Systematic Treatment Selection (STS):

Chronic Social Anxiety and Positive Treatment Outcomes in Relation to Internalizing Coping Styles

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Abstract

The Systematic Treatment Selection (STS) assessment system guides clinicians to examine individual dispositional factors (characteristics) and matching interventions that enhance outcome of psychotherapy. This study examined the central characteristics of chronic social anxiety individuals and their role in a positive treatment outcome following STS. Participants (N=121) were consecutively admitted individuals with chronic social anxiety who sought treatment at the shyness clinic, Palo Alto, California. The participants took the Minnesota Multiphasic Personality Inventory (MMPI) 2, the Personality Feelings Questionnaire (PFQ), and the Beck Depression Inventory (BDI) II after completing their intake sessions. The scores of BDI II were used as outcome measures. Results demonstrated all of the STS predictor variables were significantly and positively ($p<.001$) correlated with one another, a finding that contrasts with the past STS studies. The results also provided the effectiveness of using an approach, called "Social Fitness Training", which combined cognitive and insight oriented interventions. The effectiveness of the approach, as hypothesized, was moderated by patients' coping styles. The strength of the patients' internalizing coping styles and feelings of shame/guilt require further study in Asian Cultures since Asians tend to score high on these dimensions.

Key words: systematic treatment selection (STS), internalizing coping styles, chronic social anxiety, Social Fitness Training, Beck Depression Inventory (BDI)

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People have diverse ways of coping with stressful situations. If they are successful, individuals usually are able to reduce their levels of distress. However, some coping styles are ineffective and are associated with psychopathology. In fact, some efforts to cope, such as hypervigilance and rumination, may increase the amount of distress experienced in treatment (Castonguay & Beutler, 2006). Thus, individual coping styles may serve as indicators for choosing and applying certain interventions and then adapting particular therapeutic stances that effectively promote change. The benefits of fitting individual coping styles to the use of specific classes of interventions in psychotherapy have been established in the psychotherapy literature (Beutler & Clarkin, 1990; Beutler, Clarkin & Bongar, 2000; Beutler et al., 2012; Beutler & Harwood, 2002; Castonguay & Beutler, 2006). However, research has not yet defined the limits to which these dimensions of fit can be applied productively (Beutler et al., 2003). Chronic social anxiety and its corollary, avoidant personality disorder, comprise a wide-ranging set of problems that have been underrepresented in the treatment literature. Judging from the work of Castroguay and Beutler, this population (i.e., individuals with internalizing coping styles) may have unique coping styles that are adaptive to relational psychotherapy and studies of this adaptability may have significant implications for the future direction of psychotherapy research. Specifically, they may be characterized by

self-regulative coping styles that lead them to benefit specifically from insight-oriented therapy.

Beutler and Clarkin (1990) have identified two generalizable and stable coping styles, which they call, "externalizing" and "internalizing," which have proven to be differentially associated with the efficacy of symptom-focused and insight focused treatments, respectively. While most individuals use both styles of coping, in various degrees from time to time, those who rely dominantly on and most frequently on "externalization" manifest a common coping style associated with acting out. They can be described as impulsive, hedonistic, action or task-oriented, gregarious, aggressive, stimulation-seeking and lacking insight. In comparison, those who tend to rely more strongly and persistently on "internalization" manifest a pattern of anxiety and avoidance. They can be described as shy, retiring, self-critical, withdrawn, contained, overly controlled, self-reflective, worrisome, and inhibited. A dominance of the externalization has been found to characterize those who benefit from cognitive and behavioral therapies, while a dominance of the internalization has been found to characterize those who benefit from insight treatments (see Barber & Muenz, 1996; Beutler et al, 2012; Beutler et al., 2002; Beutler et al., 2011).

Based on Henderson and Zimbardo's findings (1997), as well as those of other researchers (Arkin et al., 1980; Clark & Arkowitz, 1975; Girodo et al., 1981; Minsky, 1985; Teglasi & Hoffman, 1982), many researchers believe that people with chronic social anxiety tend to give credit to others for success in social situations and assign failure to themselves. This attribution style leads to feelings of shame, a painful affective state, which interferes with both cognition and behavior and which may simultaneously

lead to avoidant behaviors and blaming others (Henderson, 2002; Henderson & Zimbardo, 1998). This coping response reflects an "internalizing" coping style, and may dispose these individuals to a particular form of treatment which combines symptom relief and insight.

Systematic Treatment Selection (STS)

Since 1990, Beutler and colleagues have developed an empirically based model of treatment planning called Systematic Treatment Selection (STS) which integrates 18 research-based principles (Beutler & Clarkin, 1990; Beutler et al., 2000; Beutler & Harwood, 2002). This model not only serves as a system of integrated psychotherapy but a method of planning and delivering optimal treatments consistent with the established scientific evidence and cross-theoretical approaches. Especially, based on the six STS treatment planning dimensions (i.e. patients' dispositional factors) such as chronicity, functional impairment, social support, subjective distress, coping styles and resistance, STS guides clinicians to provide assigning the context of treatment (e.g. inpatient vs. outpatient; individual vs. group/family/couples; duration/intensity of treatment; utilization of social resources) as well as its matching treatment (e.g. elevation or reduction of emotional arousal; behavior vs. insight; levels of directiveness). Therefore, using STS, clinicians can use a set of differential strategies and principles to tailor change to each patient in order to enhance the effectiveness of treatment. The current version of STS called *Innerlife* is a cloud-based assessment, planning and delivery system. The *Innerlife* (Beutler et al., 2008) added two additional patients' factors such as the preference for therapy and readiness of change and its matching specific self-help resources and therapeutic strategies respectively. The *Innerlife* can be assessed by

patients. It provides a report directly to the patient to identify potentially problematic areas and to offer recommendations for how to identify an appropriate therapist and treatment, suggest self-help materials and web-based resources.

STS Optimal Principles for the Treatment of Internalizing Coping Styles. The STS model includes two main principles that address the treatment of chronic internalizing individuals: 1) therapeutic change is most likely if the initial focus of change efforts is to alter disruptive symptoms, and 2) therapeutic change is likely to be greatest when the sub sequential focus of change among internalizing individuals employs insight and self-discovery procedures (Beutler & Harwood, 2002).

In 1984, Henderson began to develop an integrative treatment program for chronic social anxiety called "Social Fitness Training" (Henderson, 1994). Henderson's training program is a 26-week long program that combined initial in vivo exposure with interpersonal and psychodynamic therapy interventions (Henderson, 1994; Henderson & Zimbardo, 1998, 2001). Though this training was not developed with "coping style" differences in mind, it unintentionally employed interpersonal and insight-oriented interventions. These interventions are very much in line with the procedures identified by Beutler et al. (2000) as "optimal" for use in the treatment of those with internalizing coping styles. The incidental fit of this treatment to that population of individuals who have a compatible coping style offered a unique opportunity to test the predictions of Beutler, Clarkin, and Bongar (2000). That is the degree to which patient's coping styles reflected internalizing patterns would be predictive of treatment effect in a real-world clinical setting.

Purpose

The objectives of this study were 1) to examine the nature of chronic social anxiety as a style of internalization defined by STS predictor variables, such as externalizing and internalizing coping styles, subjective distress, and resistance and its relation to feelings of shame and guilt including the other characteristics; and 2) to examine positive outcomes of Social Fitness Training (combinations of CBT and interpersonal approaches) to improve outcome of psychotherapy.

STS and the Current Study. This study is designed to extend the findings obtained in previous research (Fisher et al., 2003, Corbella et al., 2002) to the application of an integrative therapy that, descriptively, is aimed at individuals who manifest a predominance of internalizing coping patterns and styles. In the current study, the population of focus was a group of avoidant individuals with chronic anxiety who manifest different levels of internalization and externalization. According to the STS model, individuals whose social anxiety is associated with a coping style of internalization may benefit from a combination that includes cognitive behavioral (CBT) interventions initially and interpersonal/thematic interventions subsequently. The combination of CBT and interpersonal interventions represents a good fit with social anxiety (internalizing) individuals who need both symptom reduction procedures and a means of working through interpersonal fears (Beuter & Harwood, 2002). Such an integrative intervention was expected to work less well among those patients whose dominant coping patterns included various levels of externalization.

Thus, consistent with the aforementioned STS principles, social fitness treatment works to 1) reduce symptoms first, and then, 2) to utilize interpersonal and insight interventions that coincidentally match the dominant internalizing coping style thought to characterize many if not most social anxiety individuals. The effectiveness of Social Fitness Training should be a direct linear function of the patient's level of internalization and the relative absence of externalizing coping styles.

Hypotheses

(1) People who experience chronic social anxiety are expected to dominantly (but not universally) display both a general style of internalization (defined by internal sensitivity, introversion, emotional restriction, and dysphoria) as well as the feelings of shame and guilt often associated with internalization.

(2) The effectiveness of the Social Fitness Training is predicted by the degree of the patient's internalization.

Method

Participants

Participants consisted of 121 U.S. residents with problem social anxiety who sought treatment at the Social Anxiety Clinic in Palo Alto, California. The sample included 72 males (59.5%) and 49 females (40.5%) with a mean age of 34.5± 9.7 years (ranging from 18 to 65 years). Additional demographic data for this sample are presented in Table 1.

Procedure

Screening. Participants were screened for eligibility to participate in the premorbid presentation of social phobia and other associated DSM diagnoses assessed by the Anxiety Disorders Interview Schedule-IV [ADIS-IV; DiNardo, Brown, and Barlow, 1994]. Participants were also required to be fluent English speakers and over 18 years of age.

Predictor Variables. The Minnesota Multivariable Personality Inventory-2 [MMPI-2: Butcher, 1990] was used to assess the level of coping styles, specifically the internalizing or externalizing coping style. For the purpose of this study, the Internalization Index formula that had been developed by Beutler and colleagues (e.g. Beutler et al., 1991; Beutler & Mitchell, 1981) was based on a ratio of eight scales from the MMPI-2. Calculations were of T scores from which the mean sum of the first set of four scales (Hs, D, P, Si) were used to assess internalizing coping styles (T=50; SD=10) and the mean of the sum of the second set of four scales (Hy, Pd, Pa, Ma) were used to assess externalizing coping styles (T=50; SD=10) (Beutler, et al., 2003). Also, levels of subjective distress and resistance were based on the T-scores of two content scales: Walsh A (Anxiety) and Treatment Resistant Trait (TRT) (Beutler, et al., 2002; Beutler & Harwood, 2002).

For additional sources of shame-guilt emotions, the Personality Feelings Questionnaire (PFQ) (Harder, & Lewis, S. J, 1986) was used. The PFQ includes 10 items each with 5 point likely scales to assess proneness to shame and guilt. The range of each score was 0 (never) to 4 (continuously or almost continuously). Higher scores demonstrated a greater degree of shame and guilt. This study used the means of subscales

of shame and guilt. Harder and Zalma (1990) assessed a coefficient alpha of .78 and test-retest for two weeks interval of .91.

Outcome Variable. In STS, depression has been referred to as the common cold of mental health. It reflects people have difficulty coping with current problems or unexpected situations. In this study, as the outcome variable, positive outcome change scores were calculated by a reference to Eugene Walker (1991). The subtraction from the scores of Pre BDI_II to the scores of multiplication between correlation of Pre and Post BDI-II scores and Post BDI-II scores were calculated as positive outcome change scores while controlling the impact of Pre BDI-II scores. Thus, the Beck Depression Inventory-Second Edition (BDI-II) (Beck, Steer, & Brown, 1996) was used as an outcome measure. Thus, the BDI will be one of the proper measurements to monitor the outcome. The BDI-II includes 21 multiple choice questions that assess the presence and severity of depressive symptoms in adolescents and adults. Each multiple-choice item has four potential answers with corresponding scores from 0-3, with the score increasing with the severity of the symptom. The maximum score is a total of 63. Scores from 0-13 are considered to be within the normal range. Scores from 14-19, 20-28, or more than 29 are considered indicative of mild, moderate, and severe depressive symptoms, respectively. Beck et al. (1996) reported a high internal consistency of .92 among outpatient and .93 college student samples on the level of severity of the items, and a high stability (test-retest) coefficient of .93 over a one-week period.

Social Fitness Training for Social Anxiety

Henderson developed Social Fitness Training, adding psychodynamic techniques to Zimbardo's learning model, embedding the interventions in the intimacy- building

skills component of treatment (Henderson, 1994; Henderson & Zimbardo, 2001). The training program is a 26-week-long program and follows an integrative psychotherapy model. During[2] the first 13 weeks of Social Fitness Training, clients engage in simulated and vivo exposures. First, clients construct a hierarchy often feared situations (e.g. saying hello to strangers; speaking out in front of colleagues, and negotiating with a boss or manager) and set specific behavioral and cognitive goals for treatment. Second, clients are taught cognitive restructuring techniques. Clients are then encouraged to expose themselves to anxiety-provoking situations via role-playing desired behavior in simulated exposures and practicing their newly learned coping skills in vivo between sessions. During the second 13 weeks, the psychotherapist helps the client practice building and deepening intimacy in their relationships using self-disclosure, building trust, expressing emotions, and resolving conflicts to enhance interpersonal relations and adaptive self-schema. It should be noted that throughout the program, clients experience a good deal of pain associated with embarrassment and shame (Henderson, 2002). Therefore, it is essential that the psychotherapist provides a safe environment that facilitates the expression of emotion and helps the client identify the underlying meanings of feelings and behaviors as they engage in interpersonal interactions (Henderson & Zimbardo, 2001).

Data Analysis

[2]Unfortunately, the naturalistic nature of this study did not provide for a test of change after the first phase. Such a measure would have allowed us to more clearly tease out the separate effects of the CBT and interpersonal/intrapsychic components of treatment. As a phase #1 study, we were restricted to testing the anticipated relationship between the exposure to the psychodynamic component and treatment outcomes among those with two distinctive coping styles.

Intercorrelations analyses were conducted to describe the samples. Relationships between the STS predictor variables (i.e., the levels of internalizing and externalizing coping styles, subjective distress, and resistance) and other predictor variables (i.e., the level of distress mood, and proneness toward shame and guilt) and the demographic variables (i.e., age, gender, years of education, marital status, occupation, and ethnicity) were assessed.

To address the first hypothesis, the STS Coping Style Index was used to identify the relative dominance of internalizing and externalizing coping styles for each. Descriptive analyses were utilized to identify central characteristics (STS factors: internalizing coping style, externalizing coping style, subjective distress, and resistance; additional three factors: depressive symptom, shame, and guilt) of individuals with chronic social anxiety.

To address the second hypothesis, a regression analysis was used. Since all variables were positively correlated at significant levels. Factor analysis was then conducted to identify factorial differences within the STS predictor variables and feelings of shame and guilt. A Hierarchical Linear Modeling (HLM) was carried out in order to view the predictors on multiple levels and examine the outcome of psychotherapy.

Results

Intercorrelation of the STS Predictor Variables

Results are shown in Table 2. Intercorrelations among the various STS predictor variables were computed in a manner like that reported by Fisher et al. (1999) and by

Corbella et al. (2003). For those who are dominantly internalizers, the result apparently showed a unique contribution of the interrelatedness of these variables.

All of the STS predictor variables were significantly and positively ($p<.001$) correlated with one another. The relationship between levels of internalizing coping style and subjective distress was especially strong and was the highest among the correlations for all STS predictor variables. The relationship between the levels of subjective distress and resistance was equivalently strong while the relationship between the levels of externalizing coping style and resistance was much more modest. Additionally, intercorrelations among all the STS predictor variables and the demographic variables were examined. We found the STS predictive variables were not related significantly to these demographic variables.

Hypotheses Testing

Hypothesis (1). Results are shown in Table 3. Individuals with chronic social anxiety are expected to display both a general style of internalization (as defined by internal sensitivity, introversion, emotional restriction, and dysphoria) as well as feelings of shame and guilt. The mean of the sum of the four "Internalizing" scales (Hs, D, P, Si) and of the four "Externalizing" scales (Hy, Pd, Pa, Ma) were calculated and compared to the expected normative mean of 50 (Beutler, et. al., 2003). The standardized mean of the internalizing scales was subtracted from the standardized mean of the externalizing scales to indicate a general preference for internalizing as a coping mechanism, compared to externalizing. Positive scores are identified as internalizing coping styles and negative scores are identified as externalizing coping styles (Beutler et al., 2003). Additionally,

descriptive analyses were conducted to assess central characteristics of individuals with chronic social anxiety.

The results revealed that there was a strong tendency for individuals with chronic social anxiety to be characterized by a dominance of internalizing qualities and coping patterns. One hundred seven of clients had the internalizing coping style, and 14 of clients were characterized by an externalizing coping style. The scores of internalizing and externalizing coping styles between these two groups were significantly different. Results are shown in Table 3. Overall, the first hypothesis was supported, indicating that a majority of the participants produced an internalizing coping style as shown in Table 4. The result of central characteristics of the 121 participants revealed that scores of internalizing coping styles, subjective distress, resistance, guilt and shame were more than 1 SD above means and scores of externalizing coping styles were higher than mean. The mean score of BDI II was within normal range (less than 13), so we used post-treatment scores of BDI II as outcome of general wellbeing while controlling effect of pre-treatment scores of BDI II.

Hypothesis (2). First, when the predictor variables were correlated with the outcome measure, all seven predictor variables produced positive correlations. Therefore, a principal component factor analysis on all criterion variables was conducted to reduce redundancy and to reduce the predictors to essential groups. The seven criterion variables, such as internalizing and externalizing coping styles, subjective distress, resistance, depressive symptom, the feeling of guilt and shame, were examined by the extraction method of component analysis. Follow-up analysis applied Varimax rotation with Kaiser normalization.

As seen in Table 5, the first component factor was comprised of five variables, including subjective distress, resistance, internalizing and externalizing coping styles, and depressive symptoms. The second component factor was comprised of three variables, depressive symptom, shame and guilt. As a result of these findings, two composite factors were extracted for the remaining analyses. The first factor was called, "internalization" and the second factor was called "shame/guilt."

The result of the principle component analysis revealed that these two factors, respectively, explained 55.58% and 14.52%, of the total variance. The sum of these two factors, therefore, explained 70.10% of the total variance in outcomes. Therefore, most of the subsequent analyses that assessed the hypothesis were restricted to these two predictors, comprised of a weighted sum of factor loadings.

Hierarchical Linear Modeling (HLM) analysis was conducted in order to see the results in multi-dimensions as shown in Table 6. Results of HLM showed that in the pre-treatment level (intercept), the "internalization" factor, but not the "shame/guilt" factor, made a unique contribution to reduced depressive symptoms. At the personal level (individual difference-slop), the shame/guilt factor than the internalization factor, made a unique contribution to reduced depressive symptoms. The result showed these individuals with both a proneness to shame and guilt experienced reduced depressive symptoms.

Discussion

Among these US and European samples (mainly co-occurring disorders of substance abuse and depression), the result of intercorrelations among the STS four predictor variables such as the strength of internalizing coping style, the strength of

externalizing coping style, subjective distress and resistance were identified independently. However, in this sample (mainly individuals with internalizing coping styles), results of intercorrelations among the STS for predictors variables were identified interdependently. It apparently demonstrates interventions for self-regulative coping approaches especially, insight-oriented interventions.

Thus, this study confirmed the role of one's relative coping styles in predicting the value of insight- based interventions after conducting interventions of symptom reductions for patients with chronic social anxiety. The relative dominance of internalizing coping patterns was strongly predictive of the efficacy of treatment that combined both symptom and thematic interventions. This finding was in keeping with the principles from which were derived the STS (Beutler & Harwood, 2002). During the first 13 weeks of Social Fitness Training, individuals with chronic social anxiety learn about adaptive cognition and behaviors using simulated and in vivo exposures in a CBT framework in order to reduce subjective symptoms. Since approximately 90% of these individuals have an internalizing coping style, the last 13 weeks of Social Fitness Training may further promote change by focusing on interpersonal interventions. However, therapists should consider the following during their treatment: (1) since these individuals with a high internalizing coping style have significant amounts of resistance, they may show noncompliance with using directive approaches like CBT and may benefit more from the use of self-directive approaches; and (2) since 10% of these individuals have an externalizing coping style, they may not benefit as much from interpersonal interventions. However, clinical observation suggests that the benefit from interpersonal interventions accrues in the form of the feedback that group members and therapists give

these clients in relation to the impact of their behavior on others (Henderson, 1994). Frequently clients have not received direct feedback before entering groups. These findings suggest that therapists must be flexible in working with the individual differences in chronic social anxiety.

The second hypothesis was supported. An internalizing coping style predicted the positive outcome data of Social Fitness Training. There is a limitation to understanding the systematic approach of treatment because a post-treatment of BDI-II score after the first 13 weeks did not exist. Moreover, these results require future investigation because of the small sample sizes and need to consider other demographic variables. However, the level of internalization and the level of guilt and shame seemed to be differentially associated with improvement in Social Fitness Training, and the degree of benefit experienced was expected to be directly associated with the intensity of internalization and shame and guilt initially present.

There is a need for future research to explain functional outcome data besides the data on depressive symptoms. There is also need to investigate effective approaches in the treatment of painful feelings of shame and guilt. Outcome studies during the first 13 weeks of CBT treatment and after the final 13 weeks of interpersonal therapy are needed to assess treatment effectiveness systematically. Lastly, the predictor variables may apply to demographic variables not included in this study. Another problem with this study, as well as many other culturally related studies, is the inequality of ethnicity ratios amongst participant groups.

Implications for Future Social Anxiety Research in Asian cultures

When working with social anxiety individuals, researchers will find that the relative intensity of levels of internalization over externalization, and the strength of patient shame will be independent and useful indicators for prediction the effectiveness of a combined intervention like social skills training. Moreover, authors are interested in Asian Coping, which may have the degrees of these STS treatment planning dimensions are associated internally. It is because Asians tend to blame themselves for social failure, and Asian culture emphasizes expressing the feeling of anger is not appropriate as social behaviors, called "silence is golden." These cultural disciplines may reduce blame others and increase internal coping and feeling of shame to enhance psychological growths, based on the results of this study. It may be quite different from results of shame research in the Western cultures.

However, if Asians hold traumatic events or painfully emotional experiences such as earthquakes, Tsunami, car accidents, and victims of bullying, these coping styles increase hypervigilance, depressive or anxious moods, suicidal ideations since Asians tend to suppress these emotional experiences. Some Asians may not tolerate these painful emotions and cope with substance use, physical (domestic) violence, or social withdrawals. Thus, STS may be useful guidelines for clinicians to treat patients with internalizing coping styles like Asians as well as for Asian researchers to understand effective interventions since there is a lack of research studies for people with internalizing coping styles.

Conclusion

This study investigated the characteristics of individuals with chronic social anxiety in relation to central characteristics, such as coping styles, subjective distress,

resistance, depressive symptoms, shame and guilt levels. Results showed that individuals with chronic social anxiety may benefit from interpersonal psychotherapy rather than from behavioral psychotherapy after reducing their subjective distress levels through the use of CBT in simulated and vivo exposures. The results showed that individuals with a high internalizing coping style and high proneness to shame and guilt differentially reduced depressive symptoms. These differential impacts of internalizing coping styles and feelings of shame/guilt require further studies to understand effective interventions for people with internalizing coping styles.

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Table 1

Demographic Profile of Patients with Cronically Social Anxiety

Characteristics	N=121	%
Sex		
Female	49	40.5
Male	72	59.5
Age		
18-29	40	33.1
30-44	64	52.9
45-64	17	14.0
Mean Age	34.5± 9.7	
Marriage Status		
Never married	88	72.7
Married	18	14.9
Separated	3	2.5
Divorced	10	8.3
Widowed	2	1.7
Education		
Less than high school	4	3.3
High school, some college	34	28.1
College	39	31.4
Advanced degree (partial And completed)	44	36.4
Mean Education	15.9±2.8	
Occupation		
Employed	87	71.9
Unemployed	13	10.7
Student	17	14.0
Homemaker	4	3.3
Ethnicity		
Caucasian	101	83.5
African American	2	1.7
Hispanic	6	5.0
Asian	10	8.3
Other	2	1.7

Table 2

Intercorrelations between STS predictor variables (Internalizing and externalizing coping style, subjective distress, and resistance)

Variable	1	2	3	4	5	6	7
1 Internalizing Coping	-				-	-	-
2 Externalizing Coping	.60**	-			-	-	-
3 Subjective Distress	.78**	.60**	-		-	-	-
4 Resistance	.61**	.46**	.72**	-	-	-	-
5 Depressive Symptoms	.59**	.52**	.55**	.53**	-	-	-
6 Shame	.40**	.25**	.39**	.34**	.43**	-	-
7 Guilt	.34**	.27**	.40**	.25**	.40**	.47**	-
$^{**}p < .001$							

Table 3

Internalizing coping style and externalizing coping style among 121 subjects

Coping Style	N=121	% Tile	Internalizing T-scores		Externalizing T-scores	
			Mean	SD	Mean	SD
Internalizing	107	88.4%	67.6	9.5	55.6	8.1
Externalizing	14	11.6%	57.2	7.2	61.4	7.9

Table4

Central characteristics among 121 subjects

Variable (Score range)	Mean	SD	SE	95% Confidence Interval
Internalizing Coping (47.8-91.0)	66.4	9.8	0.9	64.6-68.1
Externalizing Coping (40.0-81.5)	56.3	8.3	0.8	54.8-57.7
Subjective Distress (40.0-89.0)	64.1	11.3	1.0	62.1-66.2
Resistance (35.0-89.0)	61.3	11.8	1.1	59.1-63.4
Depressive Symptoms (0-40.0)	12.6	8.3	0.8	11.1-14.1
Shame (0.6-3.8)	2.0	0.7	0.1	1.9-2.2
Guilt (0-3.7)	1.8	0.8	0.1	1.7-2.0

Table 5

Principal component analysis with varimax rotation with Kaiser normalization

depressive symptom

Variable	First Factor	Second Factor	h^2 (communalily)
Subjective Distress	.87	.59	.84
Resistance	.82	.16	.69
Internalizing Coping	.84	.26	.78
Externalizing Coping	.77	.10	.60
Shame	.22	.82	.72
Guilt	.16	.85	.75
eigenvalue	2.79	1.58	
% of variable	46.45	26.36	
cumulative %	46.45	72.81	

Table 6

Result of Hierarchical Linear Modeling analyses in 1) Pretest Level – Positive Outcome Predictors at the Pretest Level and 2) Personal Level- Reduction of Depressive Symptoms through Treatment across the Times

Fixed Effects	Coefficient (SE)	t (df)	p
Model for Intercept (Pre-test Time Point)			
Intercept	12.48 (.63)	19.70 (116)	.000
Internalization	.41 (.05)	7.86 (116)	.000**
Shame	-.01 (.03)	-.349(116)	.727
Model for Slops (Individual Difference)			
Intercept	-5.79 (.86)	-6.74(173)	.000
Internalization	-.13 (.07)	-1.83(173)	.069
Shame	-.09 (.03)	-2.59(173)	.011*