verbally the affect or response in question. Individuals differ, however, with regard to how adequate, nuanced and differentiated the expression of the affect or response to others’ affect is in an interpersonal situation.

Being able to express one’s own affects and give feedback on others' affects in a clear and differentiated way can be regarded as a prerequisite for experiencing and participating in an intersubjective context and sharing the reality with someone else. It is likely that the more the individual expresses his or her own affects in an articulated and differentiated manner and responds to others' affects, the more variegated the responses he or she will receive from others.

Interaction between consciousness about own and others’ affects

It is probable that consciousness about own and consciousness about others’ affects are dependent on each other in an interactive way, giving mutual feedback. Consciousness about others’ affects is influenced by the individual’s ability to be conscious about own affects at the same time as the consciousness about own affects is influenced by the individual’s ability to be conscious about others’ affect display. Predictions and assumptions about the nature of others’ affects are presumably dependent on the process of affect consciousness in the individual as well as others’ emotional display and this will shape the individual’s perceptions, interpretations and reactions to self and others (Ekman, 2003; Keltner & Kring, 1998; Planalp, 1998).

Connection with other concepts

There are several constructs that are conceptually related to AC or aspects of AC: e. g. alexithymia (Taylor, 1984), emotional intelligence (Mayer, Salovey, & Caruso, 2000a, 2000b), mentalized affectivity (Fonagy, Gergely, Jurist, & Target, 2002), and psychological mindedness (Appelbaum, 1973). The reconceptualization of the affect consciousness
construct in this thesis, which pays increased attention to the interpersonal and interactional aspects of affects, means that the concept of affect consciousness can also be compared with other concepts and theories such as adult attachment (Main, Kaplan, & Cassidy, 1985; Main, 1991), empathy (Hoffman, 2000), and mentalization (Bouchard et al., 2008; Fonagy & Target, 1996, 1997, 1998; Fonagy et al., 2002).

In this thesis the new conceptualization of affect consciousness is studied in relation to psychopathology, different aspect of interpersonal theory, attachment style, and the therapeutic relationship.

**Interpersonal theory**

In interpersonal theory, the cognitive and emotional experiences from past social relations are believed to be introjected to become established patterns or interpersonal schemata. Interpersonal interaction, according to Sullivan (1953, 2011), is always motivated by two basic needs – security (the need for closeness and affection) and self-respect or self-esteem.

**Interpersonal Circumplex (IPC)**

Sullivan's theory (1953) was developed by Freedman, Leary, Ossorio and Coffey (1951), and Leary (1957). Freedman, et al. (1951) arranged a list of needs in a circumplex model (the IPC model). Leary (1957) applied this model to descriptions of personality. In the IPC, interpersonal patterns are described on two underlying axes: love-hate and dominance-submission.

According to Leary (1957), personality can be interpreted on different levels; the level of public communication, the level of conscious communication, the level of private communication, the level of the unexpressed, and the level of values. Leary (1957) also states that psychopathology and normality are a question of degree in terms of accurate perception, and the ability to be both flexible and stable.

All humans are seen as being somewhere on a continuum of inappropriate interpersonal behavior, and those whom we consider as normal have a greater ability to be more flexible when needed and to be more stable when needed. The interpersonal patterns can be interpreted as more or less conscious interpersonal behavior and introjected patterns of interpersonal behavior.

Central to interpersonal theories are the notion of predictive principles (Benjamin, 1996a; Benjamin, 1996b) and the principle of complementarity (Horowitz, 1996). According to these
principles, behavior in interaction with others invokes specific complementary reactions in the partner. For example, help-seeking behavior tends to trigger supporting behavior in the partner (Horowitz, 1996). According to Benjamin (1996), complementarity is not the only principle of interaction. In the Structured Analysis of Social Behavior (SASB; Benjamin, 1996a, 1996b) the most important predictive principles are introjection, opposition, complementarity, similarity, and antithesis. For example, introjection is seen both when the parents' view of the child becomes a part of the child's view of him or herself and when the therapist's acceptance of the patient leads to self-acceptance by the patient (Benjamin, 1996a, 1996b). Thus, according to interpersonal theory, the self-image is interpersonally constructed (Kiesler, 1996).

From this conceptual frame different instruments using the interpersonal circumplex have been developed. Two examples are the Structural Analysis of Social Behavior model (SASB) developed by Benjamin (1974) and the Inventory of Interpersonal Problems (IIP) by Horowitz (1979) and Horowitz, Rosenberg, Bear, Ureño, & Villaseñor (1988), each describing different aspects of interpersonal behavior (Horowitz & Strack, 2011).

**A theory of interpersonal problems (IIP)**

The development of the IPC by Horowitz (1979) and Horowitz et al. (1988) into the Inventory of Interpersonal Problems (IIP) is perhaps one of the most influential adaptations of the interpersonal theory. In this model, patients' interpersonal problems are described in a systematic circumplex order. Horowitz et al. (1988) try to cover all essential aspects of the individual’s interpersonal relations and problems. IIP does not, however, measure the individual’s perspective on the self as the SASB model does by measuring the introject, i.e. the self-image.

**Structured Analysis Of Social Behavior (SASB)**

One of the most elaborated developments of the IPC is the SASB model (Benjamin, 1974). In contrast to the IPC model, the SASB model does not view pathology as a question of intensity but of quality (Benjamin, 1996a). The SASB model tries to encompass all levels described by Leary (1957) in three circumplex surfaces, each with a specific focus (Benjamin, 1996). One surface describes the perception of others’ actions, another the subject’s reaction to the other’s action, and a third describes the “introject” or self-image. The relations between the different surfaces are subject to the predictive principles (Benjamin, 1996) described earlier. For example, a controlling action of the parent is thought to give rise to a submissive reaction and
a self-controlling introject in the child. According to Benjamin (1996), in the SASB model all levels of personality (Leary, 1957) are recognized but they appear on different surfaces in the model. That is, a person might be conscious of the submissive reaction but not that it is a reaction to the controlling action of the parent or the self-controlling introject to which it relates. In the SASB model, however, the different surfaces are supposed to be measurable although they might be unconscious to the subject.

The relationship between the circumplex interpersonal theory as conceptualized and measured by IIP and the SASB-Introject and consciousness about own and others’ affect is outlined in study I in this thesis.

**Self-reported adult attachment style**

One attachment research tradition, mainly represented in social and personality psychology, predominantly uses self-report measures of attachment-related thoughts and feelings in adult relationships (Cassidy & Shaver, 1999). These ideas have been less strongly related to childhood attachment as measured by the Strange Situation procedure (Fraley, 2002). Theories in this tradition are based on the assumption that although the psychological processes underlying individual differences in relational styles may operate in ways that are not always conscious, the processes still have implications for the conscious thinking and attributions that the individuals make about themselves and their relationships (Crowell, Fraley, & Shaver, 1999). Self-report questionnaires seem to capture basic personality traits and some aspects of adult functioning that are theoretically meaningful in attachment theory such as self-evaluated capacity for adult intimate or romantic relationships (Roisman et al., 2007), social support and emotional status (Barry, Lakey, & Orehek, 2007) and strategies of emotion regulation (Mikulincer & Shaver, 2005; Woodhouse & Gelso, 2008). Studies that use social-psychological measures of attachment have also demonstrated consistent and often quite strong associations between reports of insecurity and psychopathology. Mickelson, Kessler, and Shaver (1997) have shown that self-reported insecurity is positively associated with all psychiatric disorders except schizophrenia in the DSM manual. Self-rated insecure attachment styles may be especially associated with depressive symptomatology (Roberts, Gotlib, & Kassel, 1996; Simpson & Rholes, 2004) and predict depressive symptoms (Hankin, Kassel, & Abela, 2005). The relationship between self-reported adult attachment style and consciousness about own and others’ affect is outlined in study III in this thesis.
The therapeutic relationship and alliance

The psychotherapeutic relationship is a very special kind of interpersonal activity. It is an asymmetric relationship wherein the participants have special roles, expectations, means of interaction and goals.

Research on the therapeutic relationship often centers on the associations between relationship and outcome. Norcross (2002) lists 11 factors in the psychotherapeutic relationship that contribute to outcome in therapy: Alliance, Cohesion, Empathy, Goal consensus and collaboration, Positive regard, Congruence, Feedback, Repair of Alliance ruptures, Self-disclosure, Management of counter transference, and Relational interpretation. The aspect of the treatment relationship that has been most frequently studied is alliance, and the concept of alliance often incorporates some of the factors listed above.

Alliance

Luborsky (1976) identified two aspects of alliance. One aspect implies that the patient receives support and help from the therapist and the other is based on a feeling of joint cooperation towards overcoming the patient’s problems. The second aspect might be hypothesized to be more closely related to a positive outcome than the first one, according to Luborsky (1976). Bordin (1979, 1994) identified three components of the therapeutic alliance: the task, the goal, and the bond between the patient and the therapist. The task entails the actual work involved in the therapy. Bordin (1979, 1994) underlined that the participants must believe that the manner in which the therapy is conducted is constructive in relation to the patient’s problem. By goal Bordin (1979, 1994) means the explicit and silent agreement about what should be achieved. The positive link between the therapist and the patient is conceptualized as a bond in Bordin’s theory. Bonds incorporate mutual trust, intimacy, and acceptance, and represent the patient’s emotional bond to the therapist and the therapist’s empathic understanding (Horvath & Bedi, 2002).

Luborsky’s and Bordin’s descriptions of alliance have been widely accepted. There are also a number of other conceptualizations of alliance and scales to measure such concepts but although there are differences between them (Horvath & Bedi, 2002) they all on the whole seem to capture the same phenomenon (Bachelor & Horvath, 1999) and most of them are equally good at predicting outcome (Martin, Garske, & Davis, 2000). Several studies have found that early alliance seems to be a robust predictor of change in treatment and that it is the
patient’s view of the alliance that correlates most strongly with outcome (Horvath & Symonds, 1991; Horvath, Del Re, Fluckiger, & Symonds, 2011).

**Alliance and affect**

In a study of early treatment markers of the therapeutic alliance, Sexton, Littauer, Sexton, and Tömmerås (2005) found that the patient’s personality and the bond between the therapist and the patient accounted for more than 50% of the variance in both the patient's and the therapist's rating of the alliance. Also, the therapist’s self-image, as rated by the SASB self-image scale (Benjamin, 1976), predicts alliance as reported by therapist and patient (Hersoug, Hoglend, Monsen, & Havik, 2001).

In a study by Sexton, Hembre, and Kvarme (1996) the alliance level in early sessions was associated with the emotional content in the session. In their study of micro-processes and alliance they found that early alliance was most associated with a mutual emotional engagement process. In therapies with high alliance in the first session therapist engagement was followed by more patient tension, which in turn raised therapist engagement even more (Sexton et al., 1996).

Therapists’ verbalizations of emotions, especially naming the patients’ anger in the therapy, have also been associated with success in therapy (Holzer, Pokorny, Kachele, & Luborsky, 1997). Not surprisingly, affects and emotions are emphasized as an important part of the psychotherapeutic relationship (Elliott, Bohart, Watson, & Greenberg, 2011; Greenberg, Watson, Elliot, & Bohart, 2001; Horvath & Bedi, 2002). In particular, the client’s emotional involvement (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996) and the patient’s view of the therapist as empathic and authentic (Greenberg et al., 2001) appear to be important for the patient’s experience of the relationship and for change of symptoms to occur in the treatment. With the exception of the work by Greenberg and Paivio (1997), not much research has been done on emotional processes in psychotherapy, however (Whelton, 2004). Of the studies that have been conducted, Whelton (2004) summarized that emotion and emotional responsiveness are of special importance for the process and the relationship in every kind of psychotherapy.

The relationship between parts of the psychotherapeutic relationship and AC is studied in study IV in this thesis.
Affect and psychopathology

Affect and general psychopathology

Problems with affect or emotion are common in most psychopathology. In the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, (DSM-IV; American Psychiatric Association, 1994) nearly all the diagnostic categories include symptoms that comprise one type of emotion disturbance or another. Although the manifestations of these disturbances between disorders differ, the frequency of emotion disturbances in psychopathology suggests that there might be some generality across disorders (Kring & Moran, 2008). The emotional problems described in DSM-IV include problems with the communication of emotions as in autistic disorder, with a lack of emotional reciprocity, or a lack of empathy as in the case of narcissistic personality disorder, regulation problems as in borderline personality disorder, excesses of emotion as is the case with fear in social phobias and anxiety, lack of some emotions in combination with amplification of other emotions, as in depression, or intense fear of losing control as in eating disorder. There are also an overwhelming number of studies pointing to the importance for psychopathology of problems with affects or emotions.

General psychopathology and own affects

The dysregulation of own affects is regarded as a core aspect of most forms of psychopathology (Berenbaum, Raghavan, Le, Vernon, & Gomez, 2003; Bradley, 2000; Cicchetti, Ackerman, & Izard, 1995; Gross & Munoz, 1995; Keenan, 2000; Schore, 2003a, 2003b). Insufficient expression of affects has been shown to have implications for a diverse range of mental disorders. In a review of emotion in schizophrenia, Kring and Moran (2008) conclude that one of the more well-replicated findings in the literature is that individuals with schizophrenia are both less vocally and less facially expressive of emotions than individuals without schizophrenia. This shortcoming is also present in other mental disorders: e.g. obsessive-compulsive disorder (Zeitlin & McNally, 1993), panic disorder (Marchesi, Fonto, Balista, Cimmino, & Maggini, 2005; Parker, Taylor, Bagby, & Acklin, 1993; Zeitlin & McNally, 1993), addiction diagnoses with impulsive-compulsive behavior (Malat, Collins, Dhayanandhan, Carullo, & Turner, 2010), and depression (Honkalampi, Hintikka, Tanskanen, Lehtonen, & Viinamaki, 2000, 2007).
General psychopathology and others’ affects

With regard to the issue of others’ affects, patients with proneness to psychosis (Germaine & Hooker, 2011) or suffering from manifest psychosis or schizophrenia (Edwards, Jackson, & Pattison, 2002; Hofer et al., 2009; Kohler, Walker, Martin, Healey, & Moberg, 2010; Mandal, Pandey, & Prasad, 1998; Penn, Addington, & Pinkham, 2006) have, like patients diagnosed with psychopathy (Hastings, Tangney, & Stuewig, 2008), and both unipolar and bipolar depression (Bylsma, Morris, & Rottenberg, 2008; Derntl, Seidel, Kryspin Exner, Hasmann, & Dobmeier, 2009; Gur, Erwin, Gur, & Zwil, 1992; Leppanen, Milders, Bell, Terriere, & Hietanen, 2004; Schaefer, Baumann, Rich, Luckenbaugh, & Zarate, 2010), been found to experience a deficit in recognizing affective expression in others. In a review of 40 studies about the relation between the processing of others’ facial emotion and major depression, Bourke, Douglas, and Porter (2010) found that patients with major depression have special problems with sad and happy affects. They concluded that patients with major depression show reduced accuracy about sad and happy faces, and selective attention toward sad expressions and away from happy expressions. These patients tend to see sad faces as more intensely sad than non-clinical control groups. Pollak et al. (2000) found that the ability to recognize others’ affects among physically abused and physically neglected preschoolers is impaired. Neglected children had most difficulty in discriminating affect expressions whereas physically abused children displayed a heightened response toward the expression of discrete affects, especially anger, in comparison with a control group. Also, adult patients suffering from post-traumatic stress disorder have been found to show less empathic resonance compared with a control group (Nietlisbach, Maercker, Rossler, & Haker, 2011).

Recognition of others’ affects also seems to be a problem in borderline personality disorder (BPD). Domes, Schulze, and Herpertz (2009) conclude in a review of the literature about emotion recognition in BPD that borderline personality disorder is characterized by severe problems in emotion regulation, resulting in affective instability, especially in interpersonal situations. Furthermore, problems with recognition of others’ non-verbally expressed affects, with a bias to negative affects and especially anger, have been suggested as an explanation for interpersonal problems in BPD (Domes et al., 2009).

In sum, problems in recognition, communication, and awareness of both own and others’ affects seem to be related to psychopathology. These are all abilities that are covered by the concept of affect consciousness. Thus, consciousness about both own and others’ affects seems to be related to general psychopathology.
Affect and psychosomatic pathology

The prominence of emotional disturbances in psychosomatic disorders and somatization may explain why alexithymia was initially conceptualized as a psychosomatic disorder (Martinez Sanchez, Ato Garcia, Adam, Medina, & Espana, 1998). In psychosomatic medicine the interaction of deficits in cognitive and emotional processing (e.g. alexithymia) and the presence of stressors are believed to aggravate the vulnerability to somatic illness (Taylor et al., 1991).

According to Krystal (1982), one of the cardinal features of psychosomatic patients is their inability to recognize and name their own feelings. Krystal (1977,1997) suggests several different ways that affect can take that explain the development of psychosomatic disorders. Krystal (1997) argues that the child, partly through the development of language and with the help of parents, learns how to recognize, differentiate, and tolerate several shades and nuances of affect and gains access and tolerance of the affect. Without this acquisition, the necessary desomatization of the affect never occurs and psychosomatic disorders may develop. Even when these abilities are developed, however, affects can become dedifferentiated, deverbalized, and resomatized (Krystal, 1977) into psychosomatic disorders. Thus, according to Krystal, psychosomatic disorders may develop because the individual has never acquired the means to desomatize and symbolize the affect or because of a regression into a state where the individual expresses the affect through the body in a non-symbolic way.

Associations between alexithymia and somatization have been established in epidemiological studies. In a Finnish study comprising 5,129 subjects aged 30 to 97, alexithymia was associated with somatization independently of somatic diseases, depression and anxiety and potentially confounding socio-demographic variables (Mattila et al., 2008).

The relationship between somatoform disorders, alexithymia, and consciousness about own affects have been investigated by Waller and Scheidt, (2004, 2006). The result showed that high consciousness of own affects correlates negatively with alexithymia and somatoform disorders. One way to express the affect with the body is through stress-related disorders; another way might be through an eating disorder.

Affect and eating disorder pathology

Affect disturbances have for a long time been linked to eating disorder. As long ago as 1698, in what is considered the first description of anorexia nervosa, Richard Morton described the cause of the disease as sadness and anxiety (Silverman, 1997). Another forerunner, Hilde
Bruch, considered a lack of ability to sort out, identify, and express emotions and other internal sensations as an important contributor to anorexia nervosa (Bruch, 1973).

**Own affects and eating disorders pathology**
The idea of increased alexithymia in eating disorders (ED) has received empirical support mainly in relation to patients suffering from anorexia nervosa (Bourke, Taylor, Parker, & Bagby, 1992; Cochrane, Brewerton, Wilson, & Hodges, 1993; Montebanacci et al., 2006; Schmidt, Jiwany, & Treasure, 1993). Eizaguirre, De Cabezon, De Alda, Olariaga, and Maite, (2004) report in a review that the rates of alexithymia in anorexia nervosa (AN) patients vary between 23% and 77%, whereas in non-clinical groups the rates vary between 0% and 28% (Quinton & Wagner, 2005). Some studies also report correlations between alexithymia and bulimia nervosa (BN; Cochrane et al., 1993; Jimerson, Wolfe, Franko, & Covino, 1994; Sureda, Valdes, Jodar, & de Pablo, 1999; Quinton, 2005).

**Others’ affects and eating disorders pathology**
Kessler, Schwarze, Filipic, Traue, and von Wietersheim (2006a) report that patients with both AN and BN scored significantly higher on TAS-20 but not on measures of problems with facial emotion recognition, compared with a control group. Also, Mendlewicz, Linkowski, Bazelmans, and Philippot (2005) could not find any differences in facial emotion recognition between AN and healthy individuals. Some other researchers have, however, found impaired recognition of facial emotions (Kucharska-Pietura, Nikolaou, Masiak, & Treasure, 2004; Zonnevijlle-Bender, van Go ozone, Cohen-Kettenis, van Elburg, & van Engeland, 2002) and vocal emotions (Kucharska-Pietura et al., 2004) in AN compared with normal control groups. In a study by Uher et al. (2004) AN patients experienced more fear and disgust, and patients with BN experienced more disgust but not fear, in response to aversive pictures compared with a non-clinical group. Ridout, Thom, and Wallis (2010) found in a study of non-clinical subjects that participants high on the Eating Disorder Inventory (EDI; Garner, 1991), and especially the bulimia subscale of the EDI, exhibited a general deficit in recognition of emotion, particularly anger. Also, Fassino, Daga, Piero, Leombruni, and Rovera (2001), using self-report measures, found reduced recognition of anger in BN, but no differences in AN compared with a non-clinical group. Waller et al. (2003) describe higher levels of problems recognizing anger in AN as well as BN, and they emphasized the association of bulimic behavior and suppression of anger in both sub-diagnoses.
Eating disorder as an escape from affect

Slade (1982) and Schmidt and Treasure (2006) have suggested that preoccupation with food, eating, weight, and shape might function as a way of avoiding affects or stimuli like interpersonal relationships that trigger affects. Thus, eating disorder pathology might function as a way to manage or regulate affects that otherwise might lead to depression and anxiety. Corstorphine, Mountford, Tomlinson, Waller, and Meyer (2007) found that ED patients report avoidance of situations that might provoke positive or negative affects to a significantly higher degree than non-clinical controls. Wildes, Ringham, and Marcus (2010) tested Slade's (1982), and Schmidt and Treasure's (2006) ideas and found that emotion avoidance in patients with AN did indeed mediate the relation between depressive and anxiety symptoms and eating disorder psychopathology.

Similarly, in a study of exercise dependence in patients with longstanding ED and non-clinical controls Bratland-Sanda et al. (2011) found that extensive physical activity and exercise primarily served to regulate negative affects and not weight/appearance in both patients and controls.

Affect regulation has also been useful for understanding the function of binge eating (Aldao, NolenHoeksema, & Schweizer, 2010; Polivy & Herman, 1993; Stice, 2001; Svaldi, Caffier, & Tuschen-Caffier, 2010; Wedig & Nock, 2010). In a meta-analysis, Haedt-Matt and Keel (2011) examined changes in affect before and after binge eating. Their results indicated that binge eating was preceded by more negative affect than regular eating (ES 0.68) and also by more average affect (ES 0.63). Negative affects also increased following binge episodes (ES 0.50) whereas they seemed to decrease following purging in bulimia nervosa (ES – 0.46). That negative affects usually also increased after the binge episode seems to contradict the hypothesis that bingeing should reduce or regulate negative affects. This conclusion, however, would require that binge eating is effective in reducing negative affects. It might of course be that bingeing is a useless strategy to reduce or escape negative affects but is still used because reduction is achieved during the bingeing. It is also possible that other affects increase during and after the bingeing than those that were experienced before the bingeing. A study by Tachi, Murakami, Murotsu, and Washizuka (2001) of a diversity of affects in episodes over a full day showed that anger (irritation and frustration) was intense before bingeing but was alleviated together with boredom once the bingeing started. Several other negative affects but predominantly shame and guilt increased with the bingeing and continued to increase after the bingeing. Tachi et al. (2001) argued that repeated bingeing (and purging) might lead to chronic development of shame and guilt and thereby contribute to the low self-esteem often
seen among bingeing patients. The study by Tachi et al. (2001) also showed that purging is a stronger regulator of affect than bingeing, with the relief of anxiety, anger, excitement, shame, and fear leading to enhanced calmness, thus indicating a kind of binge-purge cycle.

**AIM**

The overall aim of the thesis is to explore the clinical usefulness of a new conception of affect consciousness and to validate a semi-structured interview intended to capture this new definition, which incorporates consciousness of own as well as others’ affects.

**Study I**

The aim of study I was to explore the clinical usefulness of the modified version of the affect consciousness interview (ACI-S/O), that incorporates consciousness about own affects as well as reactions to others’ affects. In addition, the aim was to assess the interrater reliability and the concurrent validity of the interview.

It was hypothesized that some patterns of affect consciousness would reflect special problems of the clinical groups but also that some patterns of affect consciousness would be found in both the clinical and the non-clinical groups reflecting general structures.

**Study II**

The aim of study II was to explore further the clinical implications of consciousness about own and others’ affect in relation to eating disorders, to see whether there was a lower level of affect consciousness in the eating disorder group compared with a demographically comparable non-clinical group and if affect consciousness was related to other aspects of eating disorder pathology. The aim was also to obtain a deeper understanding of both affect consciousness and eating disorders by exploring whether affect consciousness is a state or trait in patients diagnosed with anorexia nervosa and bulimia nervosa.

**Study III**

The aim of study III was to study the relationship between affect consciousness and attachment style which is an important concept associated with interpersonal skills, self-image and psychiatric symptoms. The association between self-reported attachment style and the ability to be conscious of own and others’ affects was explored. The predictive validity of affect consciousness on self-reported attachment style was also analyzed.
It was hypothesized that affect consciousness would be associated with self-rated attachment patterns, with higher levels of affect consciousness being associated with secure attachment and lower levels with insecure attachment.

Study IV

The aim of study IV was to explore the clinical significance of affect consciousness for the treatment process and to obtain a deeper understanding of the early treatment process and patients’ consciousness about own and others’ affects in relation to the early treatment process. It was hypothesized that patients’ affect consciousness would influence their feelings towards the therapist in the early treatment process more than their view of the more instrumental aspects of the relationship.

METHODS

The setting

The designs for the studies in this thesis were all naturalistic. All patients were treated at psychiatric or psychotherapeutic services. All patients were women. Forty-three patients with eating disorders were treated as in-patients in a specialized unit for eating disorders and five were treated at an eating disorder outpatient unit. Thirteen patients with relational and social problems were treated as inpatients in two specialized treatment units for mothers who, for various reasons (e.g. severe psychiatric or drug-related problems), had problems relating to their children. Ten patients with stress-related problems participated in a special treatment program including physiotherapy and time-limited psychotherapy. The 32 therapists in study IV worked at the different units participating in the study. The 67 women in the non-clinical samples were recruited by advertisement. Owing to the particular selection of clinical groups there were only women among the patients, and hence we only included women in the control group. The non-clinical groups were not controlled for psychopathology.

Participants

Study I

In all, 95 individuals took part in study I. There were 27 individuals constituting a non-clinical sample, 47 patients with eating disorders, 13 patients with relational and social problems and eight patients with stress-related problems.
Study II
In study II the participants were 27 patients diagnosed with anorexia nervosa, 11 with bulimia nervosa, six with eating disorders NOS and 40 without any known eating pathology.

Study III
In study III there were 48 women with eating disorders (e.g. bulimia and anorexia), 11 with severe relational problems (i.e. under care for not being able to manage their child or children), and 10 with stress-related problems (e.g. burnout and on long-term sick leave) and 13 women without any known psychiatric or relational problems.

Study IV
Fifty-three female patients took part in study IV. There were 35 patients with eating disorders (i.e. bulimia and anorexia), eight with severe relational problems (i.e. under care for not being able to take care of their child or children), and 10 with stress-related problems (i.e. burnout and long-term sick leave). The participants in this investigation also constitute part of the patient sample in study I, II, and III. Of the 32 therapists, 27 were women and 5 were men.

Raters
A total of 11 raters were used and 10 raters also performed the affect consciousness interview self/other. Eight raters were psychology students and three were graduate and experienced psychologists. In all studies at least two raters for each interview were used. They were all trained in the procedures for interviewing and rating the interview. Out of the 182 interviews used in this thesis 138 interviews were rated from film and 44 from transcribed audiotapes.

Measures
The Affect Consciousness Interview- Self/Other (ACI-S/O)

The reconceptualization of affect consciousness requires a modified interview to measure the concept. The modified interview was first labeled “the affect consciousness interview – Revised” (ACI-R) but was later renamed as “The Affect Consciousness Interview- Self/Other” (ACI-S/O) because it was thought that this better reflected the reconceptualization. ACI-S/O is a semi-structured interview that partly uses the form of participant observation. The ACI-S/O aims at identifying eight dimensions of affect consciousness: (a) awareness of the individual’s own affects, (b) tolerance of the individual’s
own affects, (c) non-verbal and (d) verbal expression of the affects, (e) awareness of others’ affective reaction, (f) tolerance of others’ affective reaction, (g) non-verbal and (h) verbal response to others’ affective reaction.

The interviewer asks about seven affects: interest/excitement, enjoyment/joy, fear/panic, anger/rage, humiliation/shame, sadness/despair and guilt/remorse. Depending on how comprehensively the subject answers the interviewer is relatively free to adapt the phrasing of questions.

Two aspects of every affect category are examined and rated: consciousness of own affects and consciousness of others’ affects. The ratings of own affects are based on how conscious the interviewee is about their own affective experiences. Consciousness about others' affects relates to the interviewee's consciousness of other people's emotional experiences and how the interviewee relates to and reacts to others’ affective experiences. Each of the two aspects is examined separately in two overarching dimensions: the ability to experience affects and the ability to express affects and respond to affects, each with two components. The ability to experience affects has two components: awareness and tolerance. The ability to express and respond to affects also has two components: non-verbal and conceptual expressiveness and responsiveness.

The answers to every single affect asked for are scored on a scale from one to 10 points on each of the eight dimensions of consciousness, where 10 is the highest possible degree of affect consciousness. The scoring of the interview can be analyzed on a single-item level (e.g. awareness of own shame), according to a specific component (e.g. awareness of own affects), with regard to a specific affect (e.g. consciousness about shame), with regard to an aspect of a specific affect (e.g. consciousness about own shame), with regard to a specific aspect (e.g. consciousness about own affects), and on a total level (consciousness about own and others’ affects).

Most subjects will need help from the interviewer to answer in a way that covers all scoring possibilities. The interviewer usually has to create a dialog around the actual topics, experiences and forms of expressions that the interviewee brings up, in order to obtain scorable answers. If the interviewer has the impression that the answer simply refers to a specific episode, it is checked whether this is a typical pattern or representative of the interviewee’s behavior in other contexts as well: e.g. “Do you experience (the affect) in this way at other times or in other situations?” Sometimes the answer may be too general and
abstract. Vague or evasive answers are clarified by asking for concrete episodes. If the interviewee does not experience a specific affect for the time being or does not recognize a scene including the affect in question, the interviewer will gradually help the subject to acquire such a recognition. The scoring is dependent on the extent to which the subject needs help in order to answer and describe the points above. More nuanced and differentiated responses provide a higher score than simplistic answers. If the subject is able to recognize the actual affect category the answer might be a directly describing or a more experiential answer. If a person is only talking about the affect in a symbolic and abstract way but not in a concrete way he or she does not achieve a high score despite the fact that the person can reason about the feeling on an "intellectual" level. A high level of affect consciousness can accordingly be described as an understanding of the affect in all its stages, from the physiological to the symbolic, in all parts of the interview: awareness, tolerance, emotional or conceptual expressiveness or responsiveness.

**Self-rating instrument**

In the first study of this thesis the affect consciousness interview-self/other (ACI-S/O) is validated against two self-rating instruments intended to capture different aspects of patterns of interpersonal interaction and problems in interpersonal interactions (SASB and IIP). A measure intended to capture psychological problems is also used in this study (SCL-90).

In the second study a self-rating instrument intended to capture eating disorder pathology is used (EDI-2). In the third study ACI-S/O is analyzed in relation to self-rated adult attachment style (ASQ). In the fourth study two measures of the therapeutic relationship are used, one intended to capture the helping alliance (HAq) and one intended to capture the emotional interaction in the session (FC). Both these instruments are self-rating instruments.

*Structural Analysis of Social Behavior (Benjamin, 1974, 1987)*

The self-rating version of SASB was used in study I to assess the participants’ self-image and to validate the ACI-S/O against the self-image or introjected aspect of interpersonal relationships. Self-image according to the SASB model is the introject of past interactions with significant individuals (see Introduction for a further theoretical outline). For analysis of the ratings, SASB uses a circumplex model with two main dimensions: love-hate and control-autonomy. The questionnaire consists of 36 questions that are grouped into eight clusters. These clusters are the endpoints of the two dimensions (love-hate and control-autonomy) and the combination of these dimensions. Love and control combine to protect, love and
autonomy to explore, hate and control to criticize, and hate and autonomy to neglect. The test-retest reliability is $r=0.87$ for both the US version (Benjamin, 1987), and the Swedish version (Armelius, 2001) used in the present study.

**Inventory of Interpersonal Problems (IIP; Horowitz, et al., 1988)**
The IIP consists of 64 questions about conscious interpersonal problems. The scores are combined into eight subscales (domineering, distrustful, cold, social avoidant, non-assertive, exploitable, overly nurturant and intrusive) on a circumplex that reflects the subject’s interpersonal problems, and a global index reflecting the overall level of interpersonal problems. The test-retest reliability for IIP is $r = 0.98$ (Horowitz et al., 1988). The IIP was used to measure the interpersonal problems of the participants in study I and to validate the ACI-S/O against perceived interpersonal functioning.

**Attachment Style Questionnaire (ASQ; Feeney, Noller, & Hanrahan, 1994)**
ASQ contains 40 items intended to measure dimensions central to adult attachment, including different styles of attachment. The ASQ has been designed to be suitable for both young adolescents and older individuals without the requirement of prior experience of romantic relationships. The questions in ASQ can be analyzed as two separate factors (secure and insecure attachment), but can also be analyzed on the basis of a three-factor structure in line with Hazan and Shaver's (1987) conceptualization of attachment (e.g. secure, avoidant, and anxious). Feeney et al. (1994) reported internal consistencies for the English version and found adequate Cronbach alphas for the subscales Security (0.83), Avoidance (0.83), and Anxiety (0.85). The test-retest reliability over a period of approximately ten weeks was 0.74, 0.75 and 0.80 for the three subscales respectively. ASQ has been translated into Swedish by Håkansson and Tengström, (ASQ-sw; 1996). The internal consistency for the three subscales in the Swedish version is in the same range as the original English version (Håkanson & Tengström, 1996). The ASQ was used in study III.

**Eating Disorder Inventory-2 (EDI-2; Garner, 1991; Garner & Norring, 1994; Nevonen & Broberg, 2001)**
EDI-2 was used in study II to assess eating pathology dimensionally. The EDI-2 consists of 64 questions intended to assess psychological characteristics and behavior patterns relevant in various forms of eating problems at the moment when the questions are answered. The ratings are combined into 11 subscales that can be combined into a symptom index, a personality index and a total index. The total index was used in study II. Sensitivity of 0.90 and
specificity 0.82 have been reported for the total index in the Swedish version (Nevonen & Broberg, 2001).

**Symptom Check List-90 (SCL-90; Derogatis & Cleary, 1977)**
The SCL-90 contains 90 questions about symptoms. The ratings are combined into nine subscales and three global indexes. The scales reflect the subject’s own view of psychological and physical well-being during the previous week. The global symptom index and the symptom subscales were used in study I. Alphas for the US version (Derogatis & Cleary, 1977) range from 0.77 to 0.90, and for the Swedish version (Fridell, Cesarec, Johansson, & Malling Thorsen, 2002) from 0.75 to 0.91, depending on the subscale. The SCL-90 was used in study I and study II.

In study II (Affect consciousness and eating disorders; Lech, Holmqvist, & Andersson, 2012) the SCL-90 is wrongly specified as measuring general psychopathology in some places and the subject’s view of psychological and physical well-being in other places. Despite the differences, however, the SCL-90 is thought to reflect the subject’s view of psychological and physical well-being during the previous week, according to Derogatis and Cleary (1977), and Fridell et al. (2002).

**Helping Alliance questionnaire (Alexander & Luborsky, 1986; HAq; Luborsky, 1976; Luborsky, 1983).**
The Swedish version of the HAq used in this study is a self-report questionnaire containing 11 items rated on a 10-point scale. HAq can be analyzed by summing up all 11 items to one score, but also by summing items to two subscales, measuring two types of alliance; type 1 alliance (patient’s experience of the therapist as helpful and supportive) and type 2 alliance (patient’s experience of a joint effort with the therapist to overcome difficulties). The HAq was used in study IV.

**Feeling Checklist (FC; Holmqvist & Armelius, 2000).**
The checklist contains 24 words for feelings that the patient may have had towards the therapist during the session. The 24 feeling words in the checklist are ticked by the patient on a four-point scale, ranging from zero (“not at all”) to three (“quite a lot”). The feeling words are arranged in a circumplex model with eight subscales, based on the dimensions positive-negative and close-distant. The FC was used in study IV.
Procedure

Study I

The patients in the study had different kinds of psychological problems that could be supposed to be expressed in difficulties in identifying and expressing own and others’ affects. The non-clinical group was recruited by advertisement. The only selection criterion for this group was that they should be women and not be involved in psychiatric or psychological treatment when interviewed.

Before being interviewed with the affect consciousness interview – self/other (ACI-S/O; Lech et al., 2008) the participants answered a set of self-report inventories (SCL-90, SASB, IIP). The self-report instruments were distributed to all patients and seven individuals of the non-clinical sample. Seventy-six individuals completed at least one of the self-report instruments and the interview. Nine raters were used to rate the interviews, with at least two raters for each of the 95 interviews. They rated 51, 45, 35, 24, 13, 12, 12, 7 and 5 interviews, respectively. Six raters were psychology students and three were graduate and experienced psychologists. Eight raters also performed interviews. They were all trained in the procedures of interviewing and rating the interview.

Study II

During the first and last days of the treatment period, the selected patients were interviewed with the ACI-S/O. Before treatment, but after the first interview, the participants in the eating disorder subgroups also completed two self-report inventories (EDI-2 and, SCL-90). A non-clinical reference group of 40 women in the same age group (16 to 30) as the clinical group was recruited. The participants in this study were interviewed by six interviewers who also rated the interviews. Five were psychology students and one was a licensed and experienced psychologist. They were all trained in the procedures of interviewing and rating the interview.

Study III

In order to have a wide range of participants for whom we expected attachment patterns and levels of affect consciousness to differ, people with and without known clinical problems were included in the study. A heterogeneous sample from study I was therefore recruited.
Study IV

Before treatment the participating patients were interviewed with the ACI-R and directly after each therapy session, the participants were asked to complete the Helping Alliance questionnaire and the Feeling checklist. The ratings on the FC and the HAq from the three first sessions were summed to a composite index.

Data analysis

Study I

In study I the concurrent validity of ACI-S/O was assessed by analyzing correlations with three self-report inventories (SASB-introject, IIP, and SCL-90). Correlations between the subscales of the discrete affects of the ACI-S/O were also calculated. The interrater reliability was assessed with intraclass correlation (ICC). Differences between the participating groups were analyzed with MANOVA and follow-up univariate ANOVAS. Significant between-group effects were further analyzed with LSD corrected t-tests. A higher-order principal component analysis with oblimin rotation was performed for both own and others’ discrete affects. Factors with an eigenvalue above one were retained and factor loadings ≥ 0.40 were retained for further interpretation.

Study II

In study II the data were analyzed on two subscales of the ACI-S/O derived from the previously published factor analysis (Study I; Lech et al., 2008). The first factor is called “General affect consciousness” and the second “Guilt and shame.” The correlations between the two factors of ACI-S/O at the start of the treatment and self-report measures of eating pathology and general psychological distress were also calculated. The ratings on the two factors of ACI-S/O in the eating disorder group were compared with those of the non-clinical group. Differences between the bulimia nervosa and anorexia nervosa subgroups were also explored. The pre-post correlations for the General Affect Consciousness factor and the Shame and Guilt factor of ACI-S/O over a period of 10 to 11 weeks of treatment were further tested with Pearson’s r in order to analyze whether the ability to be conscious about both own and others’ affects is a state or trait in subgroups of patients diagnosed with eating disorders.
Study III

In study III the correlations between the ratings of ACI-S/O and scores on the three subscales of ASQ were calculated. The means, standard deviations and group differences on the ASQ and ACI-S/O were also measured and compared. Finally, the ratings on ACI-S/O were used in multiple regression analyses in order to analyze its contribution to the three different ASQ subscales. The analyses were performed separately for consciousness about own and others’ affects.

Study IV

In study IV the correlation between the two process measures, HAq and the FC, and between the ratings on ACI-S/O and the mean scores of HAq, and FC for the three first treatment sessions were calculated. A hierarchical regression analysis was performed in which the patient’s feelings after the third session were first regressed on the patient’s ratings of HAq in the first two sessions, and then on the ratings of the patient’s ACI-S/O before the treatment.

All the data analyses were done with the use of the computer program SPSS.

Ethical approval

The studies were approved by the ethical committee of Linköping University Hospital, Linköping, Sweden and all participants provided informed consent before participating in the studies.

RESULTS

Study I

The average ICC score was 0.94 for the ratings of the patients’ consciousness of own discrete affects and 0.94 for the ratings of the patients’ consciousness of others’ discrete affects. The total average for both own and others’ affects was 0.95. The average ICC score between two different judges was 0.87 (ranging from ICC =0.64 to ICC =0.99). The MANOVA showed a highly significant between-group effect for both consciousness about own affects and consciousness about others’ affects.

There were significant differences between some of the four groups on all variables. The non-clinical group had the highest scores on all variables, indicating higher levels of affect consciousness. LSD post hoc analyses showed that most significant differences were found
between the non-clinical group and the clinical groups and between the group with stress-related problems and the group with relational and social problem. All the groups, including the non-clinical sample, were rated highest on the consciousness of own positive affects; joy and interest, followed by consciousness of others’ joy, sadness and interest. The lowest scores were found for consciousness about others’ guilt, followed by own guilt. It is also notable that guilt was the affect that showed the least differences between the groups. Including age as a covariate in the statistical analysis did not significantly change the results.

Correlations between the subscales were also calculated. The average correlation between ratings of consciousness of own discrete affects was $r = 0.50$. The average correlation between consciousness of others’ discrete affects was $r = 0.51$. Higher correlations were found between own and others’ affects of the same type, e.g. own joy with others’ joy (average $r = 0.66$). All correlations but one (between Own Guilt and Own Anger) were statistically significant.

Given the rather high intercorrelations between the discrete affects a higher-order principal component analysis with oblimin rotation was performed for consciousness about both own and others’ discrete affects. Two factors that together explained 65% of the total variance were obtained. The first factor explained 55% and the second 10% of the total variance. The first factor encompassed consciousness about own and others’ interest and joy, fear, sadness and consciousness about own anger. The second factor encompassed five items, consciousness about own and others’ shame and guilt and others’ anger. The first factor was labeled “general affect consciousness.” The second factor was labeled “consciousness about shame and guilt.”

Finally, the relations between the scores on the self-report instruments and the factors attained from the factor analysis of the affect ratings were explored. The factor labeled general affect consciousness correlated significantly with most of the subscales of the three self-report instruments. The exceptions were the hostility, phobic anxiety and obsessive-compulsive subscales on SCL-90 and the overly nurturant, intrusive and dominant subscales on IIP-C. The results also show that there were only two significant correlations with the factor labeled consciousness about guilt and shame. This factor correlated negatively with the distrustful subscale on IIP-C and positively with the protecting subscale on SASB-introject.

**Study II**

First the correlation between the two factors of ACI-S/O (general affect consciousness, and shame & guilt) and the two self-report questionnaires measuring eating disorder pathology
and general psychopathology were explored. The two ACI-S/O factors were significantly correlated with each other, but neither of them was significantly correlated with the self-report measures of eating pathology and general psychological distress. Self-reported eating pathology and psychological and physical well-being during the last week were significantly correlated.

Next, the issues of whether affect consciousness was lower in the eating disorder group compared with the non-clinical group, and if the ability to be conscious of own and others’ affective reactions differed between the bulimia nervosa and anorexia nervosa subgroups, were explored. The results showed that there were no significant differences in affect consciousness between the different sub-diagnoses of eating disorders but the non-clinical group scored significantly higher than the eating disorder participants.

Finally, the question of whether the ability to be conscious about both own and others’ affects is a state or trait in subgroups of patients diagnosed with eating disorders (anorexia nervosa and bulimia nervosa) was analyzed. The pre-post correlations for the general affect consciousness factor and the shame & guilt factor of ACI-S/O over a period of 10 to 11 weeks of treatment were tested with Pearson’s r. The results showed significant pre-post correlations for both the general affect consciousness factor ($r = 0.44$ $p < 0.01$) and for the factor labeled shame and guilt ($r = 0.45$ $p < 0.01$). Thus, affect consciousness seems to be a moderately stable ability in this group of patients.

**Study III**

The non-clinical group had significantly higher ratings of secure attachment and those in the patient groups had significantly higher levels of insecure attachment. The non-clinical group had significantly higher ratings of consciousness about own and others’ affects irrespective of which specific affect they were interviewed about.

With the exception of consciousness about own guilt and others’ guilt, there were significant correlations between all scores on ACI-S/O and the scores on the ASQ scales. All the significant correlations between affect consciousness and the secure attachment scale were positive and all the significant correlations between affect consciousness and the avoidant and anxious attachment scales on the ASQ were negative.
Consciousness about own and others’ affects was used in multiple regression analyses in order to analyze their contribution to the three different ASQ subscales. The analyses were performed separately for consciousness about own and about others’ affects.

First, the subscale measuring secure attachment was used as a dependent variable. The regression using consciousness about own affects as independent variable was significant but there was no significant contribution from any single affect. The regression using consciousness about others’ affects as independent variable was also significant, and there was a significant contribution from consciousness of others’ anger. Second, the results for avoidant attachment were analyzed. The regression for consciousness about own affects as independent variable was significant but again there was no significant contribution from any single affect. The regression using consciousness about others’ affects as independent variable was also significant, and there was a significant contribution from consciousness of others’ anger and others’ guilt. Finally, the subscale measuring anxious attachment was analyzed. The regression using consciousness about own affects was significant, and there was one significant contribution by own joy. The regression for the consciousness about others’ affects was also significant, and once again there was a significant contribution from consciousness of others’ anger.

Study IV

The results of a first analysis showed that it was most usual among the studied patient sample to feel free and distant from the therapist and least usual to feel cold and close. Overall, it was more common to have positive feelings than negative feelings. The results indicated that the patients on average experienced the therapist as helpful and supportive and that there was a joint effort with the therapist to overcome difficulties. The relationship between the two process measures, the HAq and the FC, was analyzed and they were found to be moderately correlated. HAq was positively correlated with positive feelings towards the therapist, and negatively correlated with negative feelings.

The correlations between ACI-S/O and FC, and between ACI-S/O and HAq were examined. The results showed significant positive correlations between several of the ratings on ACI-S/O and the warm, positive and free subscales on the FC. Consciousness about own affects was significantly correlated with patients’ ratings of feeling warm, positive and close to their therapist during the first three sessions.
There were only a few significant correlations between the patients’ affect consciousness and the mean scores on HAq for the three first treatment sessions. Consciousness about others’ anger correlated significantly and negatively with the two HA subscales but not with the total HA score. No other significant correlation between ACI-S/O and HA was found.

In order to analyze the relations between ACI-S/O, FC, and HAq further, hierarchical regression analyses were performed. The patient’s feelings after the third session were regressed on first the patient’s rating of HA at the first two sessions, and then on the ratings of the patient’s ACI-S/O. These analyses gave significant models for warm, positive, and cold feelings even when helping alliance in the previous sessions was controlled for. Warm and positive feelings towards the therapist in the third session were associated with the patient’s affect consciousness, and particularly with consciousness about own affects. These feelings were not associated with the HA ratings in the previous sessions. Cold feelings, on the other hand, were associated with low ratings on the HA in the previous sessions, but not with the patient’s affect consciousness.

DISCUSSION

The overarching aim of the thesis was to explore the clinical usefulness of a new conception of affect consciousness, defined as “the mutual relationship between activation of basic affects and the individual’s capacity to consciously perceive, reflect on and express or respond to these affect experiences in himself or others” (Lech et al., 2008, p. 515), and to validate a semi-structured interview (ACI-S/O) intended to capture this new definition.

There are several constructs that are conceptually related to affect consciousness or aspects of affect consciousness. The reconceptualization of the affect consciousness construct with increased attention to the interpersonal and interactional aspects of affects implies that concepts with an interpersonal focus are more closely connected with affect consciousness. One such concept is empathy. In order to be empathic, the person has to be able to separate himself or herself from his or her own affect in order not only to react but also to reflect (Basch, 1983). In addition, in order to attain empathy, there must be a capacity to separate one's own feelings and emotions from others' feelings. If this capacity is not present, the subject may be able to identify with another’s feeling state but not to experience empathy. To put it in another way; the subject must be conscious about his or her own affects as well as the other’s in order to be empathic.
The concept of affect consciousness also has similarities with mentalization, but the two concepts are distinguishable. The mentalization theory as described by Fonagy (1998) is theoretically and empirically rooted in attachment theory. The theory behind the concept of consciousness about own and others’ affects also has roots in development theory but emphasizes emotion theory, evolution theory, communication theory, and self-psychology. Although the concept of affect consciousness has been reconceptualized in this thesis, the focus is still on “minding affects” versus “minding minds” in comparison with mentalization theory (Solbakken, Sandviken Hansen, & Monsen, 2011). Mohaupt, Holgersen, Binder, and Nielsen (2006) also argue that in mentalization theory affects are regarded as developing in a relationship whereas the concept of affect consciousness implies that the individual perceives and organizes his or her own affects. With regard to the reconceptualization used in this thesis this seems be a misunderstanding of the affect consciousness concept. In the theoretical background to the reconceptualization described earlier in this thesis the role of interpersonal communication of affects in early development onward is emphasized. The affect consciousness construct is thought of as describing the development of basic inborn affects into emotions influenced by environment, especially important interpersonal relationships.

The view of affects as exchangeable, as in the mentalization model (Mohaupt et al., 2006), is different from the view of affect consciousness. Although affects are emphasized in the mentalization theory, differences between mentalizing joy or shame or any other discrete affect are not taken into account whereas differences with regard to different affects are important in the theory of affect consciousness. Although the results in study I show significant correlations between different discrete affects, differences in the experience of discrete affects are evident. Regarding affects as exchangeable and not investigating possible differences between experiences of discrete affects may be problematic for mentalization theory and drain the concept of its complexity and explanatory value.

The concept of “mentalized affectivity” (Fonagy et al., 2002) comes close to what is meant by consciousness about own affects. It is noteworthy however that the concept of mentalized affectivity only encompasses the mentalization of own affects whereas the concept of mentalization first and foremost encompasses others’ mental states. The new conceptualization of affect consciousness proposed in this thesis which also integrates consciousness about others’ affects thus goes beyond the concept of mentalized affectivity. The concepts of mentalization and mentalized affectivity are closely connected with the
concept of adult attachment. Associations between high AC and secure attachment, and between low AC and insecure attachment, were shown in study III.

Another concept with an obvious (negative) relationship with affect consciousness is alexithymia. In particular, the dimension in AC that is thought to reflect verbal expression of own affects seems to be theoretically linked. Alexithymia seems however to be a more narrow construct than AC, concerned exclusively with the intrapersonal processing and regulation of the subject’s own affects, although the intrapersonal deficit is thought to be reflected in interpersonal behavior. Furthermore, in contrast to affect consciousness, the concept of alexithymia does not cover or consider different affects but only an overall lack of words for feelings.

Another concept that seems to be similar to AC is emotional intelligence (EI). One underlying idea of the construct of EI, however, is that emotions can bring about more intelligent cognition and that one can be more or less cognitively intelligent about emotions (Matthews, Zeidner, & Roberts, 2007). The conceptualizations and tests of EI have among other things been criticized for overemphasizing the cognitive aspects of knowledge about emotion (Scherer, 2007). The bias toward cognitive aspects in EI is perhaps its most distinguishing feature in contrast to the concept of AC.

Thus the reconceptualized affect consciousness theory seems to be related to other concepts about affects but also to contribute in its own unique way to the understanding of affect and its significance for psychopathology and interpersonal relations.

**The structure of affect consciousness**

In study I the clinical usefulness of the modified version of the ACI-S/O was explored. It was supposed that consciousness about own and others’ affects are dependent on each other in an interactive way, giving mutual feedback. Consciousness of own affects and consciousness of others’ affects correlated with each other to a significant degree, indicating that there is a relationship between consciousness about own affects and consciousness about others’ affects. Two factors explained 65% of the total variance. The first factor was labeled general affect consciousness and the second factor consciousness about guilt and shame.

The first factor seemed to be a general factor, related to different aspects of emotional problems and possibly protecting against them. The second factor might have a more circumscribed meaning, being less strongly associated with interpersonal problems and
psychiatric symptoms, again suggesting that this is a distinct and separate aspect of affect consciousness.

**Shame, guilt, and others’ anger**

“Though terror speaks to life and death and distress makes of the world a vale of tears, yet shame strikes deepest into the heart of man” (Tomkins, 2008, p. 351).

The finding of the two factors of affect consciousness needs to be further elaborated, as consciousness about guilt, shame, and others’ anger apparently stands out as separate from consciousness about other affects. As presented in study I all the groups (including the non-clinical group) seemed to have greatest difficulties with own and others’ shame and guilt in comparison with the other affects. The guilt and shame factor correlated positively with protecting self-image and negatively with distrustful interpersonal problems but not with other subscales of the measures of psychopathology and interpersonal behavior used in study I. The guilt and shame factor seems to have a more circumscribed meaning than the general affect consciousness factor, being less strongly associated with interpersonal problems and psychiatric symptoms, suggesting that this is a distinct and separate aspect of affect consciousness.

Patients’ consciousness about both own and others’ shame (and fear) seems furthermore to be of special importance for the experience of positive feelings toward the therapist, as presented in study IV. In study III it was found that consciousness about others’ guilt contributed significantly to the variance in avoidant attachment style. On the other hand, there were no correlations between secure attachment style and consciousness about guilt. Another observation in study III was that consciousness about others’ anger contributed significantly to all three patterns of attachment and explained a larger part of the variance than any other single affect.

As discussed elsewhere it seems to be predominantly anger, shame, and guilt that are regulated by the eating disorder behavior. High levels of affects, especially anger and shame, were associated with impulsive-compulsive psychopathology (including drinking, and eating pathology) in a study by Abramowitz and Berenbaum (2007). Regulation of anger, shame and guilt are reported to play a significant role in behavior like binge eating (Hayaki, Friedman, & Brownell, 2002), and purging (Tachi et al., 2001). Recognition of others’ anger has been reported as a problem in ED, perhaps especially in BN (Fassino et al., 2001; Ridout et al.,
2010; Waller et al., 2003). Shame or the avoidance of shame seems to be especially important for the development of psychopathology in general (Tangney, 2001) although that was not found in our analyses.

The results in this thesis with regard to consciousness about shame, guilt and others’ anger in some ways contradict each other. On the one hand, the correlations with measures of interpersonal functioning are weaker than for the general affect consciousness factor. On the other hand, consciousness about shame seems to be of importance for positive feelings toward the therapist, and consciousness about guilt and others’ anger seems to explain a larger part of patterns of attachment style than any other kind of affect consciousness. Shame, guilt and others’ anger might be regarded as affects that are used to regulate close relations.

According to Tomkins (2008), on an affect level guilt, shame and shyness are all versions of the same discrete affect although on the conscious emotional level they might be experienced as distinct from each other. Other components that are experienced together with shame make the experience of them different (Tomkins, 2008). Nathanson (1994) states that guilt is an emotion that is triggered when we become aware that through our acts we have harmed another person. Shame on the other hand is an affect that has to do with the quality of our self (Nathanson, 1994). Guilt thus requires a cognitive elaboration about our impact on another person whereas shame is evoked by a reflection about our self. According to Tomkins (2008), the affect shame is triggered when the individual becomes aware of the self or the interest of some other person in our self. Shame is therefore our most self-reflecting affect.

Tomkins regards shame as an auxiliary affect and as an incomplete inhibitor of the affects of interest and enjoyment intended to reduce exploration or self-exposure which may be exaggerated by excitement or joy (Tomkins, 2008). The incompleteness of the reduction of interest or joy by shame is important because it is the ambivalent hope that we shall once again feel excitement or joy that keeps shame going. Unlike contempt, that is likewise linked to hate, in shame the object is not completely renounced. When ashamed there is still hope that everything will be good again.

Contempt shown by others is a likely producer of shame. However contempt might produce anger, surprise or fear but not shame unless joy or excitement or an emotional derivate from those affects are present in the subject. Contempt shown by others becomes an activator of shame only if one expects something connected to joy or excitement to be evoked by the other (Tomkins, 2008). If the interest or joy is completely cut off, disgust or contempt for the self is
likely to result. Of course, it need not be a reduction of the distinct affect of excitement or enjoyment that gives rise to shame. It might also be some more complex emotion like pride. According to Nathanson (1994), shame is at one end of an axis where pride is at the other end. In other words, shame can be seen as a fall from something we feel an urge for, like being proud of our self or being accepted by others that we care about or that we want to keep in contact with, into indignity or defeat, or from an interpersonal relationship to alienation.

Excitement and enjoyment are at the heart of sociality because they amplify activities so that we feel pleasure in doing them. Humans seem to be born with a special interest in other humans and to prefer them to other objects. Shame, guilt and anger are all used to keep participants in our group within the norms that the group has as reference for proper behavior. Possibly we use those affects in such a way because they are more painful to experience than other affects and shut off the positive affects to some extent. As Tomkins (2008, p. 351) put it, “Shame is felt as an inner torment, a sickness of the soul… he feels himself naked, defeated, alienated, lacking in dignity or worth.” The use of shame to keep participants in our group within the given norms only works insofar as the ideal of the group has been internalized and as long as we fear being alienated by the group (Tomkins, 2008). The painfulness of shame and connection with social stigma might be part of the explanation for the fact that all groups in this study seemed to have the greatest difficulties in being conscious about own and others’ shame and guilt.

According to Tomkins (2008), shame is as an obstacle to love and identification. A speculation in line with Tomkins (2008) could be that it is especially in close relations like the therapeutic, romantic or other attachment priming relations that consciousness about guilt, shame and others’ anger becomes really important. Presumably it is important not to be ashamed, feel guilty or be afraid of others’ anger if one engages in a close relationship.

The relation between shame and positive affects or emotions could, as will be discussed later, explain some of the most mysterious features of psychopathology like the persistence of symptoms or lack of motivation for change.

**Psychopathology**

Earlier reported studies about problems in recognition, discrimination, regulation, and expression of own and others’ affects point to a relation between various deficits and general psychopathology (see under “Affect and general psychopathology” in this thesis for
references). Thus, in the light of the results of earlier reported studies both own and others’ affects seem to be related to general psychopathology.

The integration of affects sometimes breaks down or does not work in adaptive and flexible ways. Affects lose meaning for the individual, or become overwhelming and result in a disorganization of experience about ourselves and the external world. The disorganization of affects seems to be related to the development of psychopathology. Furthermore, different kinds of psychopathology might have specific patterns of disorganized affect. The relationship between consciousness about own and others’ affects and psychopathology is investigated in study I and study II. Three different clinical groups and a non-clinical group were compared in study I in order to investigate the clinical value of the interview. The non-clinical group also had significantly higher consciousness about own and others’ affects than the patient group, regardless of which single affect they were interviewed about. The same groups as in study I were also compared in study III in relation to self-reported attachment style. Significant differences in self-reported attachment style were found between the clinical group and the non-clinical group. The clinical group had significantly higher levels of insecure attachment and the non-clinical group had significantly higher levels of secure attachment.

The differences between the patients and the non-clinical sample were in every aspect of the interview significantly in favor of the non-clinical sample, indicating that the interview had the capacity to differentiate between non-clinical and clinical groups. The pattern of affect consciousness seemed to be approximately the same in both clinical and non-clinical groups. All the groups had the greatest difficulties with own and others’ shame and guilt and moreover, as also was expected, all groups scored highest on own and others’ joy in comparison with the other affect scores. In study I, the difference in affect consciousness between the non-clinical group and the clinical group was greater than the difference between the clinical groups. Although not always statistically significant, the trend seemed to be that the group with stress-related problems had higher ratings on the ACI-S/O in comparison with the other two patient groups, and that the group with eating disorders had higher ratings in comparison with the group with relational and social problems. The clearest difference between the patient groups was between the group with relational and social problems and the group with stress-related problems. The differences between those two groups were most pronounced with regard to consciousness of others’ affects in that the group with relational and social problems had lower scores on these ratings than the group with stress-related
problems. The differences between the group with eating disorders and the group with relational and social problems were greater with regard to consciousness of others’ affects than with regard to consciousness of own affects. Consequently, the group with relational and social problems had the largest problems in comparison with the other groups with regard to others’ affects, especially others’ interest, shame and fear.

The level of affect consciousness was further compared between the largest group of patients (eating disorder) and a comparable group of non-clinical individuals in study II. Furthermore, different kinds of eating disorder (bulimia nervosa, and anorexia nervosa) were also investigated in relation to consciousness about own and others’ affects. There were no differences between the two diagnostic subcategories of eating disorder, but the eating disorder group as whole had significantly lower affect consciousness than a non-eating disorder comparison group.

The results imply that affects as conceptualized in the theory of affect consciousness may be seen as organizers of self-experiences (Monsen et al., 1996), as well as coordinators of social interactions in a way that helps humans shape and maintain helpful relationships (Keltner & Kring, 1998).

The difference in consciousness about affects between the non-clinical group and the different clinical group indicated that affect consciousness is associated with psychiatric problems. Different kinds of psychiatric problems seem to be related to specific patterns of affect consciousness.

**Affect consciousness and psychosomatic problems**

As reported earlier, in psychosomatic medicine the interaction of deficits in cognitive and emotional processing and the presence of stressors are believed to aggravate vulnerability to somatic illness (Taylor et al., 1991). According to Krystal (1982) one of the features of psychosomatic patients is the inability to recognize and name their own feelings.

Taking the long sick leave in to account, the group with stress-related problems seem to have rather severe psychosomatic problems. Being on sick leave in this group might also be a sign of insight or capacity for reflection on own limitations, however. According to Krystal (1977, 1997) psychosomatic disorders could develop because the individual has never acquired the means to desomatize and symbolize the affect or because of regression to a state where the individual expresses the affect through the body in an unsymbolic way. Thus, problems with
awareness, tolerance and ability to express the affect verbally might according to Krystal be owed to a trait acquired in the individual's early development or to a state that the person has got into. The reason for psychosomatic disorders according to Krystal (1977, 1997) seems to be what is called here low consciousness about own affects, although in the theory of affect consciousness non-verbal expression of own affects and consciousness about others’ affects are also taken into account.

**Trait or state**

The question of whether affects should be regarded as inborn or learned is somewhat parallel to the question of whether affects and different aspects of affects should be regarded as a trait or a state. This could also be formulated as a question about what instrument should be used when one is measuring affects or aspects of affects. If affects or a particular aspect of affects are regarded as something cognitively achieved it might be possible to measure them with self-rating questionnaires, but if affects are something inborn, trait-like, and not so cognitively achievable then self-rating instruments like questionnaires might not be suitable.

If the ability to describe and identify affects is best regarded as a trait or state in ED has also been debated (Eizaguirre et al., 2004). In ED the debate about trait vs. state seems to be a question not so much about whether affects are inborn or learned but whether states like starvation or comorbidity (e.g. depression, anxiety) are the reason why different competences with regard to affect seem to be disorganized or impaired or if this shortfall is owed to some trait or other.

A review by Oldershaw et al. (2011) of nine affect recognition studies on AN showed mixed results in relation to trait or state. They concluded, however, that although studies about the contribution of state variables are limited psychical variables might mediate or worsen impaired emotional and cognitive processing in AN.

The disorganization of AC could also be of the moment or comprise a more stable pattern. This question in relation to eating disorder is addressed in study II. Moderate short-term stability of AC over 10 to 11 weeks for the two factors “general affect consciousness” and “consciousness about guilt & shame” showed that affect consciousness is moderately stable in this group of patients. Thus, the results from study II indicate that AC could be a stable dimension on its own, unrelated to current symptoms but possibly serving as a general vulnerability factor for the development of eating pathology.
Affect consciousness and eating disorders

As described in the Introduction, ED patients and especially AN patients are reported to have problems in understanding, differentiating, describing, and expressing own affects. The results with regard to ED patients’ recognition of and reaction to others’ affects were more ambiguous. Most studies seem to support the notion that ED patients have some impairment in the recognition of and reaction to others’ affects, although the kind of affect that ED patients seem to have problems with differed somewhat between the studies. One explanation seems to be that eating disorder pathology might function as a way to escape, manage or regulate affects that are otherwise unbearable.

Problems with measuring affect in eating disorders

Previous studies on affect in eating disorder patients suffer from several shortcomings. A number of studies on the relationship between various kinds of affect deficits (e.g. regulating, recognizing, describing, expressing affects) and eating disorder pathology were performed on non-clinical subjects (Griffiths & Troop, 2006; Jones, Harmer, Cowen, & Cooper, 2008; Kitsantas, Gilligan, & Kamata, 2003; Markey & Vander Wal, 2007; Mayer, Bos, Muris, Huijding, & Vliezander, 2008; Wheeler, Greiner, & Boulton, 2005). In addition, measurements have predominantly been taken by self-report measures (e.g. TAS: Taylor, Ryan, & Bagby, 1985) or on levels of cognitive bias using pictorial stimuli of others’ affective expressions (e.g. Jones et al., 2008). Such studies might exaggerate eating disorder patients’ problems with affective processing.

The use of self-report questionnaires

Studies of emotional awareness in ED have almost entirely relied on the TAS-20 and predominantly AN patients. Difficulties in regulation of emotions have on the other hand mostly been linked to BN (Gilboa-Schechtman, Avnon, Zubery, & Jeczamien, 2006). The need to use additional concepts and observer measures has been highlighted (Gilboa-Schechtman, et al., 2006). Lundh, Johnsson, Sundqvist, and Olsson (2002) have questioned whether TAS-20 actually measures lack in understanding, differentiating, describing, and expressing emotions in AN. Rather, Lundh et al. (2002) argue that TAS-20 measures lack of perceived meta-emotional self-efficacy or the individual’s beliefs about the lack of these abilities. Furthermore, Lundh et al. (2002) also found that the increased ratings on TAS-20 in AN patients might be explained by the perfectionism often seen among anorectic patients.
According to Lundh et al. (2002), this perfectionism might increase the ratings of anorectic patients, owing to their high self-imposed demands on meta-emotional ability. To self-evaluate problems in describing and identifying affects as when measured with TAS-20 comprise a logical problem, as Lund et al. (2002) aptly describe. This problem also indicates a need to be cautious when interpreting outcome results from studies using self-evaluation of affect problems.

Comorbidity
Data suggest that ED might be related to difficulties in affective functioning and not only eating behavior and body image (Gilboa-Schechtman et al., 2006); however, the affective problems might be mediated by other diagnoses. Depression and anxiety have been suggested as accounting for the relationship between ED and alexithymia as measured by TAS-20. When controlling for depression Corcos et al. (2000) found that scores in the TAS-20 no longer differentiated between AN and BN. Bydlowski et al. (2005) and Eizaguirre et al. (2004) found that the difference in levels of alexithymia between eating disorder patients and control groups disappeared when anxiety and depression were controlled for. Sexton, Sunday, Hurt, and Halmi (1998) showed that, after controlling for depression, only the alexithymia subscale measuring difficulty in describing feelings significantly differentiated eating disorder patients from controls.

Skårderud and Fonagy (2012) discuss the possibility of shared etiology between borderline personality disorder and ED as an explanation of difficulties in mentalizing in both diagnoses. They conclude, however, that this is unlikely and speculate that eating disorder instead might represent an own kind of personality disorder.

Starvation
It is important to bear in mind, when studying affect problems in eating disorder patients, that starvation might lead to emotional deterioration and have an impact on mood (Altemus & Gold, 1992; Cowen, Anderson, & Fairburn, 1992; Keys, Brozek, Henschel, Mickelsen, & Taylor, 1985). Ioakimidis et al. (2011) hypothesize that because of shared neuro-anatomy between emotion and eating, both positive and negative emotions can be caused by changes in eating behavior. In a study by Parling, Mortazavi, and Ghaderi (2010) comparing a non-clinical group with an AN group after weeks of adequate nutrition (thus the patients were no longer starved), and controlling for depression, and anxiety, no differences on TAS-20 or the Levels of Emotional Awareness Scale (Lane, Quinlan, Schwartz, & Walker, 1990) were
found. Consequently the failure in identifying and expressing own affects in anorexia nervosa could in part be owed to starvation. This does not explain the affect deficits in bulimia nervosa and binge eating where starvation is seldom the problem, however. In Parling et al. (2010) the role of the relationship between the patient and the staff administrating the nutrition, binge eating, purging and other compensational behavior was not controlled for. In fact, a significant proportion of the patient sample was still severely underweight. Thus we do not know if there is some other explanation for the lack of differences between the AN group and the control group in Parling et al. (2010).

The diagnostic criteria
Studies suggest that patients with different sub-diagnoses of eating disorders (e.g. anorexia nervosa and bulimia nervosa) show many similarities and often tend to change between different sub-diagnoses, suggesting that AN and BN share a common pathology (Fairburn & Harrison, 2003; Fairburn, Cooper, & Shafran, 2003; Fairburn & Bohn, 2005; Hay & Fairburn, 1998). Other studies suggest, however, that patients with AN and BN have different kinds of deficits in emotional processing (Speranza, Loas, Wallier, & Corcos, 2007), indicating that they may have different kinds of pathology and that different modes of emotional processing could be part of the pathology. One reason for the different findings could be that affective processing is unrelated to other aspects of the pathology and is best regarded as state-dependent and not as a trait in the eating disorder population. Another reason could be that affective processing in fact is a trait but is unrelated to the other aspects of the eating disorder symptomatology. Of course, it is also possible that the eating disorder diagnoses (and perhaps other diagnoses) are artifacts or that the current diagnostic criteria are not clinically (or theoretically) relevant (Clinton, 2010; Fairburn & Bohn, 2005; Fairburn et al., 2003; Fairburn & Harrison, 2003; Hay & Fairburn, 1998).

The results in these studies suggest that patients with ED have problems in sorting, identifying, expressing and recognizing both own and others’ affects. Preoccupation with food, eating, weight, and shape as well as the actual eating and purging in ED might function as a way of regulating or avoiding affects or stimuli like interpersonal relationships that trigger affects. It further seems that it is predominantly anger, shame and guilt that are regulated although other affects also could be involved or regulated. Although it did not study discrete affects the results from a study by Lampard, Byrne, McLean, and Fursland (2011) measuring the use of cognitive and behavioral ways to handle emotion showed that the avoidance of positive as well as negative emotion might be important in ED.
The body as a regulator of affects

Insufficient “theory of mind” (ToM) ability has been found to be related to ED (Gillberg & Rastam, 1992; Russell, Schmidt, Doherty, Young, & Tchanturia, 2009; Tchanturia et al., 2004). ToM is an aspect of mentalization that in turn is operationalized through reflective functioning. Fonagy et al. (1996) and Ward et al. (2001) found that ED patients had a reduced capacity for reflective functioning. Adult attachment style could be seen as a mediating process between AC and ED pathology, as indicated in study III. The study was cross-sectional, however, and used self-report questionnaires for the measure of adult attachment style and it might well be that the causation is the other way around. Skårderud (2007a, 2007b) argues that a lack of reflective functioning renders the emotions concretized in the body (or the way the body is used in symbolization) in AN. The “living body” (i.e. the experiencing, intentionally acting, and existential body, not its physical aspects) gives rise to metaphor production that is used to experience and express emotions and cognitions. A qualitative study by Skårderud (2007a) shows how emotions (and other mental states) in AN are concretized in a direct translation into the physical body through concrete metaphors. Patients with other kinds of ED may also use the body or the ED behavior as a concrete metaphor for affects but in slightly different ways and with other symbolic meanings. Importantly, Skårderud and Fonagy (2012) suggest that concrete metaphors, like body rituals, might have many different symbolic meanings.

The idea of the body as a concrete metaphor for emotions is in line with the finding that affect consciousness seemed to be unrelated to current symptoms. Affect consciousness might be a general vulnerability factor for the development of eating pathology. Patients with ED might use their body, food, and eating disorder behavior as a concrete metaphor to regulate or escape affects that are otherwise intolerable.

Lack of motivation

According to Tomkins (2008), shame is triggered when the individual becomes aware of the self or the interest of some other person in our self. Shame is regarded by Tomkins (2008) as an auxiliary affect of interest and enjoyment (or derivates from affects such as pride) intended to reduce exploration or self-exposure.

One problem in the clinical work with some patients suffering from ED is the lack of motivation for change. This is especially seen in AN. Skårderud (2007c) describes the relationship of pride and shame with motivation in AN. He concludes that using the concepts pride and shame might help us to understand why the illness is maintained and why there is
such a lack of motivation for change in some patients with AN. To lose weight, be slim, control appetite and perhaps also control other people, success in changing the body shape might be connected to a sense of pride, joy and excitement, especially in a culture which glorifies control and slenderness. Bingeing behavior and loss of control might, on the other hand, as Skårderud (2007c, p. 95) puts it, “be experienced as a defeat and as shameful.” Consequently BN and Binge Eating Disorder patients might be more motivated for change than patients suffering from AN because change means a reduction in shame for BN and Binge Eating Disorder patients but increased shame for patients suffering from AN. It anyway seems important to address the shame and try to enhance the consciousness about shame and connected affects when working with patients suffering from ED.

**Interpersonal aspects of affect consciousness**

As this new definition focuses on affect consciousness as organizer of both the subject’s own affect and the impact of others’ affect on the subject it tries to capture an interactional aspect of affect consciousness that has never been explored before. The mutual importance of communication of affect and interpersonal relationships has been described in this thesis.

The mutual relationship between the new conceptualization of affect consciousness as measured by the ACI-S/O and two aspects of interpersonal behavior as measured by the IIP and SASB-Introject were explored in study I. Another concept associated with interpersonal skills, self-image and psychiatric symptoms is attachment style. The relationship between affect consciousness and attachment style was outlined in study III and the predictive validity of affect consciousness on attachment style was analyzed. A special kind of interpersonal relationship in which the affective interaction seems to play a special role is the psychotherapeutic relationship. In study IV the influence of patients’ affect consciousness on the psychotherapeutic relationship and the early treatment process was explored.

In study III several significant correlations between affect consciousness and attachment style emerged. Secure attachment was associated with all the affects except for guilt, and the insecure attachment patterns were associated with the same variables but in the opposite direction. One implication might be that securely attached persons have more conscious means of access to their affects than insecurely attached persons. Regression analyses showed that there were significant contributions from both consciousness of own and others’ affects to the variance in the different attachment styles. The contribution from consciousness about others’ affects appeared somewhat greater than the contribution from consciousness.
about own affects. In addition to the contribution from the overall consciousness of affects, some single categorical affects independently contributed to the variance in attachment ratings. Consciousness about others’ anger in particular had special importance for the variation in self-assessed attachment style as it contributed significantly to the variance in all attachment styles. To be able to experience and respond to others’ affects and especially anger consequently seems to contribute to the development of a secure attachment style. A person’s problems in handling affects and especially others’ anger may intervene in his or her way of managing close relations. To be less able to manage own joy seems to contribute to an anxious attachment style and to be more able to manage others’ guilt seems to contribute to an avoidant attachment style. In other words, to be able to express and experience own joy but not notice and act in response to others’ guilt seems to be useful as it protects against an insecure attachment style. One way to interpret these findings is that if a person is not able to perceive, tolerate and/or express their joyful affects, then a preoccupation with the other person, and perhaps especially the other person’s feeling of guilt in the relationship, can result in a need for approval from the other. If a person is preoccupied with managing others’ guilt it might lead to discomfort with closeness and mean that the person is tuned in to achievement rather than relationships.

The results in study IV show that affect consciousness, especially about shame and fear, and about own affects generally, seems to be of special importance for the experience of warm and positive feelings toward the therapist. Several significant correlations were found between the patients’ affect consciousness and their positive feelings towards the therapists but only one, negative, association between patients’ pre-treatment affect consciousness and their ratings of the early helping alliance. Affect consciousness might enhance the propensity to have positive feelings but does not seem to influence negative feelings in a therapeutic relationship, nor the patients’ view of the therapist as helpful nor their common work as constructive. One interpretation of this difference concerning the association between affect consciousness and the positive emotional aspects vs. the more instrumental aspects of the early treatment process is that these aspects may be seen as rather discrete dimensions of the therapeutic relationship. A hierarchical regression analysis further showed that warm and positive feelings towards the therapist in the third session were predicted by the patients’ consciousness about own affects, even when helping alliance in earlier sessions was controlled for. Cold feelings, on the other hand, were associated with the instrumental aspect of the early treatment process but not with the patients’ affect consciousness. High degrees of
affect consciousness seem to enhance the extent of positive feelings but do not influence the extent of negative feelings towards the therapist. It might be that cold feelings in the early treatment process negatively influence the patient’s experience of the therapist as helpful and supportive and the effort to overcome difficulties together with the therapist and vice versa that problems in the more instrumental aspect of the process may give rise to cold feelings toward the therapist.

On the basis of both theory and the clinical findings in study IV and in studies reported earlier it is probable that the patient’s view of the emotional part of the relationship in treatment is informed by his/her ability to apprehend the affective communication with the therapist and the affective signal within himself or herself, i.e. his or her affect consciousness.

Consciousness about own and others’ affects seems to be important for adequate management of interpersonal relations, and especially the kind of close relations of which the psychotherapeutic relation is an example.

**Limitations and shortcomings**

**Methodological aspects**

The fact that only two factors explained 65% of the total variance in affect consciousness indicates that the interview mainly captures a general ability to be conscious about affects. This raises the question of whether it makes sense to ask about seven different affects and if it is meaningful to extract 17 scores from the instrument. The factor analysis presented in this study, however, was based on summary scores (e.g. higher-order factor analysis). On the single-item level the result might have been different. The number of participants in this study was too small for factor analysis on the item level, and hence the analysis must be regarded as preliminary.

**The participating groups**

Some of the groups used in the thesis were rather small, and only women were included in the different studies. The size of the groups differed, with almost half of the total patient sample being diagnosed with eating disorders. One of the non-clinical groups and the group of patients with stress symptoms were significantly older than the other groups. The psychopathology of the participants in the non-clinical groups was not controlled for. The level of education, theoretical orientation and experience among the therapists participating in study IV were not controlled for. Important diagnostic groups like people with personality...
disorders, diagnosed anxiety or depression were lacking in the studies and thus the results may be hard to generalize to those groups. In the group with social and relational problems no psychiatric diagnoses at all were obtained. Considering the kind of problems the patients in this group had, however, it is likely that they had one or more psychiatric diagnoses. The possibility of unknown comorbid psychiatric or physiological problems is of course of concern as it might endanger the validity of the study. As the patients were recruited from clinical settings, however, the mix of problems may have enhanced the ecological validity of the studies.

**Future research**

It is important to replicate and extend the present findings with other clinical groups and with men, before making more definite statements about the psychometric qualities and clinical usefulness of the ACI-S/O. Longitudinal studies of affect consciousness in eating disorders and other disorders also seem to be of importance. The relational aspects of psychopathology including ED, indirectly addressed in this thesis by the measurement of affect consciousness, could be an important area for further studies. There is a need for further studies about the influence of affect consciousness on treatment process. One aspect that is not studied is the importance of the therapist’s affect consciousness and the interaction between this and the patients’ affect consciousness. It might be possible to study affect consciousness as an interactional phenomenon. It is in addition important to investigate the effect of affect consciousness on later parts of the treatment process and on the outcome of the treatment. The role of affect consciousness as a potential moderator or mediator of treatment effects would be interesting to analyze in treatment trials. It would also be fruitful to explore the connection between affect consciousness and other clinically important concepts, especially concepts that are supposedly related to the concept of AC, some of them described above. The results from the papers included in this thesis with regard to consciousness about shame, guilt and others’ anger seem to contradict each other. The relation to interpersonal functioning is weak but consciousness about shame seems to be of importance for positive feelings toward the therapist, and consciousness about guilt and others’ anger seem to explain a larger part of patterns of attachment style than any other kind of affect consciousness. There is thus a need to investigate consciousness about those affects further.

There are also several interesting ways to further develop and investigate the interview. It would be interesting to ask about other affects and in greater relation to the problems that the
Implications
The results indicate that the ACI-S/O is a useful tool for the understanding and assessment of psychiatric problems, and as an instrument for the planning of psychological interventions.

The findings in this thesis may also have implications for psychological treatment where affects and the regulation of affects in the therapy relationship can be vital. Knowledge about the relationship between specific affects or specific dimensions of affects and the capacity for interpersonal and intimate relationships might be helpful. Perhaps there is a need for more affect-focused treatment in order to change affect consciousness. If self-image and interpersonal problems are related to consciousness about own and others’ affects, it may be important to work with the individual’s consciousness about affects in many areas of clinical work. In ED consciousness about shame might be of special importance. Attempts to enhance patients’ affect consciousness might also contribute to positive feelings towards the therapist, and, in the next stage, to potentially better outcome.

For clinical use the range of affect consciousness in different samples might be of interest. Range is not reported in the papers but for the general affect consciousness factor the participants with relational and social problems scored from 3.2 to 4.9 (mean = 4.0), the eating disorder sample ranged from 3.0 to 6.1 (mean = 4.3), the sample with stress-related problems ranged from 3.9 to 5.8 (mean = 5.0), and the total non-clinical sample (n=67) ranged from 3.3 to 7.4 (mean = 5.5). For the shame and guilt factor the sample with relational and social problems ranged from 2.0 to 4.1 (mean = 3.1), the eating disorder sample ranged from 2.1 to 5.1 (mean = 3.6), the sample with stress-related problems ranged from 3.0 to 5.3 (mean = 3.8), and the total non-clinical sample (n=67) ranged from 1.9 to 6.6 (mean = 4.5). The non-clinical sample had the greatest distribution for both factors, followed by the eating disorder sample, the sample with stress-related problems and lastly the sample with relational and social problems.

CONCLUSION
The reconceptualized AC theory seems to be related to other concepts that involve aspects of affect but AC seems also to contribute in its own unique way to the understanding of affects and the significance of affects for psychopathology and interpersonal relations.
The results indicate that it was possible to score the interview answers reliably, that the scores correlated meaningfully with other measures of mental functioning, and that the interview discriminated between different clinical groups and non-clinical participants. The results also indicate that the capacities to be conscious about own and others’ affects are intertwined and co-dependent. Two factors, labeled general affect consciousness and consciousness about guilt and shame, explained 65% of the total variance in affect ratings. General affect consciousness had the strongest correlations with measures of psychopathology, and with interpersonal functioning. The results with regard to the factor consciousness about guilt and shame seem to contradict each other, as it seems important to emotionally close relations like the psychotherapeutic relationship or other attachment relationships but not so important to interpersonal functioning.

The difference in consciousness about affects between the non-clinical group and the different clinical groups indicated that affect consciousness is associated with psychiatric problems. Different kinds of psychiatric problems seem to be related to specific patterns of affect consciousness.

The reconceptualized AC construct is a useful concept and ACI-S/O seems to be a useful instrument for understanding, evaluating and working with psychological problems, especially when they involve interpersonal aspects of affects. To be able to experience and respond to others’ affects, especially anger, could contribute to the development of a safe attachment style. This ability may also be important for managing close relationships.

Consciousness about own and others’ affects is important for adequate management of interpersonal relations, especially close relations such as the psychotherapeutic relationship. AC and particularly consciousness about shame and fear influence the patients’ feelings toward the therapist more than other aspects of alliance.

AC seemed to be unrelated to current symptoms of ED but may be a rather stable and general vulnerability factor for the development of eating pathology regardless of sub-diagnoses.

The results in this thesis indicate that the interview that measures consciousness about others’ affects is a valuable complement to the original affect consciousness interview.
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