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Dissociation and Metacognition: A Mixed Methods Analysis

by

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Presented to the Faculty of the

Graduate School of Clinical Psychology

George Fox University

in partial fulfillment

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Doctor of Psychology

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Newberg, Oregon

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Dissociation and metacognition: A mixed methods analysis of patients with PTSD and dissociative disorder or PTSD with dissociative features

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at the

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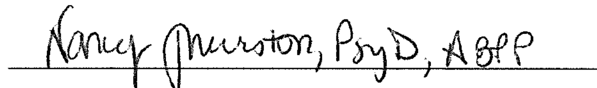

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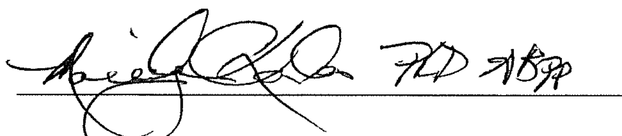

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Dissociation and Metacognition: A Mixed Methods Analysis

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Abstract

Dissociation commonly occurs as a defense against trauma and can be understood as a breakdown in metacognition. The present research investigated the relationship between trauma, dissociation, and metacognition in subjects with PTSD, a trauma-related disorder. Specifically, we investigated a potential inverse relationship between metacognition and dissociation in participants who have undergone psychoanalytic therapy. Participants were patients admitted to the Austen Riggs Center, who consented to be a part of the Follow Along Study (FAS), a longitudinal investigation spanning 15 years. Quantitative and qualitative analyses examined differences in themes of dissociation across initial and follow-up-clinical interviews. Quantitatively, all subscales for metacognition showed significant and large improvements after psychoanalytic therapy. Qualitatively, follow-up-interviews revealed greater remembering, self-acceptance, emotional accessibility, generosity, and social connectedness. Thus, psychoanalytic therapy increased participants' metacognitive abilities, allowed participants to develop a more

coherent narrative of the self, and reduced participants' dissociative tendencies. Implications and future directions are discussed.

Keywords: dissociation, metacognition, PTSD, dissociative disorder, trauma, psychoanalytic therapy

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Chapter 1

Introduction

Many people seek treatment with symptoms that can be traced to previous trauma and neglect. Notably, we are learning that attachment difficulties form an important and debilitating subgroup when considering traumatic antecedents to extreme psychological distress (Delvecchio, Di Riso, Salcuni, Lis, & George, 2014). Clinical experience and previous studies also link early trauma and neglect to deficits in metacognitive capacities (Gumley, 2010; Myers & Wells, 2015). Previous findings suggest that symptom severity is related to the individual’s ability to make use of their metacognitive capacities to manage their distress (Lysaker, Dimaggio, et al., 2015). In this study, we look at metacognitive difficulties in individuals diagnosed with symptoms of trauma, and also consider how those difficulties change over time after psychoanalytic psychotherapy.

Psychological Trauma

The impact of psychological trauma is extensive and diverse. Many people experience some form of psychological trauma at some point in their lives (McWilliams, 2004). Our global community knows trauma in the form of natural disasters, wars, terrorist attacks, and school shootings, to name a few overt examples. The world is all too familiar with the unfolding revelations of rampant child sexual abuse within religious institutions, sexual assault and racial discrimination in the workplace, the impact of poverty inside and outside of the home, and the

strife of individuals with marginalized identities, the extent and breadth of which illustrates the prevalence of traumatic experiences in our midst.

Trauma can also transcend the boundaries of time and space in its effect on an individual or group of people. For example, intergenerational trauma that occurred decades ago can be transmitted through a lineage, from ancestry to posterity, through repetitive traumatization (Grand & Salberg, 2017). Notably, the attachment literature shows us that unmourned losses perpetuate the traumatic effects of disorganized attachment across the generations, even in families that try to do better than their own parents had done. When parents are inaccessible to the child because they are preoccupied with their own unresolved losses, they are unavailable as a reliable partner in the development of self-regulatory capacities, leaving an inherent instability that impedes further development (Liotti, 2004; Main & Hesse, 1990). Also missing in such households tends to be stability in the empathic parental attention and *marked mirroring* so essential to healthy self-regard (Mayes, Fonagy, & Target, 2007). In this way, the disruptions associated with disorganized attachment also lead to incoherence in the narrativization of self that is integral to identity development (Fivush, Habermas, Waters & Zaman, 2011), leaving the individual more vulnerable to future traumatic destabilization.

In addition, those in the helping professions who support victims of trauma often suffer vicarious trauma, exhibiting remarkably similar reactions to the survivors themselves (Knight, 2013). Some scholars have even suggested that the root of most, if not all, psychological maladies are linked to some form of post-traumatic experience (Renik, 2006). In the United States, 25% of adults are diagnosed with a mental illness, and approximately 50% of adults will go on to develop a mental illness in their lifetime (Centers for Disease Control and Prevention,

Mental Illness Surveillance Among Adults in the United States, 2011). The economic cost of mental illness alone was approximately $300 billion in 2002 (Centers for Disease Control and Prevention, Mental Illness Surveillance Among Adults in the United States [CDC], 2011), and the societal cost of mental illness is becoming more palpable as families, schools, and communities are constantly being rattled by the steady increase in suicide rates. Over a million people attempt suicide every year in the U.S., and 44,000 completed suicides were recorded in 2015 (CDC, 2015). The traumatic effects of being a survivor of suicide is well-documented and a known risk factor for increasing suicidality in the survivor him- or herself (CDC, 2015).

In general, while we may be consciously aware of the many effects of trauma, what occurs on the unconscious level is largely unknown. There are continuous efforts at elucidating this unknown with a growing body of experimental and clinical research validating the existence of an unconscious realm of mental life (Gabbard & American Psychiatric Association [APA], 2017). Recent research in the field has conceptualized the unconscious in terms of a memory system. For instance, effortful processes of suppressing emotions are explicit; whereas, unconscious defense mechanisms are considered implicit emotional regulation (Gabbard & APA, 2017). Essentially, this part of the memory system is involuntary and hidden to the individual as it maintains and modulates the emotional and mental states of the individual.

Due to the unseen, implicit, and often unconscious dimensions of trauma, modalities such as psychoanalytic psychotherapy may be especially effective. By helping patients curate a space for attending to the unconscious processes through the therapeutic relationship, this modality facilitates bringing previously unconscious emotions and thoughts to conscious awareness. For this reason, investigating this modality of mental health treatment within the context of

psychological trauma, and focusing on unconscious defenses such as dissociation, holds out hope for ameliorating the extensive effects of trauma. This study aims to add to the current literature by analyzing the impact of psychoanalytic treatment on dissociative presentations post-trauma through examining the longitudinal interviews collected by researchers at the Austen Riggs Center Erikson Institute during the initial stages of treatment and after substantial treatment has been conducted.

Dissociation

Dissociation is a common response to trauma (McWilliams, 2011). It typically occurs as a defense against a terrifying and dangerous experience and can be understood as a breakdown in metacognition (i.e., experiencing "compartmentalization" and "detachment" instead of the capacity to reflect and thinking freely; Liotti & Prunetti, 2010). In their book, *Adult Survivors of Childhood Sexual Abuse*, Davies and Frawley (1994) define dissociation as:

> The process of severing connections between categories of mental events—between events that seem irreconcilably different, between the actual events and their affective emotional significance, between actual events and the awareness of their cognitive significance, and finally, as in the case of severe trauma, between the actual occurrence of real events and their permanent, symbolic, verbal mental representation (p. 62)

From an evolutionary perspective, dissociation can be seen as a survival mechanism to protect and preserve individuals from damaged parts of the self during and after a traumatic experience (Liotti & Prunetti, 2010). Dissociation is a psychic means of quarantining off damaged parts of the self so that they will not "contaminate" other parts−other parts of the self

that could not tolerate the trauma. In other words, dissociation is a byproduct of trauma, a mechanism to defend against psychic pain (Liotti & Prunetti, 2010). From a relational and attachment perspective, dissociation can be seen as a disorganization of internal psychic processes in response to trauma, as can be seen in disorganized memory and consciousness (Meares, 2000). As commonly witnessed in the consulting room, many childhood survivors of sexual and physical abuse have difficulty remembering their childhoods and are unaware of the unconscious mechanisms rooted in trauma, which continue to influence their perceptions of self and others in the present. Some survivors remember the trauma in explicit detail but do not have access to the emotions attached to their experience. Some do not remember the trauma but are triggered and flooded by seemingly unrelated events, losing contact with their ability to think. Dissociation is a secret kept from oneself, and psychoanalytic treatment is the process of illuminating and integrating this secret to one's consciousness (Bromberg, 2011).

Interestingly, severe and chronic trauma or trauma responses are not necessarily correlated with severe and persistent dissociative symptoms (Lysaker, Dimaggio, et al, 2015). An answer to this apparent paradox may be found in metacognition, which has been found to be a protective factor against trauma (Wallin, 2007). For example, when children have the capacity or opportunity to think about their traumatizing caregivers (e.g., "Dad is weird and he's different from other dads"), they are better able to protect themselves against the effects of trauma (Wallin). Therefore, examining themes of dissociation and its relationship with metacognition will be pertinent to a fuller understanding of the experience, capacity, and healing opportunities available to the traumatized individual.

Metacognition

The term metacognition is broadly defined as an individual's capacity to "think about one's thinking" and/or to think about the thinking of others (Lysaker et al., 2010). There is an overlap in terminology between the literature on metacognition and that pertaining to theory of mind, mentalization, social cognition, social understanding, mind reading, and psychological mindedness. Regardless of the terminology and approaches employed, the various ways of conceptualizing and treating severe psychopathology have evolved around the common goal of increasing a patient's reflective functioning toward self and others (Dimaggio & Lysaker, 2010). This reflective function not only demonstrates the capacity to think about thinking but also creates a space that insulates the thinker from the thought. For this study, the conceptualization of metacognition consists of four domains that are detailed in the abbreviated Metacognition Assessment Scale (MAS-a) below.

- Self-Reflectivity (S) is the capacity to think about one's own thinking. It is the ability to form representation of oneself, which are increasingly complex and integrated. Lower scores may reflect an ability to merely identify one's thoughts as one's own. Higher scores may reflect an understanding of the relationship between thoughts, emotions, and other social or interpersonal variables across different life events (MAS-a Coding Manual; Lysaker, Buck, & Hamm, 2015; Semerari et al., 2003).

- Awareness of Other's Mind (O) is the capacity to think about other individuals' thinking. It is the ability to form increasing complex and integrated representations of another person, and refers to an awareness of a particular person or well-recognized group, such as a family. Lower scores reflect the mere ability to recognize that others have unique thoughts or the

ability to distinguish the different cognitive operations and emotions that others employ or experience. Higher scores reflect the ability to understand the relationship between thoughts, emotions, behaviors, and developmental or interpersonal variables (MAS-a Coding Manual; Lysaker, Buck, et al., 2015; Semerari et al., 2003).

- Decentration (D) is the capacity to move through the world existing with other individuals who have independent thoughts. It measures the ability to recognize that other people lead lives that may intersect with the participant, but that the lives of others concern much more than the interests of the participant, and that the participant is consequently not the center of the lives of others. As such, this scale reflects the ability of participants to situate their ideas of themselves in the larger social world. At lower levels, all events are understood by participants as being in reference to themselves while, at higher levels, participants recognize that there are multiple valid viewpoints and each person is pursuing his or her own way through life (MAS-a Coding Manual; Lysaker, Buck, et al., 2015; Semerari et al., 2003).

- Mastery (M) is the ability to use metacognition to mitigate psychological problems and life distress. It measures an individual's ability to utilize metacognitive knowledge about oneself and others to cope with psychological problems that are a source of distress. This scale is not a measure of general problem solving ability, but rather a measure of the ability to use the metacognitive knowledge reflected in the other scales in order to master problems specifically related to mental health (MAS-a Coding Manual; Lysaker, Buck, et al., 2015; Semerari et al., 2003).

Use of these domains aids us in parsing out and reflecting upon the different facets of metacognition and how changes in metacognition may shape the traumatized individual and their treatment.

Further, research has linked dissociation with metacognitive breakdown, which in many cases is related to experiences of trauma (Liotti & Prunetti, 2010; Davies & Frawley, 1994). Using the MAS-a, studies have found metacognitive deficits in traumatized patient populations, such as deficits in Self-Reflectivity and Mastery (Liotti & Prunetti, 2010; Lysaker, Dimaggio, et al., 2015). In sum, psychological trauma and its correlates reflect an inhibited metacognitive process, exhibiting failures in varying dimensions of reflective functioning. Investigating the effects of psychoanalytic psychotherapy on subjects diagnosed with PTSD may provide additional insight into rehabilitative treatment approaches for traumatized individuals.

Psychoanalysis, Metacognition, and Dissociation

Psychoanalytic therapy has evolved for generations without a large body of “hard science” to support its utility. Fortunately, more recent efforts have been directed at documenting therapeutic outcomes of psychoanalytic psychotherapy including, importantly, the work of Shedler (2010). In his meta-analysis, Shedler shows the efficacy of psychoanalytic psychotherapy, finding an overall effect size of 0.97 for general symptom improvement, with effect sizes increasing to 1.51 when the patients were assessed at long-term follow-up (nine months post-treatment). There were consistent trends of larger effects sizes at follow-up (e.g., somatic symptoms, anxiety ratings, depressive symptoms), which suggest lasting positive outcomes of psychoanalytic therapy. However, there is a gap in research regarding the impact of psychoanalytic treatment on less observable, more implicit psychic processes such as

metacognition, and how increased reflective function (i.e. metacognition) can reduce the negative dissociative effects of trauma. This study aims to fill in part of this gap by analyzing the effects of long-term psychoanalytic treatment on subjects who utilize dissociation as a primary defense.

Purpose of This Study

The extensive interview data compiled from the Erickson Institute Follow-Along Study (FAS), tracking treatment offered at the Austen Riggs Center in western Massachusetts, presents an opportunity to address empirical questions about whether and how psychoanalytic treatment impacts metacognition, and what subsequent impact such change may have on dissociation. It is hypothesized that overall metacognition scores will *quantitatively* increase as a result of psychoanalytic treatment at Austen Riggs. Likewise, it is hypothesized that, following treatment, there will be a corresponding *qualitative* difference in participants' discourse with participants displaying a greater ability to recall traumatic memories as well as having a more coherent narrative in experiencing oneself.

For the present study, the following hypotheses are tested:

Hypothesis 1: Quantitatively, metacognitive scores will increase from treatment outset to treatment follow-up after the intervention of intensive psychoanalytic therapy.

Hypothesis 2: Qualitatively, dissociation themes will change from not recalling to a greater recognition or a more coherent narrative of the self.

Outcomes and Benefits

We hoped that the results of the proposed study would increase our understanding of metacognition in participants with PTSD and dissociative disorder or PTSD with dissociative

features. In particular, we hoped to shed light on the potential healing aspects of psychoanalytic psychotherapy that involve strengthening the patient's metacognitive capacity. We also hoped to add to the literature by investigating psychoanalytic treatment outcomes using a mixed-method analysis.

Chapter 2

Method

Austen Riggs Center (ARC)

The participant data set comes from the Austen Riggs Center (ARC), a private psychiatric hospital located in Stockbridge, Massachusetts. It is an open hospital, where patients are neither locked-in nor constantly monitored but rather are free to come and go as they please. The majority of the patient population at the ARC are individuals that have been deemed “treatment-resistant,” implying a persistent severity in symptomology and impaired psychological functioning that have not abated with various prior treatment efforts. The ARC differs from mainstream psychiatric hospitals with its meta-communication of trust, respect, and the value of patients’ autonomy, which is embedded in its structural environment and also in its clinical orientation. Specifically, its clinical orientation focuses on providing intensive psychoanalytic therapy to patients diagnosed with severe and persistent mental illnesses. Overall, the treatment philosophy of the ARC is highlighted in the following three tenets: (a) Centrality of relationships; (b) Symptoms are things not just to get rid of, but rather to make meaning of; and (c) Valuing the agency of each individual in their pursuit of healing (Austen Riggs Center, 2018).

The focus of the current study is on the effects of psychoanalytic psychotherapy on subjects who were admitted to the ARC and consented to the follow along study (FAS). The FAS was conducted over 15 years to track participants’ progress pre-treatment and after substantial treatment had been conducted. Participants in the FAS were offered four sessions of

psychotherapy per week during their time at ARC. Each participating patient was paired with a team consisting of a psychoanalytic psychotherapist, psychiatrist, nurse, case manager, and sometimes others, providing the individual with a holistic approach to healing and wellness. Further, patients were encouraged to attend group therapy along with other optional offerings such as art, yoga, and gardening.

Participants

Archival data was used from the ARC's 15-year FAS. Subjects consisted of those who consented to be a part of the FAS when they were admitted to the ARC. Participant data were collected at six-month intervals via 50-minute clinical interviews until the treatment was concluded and/or the participant was no longer reachable. The participants selected for this study included 10 adults who met the criteria for a diagnosis of PTSD and dissociative disorder or PTSD with dissociative features according to the *Diagnostic and Statistical Manual of Mental Disorders,* (4th ed., text revision) (*DSM-IV-TR;* APA, 2000). Participants were also narrowed down based on the availability of a written transcript of the initial interview conducted around the time participants were first admitted to the ARC and the 12th follow-up interview (i.e., approximately six years after the initial evaluation). Participants were largely Caucasian and of high SES.

Instruments

The Dynamic Interview (Fowler & Perry, 2005; Perry, Fowler, & Seminiuk, 2005) was used as a semi-structured interview to gather clinical information from participants pre-treatment and at follow-up. These interviews lasted approximately 50 minutes each. The abbreviated Metacognition Assessment Scale (MAS-a) was used to examine metacognition (Lysaker, Buck,

et al., 2015; Semerari et al., 2003). The MAS-a consists of four domains – Self-Reflectivity (S), Awareness of Other's Mind (O), Decentration (D), and Mastery (M) – as well as a Total Metacognitive score (T), the sum of the four domains. Past research found that the MAS-a exhibits good inter-rater reliability (Lysaker, Buck, et al., 2015). Likewise, the present analysis found that the inter-rater reliability of each domain was sufficient (see Table 1). Past research has also demonstrated test-retest reliability with correlations ranging from 0.68 (D) and 0.85 (T), with strong internal consistency across metacognitive domains (Lysaker, Buck & Ringer, 2007). Additionally, significant intra-class correlations were discovered for all four MAS-a subscales (D, $r = 0.61$, $p < 0.05$; T, $r = 0.93$, $p < 0.001$) (Lysaker, Buck, Taylor, & Roe, 2008).

Table 1

Reliability Statistics

Subscale	*Pearson correlation*
Self-reflectivity	.495
Awareness of Other's Mind	.585
Decentration	.758
Mastery	.725

Note. *N* = 2 items for all cells.

Procedure

This study investigated Hypotheses 1 and 2 using a mixture of quantitative and qualitative methods.

Quantitative. De-identified participant transcripts (initial interview and 12th follow-up clinical interviews) were scored by two clinicians for metacognition using the MAS-a (Lysaker, Buck, et al., 2015; Semerari et al., 2003). In accordance with past research, metacognition scores were assessed as four sub-domains and an overall sum. The metacognitive coding was scored by two coders (the first two authors), and the coders were blind to whether they were coding the pre-treatment or follow-up interview.

Qualitative. The initial and follow-up transcripts were coded and compared for themes of dissociation. This was done blind interview time points through qualitative analysis based on Grounded Theory (Charmaz, 2014), employing highlighters to track and note taking to distill themes−in this study, of dissociation−and their change over time. Qualitative themes were investigated by one investigator, the first author, at initial and follow-up points in psychoanalytic treatment, which helped illustrate the relationship between trauma, dissociation, and other nuanced themes including emotion regulation, relational dynamics, and creativity and play.

Chapter 3

Results

Analytic Procedure

The proceeding results contain two sections. First, a quantitative analysis was conducted in which total metacognitive scores were calculated for both initial and follow-up clinical interviews (Hypothesis 1). Due to the small sample size, a Hedges' g was computed to examine the effect size of initial and follow-up MAS-a scores. Second, a qualitative analysis investigated pre-post themes of dissociation in the initial and follow-up clinical interviews, looking at the change in themes of dissociation and other themes that may emerge across time and intervention (Hypothesis 2).

Quantitative Results

MAS-a scores consist of four domains: Self-Reflectivity (S), Awareness of Other's Mind (O), Decentration (D), Mastery (M), and Total Metacognitive score (T), which is the sum of the aforementioned four domains. The changes in the MAS-a scores from initial to follow-up-clinical interviews are as below:

Self-reflectivity (S). S is the capacity to think about one's own thinking**.** There was a significant difference between Self-Reflectivity and Post Self-Reflectivity, $M_{\text{diff}} = 1.55$, $SD_{\text{diff}} = .68$, 95% CI_{diff}: [1.06, 2.04], $t(9) = 7.15$, $p < .001$, Hedges G = 1.64, such that Self-Reflectivity was greater at 12th follow-up. On average the scores increased from a mean of 4.50 (Patients can name and distinguish between different cognitive operations and also between significantly different valenced emotions) to 6.05 (Patients can recognize that their ideas a subjective and

fallible and that what they think and want may not match what is possible in reality). See Table 2 for descriptive statistics.

Table 2

Descriptive Statistics

Subscale	*Timepoint*	*Mean*	*SD*	*Std. Error*
Self-reflectivity	Pre	4.50	0.60	0.19
	Post	6.05	0.81	0.26
Awareness of Other's Mind	Pre	3.88	0.44	0.14
	Post	5.10	0.27	0.08
Decentration	Pre	1.03	0.36	0.11
	Post	1.68	0.47	0.15
Mastery	Pre	3.90	0.74	0.23
	Post	6.05	1.07	0.34
Total	Pre	13.23	1.43	0.45
	Post	18.73	2.36	0.75

Note. $N = 10$ for all cells.

Awareness of other's mind (O). O is the capacity to think about another individual's thinking. For Awareness of Other's Mind (O), the analysis yielded a similar result, such that there was a significant difference between Pre O and Post O, $M_{\text{diff}} = 1.23$, $SD_{\text{diff}} = .61$, 95% CI_{diff}: [.79, 1.66], $t(9) = 6.39$, $p < .001$, Hedges G = 1.86. Specifically, Awareness of Other's Mind was greater at 12th follow-up. In this domain, the scores increased from a mean of 3.88 (At level 4, the individual can recognize and distinguish between another person's different cognitive operations and also between different emotions experienced by another) to 5.10 (At level 5, the

individual can make plausible inferences about the mental state of another person, recognizing the meaning of verbal and non-verbal communications). See Table 2 for descriptive statistics.

Decentration (D). D is moving through the world as existing with other individuals having independent thoughts. Likewise, for Decentration, the analysis yielded a similar result such that there was a significant difference between Pre D and Post D, $M_{\text{diff}} = .65$, $SD_{\text{diff}} = .65$, 95% CI_{diff}: [.19, 1.11], $t(9) = 3.17$, $p < .011$, Hedges G = 0.91, with greater Decentration scores at 12th follow-up. The Decentration scores increased from a mean of 1.03 (A score of 1 suggests the ability to recognize the one is not necessarily the center of another person's mental activities; that some of the actions of others stem from reasons or goals not related to oneself) to 1.68 (A score of 2 suggests that one can recognize that others can perceive or interpret events in a validly different way than oneself). See Table 2 for descriptive statistics.

Mastery (M). M is the individual's ability to use metacognition to mitigate psychological problems and life distress. There was a significant difference between Pre M and Post M, $M_{\text{diff}} = 2.15$, $SD_{\text{diff}} = 1.40$, 95% CI_{diff}: [1.15, 3.15], $t(9) = 4.86$, $p < .001$, Hedges G = 2.05, with greater Mastery scores at 12th follow-up. Mastery scores increased from a mean of 3.90 (Level 4 suggests that the person is able to respond to psychological challenges through gross avoidance or passive activities that grossly reduce distress) to 6.05 (Level 6 marks the ability to respond to psychological challenges by changing how one thinks about the problem or oneself). See Table 2 for descriptive statistics.

Total metacognition (T). T is the sum of all four sub-scales of metacognition. There was a significant difference between Pre T and Post T, $M_{\text{diff}} = 5.50$, $SD_{\text{diff}} = 2.76$, 95% CI_{diff}: [3.52,

7.48], $t(9) = 6.29$, $p < .001$, Hedges G = 3.63, such that Total metacognitive scores were greater at 12th follow-up. See Table 2 for descriptive statistics.

Qualitative Results

Five prominent themes emerged from the pre-post clinical interviews.

Theme 1: Changes in remembering. Broadly, dissociative theme content in the initial interview included language that illustrated a blockage in retrieval of episodic memory. Comparatively, language in the follow-up interview had more coherence in narrative, awareness, understanding, and overall acceptance of the participant's past and present circumstances. See Table 3 for qualitative examples that were prevalent throughout the FAS transcripts.

Table 3

Example Initial and Follow-up-Interview Excerpts Showing Theme 1: Changes in Remembering

Initial	Follow-up
"I don't know…"	"I remember…"
"I forget…"	"…so my typical day is…[able to recount details]"
"I can't remember…"	"I do believe…"
"…don't have any memory of that."	"…trying to get oriented to…"
"I've been keeping it all off…"	"I'm not surprised that…"
"I'd be alone in my room crying and don't know why."	"I'm getting to be aware of when I get in a rut…and then can sort of identify the cause…"

Theme 2: Changes from self-harm to self-acceptance. In the initial-interview, themes of early childhood trauma and persistent depressive states were connected to suicide attempts or

non-suicidal, self-injurious behavior. In this context, suicide appears to be a final act of dissociation and a permanent end to the painful reverberations of past trauma. The theme of attempted suicide was noted by this author as a recurrent move toward finding relief in the majority of the pre-interviews. In follow-up interviews, there was an acceptance of life and an understanding of the pain that accompanies it. In the post-clinical interviews, the participants appear to have used the therapeutic intervention as a space to think, feel, and accept oneself, which provided relief in lieu of the relief sought from harming oneself. As a result, there was a marked decrease in reports of suicidality and increased verbiage that conveyed self-acceptance in the post-interviews. See Table 4 for qualitative examples that were prevalent throughout the FAS transcripts.

Theme 3: Changes in being cut-off to accessible. In the pre-interviews, participants showed either emotional disconnection or emotional flooding, the latter which led to a disconnected capacity to feel or think. Participants in the post-interview seemed generally more observant and could better recognize feelings states. Likewise, participants communicated greater access to their cognitions and demonstrated a meta-awareness and connectedness to their experience. The transformation of language depicts an increase in self-efficacy and agency that comes from a more integrated sense of self. See Table 5 for qualitative examples that were prevalent throughout the FAS transcripts.

Theme 4: Changes from survival to generosity. In the pre-interviews, participants mainly focused on surviving, either focusing on themselves or citing an obligatory sense of survival for the sake of others who were dependent on them. Conversely, in post-interviews,

Table 4

Example Initial and Follow-up-Interview Showing Theme 2: Changes from Self-harm to Self-acceptance

Initial	*Follow-up*
"I tried to kill myself twice."	"I am accepting the fact that…"
"I overdosed before…"	"I'm not looking for perfection…just want to be able to cope with life…"
"I just decided to drink and cut myself…I felt very isolated."	"I've stopped expecting there to be answers to all my questions…"
"…really wanted to die…"	"I know the medications help"
"…no one cared…"	"I was away from my father…he was an abuser."
"…felt excluded by groups…"	"…I think we are doing the best we can."
"I've been having many suicide attempts like hanging…"	"I haven't cut for 2 to 3 years."
	"…[therapist] is not my mother or my father I did not have, [therapist] is just a safe place and it's incredible."

participants expressed wanting to give to others or make others' lives better (e.g., through raising children, entering a helping profession, directly giving back to a community, caring for animals, etc.). Essentially, the participants wanted to give the very thing they did not receive, sublimating their lack into generative action. See Table 6 for qualitative examples that were prevalent throughout the FAS transcripts.

Table 5

Example Initial and Follow-up-Interview Showing Theme 3: Changes in Being Cut-off to Accessible

Initial	*Follow-up*
"I wasn't really feeling anything…very separated from myself."	"I'm getting to be more aware of…"
	"I'm getting to be aware of when I get in a rut…and think what is doing this…and I can sort out and identify the cause"
"…doesn't seem real, doesn't seem like my body anymore"	"I am beginning to identify the cause of…" "…and this is what I do, and I know I'm doing it."
"I had no idea why…" "…so confusing"	"Then I can think well…"
	"I'm just not ready to do that"
"…impulses come over…"	"I didn't allow myself to do that"
"I think I get love and pain mixed up…"	"I think, what I've noticed in past relationships is…"
	"I was feeling neglected…"
"I just get overcome…"	"…it was really quite sad for me..."
"all of a sudden something happens to me"	
"not consciously"	
"totally out of control"	
"I can't feel my feelings very long" "there's no pain involved in it"	

Table 6

Example Initial and Follow-up-Interview Excerpts Showing Theme 4: Changes from Survival to Generosity

Initial	*Follow-up*
"I just couldn't see the bottom of the future…there was nothing I could see that was worthwhile."	"I realized I was an okay mom without having to be a super mom" "I will be working with congregates…covering trauma resolution"
"Felt like I wasn't really contributing in anyway"	"…I do want to get back to my kids and be present in their life…"
"I did not want to hurt my friends…and that not being a factor there was no reason to live…"	
"I was completely self-sufficient by 10 years old…"	

Theme 5: Changes from isolation to social connectedness. Lastly, participants in the pre-interview evinced more shortsightedness, isolation, alienation, not belonging, and not fitting in. In the post-interviews, the participants used language that was more relational, indicative of a more complex understanding of the dynamic between self and other. This was demonstrated by, for example, (a) an increased sense of play, which at times was evident even in the interaction with the interviewer, (b) becoming unstuck in their creative pursuits, (c) the presence of or attempts to create healthy boundaries, and (d) planning for the future. See Table 7 for qualitative examples that were prevalent throughout the FAS transcripts.

Table 7

Example Initial and Follow-up-Interview Excerpts Showing Theme 5: Changes from Isolation to Social Connectedness

Initial	*Follow-up*
“I feel so alone”	“I just want to feel connected”
“I was really lonely…”	“I am excited…I really like school and learning new and different things”
“[There was] no one else…”	“I’m really interested in my music and my creative pursuits”
“felt very disconnected from my environment and the people around me”	“…I’ve found the love of my life…” “…ah, this is why I liked paint…nobody ever died…from making the wrong brush stroke.”
“felt excluded by groups…”	“Funny, I’ve met a guy…”
“afraid people didn’t care”	“I’ve been making some contacts in the community as well…”

Discussion

Chapter 4

Dissociation is an involuntary psychological defense against past traumatic experiences, providing protection from the psychological ramifications of trauma. However, in the case of PTSD with dissociative features, dissociation loses the productive functionality it once had during the initial traumatic event. Instead, it begins to hijack the individual's emotional and cognitive capacities, imprisoning them in an involuntary, unhealthy, and unconscious loop. Metacognition, on the other hand, buffers against trauma through opposite means: it requires one to consciously connect and reflect on self and other as related to the traumatic event (Wallin, 2007). This distance from the concrete immediacy of the traumatic encounter, to the safety of being able to use one's cognitive capacities to self-regulate, is usefully marked in Lysakers's scale. Through that vantage point, we can mark the increased development of the subjects in our study to not only think with increased cogency about what is happening internally and interpersonally, but also to make use of that knowledge in adaptive ways.

Although both metacognition and dissociation can both buffer individuals from trauma, past research has very rarely ever investigated the possible therapeutic benefits of metacognition, for example, through psychoanalytic therapy. This study has thus sought to investigate the impact of psychoanalytic therapy on individuals with extensive trauma and prominent dissociative features. The present research accomplished this task by examining qualitative and

quantitative changes in metacognition and themes of dissociation between pre- and post-psychoanalytic therapy. Further discussion of the quantitative and qualitative results follow.

Quantitative Results

Changes in self-reflectivity. The Self-Reflectivity scale ranges from 0 (representing a lack of awareness that the patient has mental experiences), to 9 (where patients are able to recognize psychological patterns across their life synthesizing multiple narrative episodes into a coherent and complex narrative which integrates different modes of cognitive and/or emotional functioning; MAS-a Coding Manual; Lysaker, Buck, et al., 2015; Semerari et al., 2003). In the present study, patients' Self-Reflectivity increased from 4.5 to 6.05. At approximately anchor-point 4, patients can name and distinguish between significantly different valenced emotions. At approximately anchor-point 5, patients can recognize that the ideas they have about themselves and the world are subjective, have changed, or are changeable and/or are fallible. By the end of the treatment, participants were on average closer to anchor-point 6, indicating that they could recognize that what they expect, think, and want may not match what is possible in reality. This metacognitive change in Self Reflectivity demonstrates a participant with a more nuanced metacognitive state, who is aware of and interacting with the realities of one's internal and external environment (MAS-a Coding Manual; Lysaker, Buck, et al., 2015; Semerari et al., 2003).

Changes in awareness of the other's mind. The Awareness of the Other's Mind scale ranges from 0 (representing patients who cannot recognize that the other experiences mental functions), to 7 (where patients can form an integrated idea of another person's mental states across multiple narrative episodes into a coherent narration; MAS-a Coding Manual; Lysaker,

Buck, et al., 2015; Semerari et al., 2003). In the present study, patients' Awareness of Other's Mind moved from an average score of 3.88 to 5.10. At approximately anchor-point 3, patients can distinguish between another person's different cognitive operations (e.g., remembering, imagining, wishing, deciding, and anticipating), but not with nuanced understanding. At approximately anchor-point 4, patients are able to distinguish many different emotional states experienced by another person. By the end of the treatment, participants were on average closer to anchor-point 5, indicating that they could make plausible inferences about the mental state of another person, recognizing the meaning of verbal and non-verbal communications. This metacognitive change in Awareness of Other's Mind demonstrates a movement from being able to notice the various thinking states of others to a more relational process of being able to infer and read between the lines (MAS-a Coding Manual; Lysaker, Buck, et al., 2015; Semerari et al., 2003).

Changes in decentration. The Decentration scale identifies the following four anchor-points ranging from 0 (where patients cannot recognize they are not the center of other people's mental activities) to 3 (where patients can recognize that the event that occur in regular life are often the result of complex emotional, cognitive, social, and environmental factors which vary according to the individual people involved; perceiving the larger world as involving unique individuals who have unique relationships with one another). In the present study, participants' significant shift in Decentration scores from 1.03 to 1.68, which demonstrates a movement towards a more connected understanding of the existence of others' independent perceptions and the validity of such separate mental operations, instead of only being able to recognize that they

are not at the core of others' mental activities (MAS-a Coding Manual; Lysaker, Buck, et al., 2015; Semerari et al., 2003).

Changes in mastery. The Mastery scale ranges 0 (where patients cannot formulate any plausible or implausible psychological challenges) to 9 (where patients are able to respond to psychological challenges by utilizing unique metacognitive knowledge about themselves, specific others, others in the general, and the human condition; MAS-a Coding Manual; Lysaker, Buck, et al., 2015; Semerari et al., 2003). In the present study, patients' Mastery increased from 3.90 to 6.05. At approximately anchor-point 3, patients are able to respond to challenges with gross avoidance or specific avoidance that reduce stress. At anchor-point 4, patients are able to respond to psychological challenges by generally actively avoiding very specific things or by seeking support from others. By the end of the treatment, participants were on average closer to anchor-point 6, indicating that they could respond to psychological challenges by changing how they think about the problem or themselves (MAS-a Coding Manual; Lysaker, Buck, et al., 2015; Semerari et al., 2003). The improvement in Mastery shows how participants who previously employed more primitive strategies in responding to psychological hardship shifting towards using more highly nuanced metacognitive strategies, such as thinking about their thinking and adapting their thinking of self, others, and the situation in the face of psychological challenges.

Quantitatively, all subscales for metacognition (Self-Reflectivity, Awareness of Other's Mind, Decentration, and Mastery) showed significant and large improvements after psychoanalytic therapy. In particular, Mastery, the ability to utilize metacognitive strategies, showed the largest change among subscales.

Qualitative Results

Follow-up-interview excerpts revealed greater (a) remembering, (b) self-acceptance, (c) emotional accessibility, (d) generosity, and (e) social connectedness, which dovetail with the improvements in metacognition demonstrated in the quantitative results. In summary, this study's results supported the hypotheses that psychoanalytic therapy increased participants' metacognitive abilities, allowed participants to develop a more coherent narrative of the self, and reduced participants' dissociative tendencies.

Psychoanalytic therapy attends to unconscious processes (e.g., dissociative phenomenology), what is unspoken, un-symbolized, and unformulated, exploring the meaning of underlying symptoms. Therefore, psychoanalytic therapy may be particularly effective for patients presenting with trauma and dissociative features that by their nature are difficult to consciously discuss.

Implications

This study suggests that psychoanalytic therapy for individuals with PTSD with dissociative features may have long-term, positive impacts including decreased suicidality, becoming more future oriented, increased ability to connect with self and other, and having more agency over the vicissitudes of life. The present research has at least three germane implications.

First, psychoanalytic therapy is a viable option for treating patients with PTSD with dissociative features because it can increase metacognitive abilities. Specifically, both qualitative and quantitative results support the conclusion that psychoanalysis can help patients make the unconscious conscious, while also providing thematic milestones for clinicians to track their patients' progress. This study's findings reinforce the conclusions of past meta-analyses, which

found that patients who underwent psychodynamic therapy had the same degree of improvement as those who underwent other evidence-based therapies, but with the added benefit of maintained therapeutic gains and seemed to progress post-treatment (Shedler, 2010). We understand these findings to affirm that what occurs in psychoanalytic treatment can be viewed as a fundamental learning process that generalizes beyond the specifics of the time or environment.

Second, metacognitive improvements may be relatively long-term and sustained, even for those deemed treatment-resistant. Indeed, by this study's 12th follow up (approximately six years beyond the beginning of ARC treatment), all metacognition sub-scales had significantly improved. In the same timeframe, there was also a qualitative decrease in themes of dissociation and self-harm (e.g., reduction of suicidality), and an increase in themes of connection, coherence, and self-compassion, which correspond with general themes of psychological health and wellbeing. Thus, this study showed lasting improvement in both the four metacognitive domains and the qualitative themes.

Lastly, even the "treatment resistant" participants of this study who engaged in intensive psychoanalytic therapy increased in metacognitive ability, which in turn decreased dissociative experiences. If psychoanalytic therapy improved "treatment resistant" individuals to such a degree, one can imagine the therapeutic impact if psychoanalytic treatment were presented to all as a viable treatment option (whether treatment resistant or not), alongside other evidence-based modalities. Thus, it is imperative that psychoanalytic treatment be explored further as an option for individuals suffering from PTSD with dissociative features—regardless of severity.

In sum, this study has shown that among treatment resistant patients with PTSD and dissociative features, psychoanalytic therapy greatly improved treatment outcomes. Thus,

mainstream mental health care should strongly consider the benefits of using psychoanalytic therapy with patients suffering from PTSD with dissociative features. Not only will we benefit from decreased economic costs associated with post-hoc responses to mental illness and psychiatric emergencies, but more importantly, the most traumatized and disconnected individuals on the outskirts of society may have the opportunity to reconnect, reengage, and re-contribute to society as more integrated and authentic version of themselves. These findings demonstrate the capacity for healing and resilience in a society where trauma is rampant.

Limitations

One limitation of this study is the generalizability of its findings due to the small sample size and unique treatment setting of the ARC. Additionally, for the qualitative study, there was only a single rater, and despite the rater being blind to whether they were coding pre- or post-clinical interviews, the rater was aware of the study's hypotheses at the time of coding, which had the potential to influence what was highlighted.

Second, at the ARC, psychoanalytic therapy is one of many interventions at their residential program, which also include group psychotherapy, psychological assessments, artistic outlets, yoga, and other therapeutic avenues that guide healing and recovery. Nonetheless, the success of these findings is meaningful because none of these other avenues on their own are likely to have produced the considerable gains in metacognition and reduction in themes of dissociation observed in this study. The intensive psychoanalytic therapy that patients received as a relatively unique feature of treatment at the ARC remains the most likely factor contributing to the observed benefits for individuals suffering from psychological trauma.

A final limitation is the specific sample used in the present study, which represents a niche demographic. Namely, in the study, all the participants were adults, and the majority identified as female. The study may also have represented those of relatively higher socioeconomic status, since participants in the present research had the resources to be admitted to undergo psychiatric treatment at the ARC in the first place. Thus, it would be helpful in the future to bolster the present findings with similar research that spans gender, age, and socioeconomic boundaries.

Future Directions

Treatment that improves metacognition often requires patients to acknowledge particularly painful past experiences. It is therefore important for practitioners to approach treatment of individuals with trauma and dissociative features with nuance, giving individualized attention to conscious and unconscious processes, and availing themselves of specialized training and support (Bromberg, 2011; Chefetz, 2015).

A closer investigation of the relationship between metacognition and suicidality may be particularly helpful for the field of psychology in addressing the current suicide epidemic. Further, replicating the study with more participants and in a variety of treatment settings (e.g., outpatient community mental health, private practice, university counseling centers, Veteran Affairs) would increase the strength and prevalence of the findings.

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Appendix A

Curriculum Vitae

RICHARD E. NALBANDIAN

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EDUCATION

PsyD Clinical Psychology (Present)
George Fox University, Newberg, OR
APA accredited
Anticipated Graduation May (2020)

MA Clinical Psychology (2017)
George Fox University, Newberg, OR

BA Bachelor of Art in Psychology (2011)
California Lutheran University, Thousand Oaks, CA

CLINICAL TRAINING

Internship—Doctoral Psychology Intern Present
The *Danielsen Institute at Boston University, Boston, MA*

- Population: Medicaid, low socioeconomic status, undergrad and graduate students, sexual minorities, clergy, and undocumented immigrants
- Provide individual and couples psychotherapy for patients presenting with trauma, anxiety, depression, religious/spiritual concerns, and suicidality from a relational psychoanalytic perspective
- Psychological evaluations: clergy and neuropsychological evaluations.
- Supervisors: David Rupert, PsyD; George Stavros, PhD, Theresa Gilmore, PhD, & Miriam Waldheter, PhD

Pre-Internship—Doctoral Student Therapist 2018
Portland Mental Health and Wellness, Portland, OR

- Population: Medicaid, low socioeconomic status, LGBQ, Transgender, Gender non-conforming, undocumented immigrants
- Provide long-term and brief psychodynamic individual psychotherapy for patients presenting with trauma, anxiety, depression, and suicidality from a relational psychoanalytic perspective
- Supervisors: Del Rapier, PsyD; Brad Larsen-Sanchez, PsyD

Practicum II—Doctoral Student Therapist 2017

Willamette Family Medical Center, Salem, OR

- Population: Ethnically/racially diverse rural community, undocumented immigrants, low socioeconomic status
- Provide behavioral health consultation, family therapy, and individual long-term psychodynamic psychotherapy for patients presenting with trauma, anxiety, depression, psychosis, and suicidality
- Conducted comprehensive neuropsychological, projective, and personality assessments
- Supervisor: Ross Bartlett, PsyD; Karim Afzal, PhD

Supplemental Practicum—Doctoral Student Therapist 2017

- Provide long-term psychodynamic psychotherapy with adult clients; supplemental Rorschach consultation
- Case conceptualization, treatment planning, diagnosis, and session notes from a psychodynamic orientation
- Supervisor: Nancy Thurston, PsyD, ABPP/CL, Certified Psychoanalyst; Ryan Kuehlthau, PsyD

Practicum I—Doctoral Student Therapist 2017

George Fox University Health and Counseling Center, Newberg, OR

- Population: Ethnically/racially diverse undergraduate students, non-traditional students, first-generation college students
- Provide individual therapy for students struggling with trauma, anxiety, depression, and suicidality from Time-Limited Dynamic therapy and psychodynamic perspectives
- Supervisors: William Buhrow, PsyD & Luann Foster, PsyD

Pre-practicum Therapist 2016

George Fox University Grad. Dept. of Clinical Psychology, Newberg, OR

- Population: Undergraduate students
- Provided individual therapy for two students from a client-centered orientation
- All sessions video recorded and reviewed by supervisors
- Supervisors: Glena Andrews, PhD, Julia Terman, MA

Facilitator of Depression Management 2015

Providence, Newberg Medical Group

- Outpatient Medical
- Provided psychoeducation to patients regarding depression and its known causes, as well as strategies to allay the effects of depression
- Facilitated a therapeutic process group consisting of the members of the depression management program
- Supervisors: Tammy Rogers, MD, Glena Andrews, PhD

RESEARCH EXPERIENCE

Doctoral Dissertation
Prelim Anticipated May (2018). Dissocation and metacognition: A mixed methods analysis of patients with PTSD with dissociative features
Dissertation chair: Nancy Thurston, PsyD, ABPP/CL, Licensed Psychologist and Certified Psychoanalyst

Research Vertical Team Member
Collaborate and design various research projects with team members
Formal presentation of research project and results, anticipated April (2017)
Supervisor: Nancy Thurston, PsyD, ABPP/CL, Licensed Psychologist and Certified Psychoanalyst

PUBLICATIONS & PRESENTATIONS

Neal, D., Bufford, R., Striklen, J., Nalbandian, R., Thurston, N., Charles, M. (2017). *Metacognitive outcomes of psychodynamic therapy for severe and persistent mental illness*. Poster accepted for presentation at the American Psychological Association, Division 39 Annual Convention, New York City, NY, April 2017

Thurston, N. S., Adams Shirley, M., Summerer, A. L., Johnson, B., Nalbandian, R., & Neff, M. A. (2018, April). *Predoctoral psychoanalytic training: Process as pedagogy.* Symposia presentation at the Annual meeting for Christian Association for Psychological Studies, Norfolk, VA.

LEADERSHIP EXPERIENCES & PROFESSIONAL/ ACADEMIC AFFILIATIONS

Student Member, American Psychological Association
Student Affiliate, Oregon Psychoanalytic Institute Reading Group
Student Member, George Fox University Psychoanalytic Reading Group
Student Member, Psi Chi
Student Member, The International Society For Psychological and Social Approaches To Psychosis
Student Member, American Psychological Association, Division 39

OTHER WORK EXPERIENCE

Behavior Therapist 2012
Center for Autism and Related Disorders, Woodland Hills, CA
- Supervisor: Diana Agresto, MA

Assistant Coordinator to Academic Director 2011

School for International Training, Bali, Indonesia
- Academic Director: Wayan Ariati, PhD

Gerontology Internship, Guided Autobiography 2010
California Lutheran University, Thousand Oaks, CA
- Supervisors: James Birren, PhD, Marylie Gerson, PhD

SELECTED PROFESSIONAL TRAINING

Clinical Team 2015 – Present
Consultation group that meets weekly to present and discuss cases from various clinical perspectives
Consultants: Brooke Kuhnhausen, PhD, Kristie Knows His Gun, PsyD, Carlos Taloyo, PhD, Nancy Thurston, PsyD, ABPP/CL, Licensed Psychologist and Certified Psychoanalyst

Interpersonal Psychotherapy, Carlos Taloyo, PhD 2018

Psychoanalysis in El Barrio with Discussion Panel 2018
Adrian Larsen-Sanchez, PsyD, Adam Rodriguez, PsyD, & Carlos Taloyo, PhD

The Enigma of Desire, Galit Atlas, PhD 2018

Dramatic Dialogues with Harold Searles, Aron Lewis, PhD 2018

TeleHealth, Jeff Sordahl, PsyD 2017

International Society for Psychological and Social Approaches To Psychosis
Gogo Ekhaya Esima, Narsimha R. Pinninti, MD 2017

Love Is Giving What You Don't Have, Bruce Fink, PhD 2017
Community-Based Participatory Research, Gil-Kashiwabara, PsyD 2017

Exploring the Clinical Moment: Listening Psychoanalytically 2017
Presenter: Kate Blumner & Discussant: MD, Cynthia Ellis Gray, MD

Domestic Violence: A Coordinated Community Response 2017
Patricia Warford, PsyD & Sgt. Todd Baltzell

Native Self-Actualization: Its assessment and application in theory 2017
Sydney Brown, PsyD

Brookhaven Institute: Object Relations Module 2017
The therapeutic use of optimal stress: Precipitating disruption to trigger recovery
Martha Stark, MD

Race, Class, Culture in Psychotherapy, Neil Altman, PhD 2016

Exploring the Clinical Moment: Listening Psychoanalytically 2016
Debra Carriere, PhD, Ralph Beaumont, MD

The Therapist's Use of Subjectivity – In Memory of Harold Searles 2016
Lewis Aron, PhD, ABPP, FABP

Summer Intensive Rorschach Training Workshop 2016
Nancy Thurston, PsyD, ABPP/CL, Licensed Psychologist and Certified Analyst

Relational Psychoanalysis and Christian Faith: A Heuristic Dialogue 2015
Marie Hoffman, PhD

COMMUNITY SERVICE

Juliette's House (serve day)

ADDITIONAL

Conversationally fluent in Bahasa Indonesia
Lifelong surfer, amateur geologist, and culinary enthusiast

REFERENCES

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Brooke Kuhnhausen, PhD, Licensed Psychologist
Adjunct Professor of Clinical Psychology, George Fox University Graduate Department of Clinical Psychology
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