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## Self-Image Pattern and Treatment Outcome in Severely Disturbed Psychiatric Patients<sup>1</sup>

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The relationship between patients' initial ratings of their self-image and the outcome of long-term psychiatric treatment was studied in a five-year follow-up study. The subjects were severely disturbed psychiatric patients, mainly schizophrenics, treated in small treatment homes. A comparison was made between patients with a psychotic personality organization (PPO patients) and a non-psychotic personality organization (non-PPO patients), classified according to Kernberg's (1981) criteria. Self-image was assessed with the introject surface of Benjamin's SASB (Structural Analysis of Social Behavior) model and two self-image patterns were computed: a positive-negative pattern and a control-autonomy pattern. Two outcome measures (expressed as Effect Size) were used: *subjective outcome* was a combination of self-rated methods and *judged outcome* was a combination of observer ratings. The relationship between the two self-image patterns and outcome depended both on the patients' diagnosis and type of outcome. Judged outcome could not be predicted from the self-image for the PPO patients; for the non-PPO patients more improvement was related to more self-control. For both patient groups subjective outcome was related to a more negative self-image; however, this relationship was much stronger in the non-PPO group.

Key words: introject, self-image, psychiatric treatment outcome, psychotic patients, borderline patients

In different theories, the self has been emphasized as an important mediator of psychic well-being. According to, e.g., Kohut (1977; 1984) psychic health is achieved by curing an earlier fragmented self. Since Kohut, authors have continued to develop theories of the self. Stolorow, Atwood, and Brandchaft (1993) took up the interpersonal thread from the concept of *self-object* when they advanced their theories of the self from an intersubjective perspective. According to them, an individual's self-experience is always organized within a constituting intersubjective context (Monsen, 1997).

Sullivan's (1953) interpersonal theory inaugurated an empirical line in the development of theories of the self that has been carried on by, e.g., Kiesler (1983), Wiggins (1982), and Benjamin (1974). Empirical studies have confirmed that there is a correlation between self-image and mental health. *Self-image* is described in a circumplex model that combines the dimensions of *affiliation* and *control* (Pincus, 1994). The best established result is that a negative self-image is positively correlated with more symptoms and worse functioning. Thus a negative self-image has been shown to be present in patients with anorexia (Swift, Bushnell, Hanson, & Logemann, 1986), bulimia (Wonderlich, Klein, & Council, 1996), alcoholism, (Ichiyama & Zucker, 1996), dissociative disorder (Alpher, 1996) and borderline personality disorder (Armelius & Granberg, 2000). Mestel and Voltsmeier (1997) showed that a decrease in symptoms was connected to a positive change in self-image for patients with eating disorders and a borderline pathology. In normal subjects,

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too, the affiliation dimension of the self-image seems to be important for a person's well-being. Jeanneau and Armelius (2000) found that psychiatric personnel with a more negative self-image were more burned out a year later.

The few studies that have focused on the control dimension and mental health indicate that more self-control is positively related to mental health. More self-control is related to patients' ratings of themselves in their best state, while less self-restraint is rated in their worst state. This has been demonstrated for different patient groups such as borderline patients, patients with bipolar and unipolar depression (Benjamin & Wonderlich, 1994), bulimic patients (Wonderlich, Klein, & Council, 1996). Henry, Schacht, and Strupp (1990) also demonstrated that better outcome after psychotherapy was related not only to a more positive self-image but also to more self-control. Thus, a negative self-image and less self-control seem to be related to various kinds of psychopathology and to less well-being, at least in patients with a non-psychotic disorder and in normal subjects.

An expectation based on the empirically established association between a negative self-image and various forms of psychopathology is that a deviant self-image should be common in more severely disturbed patients, such as those suffering from psychotic disorders and schizophrenia. However, we have found in earlier studies based on the SASB model (e.g., Öhman & Armelius, 1990) that schizophrenic patients unexpectedly had a positive self-image, with self-control almost like that of "normal" groups. There may be alternative explanations for this, e.g., that the positive self-image is a result of a defense, or that it reflects a distortion of reality testing. Whatever the explanation it seems obvious that it will lead to difficulties in the patient's relations with others, since there would be great differences between the patient's self-perception and the way others perceive her or him. In this study we will go one step further, to explore the self-image of severely disturbed patients and relate it to changes due to treatment.

Theoretically, self-image should be a very important factor to consider in the treatment of patients. According to interpersonal theory a person interacts with others so that his/her self-image is confirmed. With a deviant self-image, therefore, there is a risk that the interpersonal interactions will also be disturbed and the other is drawn into complementary reactions that will confirm the person's deviant view of him/herself. In treatment this might lead to worse outcomes for patients with a negative self-image. This has been confirmed in some studies. Henry et al. (1990) found that a negative self-image initiated a more negative therapeutic process and a worse outcome. Filak, Abeles, and Norquist (1986) found that outpatients with better outcome had a more affiliative interpersonal attitude compared to patients with a hostile attitude and that the successful clients changed their interpersonal attitude from a submissive to a dominant style. The patients followed in those studies were generally less severely disturbed, with a non-psychotic diagnosis. Holmqvist and Armelius (2000) found that the staff's reactions towards the patients could be related to the patients' self-image and that patients who had a more negative self-image evoked more negative feelings.

Studies of psychological distress have demonstrated that more distress as measured by symptom ratings is related to positive change (Mohr et al., 1990). This was interpreted as reflecting patients' motivation for change. As stated by the authors, "an awareness of disturbed functioning even if one is unable to specify its source or nature is important for motivating change in psychotherapy and the absence of such self-acknowledged dysfunction may even portend treatment-related deterioration" (p. 627). Thus we are left with two opposite predictions: a negative self-image would, according to interpersonal theory, initiate negative interpersonal processes and worse outcome. On the other hand a negative self-image should be related to psychological distress or symptoms that would function as a motivating factor leading to better outcome, at least for patients with a non-psychotic personality organization.

A complicating factor in comparing outcome studies is that they evaluate outcomes differently. Here we will not go into that issue in any detail, but just point out that there

seems to be a difference in outcome depending on whether the patient him/herself is making the evaluation or if others assess outcome. For example, McGlashan (1984) found that his schizophrenic patients tended to overestimate their mental health and outcome compared to observer ratings of outcome. Some authors have pointed to the importance of considering the perspective of the evaluator when mental health is evaluated. Strupp and Hadley (1977), Garfield (1994) and Cook, Blatt, and Ford (1995) all agree that when different interested parties focus on different facets of mental health, different results are likely.

There have been contradictory conclusions about the possibility of predicting outcome of treatment for severely disturbed psychiatric patients. Some authors, like McGlashan (1991) in his overview of the North American long-term follow-up studies of schizophrenia, doubt whether these studies have answered any questions about treatment. Others, like Strauss and Carpenter (1974), think that several variables can to some extent help predict treatment of schizophrenia, though their standpoint that there is a lack of detailed understanding of the power of these predictors and the nature of these predictive processes still seems to be true.

In their efforts to find predictor variables that will decide the outcome of therapeutic interventions with severely disturbed patients they asked if predictor variables relate specifically to particular outcome functions and if different patient groups have different prediction– outcome relationships. Most studies seem to agree on the finding that better therapeutic outcome is obtained with less disturbed patients (e.g., Garfield, 1994). However, Cook, Blatt, and Ford (1995) also reported contradictory findings. Although a lot of research is needed to establish even a basic relationship between predictor and outcome variables, authors like Luborsky, Crits-Christoph, Mintz, and Auerbach (1988) maintain that some type of initial information about the patient will predict outcome significantly, if only modestly.

The purpose of the present study was to investigate the relationship between self-image and outcome of treatment for two groups of severely disturbed patients, with and without psychotic disorders. Self-image was assessed by the introject surface of the SASB model with its two basic dimensions of affiliation and control. Outcome was assessed with two measures based on the differences before and after treatment. One outcome measure was based on the patients' own ratings of self-image and symptoms, using the symptom checklist SCL-90 (Derogatis & Cleary, 1977). The other was an aggregate measure based on independent judgments of the patients. The treatment evaluated was treatment at small treatment homes, where the patients were engaged in different kinds of psychotherapeutically based interventions, such as individual psychotherapy, milieu treatment, music therapy etc. The treatment is described in more detail in Jeanneau and Armelius (1994).

## Method

### *Subjects*

The subjects of this study were 131 patients participating in the Swedish Small Treatment Homes Project (Jeanneau & Armelius, 1994). In the project, 155 patients were followed over five years with a number of different methods. The reason why not all patients were included in the present study was that at the time of the study they had missing data on some of the instruments used to compute outcome. The patients who were not used in our study did not differ significantly from the other patients in diagnosis or in their self-image ratings at the start. The majority of the patients (63%) were diagnosed with Kernberg's structural interview (Kernberg, 1981) as having a psychotic personality organization (PPO), 27% had a borderline personality organization (BPO) and 10% a neurotic personality organization (NPO). The patients were also diagnosed according to the DSM-III R system.

Using this measure, 86% of the PPO-patients had a diagnosis of schizophrenia or another severe psychosis. In the non-psychotic group, 73% had a diagnosis of a personality disorder or an axis-I diagnosis that was not a psychosis. Data on sex and age in the two groups are presented in Table 1, as well as data on onset and duration of illness, and length of treatment.

As seen in Table 1, these patients all had a serious mental illness. All had been ill for a long time, with an early onset. Also (not shown in the table) all had previous psychiatric treatment. A psychiatrist connected to the home carried out the medical treatment of the patients and all patients were on medication both at admission and at the end of treatment.

The present study uses the results for 131 patients who had outcome data at the time of the study. Eighty-three had a PPO diagnosis, thirty-five a BPO diagnosis and thirteen a NPO diagnosis. The patients in the present study did not differ from all patients in any of the aspects shown in Table 1. Contrasted with the PPO patients, the BPO and NPO patients showed a great resemblance to each other with respect to the introject patterns of this study. To increase the number of subjects in the non-psychotic group, the BPO and NPO patients were therefore collapsed into one non-PPO group that was compared with the PPO-patients.

Table 1.

*Sex, Age, Onset and Duration of Illness, and Years in Treatment Home in the PPO and Non-PPO Groups.*

	PPO	Non-PPO
Percent male	61	49
Mean age	28.0 ( <i>SD</i> =6.1)	28.0 ( <i>SD</i> =9.0)
Mean onset of illness (age)	20.0 ( <i>SD</i> =4.6)	19.0 ( <i>SD</i> =6.0)
Mean duration of illness (yr)	7.0 ( <i>SD</i> =4.9)	8.0 ( <i>SD</i> =7.2)
Mean years in treatment home	3.2 ( <i>SD</i> =1.4)	2.5 ( <i>SD</i> =1.4)

#### *Comparison Group*

The comparison group for the SASB consisted of 52 subjects, 24 males and 28 females, with mean age of 33 years (*SD*=9.5, range=20-56). All subjects in the comparison group were either working or studying and none had any known psychiatric problems at the time of the testing.

#### *Instruments*

*SASB.* Self-image was assessed using the SASB model (Benjamin, 1974). In this model, self-image is analyzed on two dimensions: affiliation (ranging from love to hate) and interdependence (ranging from control to autonomy). The self-image is also called the introject since it is supposed to reflect early interactions with important people that are "introjected" into the self.

The SASB is unique in having three different foci: on actions, on reactions and on self-image or actions towards the self. The cluster version of the model is divided into eight clusters containing different loadings of affiliation and interdependence (see Figure 1).

*Self-Image Patterns.* Two different self-image patterns were used to predict treatment outcome. In essence they were more simply computed versions of Benjamin's (1977) attack- and control-coefficients. More specifically, a set of dummy values reflecting a *positive-negative* self-image and another set reflecting a *controlled-autonomous* self-image were created. Thus, the positive-negative dummy values were 50, 60, 70, 60, 50, 40, 30, 40 for clusters 1 through 8 and the controlled-autonomous dummy values were 30, 40, 50, 60, 70, 60, 50, 40. The dummy values were correlated with the patients' cluster scores,

resulting in two self-image patterns called the positive-negative self-image pattern and the control-autonomy self-image pattern.

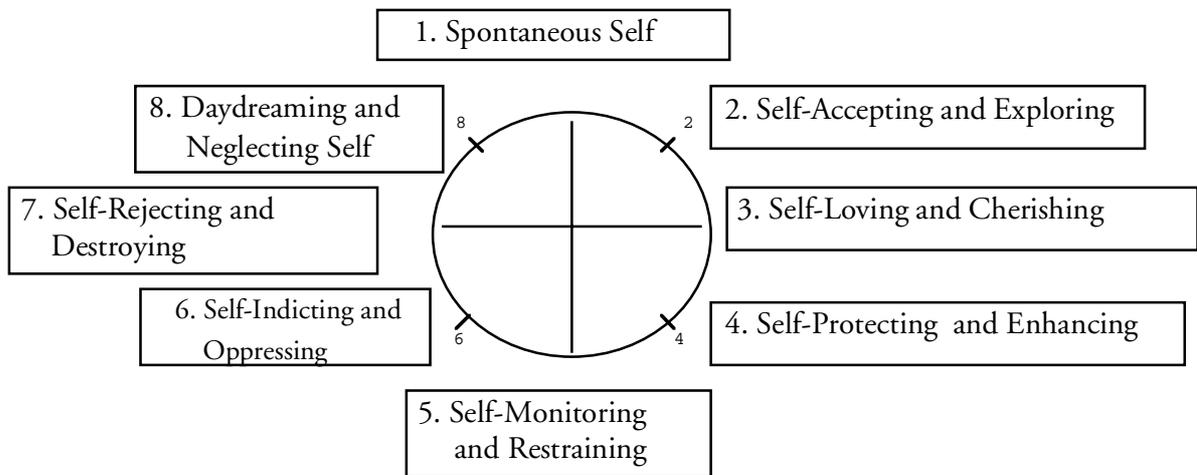


Figure 1. The introject surface (self-image) of the Structural Analysis of Social Behavior (SASB).

#### *Outcome Measures*

Two measures of outcome were used in the present study, both computed as ES-values for each patient. Depending on whether the assessments were self-ratings or observer ratings, the outcome measures are called *subjective outcome* or *judged outcome*. The subjective outcome measure was based on the patients' pre- and post ratings of their symptoms and of their self-image with SCL-90 (Derogatis & Cleary, 1977). Subjective outcome was computed as the difference in symptom ratings and self-image ratings before and after treatment divided by the standard deviation before treatment. Judged outcome was based on pre- and post assessments of global functioning rated with the Strauss–Carpenter scale (Strauss & Carpenter, 1974), of mental health using Luborsky's (1975) Health Sickness Rating Scale (HSRS) and of personality organization assessed using Kernberg's structural interview (Kernberg, 1981). Independent observers who were members of the research team made these ratings. All were psychologists trained to use the different techniques. Outcome was computed as the difference before and after treatment divided by the standard deviation before treatment. The standard deviations used were taken for each patient group and the mean difference was always computed so that a positive ES-value meant an improvement for the patient.

#### *Statistical Methods*

Differences between the two patients groups were tested with the t-test for independent groups and differences between patient groups and outcome groups were tested with ANOVA.

## Results

### *Self-Image*

Table 2 shows the patients' self-image ratings before treatment.

Table 2.  
*Mean Ratings of Self-Image Before Treatment.*

Group		Cluster							
		1	2	3	4	5	6	7	8
PPO	<i>M</i>	47	54	50	57	56	39	32	31
	<i>SD</i>	19	24	21	21	19	25	22	19
Non-PPO	<i>M</i>	40	36	36	48	57	56	46	38
	<i>SD</i>	16	24	20	22	19	25	24	22
Comparison	<i>M</i>	40	61	58	58	52	26	16	19
	<i>SD</i>	12	18	17	12	17	21	15	11

The PPO patients had significantly higher ratings for the positive clusters (2, 3 and 4) and significantly lower ratings for the negative clusters (6, 7 and 8) than the non-psychotic patients. For the self-emancipating cluster 1 but not for self-control (cluster 5) their ratings were significantly higher. The standard deviation for all clusters did not differ in the two groups. As seen in the table, the PPO-patients did not differ much from the normal comparison group in their ratings for the positive clusters but had higher ratings for the negative clusters.

### *Outcome*

The two outcome measures for each group are shown in Table 3.

Table 3.  
*Judged and Subjective Outcome (ES-values) for the Two Patient Groups*

Outcome	PPO		Non-PPO	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Judged*	.42	.92	.78	1.10
Subjective*	.16	.77	.48	.90

\* $p < .05$  for the difference between the groups.

There were significant differences between the two groups for both judged and subjective outcome. As expected, the non-PPO patients had improved more than the PPO-patients on both outcome measures. For both patient groups, judged outcome was better than subjective outcome. According to Cohen's (1988) interpretation of the ES-values the non-PPO patients showed a large improvement for the judged outcome and a medium improvement for the subjective outcome. The PPO-patients showed change in the medium region for judged outcome and small for subjective outcome.

### *Self-Image Patterns*

Table 4 shows the average of the two initial self-image patterns (positive-negative and control-autonomy) for the two groups.

Table 4.

*Mean of Positive-Negative and Control-Autonomy Self-Image Patterns in the Two Patients Groups Initially*

Self-image pattern	PPO	Non-PPO
Positive-Negative***	.29	-.16
Control-Autonomy**	.16	.32

\*\* $p < .01$ , \*\*\* $p < .001$

There were significant differences between the two groups for both patterns. For the PPO-patients, both pattern correlations were positive. This indicated a generalized self-image that is high on the positive side and low on the negative side and more self-controlling than autonomous. For the non-PPO group, the positive-negative pattern correlation was negative and the control-autonomy positive. Thus, these patients had a generalized self-image that was negative and with self-control. There were significant differences between the two groups for both self-image patterns. Notably, the non-PPO patients had both a more negative and a more controlled self-image than the PPO-patients.

### *Relation Between Self-Image and Outcome*

To find out to what extent outcome could be predicted by the two self-image patterns, each pattern was correlated with the two outcome measures. This correlation tells us if the outcome of a treatment, in this case milieu treatment in small treatment homes, can be predicted by assessing the patients' self-image on the SASB in advance. The mean correlations in each group are shown in Table 5.

Table 5

*Correlation Between the Self-Image Patterns and Outcome for the PPO and non-PPO Patients*

Outcome	Self-image pattern	PPO	Non-PPO
Judged	Positive-Negative	.07	-.23
	Control-Autonomy	.01	.30*
Subjective	Positive-Negative	-.26*	-.43**
	Control-Autonomy	.09	.24

\* $p < .05$ , \*\* $p < .01$

In Table 5 it can be seen that for *judged outcome* there was no significant relation between the self-image patterns and outcome in the PPO group. In the non-PPO group a higher control-autonomy pattern was significantly related to more improvement. For *subjective outcome* a more negative self-image before treatment was related to more improvement in both groups, although weaker in the PPO-group. Thus, the relationship between the patient's self-image before treatment and the outcome seems to depend both on his or her diagnosis and type of outcome.

### Multiple Regression Analysis

The relationships between outcome and self-image patterns were also tested in a multiple regression analysis, where the two outcome measures were dependant variables and the self-image patterns were predictor variables. Thus, four equations were tested, one for each group (PPO and non-PPO) and outcome measure (judged and subjective). For judged outcome there was no significant relationship between the self-image patterns and outcome in the PPO-group. In the non-PPO group the control-autonomy pattern was significantly related to outcome:  $R = .30$  ( $p < .05$ ). For subjective outcome the positive-negative self-image pattern was related to outcome in both patient groups. In the PPO-group  $R = .27$  ( $p < .05$ ) and in the non-PPO group  $R = .44$  ( $p < .01$ ). Thus, for the non-PPO patients more self-control was related to better judged improvement and in both groups a more negative self-image was related to more subjective improvement. This relationship was stronger in the non-PPO group.

### Contrast Groups

Another way to investigate the relevance of the self-image patterns for predicting outcome is to compare contrast groups in judged and subjective outcome. The patients were divided into contrast groups where patients that had an outcome  $> .30$  were called improved and those that had an outcome  $< .00$  were called not improved. The number of patients in each group is shown in Table 6.

As seen in Table 6, for both judged and subjective outcome a greater percentage of the non-PPO patients were improved compared to the PPO-patients.

Differences in the patients' initial self-image patterns were compared for the two outcome groups in the PPO and non-PPO groups, respectively, with a two-way ANOVA (diagnosis: PPO and non-PPO)  $\times$  (outcome: improved or not improved) for each kind of outcome. Mean correlations for the positive-negative and control-autonomy self-image patterns are shown in Figures 2 and 3, respectively.

Table 6.

*Number of Improved (I), Not Improved (N) and Unchanged (U) Patients for Judged and Subjective Outcome in the Two Patient Groups.*

Outcome	PPO			Non-PPO		
	I	N	U	I	N	U
Judged	$n=41$ (49%)	$n=27$ (33%)	$n=15$ (18%)	$n=30$ (63%)	$n=14$ (29%)	$n=4$ (8%)
Subjective	$n=32$ (42%)	$n=32$ (42%)	$n=12$ (16%)	$n=25$ (56%)	$n=15$ (33%)	$n=5$ (11%)

For judged outcome the main effect of diagnosis was significant ( $p < .01$ ). The PPO-patients had a more positive self-image pattern than the non-PPO patients. In addition, there was a weak tendency ( $p < .15$ ) that not-improved patients had a more positive self-image than improved patients. As seen in Figure 2 both improved and not-improved PPO-patients tended to have the same positive-negative pattern, but improved non-PPO patients tended to have a more negative self-image than not-improved patients. However the interaction was not significant ( $p < .15$ ).

For *subjective outcome* the main effects of diagnosis ( $p < .01$ ) and of outcome groups ( $p < .01$ ) were significant. Non-PPO patients had a more negative self-image than PPO-

patients. Improved patients had a more negative self-image than not-improved patients but since this pattern was the same in both groups, the interaction was not significant.

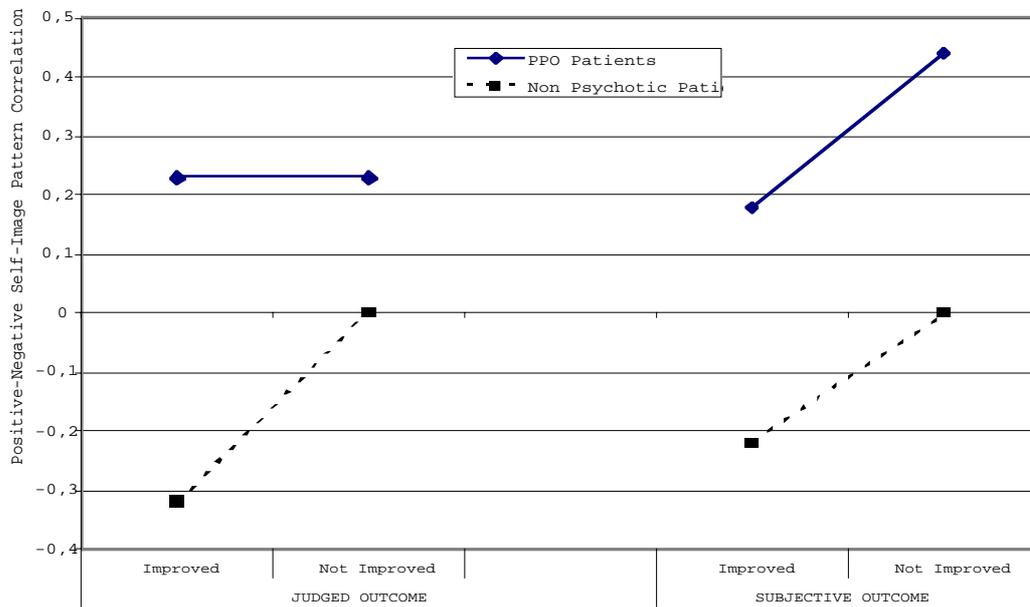


Figure 2. Positive-negative pattern for judged and subjective outcome and for improved and not improved PPO and non-PPO patients.

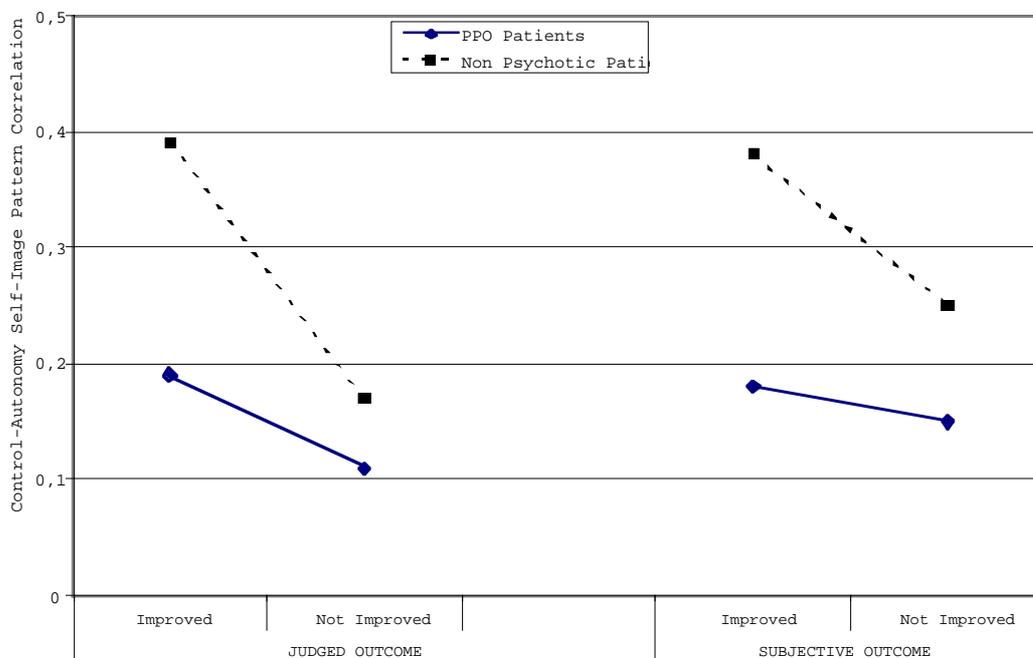


Figure 3. Control-autonomy pattern for improved and not improved PPO and non-PPO patients and for judged and subjective outcome.

In sum, the PPO-patients had a more positive self-image than the non-PPO patients for both *judged outcome* and *subjective outcome* and the patients that had improved in subjective outcome had a more negative self-image pattern compared to the not improved patients.

Figure 3 shows the results for the control-autonomy self-image pattern. A two-way ANOVA (diagnosis: PPO and non-PPO) x (outcome: improved-not improved) for each kind of outcome was performed. For *judged outcome* there were significant main effects of both diagnosis ( $p < .05$ ), and of outcome ( $p < .05$ ). The non-PPO patients had more self-control than the PPO patients, and patients that had improved in judged outcome had a more self-controlled self-image than not-improved patients. For *subjective outcome* there was a significant effect for diagnosis ( $p < .10$ ) only. The non-PPO patients had a more self-controlled self-image than the PPO-patients. Thus, even though the contrast group was created from the results, so that the two factors might not be considered truly independent, the pattern of this analysis agrees with the other analysis performed.

### Discussion

The current study has replicated the conclusions of our previous research (Armeliu & Granberg, 2000). Again, PPO patients were shown to have a more positive self-image than non-PPO patients. Almost none of the PPO patients had a negative self-image. Their serious mental illness was not reflected in their self-ratings. In fact, their self-image was more or less normal, especially for the positive clusters. According to interpersonal theory, a person interacts with others in a way that will confirm his/her self-image. A positive self-image should therefore induce complementary positive reactions and result in positive interpersonal relationships. However, also according to interpersonal theory, when there is a great discrepancy between different perspectives, there will be interpersonal problems. In spite of the PPO patients' own opinions of having a positive self-image, it will be very difficult to get confirmation from others that they are "okay as is" (SASB, cluster 2) or that they are "aware of positive and negative aspects in their self" (SASB, cluster 2). Therefore, a positive self-image might make interpersonal relations and treatment more difficult for patients with a psychotic or schizophrenic disorder. We might ask if the tendency to make delusional interpretations of the social environment serve the function of preserving the positive self-images?

For the non-PPO patients, a systematic result from all the analyses in the present paper was that more self-control correlates with better *judged outcome*. For patients with a non-psychotic disorder, having more self-control (as opposed to a free and spontaneous self) seems to be a prerequisite for benefiting from the kind of long-term treatments that were used in the present setting. In the study by Filak, Abeles, and Norquist (1986) successful patients changed from being submissive to being interpersonally more dominating. The dominant attitude might be a way to get more control in interpersonal situations. To be in charge of yourself and your relationships might signal a person's ability to change. Most of the non-PPO patients in the present study had a borderline personality organization and should have had poor control over their aggressive impulses. Also, according to the DSM-system, borderline disorder is characterized by poor impulse control. However, in the present study these patients presented themselves as having more self-control than spontaneity. It may be important to separate the patient's own view of what he/she tries to do from the view that outside observers might have of the patient's behavior. The processes behind self-destructive behavior and poor control of feelings may be something other than lack of self-control as experienced by the patients.

Another finding of the present study was that a negative self-image was positively correlated with a better outcome. This was true for both PPO and non-PPO patients and strongest for *subjective outcome*. Thus, a negative self-image seems to function as a

motivating factor that improves the outcome. A negative self-image may mediate some kind of distress that makes the patients more in need of change. This distress hypothesis is in accordance with findings from other studies that a negative self-image is related to various signs of decreased well-being and a worse state in patients. However, the results do not agree with interpersonal theory or with the findings by Henry, Schacht, and Strupp (1990) who found that a more negative self-image was correlated with a negative therapeutic process and worse outcome. There are a number of known and unknown factors that differ between their study and ours. The self-image of patients with high ratings of blaming, destroying and rejecting the self, as was the case for the non-PPO patients in the present study, will agree with how other people see them.

This might make interpersonal relations more predictable for the non-PPO patients in this kind of long-term treatment facility. At least it seems to be beneficial for outcome of treatment in comparison with the great difference in perspectives that exists for the PPO-patients. In a recent study using data from the same setting as ours, Holmqvist (2000) found that a more positive outcome for the non-PPO patients was related to more negative feelings in the staff. However, this was not the case for PPO-patients. The negative self-image of the non-PPO patients appeared to induce negative feelings in the staff, as predicted from interpersonal theory. However, the result was not a worse outcome but a better one. There seems to be something in this particular long-term treatment approach that provides the necessary conditions for severely disturbed non-PPO patient to improve. One explanation could be that it gives the opportunity for projective identifications (Ogden, 1982) that competent staff can use to understand the patients.

In the present study we have shown that self-control is an important predictor of positive outcomes in patients with a non-psychotic disturbance, when outcome is judged with various instruments that measure changes in both function and psychological structure. We have also shown that a more negative self-image is a factor related to more positive outcome for both PPO and non-PPO psychiatric patients.

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